Preventing and Treating Opiates Addiction and HIV/AIDS Epidemics in Afghanistan and Neighbouring Countries

November 2008 – Work in Progress
This document is part of the UNODC’s Rainbow Strategy which aims to reduce the supply, trafficking and consumption of opiates in Afghanistan and neighbouring countries. Each of its seven operational plans addresses jointly agreed targets in the region; supplements existing interventions from national governments and other Paris Pact partners; and allows for constructive engagement with prime regional actors.

This document has not been formally edited. The boundaries, names and designations used in the maps do not imply official endorsement or acceptance by the United Nations.

This report is a work-in-progress produced in November 2008 and has been jointly drafted by the Health and Human Development Section and the Europe, West and Central Asia Unit.

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Acronyms

AIDS    Acquired Immune Deficiency Syndrome
ARQ    Annual Reports Questionnaire
ART    Anti Retroviral Therapy
ATS    Amphetamine type substances
CND    Commission on Narcotics Drugs
GAP    Global Assessment Programme on Drug Abuse
GFATM    Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV    Hepatitis B Virus
HCV    Hepatitis C Virus
HIV    Human Immunodeficiency Virus
IDU    Injecting drug user
NGO    Non Governmental Organization
OST    Opioid Substitution Therapy
STD    Sexually transmitted disease
TB    Tuberculosis
UN    United Nations
UNAIDS    Joint United Nations Programme on HIV/AIDS
UNICEF    United Nations Children’s Fund
UNODC    United Nations Office on Drugs and Crime
WHO    World Health Organization
# Preventing and Treating Opiates Addiction and HIV/AIDS Epidemics in Afghanistan and neighbouring countries

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Introduction and background

The South West and Central Asian region comprising Afghanistan, the Islamic Republic of Iran and Pakistan in the South West and Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan in Central Asia, have one of the highest prevalence of opioid use – heroin, opium and other opiates, in the world. While most countries in this region have had a long history of traditional opium use among certain sections in the society, the emergence of heroin in the local markets in the past decades has resulted in a surge of heroin and other opiates use with social and health consequences for the drug users as well as the society at large.

Given that opium production in Afghanistan in 2007 reached a high level of 8,200 metric tonnes, it is anticipated that this would in turn result in high volumes of opiates being trafficked within the region. As a consequence, it is speculated that in the South West and Central Asian region there would be an increased availability of heroin with varying purity levels and prices. These market dynamics, depending on the situation, can then result in a myriad of patterns of heroin use - smoking or snorting heroin, or even higher injecting rates, multiple or poly drug use, more and younger people initiating heroin use, high levels of risky behaviours and vulnerability to HIV, increased criminality and increased overdose cases and deaths. Given that there is currently less emphasis on the prevention of drug use and treatment of drug dependence in most parts of the region, the situation may result in catastrophes for these societies. Also, in the absence of well established drug abuse monitoring systems that may also serve as early warning to policy makers, the resulting responses may be ad hoc and not well grounded on evidence.

Figure 1: Abuse of opiate (including heroin) 2006 - 2007 (or latest years available) UNODC WDR 2008
The indigo paper is an action plan to address opiate abuse and HIV infections among drug users in Afghanistan and the surrounding countries in the South West and Central Asia.

**Common regional and national challenges**

Nearly thirty years of war and fighting in Afghanistan have resulted in the country becoming one of the least developed and impoverished, with disintegration of the country’s public sector institutions including health care and social services. Building these state institutions is a current priority for the Government of Afghanistan but is hampered by a lack of trained professionals in most sectors but essentially in the public health sector, e.g., there are only 19 physicians per 100,000 of population in the country.

The social disruption in Afghanistan has also devastated the traditional coping mechanisms and has left the population extremely vulnerable to a range of mental health problems, particularly chronic depression, anxiety, insomnia, post-traumatic stress disorder and drug dependence. Underlying many of these mental health problems is the central problem of loss of family members, home, job, well-being, personal security, and even country in the case of refugees.

The Central Asian countries, of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, after their independence in the early nineties had to undergo major economic, social
and political transitions. With the social infrastructure – education and health care systems - still undergoing reforms, the countries in addition to meeting the continuing education and health care needs of the population have to address emerging issues such as drug abuse and HIV and AIDS. With the dynamics of change, social deprivation and economic disparities and inequalities between genders, young and elderly and rural and urban areas have become evident. Many of the countries in the region are also faced with poverty, unemployment or underemployment especially of young people resulting in both internal and external migration of people. Despite all the challenges, the governments in Central Asia continue to invest resources in the health care and education. The public expenditure on health care as percentage of the GDP ranges between 3.3 percent in Kazakhstan to 1 percent in Tajikistan, while in the education sector it ranges between 4.4 percent of the GDP in Kyrgyzstan to 3.5 percent in Tajikistan.

<table>
<thead>
<tr>
<th></th>
<th>Pak</th>
<th>Iran</th>
<th>Alg</th>
<th>Kyrgyz</th>
<th>Kaz</th>
<th>Taj</th>
<th>Turk</th>
<th>Uzb</th>
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<td>HDI Rank</td>
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<td>94</td>
<td>NA</td>
<td>116</td>
<td>73</td>
<td>122</td>
<td>109</td>
<td>113</td>
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<td>HDI value</td>
<td>0.53</td>
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<td>0.69</td>
<td>0.79</td>
<td>0.67</td>
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<td>GDP per capita (PPP US$)</td>
<td>2225</td>
<td>7968</td>
<td>1927</td>
<td>7857</td>
<td>1356</td>
<td>3838</td>
<td>2063</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>62.9</td>
<td>70.2</td>
<td>42.9</td>
<td>65.6</td>
<td>65.9</td>
<td>66.3</td>
<td>62.6</td>
<td>66.8</td>
</tr>
<tr>
<td>Adult literacy rate (% of 15 and older)</td>
<td>49.9</td>
<td>82.4</td>
<td>28</td>
<td>98.7</td>
<td>99.5</td>
<td>99.5</td>
<td>98.8</td>
<td>NA</td>
</tr>
<tr>
<td>Combined gross enrolment for primary, secondary, and tertiary schools (%)</td>
<td>38.4</td>
<td>72.8</td>
<td>42.8</td>
<td>77.7</td>
<td>93.8</td>
<td>70.8</td>
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<td>73.8</td>
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<tr>
<td>Public expenditure on education (as % of GDP)</td>
<td>2</td>
<td>4.7</td>
<td>NA</td>
<td>4.4</td>
<td>3.9</td>
<td>3.5</td>
<td>3.9</td>
<td>NA</td>
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<tr>
<td>Public health expenditure (as % of GDP)</td>
<td>0.7</td>
<td>3.2</td>
<td>0.7</td>
<td>2.3</td>
<td>2.3</td>
<td>1</td>
<td>3.3</td>
<td>2.4</td>
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<td>Private health expenditure (as % of GDP)</td>
<td>1.7</td>
<td>3.4</td>
<td>3.7</td>
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<td>2.7</td>
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<td>Health expenditure per capita (PPP US$)</td>
<td>48</td>
<td>604</td>
<td>19</td>
<td>102</td>
<td>264</td>
<td>54</td>
<td>245</td>
<td>160</td>
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<tr>
<td>Physicians per 100,000 population</td>
<td>74</td>
<td>87</td>
<td>19</td>
<td>251</td>
<td>354</td>
<td>203</td>
<td>418</td>
<td>274</td>
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<tr>
<td>Total population</td>
<td>158081</td>
<td>69421</td>
<td>25067</td>
<td>5204</td>
<td>15211</td>
<td>6550</td>
<td>4833</td>
<td>26593</td>
</tr>
<tr>
<td>Population 0 - 4 (%)</td>
<td>11.9</td>
<td>8.8</td>
<td>18.6</td>
<td>9.6</td>
<td>7.9</td>
<td>13.1</td>
<td>10.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Population 5 – 14 (%)</td>
<td>25.2</td>
<td>20</td>
<td>28.4</td>
<td>21.4</td>
<td>16.4</td>
<td>26.2</td>
<td>21.7</td>
<td>22.5</td>
</tr>
<tr>
<td>Population 15 – 24 (%)</td>
<td>22.1</td>
<td>25.2</td>
<td>19.6</td>
<td>21.1</td>
<td>19.5</td>
<td>22.3</td>
<td>21.5</td>
<td>21.7</td>
</tr>
</tbody>
</table>

Table 1: Selected Human Development Indicators (2008, UNDP HDR)

The UNDP Human Development Report (2008) ranks Islamic Republic of Iran as 94th among the medium developing countries. The Islamic Republic of Iran has a population of around 70 million out of which 35 percent are under the age of 24. It is estimated that between 38 and 40 million people in Islamic Republic of Iran are within 15 to 49 years old. Within the South West and Central Asian region, the Islamic Republic of Iran has one of the highest GDP (per capita PPP) of USD 7,968. The life expectancy at birth of 70 years is also one of the highest in the region. The adult literacy rate for the Islamic Republic of Iran is around 82 percent, with 72
percent combined gross enrolment in the education system. The public expenditure on health, as percentage of the GDP, is reported as 3.2 percent while the public expenditure on education is 4.7 percent of the GDP. In spite of these human development indicators Islamic Republic of Iran has one of the highest rates of heroin and opium use in the region.

Pakistan’s human development ranking is 134th out of a total of 177 countries. The life expectancy at birth is estimated at 63 years, while the adult literacy rate (as percentage of those aged 15 and older) is 49.9. Pakistan’s estimated population is around 160 million, out of which almost half of the population are 24 years or younger. Although government expenditure on education and health has increased in recent years, the public health expenditure (as percentage of GDP) stands 0.7 percent, with per capita health expenditures as 48 (PPP US$). Similarly, the public expenditure on education as percentage of GDP was reported as 2 percent. This remains lowest than in comparable countries in the South West and Central Asian region. Therefore, poor health, illiteracy, and gender and social discrimination are widespread. These conditions are conducive to a societal lack of respect for the rule of law, disregard of human rights, increase in criminality and gross ignorance - including low public awareness of the consequences of drug abuse and of the means of transmission of HIV/AIDS, Hepatitis C, etc.

Overall, the countries in South West and Central Asia are characterized by a young and dynamic population – almost half of the population in these countries are below the age of 25; there are common issues of gender inequality and low participation of women in national development; there are large rural populations who suffer from inequitable distribution of resources with widening urban and rural disparities that result in internal and external migration of the population; a health care and social protection system which generally is not fully equipped to address the emerging social and health care needs of the population. All of these pose an increasing challenge for each country to effectively address drug abuse and its social and health consequences within the myriad of competing social, economic and development challenges faced in the countries.

Furthermore, the regional countries will continue to be at cross roads of major trafficking routes from Afghanistan to Western Europe and Russia. Therefore with an increase in opium production in Afghanistan over the past years the local heroin supply in these countries including Afghanistan itself will remain unabated if not increased dramatically. Similarly, the street level purity levels and prices will continue to fluctuate in the region and may result in still high levels of opiate consumption and its accompanying social and health consequences of drug abuse including increased criminality, overdose incidents, HIV, HCV and other blood borne infections.

**Opiate use**
The world prevalence of opiate use is estimated around 0.4 percent of the world’s population aged 15 – 64 or an estimated 16.5 million opiate users. The highest levels of use are found along the main drug trafficking routes out of Afghanistan. Therefore, compared to the world average, the South West and Central Asian region has one of the highest prevalence of opiate use.

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2. UNODC World drug report, 2008
3. Ibid Trends in the world drug markets opium/heroin markets
use which ranges from 2.8 percent of the adult population (15 – 64 years) in the Islamic Republic of Iran to 0.6 percent of the population in Tajikistan⁴. In terms of absolute number, there are an estimated 2.5 million regular opiate users in these countries or over 16 percent of the world’s total estimates.

Except for Afghanistan and the Islamic Republic of Iran, heroin remains the primary opiate being used by the majority of users in the region. In Pakistan 77 percent and in the Central Asian countries, more than 90 percent of the opioid users had used heroin in their lifetime. Due to cultural and social taboos female drug users tend to be more hidden than their male counterparts; therefore it is difficult to determine the true nature and extent of opiate use among women in the region. However based on the various assessments and reports of officially registered drug users, especially from Central Asian countries, the proportion of female opiate users varies between 23 percent in Kazakhstan to 2 percent in Pakistan.

⁴ Ibid
Traditional and current opium use

The entire region, South West and Central Asia has a long history of traditional use of opium. In the absence of health care services in many parts of the region, opium was used as a readily available home remedy for ailments such as coughs, diarrhoea, restlessness, acute and chronic pain for all ages including infants and children. Opium still remains a main component of many traditional medicines prepared by traditional healers - Hakims or Tabibs or used for medicinal purposes in rural areas in Pakistan, the Islamic Republic of Iran and Afghanistan where modern health care facilities may still not be easily accessible. Many of those regularly using opium for medicinal purposes also tend to become dependent. For instance, the Afghan communities in the north such as the Turkmen carpet weaving women regularly use opium to cope with their stress and aches caused by arduous carpet weaving. The carpet weavers also give opium to their children to pacify them during their own work. The pregnant carpet weavers with their drug habit give birth to opium dependant babies who would continue to be dependant on opium in later ages.

Opium smoking and ingestion for recreational use has also been a common practice in the region. Opium along with hashish or cannabis was the main drug of abuse in the region, till it was replaced to an extent by Heroin in the late 70s in the Islamic Republic of Iran and Pakistan and in nineties in the Central Asian countries. Up till 1979 regular opium users were registered in the Islamic Republic of Iran and Pakistan and could get their dose of opium from a special government controlled shop (e.g., the opium vend system in Pakistan). The use of Opium due to its long standing history of traditional use and medicinal value has had a quasi social

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Table 2: Summary information - opiate use, injecting drug use prevalence

<table>
<thead>
<tr>
<th></th>
<th>Opiate users</th>
<th>Injecting drug users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Prevalence</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>200,000</td>
<td>1.4</td>
</tr>
<tr>
<td>Iran</td>
<td>1,200,000</td>
<td>2.8</td>
</tr>
<tr>
<td>Pakistan</td>
<td>640,000</td>
<td>0.7</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>103,000</td>
<td>1.03</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>26,000</td>
<td>0.8</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>23,000</td>
<td>0.6</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>32,604</td>
<td>1.06</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>131,000</td>
<td>0.8</td>
</tr>
</tbody>
</table>

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5 For the Central Asian countries and Pakistan based on the National Assessment Studies conducted by UNODC with the local counterparts (2006 and 2007). Afghanistan UNODC Afghanistan Drug use Survey 2005. Iran: Rapid Situation and Response Assessment on the drug use Situation in Iran conducted in 1998, reported by UNODC/COIRA. Turkmenistan information is based on the officially registered opioid users as reported by the Government to UNODC/ROCA and ARQ, 2007. The prevalence is as % of population aged 15 - 64 based on the UN population estimates. All of the above information is also reported in the UNODC World Drug Report 2007 and 2008.
acceptance and tolerance compared to the social stigma associated with heroin or injecting drug use in the entire region.

Opium continues to be a main drug of abuse in the region. In Kazakhstan and Kyrgyzstan up to one third of the opiate users interviewed had used opium in their lifetime. In Tajikistan up to one quarter and in Uzbekistan around 10 percent had used opium at least once in their lifetime\(^6\). Most of these regular opium users had been injecting (66 percent) or used opium through ingestion (23 percent). In Pakistan, around 44 percent of the opioid users interviewed had used opium at least once in their lifetime\(^7\). There were no significant differences between use of opium in the rural or urban areas or within genders. Similarly in the Islamic Republic of Iran, 95 percent of the opioid users interviewed had smoked opium at least once in their lifetime as well as recently\(^8\). In Afghanistan, the number of regular opium users is estimated around 150,000 (compared to 50,000 heroin users)\(^9\), out of these around 10 percent were females, and more than two thirds were in the rural areas.

**Injecting drug use**

In the Central Asian countries injecting remains the predominant method of using heroin, opium and khanka\(^10\), where between 60 percent in Uzbekistan to almost all opiate users in Kazakhstan and Kyrgyzstan inject them. In South West Asia, although lesser proportion of opiate users are injecting, this has been observed as an increasing trend in the three countries - varying between 29 percent in Pakistan, to around 21 percent in the Islamic Republic of Iran and 16 percent in Afghanistan who reported injecting opiates at least once in their lifetime\(^11\). Use of non sterile injecting equipment is a common phenomenon observed among injecting drug users in the entire region, which coupled with unsafe sexual behaviours place opiate users at a greater risk of HIV and other blood borne infections.

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\(^6\) UNODC, National Assessment of Problem Drug Use in Kazakhstan, Kyrgyzstan Tajikistan and Uzbekistan, 2006/07
\(^7\) UNODC, National Assessment of Problem Drug use in Pakistan, 2008
\(^8\) UNODC, Rapid Situation Assessment of Drug Abuse in Iran (1998 – 99)
\(^9\) UNODC, Afghanistan, Drug use survey, 2005
\(^10\) A concoction prepared by boiling poppy straw
\(^11\) The information from Pakistan and Afghanistan are based on the UNODC drug abuse surveys or assessments conducted in 2006 and 2005 respectively, whereas the information from Iran is based on the assessment conducted in 1998.
Figure 4: Prevalence of injecting drug users and HIV prevalence among IDU

Other drugs
Poly drug use is also a common observation among the opioid users in the entire region. In Afghanistan, more than half of the drug users reported use of more than one substance in combination or at different times. The substances listed included hashish, narcotic analgesics, sedatives and tranquilizers, antihistamines and alcohol. In Pakistan, around 40 percent of the opioid users reported regularly using benzodiazepines. Also, use of combinations such as antihistamines, sedative or tranquilizers, is commonly observed in Pakistan. Among the range of narcotic analgesics buprenorphine is one substance found to be commonly used (injected) in the Islamic Republic of Iran, Pakistan and Afghanistan. Key informants interviewed in the Central Asian countries, Pakistan and Afghanistan list Cannabis or hashish as a commonly used substance, along with alcohol, tranquilizers and sedatives.

Drug use among children
Inhalants and cannabis are also two substances reported to be commonly used among street children and adolescents in the region. The results of UNODC surveys conducted among secondary school students in four Central Asian countries indicated that, along with tobacco and alcohol, cannabis and inhalants were the two substance reportedly used by secondary school students. Among the students who participated in the school surveys, a substantial proportion of students considered there were little or no risks involved in smoking cigarettes

\[1{\text{2 School survey on alcohol, tobacco and drug use among secondary school students were conducted as part of the national assessment of problem drug use in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan.}}\]
occasionally, trying cannabis a few times or smoking cannabis regularly. On the other hand less than half of the students considered there were moderate or great risks involved in trying heroin once or twice.

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Tajikistan</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
<td>All</td>
<td>Boys</td>
</tr>
<tr>
<td>Tobacco</td>
<td>58.4</td>
<td>42.5</td>
<td>50.3</td>
<td>43</td>
</tr>
<tr>
<td>Alcohol</td>
<td>72.9</td>
<td>64.5</td>
<td>68.6</td>
<td>43.3</td>
</tr>
<tr>
<td>Any drug use</td>
<td>17.6</td>
<td>7.4</td>
<td>12.4</td>
<td>8.7</td>
</tr>
<tr>
<td>Cannabis</td>
<td>16.8</td>
<td>7</td>
<td>11.8</td>
<td>8</td>
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<tr>
<td>Inhalants</td>
<td>10</td>
<td>7.1</td>
<td>8.5</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Table 3: Self reported use of substances among secondary school students – lifetime (as %)

The Afghanistan drug survey states that around 0.7 percent (60,000) of the total child population of the country (i.e., less than 15 years) were using different substances. Most of these were reported using inhalants, tranquilizers and narcotic analgesics such as diazepam, pentazocine, mandrax, etc. A study among street children in Pakistan indicted that among 400 street children interviewed, around 90 percent had used inhalants – 60 percent among these had been regularly using inhalants for over 2 years.

Prison population
Prisons are one setting where drug users are likely to be found in high proportions and also reportedly indulge in risky injecting and sexual behaviours. According to UNODC national assessment studies between one quarter and one third of drug users in the region have been arrested and/or incarcerated at least once in their lifetime. Prisoner overcrowding, men having sex with men, violence, corruption and poor prison management create an environment that increase vulnerability of inmates to HIV infection and other diseases such as tuberculosis and hepatitis and other sexually transmitted infections. In Central Asian countries from where more information on HIV among prisoners is available it is estimated that the HIV prevalence may range from 1.5 percent in Uzbekistan to 3.5 percent in Kyrgyz Republic. Most of the HIV infection cases are reported among incarcerated opiate users. Coupled with HIV, Tuberculosis is another co-morbidity with high prevalence reported in the prison system.

Refugees
Nearly thirty years of war and fighting in Afghanistan had forced around 8 million Afghans to live as refugees in other countries, mostly in Pakistan and the Islamic Republic of Iran. Living in refugee camps, bearing loss of family members, enduring physical disabilities for some, undergoing post traumatic stress, general psychological, social and economic vulnerability as

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13 UNODC, Solvent abuse among street children in Pakistan, 2004
14 Referenced in the preceding sections
refugees has led many Afghans to initiate drug use. Therefore a higher rate of drug use is found among returning refugees and ex-combatants in Afghanistan\textsuperscript{15} - returning refugees accounted for one third of opium and heroin users in the country, most of these had initiated their drug use in the Islamic Republic of Iran or Pakistan. The survey also indicated that around 13 percent of the regular drug users, who were interviewed, were ex-combatants. Many Afghans have also been internally displaced, initially due to the insecurity and later instability in their areas of residence due to lack of social protection – lack of governance, economic opportunities, health care, social assistance, education and any other infrastructure. The continuing instability and insecurity in Afghanistan therefore renders a substantial proportion of the population, especially young people, vulnerable to economic, social, and psychological problems that coupled with availability of opiates in abundance put an increasing number at risk of drug dependence and its social and health consequences.

**HIV situation**

In the entire region while there is low HIV prevalence among the general population, there is a concentrated HIV epidemic among injecting drug users. In Central Asia for instance, in 2006 close to two third of newly infected HIV cases were attributed to injecting drug use and one third to unprotected heterosexual intercourse\textsuperscript{16}. Similarly, in the Islamic Republic of Iran and Pakistan injecting drug use was attributed to 66 and 27 percent of the total HIV cases respectively in 2007. There is also an indication of an HIV outbreak among injecting drug users in Kabul, Afghanistan where 3 percent of 463 injecting drug users tested positive for HIV in a 2006 study\textsuperscript{17}. The highest HIV prevalence among injecting drug users is in Uzbekistan where it is estimated around 21 percent among injecting drug users, followed by the Islamic Republic of Iran (18 percent) and Tajikistan (15 percent).

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|}
\hline
& \textbf{Adults (15+)} \textsuperscript{18} & \textbf{IDU} \textsuperscript{19} \\
& \textbf{Prev (%)} & \textbf{Est. #} & \textbf{Prev (%)} \\
\hline
Afghanistan & NA & NA & 3.4 \\
Iran & 0.2 & 85,000 & 15 \\
Pakistan & 0.1 & 94,000 & 10.8 \\
Kazakhstan & 0.1 & 12,000 & 9.2 \\
Kyrgyzstan & 0.1 & 4,200 & 8 \\
Tajikistan & 0.3 & 10,000 & 14.7 \\
Turkmenistan & <0.1 & <500 & NA \\
Uzbekistan & 0.1 & 16,000 & 20.75 \\
\hline
\end{tabular}
\caption{HIV prevalence among adult population (+15) and IDU}
\end{table}

\textsuperscript{15} UNODC, Afghanistan drug use survey, 2005
\textsuperscript{16} UNAIDS, AIDS epidemic update 2007
\textsuperscript{18} UNAIDS World Epidemic Update, 2008.
\textsuperscript{19} The information on HIV prevalence among injecting drug users is taken from UNODC assessments, Sentinel Surveillance data and the United Nations IDU reference group on IDU and HIV, University of NSW, Australia.
Regional and national responses
The national governments in the region, with support from UNODC and other international stakeholders have a commitment to address prevention of drug use, treatment of drug dependence, and prevention, treatment and care of people living with HIV including those who are injecting drugs and those in prison settings. These commitments are evidenced from the national strategic programmes for drug control and HIV and AIDS prevention treatment and care, as well as the UNODC national and regional Strategic Programme Frameworks (for a summary of national priorities and programmes see Annex III). Some specific issues with regard to programme implementation and areas for regional initiatives are discussed in the following paragraphs.

Monitoring and evaluation
The information on the extent and pattern of drug abuse and HIV among injecting drug users, has recently improved in the region, mainly through the efforts of UNODC – Global Assessment Programme on Drug Abuse (GAP), and HIV sentinel surveillance work conducted by UNAIDS or the Centre for Disease Control. However, there are still many gaps in the information especially since monitoring the drug abuse situation and responses has still not been instituted in the countries. The Central Asian governments still rely largely on the number

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20 Centre for disease control and prevention (Atlanta, Georgia) programme in Central Asia
of registered drug users by law enforcement bodies or state run drug treatment services. There remain many other challenges - for instance in the Islamic Republic of Iran where the last drug abuse assessment was conducted in 1998 and since then the estimated number of drug users and prevalence being quoted have not been updated. The other challenge until recently has been Turkmenistan from where no robust prevalence estimates are available for opiate use and HIV among different at risk groups.

As for an ongoing monitoring and evaluation system of responses either on prevention of drug use, treatment of drug dependence or HIV prevention and care among at risk population, these are either very rudimentary or just do not exist. In most cases the available information is either aggregated numbers, for instance of registered drug users or HIV cases as in Central Asia, or reporting on activities implemented. A regional initiative could include the development of indicators, reporting templates and mechanisms for implementation that could result in harmonised information on the drug abuse and HIV and AIDS situation among at risk groups as well as for the responses to address these issues.

An important area of common regional initiative is for the countries to set common targets for universal access to HIV prevention and treatment for injecting drug users, and in prison settings, to develop corresponding common coverage and service indicators to measure the access, and share experiences and practices in monitoring and evaluation of these programmes.

Most importantly, there is a continuing need to build capacity of national experts and provide technical assistance in implementing the key epidemiological indicators of drug abuse within an integrated drug abuse monitoring system. At the regional level there is a need to support development of a regional epidemiological network for sharing of expertise and information. The key epidemiological indicators for which there is an international consensus\(^{21}\), and comprise the core items included in the ARQ Part II\(^ {22} \) are following:

- Drug consumption among general population (prevalence and incidence)
- Drug consumption among youth population (prevalence and incidence)
- High risk drug abuse (estimate numbers of injecting drug users and proportions engaging in high risk behaviour, estimates of daily users)
- Service utilization for drug problems (treatment demand indicator – number of individuals seeking help for a drug problem)
- Drug related morbidity (HIV, HCV, HBV – prevalence among illicit drug consumers)
- Drug related mortality (deaths directly attributable to drug consumption)

### Prevention of drug use

Prevention of drug use has been addressed in the region mainly through programmes that aim at building public awareness on the dangers of drugs. Most of the programmes in the region either national or regional have focused broadly on community centred prevention targeting various community groups – parents, youth, civil society organizations and media. This includes the

\(^{21}\) CND 43rd session, March 2000; Drug information systems: Principles, structures and indicators. The CND paper is based on the Lisbon consensus jointly organized by UNODC and EMCDDA at Lisbon January 2000.

\(^{22}\) Annual Reports Questionnaire Part II: Extent, Patterns and Trends of Drug Abuse is filled annually by Member States and submitted to Commission on Narcotics Drugs (CND)
notable example of the Demand Reduction Action Teams (DRATs) in Afghanistan (see Annex I)

With regard to UNODC action in the region, there are three projects in Afghanistan that address capacity building for various community members for prevention of drug use and community based treatment in the selected regions within Afghanistan and in refugee camps in Pakistan. All of these projects are due for completion in 2008. In Iran two projects have been recently initiated that will focus on a) nation wide prevention efforts and b) regional cooperation and advocacy for demand reduction programmes primarily through supporting exchange of information and expertise among NGOs and civil society organizations. In Pakistan while there are project addressing HIV prevention among street children or HIV awareness among prisoners, there have been no current or recently completed prevention projects that were implemented by UNODC. In Central Asia, the regional project addressing prevention of drug use through mass media, NGO and civil society, had one component on life skills education for school children in Uzbekistan added to it. This project is operationally completed in 2008 and national level prevention projects have been prepared for which funding is being sought.

A comprehensive drug prevention strategy in the region would build on these past and ongoing activities as well as on the following regional and national specificities:

a) The strength of the family
Despite the urbanization and social transition to nuclear families in the region the ties with and influence of the family members - spouse, parents, and the extended family (grandparents, uncles, aunts and cousins) is still very strong. These are reflected in the traditions of respect to the elders, and caring for and supporting other members of the extended family in times of need. Therefore family as an institution can be an important consideration for implementation of prevention and treatment interventions.

b) The strength of religion
All the countries in the region predominantly have Muslim population. Islamic teaching categorically prohibit the use of intoxicants and mild altering substances, Therefore the institution of religious leaders can be an important element for prevention of drug use and to an extent in treatment of drug dependence as part of a spiritual therapy.

c) Use of opium as medicine
As noted above, in some parts of the region, most notably in Afghanistan, opium is still used as or included in traditional remedies for a variety of ailments due to the weakness of the primary health care system. In some cases, the use of opium is linked to the difficult working conditions of specific occupational groups (e.g. carpet weavers). It is clear that preventing this kind of use necessitates interventions aimed at removing the root cause of such use (a functioning primary health care system, healthy working conditions), well beyond raising awareness on the dangers of using opium as medicine.

Therefore, as a regional initiative, the following evidence-based approaches need to be integrated into existing and planned prevention programmes:
i) Schools
Integrate in the school curriculum the delivery of evidence based drug education based on life skills. In general, this entails the delivery of a series of highly interactive sessions (a minimum of 8-10 has been found effective) by trained teachers in the context of a policy promoting no use of tobacco, alcohol and other drugs in the school by both students and staff.

ii) Family
Adapt family skills training programmes to the strong family structures in the region and rigorously evaluate their effectiveness in improving the capacity of families to act as powerful protective factors for the healthy development of their children.

iii) Workplace prevention
Develop, implement and rigorously evaluate specific interventions targeting the difficult working conditions of specific occupational groups (e.g. carpet weavers). Such interventions should take clearly into account gender issues and provide an integrated package including: improved working conditions, access to non-opioid pain killers and awareness about the dangers of opium and about the benefits of simple physical exercises, and, counselling, and, referral to appropriate treatment in case of dependence.

iv) Refugees and street children
Develop, implement and rigorously evaluate specific intervention targeting the difficult living conditions of both refugees and street children. In general, such intervention would provide an integrated package including as necessary: immediate shelter, food and basic needs, a sustainable livelihood, awareness about the dangers of drugs and about how to lead a healthy lifestyle, counselling, and, referral to appropriate treatment in case of dependence. In addition to this, therapy for post traumatic stress disorder, vocational skills, and personal and social skills might also need to be included.

v) Religious institutions
Develop, implement and rigorously evaluate programmes involving religious leaders in raising the awareness of the population on the dangers of using drugs and the fact that addiction is a disease that needs and can be treated and should not be stigmatised.

Treatment of drug dependence
Most of the treatment programmes in the regional countries focus on abstinence based interventions with the main component being medical detoxification and in most instances the wide range of treatment options or opportunities are not offered to the drug dependent persons seeking help. In most situations, outreach interventions including motivational interviewing, initial screening or referrals on one end and aftercare and social reintegration are services that seem to be rarely offered to drug dependent persons. In general, there is not provision in the region for offering treatment as an alternative to imprisonment or other penal sanction to drug addicts. This is compounded by a general lack of provision of equivalent health care and drug treatment and rehabilitation to drug addicts in prison settings. Finally, the treatment modalities and approaches offered in the region have not been evaluated to determine their effectiveness and meeting the diverse needs of the clients.
The drug abuse assessment studies conducted by UNODC in Pakistan and Central Asian countries in 2006 show that a large majority of opioid users had an unmet need for treatment, i.e., they were unable to get treatment when they needed them. Most of the drug users did not consider the treatment services affordable or accessible. In fact, most of the key informants interviewed in the studies said that they did not consider the current treatment services to be effective or meeting the diverse need of people in treatment.

The Islamic Republic of Iran is the first country in the region to have introduced opioid substitution therapy (OST) at a wide scale especially through establishment of 500 private and public centres. Kyrgyzstan (2002) and Uzbekistan (2006) are the two countries that have initiated pilot programmes for OST. In Kyrgyzstan OST has been introduced in 8 or 9 additional sites while the expansion of OST is being considered in Uzbekistan. The other countries in the region – Pakistan, Kazakhstan, Turkmenistan and Tajikistan are contemplating introduction of OST, but mainly as an approach for prevention of HIV among injecting drug users and not as an optional / alternative treatment for opioid dependence for the larger population of drug users. Overall, the opiate substitution therapy, coupled with counselling for behavioural change (safe injecting and sexual behaviours), is being provided to a limited number of injecting drug users in the region.

With regard to UNODC programmes, most of the projects addressing drug dependence treatment in the region in parts or as the main objective, with the exception of Pakistan, are due to finish in 2008 (e.g., projects in Afghanistan) or funding is being sought for projects that would specifically address treatment of drug dependence as the main focus (Central Asia, the Islamic Republic of Iran and Afghanistan). UNODC’s “Treatnet Phase 2: Programme to improve the availability and quality of drug dependence treatment and rehabilitation” aims at building a sustainable and expanded network of drug dependence treatment and rehabilitation resource centres, universities, and government institutions responsible for drug dependence treatment. All countries and projects within the region will benefit considerably through integration of the programme’s main approaches, i.e. advocacy of principles of evidence based treatment of drug dependence as a comprehensive package of services for prevention of HIV among injecting drug users, development of national and regional resource centre and their networking, sharing of training resources and expertise.

A comprehensive drug treatment and rehabilitation strategy in the region would build on these past and ongoing activities as well on the following regional and national specificities.

a) Misconceptions about drug addiction and drug treatment and rehabilitation
One main barrier to the introduction of opioid agonist medication in the region is the lack of understanding that drug dependence is a multi-factorial health disorder that follows the course of relapsing and remitting chronic disease, and that a health sciences multidisciplinary approach needs to be applied to research, prevention and treatment23. Moreover, many policy makers and practitioners consider that medically assisted treatment or use of opioid agonists for short or long term treatment is not treatment but is facilitating the person’s drug use and dependence.

23 WHO and UNODC, Principles of drug dependence treatment, 2008
b) Reduced accessibility to treatment for women and children
The cultural and societal norms in the region also heavily stigmatize drug use among women. Therefore, on the one hand drug use among women is more of a hidden phenomenon, and on the other limits the women’s access to health care system for treatment of their drug dependence.
Most of the existing programmes do not take into consideration the special social, psychological and health care needs of women especially those that may be pregnant, have infants and children that need to be taken care of. Current treatment programmes do not provide for special psychological and social needs of children and minors seeking treatment for their drug dependence and put them through the same regimen of treatment as the adults in treatment.

In this context, a regional initiative should build on existing efforts including the following components.

i) Advocacy
The main focus in the region needs to be for systematic advocacy to promote a sound understanding of drug dependence and its treatment as a continuum of care, counteract stigma and discrimination for drug users and facilitate contact with health institutions and entry into treatment. In particular, the introduction of OST, as one component of comprehensive approach for HIV prevention and one of the options within a range of services for treatment of drug dependence, to a wider population of opioid users should be promoted.

ii) Capacity building
The second component needs to be building capacity of professionals and service providers to offer a range of services including outreach interventions, motivational interviewing, initial screening and referral, psychosocial support, family involvement and support to treatment, and social reintegration as a continuum of care to drug dependent persons.

iii) Expansion of treatment systems
Thirdly, the respective governments in the region need to be supported to provide evidence-based, high quality drug dependence treatment mainstreamed in the public health system and in different settings. The provision of such services should be solidly grounded in the basic principles of human rights, the right to health and the dignity of the patient. In general, low cost treatment centres should be developed in association with the primary health care system to increase accessibility of services throughout the country at the community level. Moreover, alternatives to imprisonment for drug users, implementation of penal sanctions within the community, provision of health care and drug treatment and rehabilitation in prison settings should all be developed. Further, differentiated and targeted treatment need to be available for specific sub-groups of drug dependent persons, in particular traditional opium users, children, women and drug dependent persons with possible concomitant psychiatric and physical disorders. Finally, a different concept of reintegration in the community needs to be promoted, eradicating the stigma surrounding former drug user and supporting the idea that former drug users can and do lead healthy and productive lives.

24 UNODC, Reducing the social and health consequences of drug abuse: A comprehensive approach, 2008
HIV prevention, treatment and care among injecting drug users
Most countries in the region have established needle and syringe exchange programmes, as part of outreach interventions, mobile units or as stationary services such as drop in centres in community settings, (the Islamic Republic of Iran and Pakistan) or as Trust Points (Central Asian countries). In Afghanistan and Turkmenistan needle and syringe exchange programmes are yet to be initiated. In Pakistan, since the NGO sector is more developed the bulk of programmes are being implemented by national NGOs supported directly by international organizations with minimal monitoring by the national authorities. In the Islamic Republic of Iran, Kazakhstan, Kyrgyzstan, and Tajikistan, there is a mix of NGOs and state run programmes – in case of NGO they are in turn also supported by the state. In Central Asian countries the main delivery of HIV prevention services are funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) grants. Two issues regarding needle and syringe exchange programmes in the region that need to be further explored and evaluated are a) the range of services and their coverage of injecting drug users in different settings and locations; and b) the accessibility and quality of the services, either outreach interventions or stationary services, that are offered to injecting drug users including issues of “client satisfaction and the user friendliness”.

As a regional initiative, the countries in the region can benefit from each other’s experience in implementing the needle syringe programmes, especially from the Pakistani and Iranian experiences of implementing community based and NGO run services and programmes, and also benefit from their experiences in training of outreach workers. The Iranian National Centre on Addiction (research and training) (INCA), Nai Zindagi programme in Pakistan, and the Central Asian Harm Reduction Training and Resource being established in Kyrgyzstan are three institutions that can serve the training and mentoring needs in the region.

It is imperative to note that a comprehensive approach to reducing the adverse consequences of drug abuse and halting the epidemic of blood borne diseases requires three parts strategy that include: a) preventing drug abuse; b) facilitating entry into drug dependence treatment; and c) establishing effective measures to reduce adverse health and social consequences of drug abuse. Therefore, HIV and AIDS prevention services need to be developed in parallel and together with drug dependence treatment and rehabilitation. Policy and programme considerations need to include steps to reach out and engage drug users in prevention, treatment and care strategies that protect them, their partners and families from infectious disease, health problems in general and encourage entry into substance dependence treatment and medical care and rehabilitation. Also taking into account the individual right to a healthy life and the interest of the entire society, specific interventions have to be promoted to reduce the adverse health and social consequences of drug abuse. These strategies need to target the sub-groups of the population that are not sensitive to prevention programmes, drug dependent individuals who are not motivated to attend treatment facilities, non-responders to treatment who continue to abuse illicit drugs, and those patients who easily relapse into substance abuse.

25 UNODC, Reducing the social and health consequences of drug abuse: A comprehensive approach, 2008
26 ibid
HIV prevention, treatment and care in prison settings

Although prisons in the region have reportedly high prevalence of HIV among inmates including a high proportion of injecting drug users, HIV prevention treatment and care programmes in the prison have not been widely introduced and are one major area of concern in the larger region. Notwithstanding this, the Islamic Republic of Iran has a major lead in implementing prison based programmes for HIV prevention and care including opiate substitution therapy and other services for injecting drug users. In Pakistan, recently through the UNODC projects HIV prevention services will be offered in 4 prisons in the country, while another project will focus on HIV prevention among female prisoners. A similar project focusing on HIV prevention among female prisoners in Afghanistan is being launched. In the Central Asian countries, Kyrgyzstan in the only country which has introduced HIV prevention and care programmes in the wider prison system and a wide range of service from OST, voluntary counselling and testing for HIV, needles and syringe exchange, and treatment of STI and TB is provided to the prison inmates. In Kazakhstan, Tajikistan and Uzbekistan, except for opiate substitution therapy and needle syringe exchange other services for HIV prevention, treatment of STI and tuberculosis are offered within the prison system. In Turkmenistan, there is limited or no information available on the nature of services available for HIV prevention in the prisons.

In Central Asia and Azerbaijan, UNODC is implementing a major regional project in which aims at establishing a favourable environment, or improved HIV prevention, treatment and care services for injecting drug users and in prison settings through addressing normative policy and programmatic aspects and capacity building. In the other countries, there are more focused projects, e.g., in Pakistan and Afghanistan for selected prisons and female injecting drug users and female prisoners, UNODC is taking the lead in providing technical assistance to the national and regional counterparts in its mandated area of HIV prevention, treatment and care among injecting drug users and in prison settings.

The regional initiative for HIV prevention, treatment and care in prison settings could be for further advocacy for provision of comprehensive package of services in the prison, facilitating exchange of experiences and expertise with the countries (the Islamic Republic of Iran and Kyrgyzstan) that have experience of prison services, and capacity building of prison staff and other service providers. In general, prison programme need to be developed on the following principles:

a) Treatment and HIV prevention services available in prisons are equivalent to those in the community – the principle of equivalence
b) Impact on crime rate and recidivism
c) Link prisoners to community services after release

Principles and interventions of successful prevention, treatment and reduction of health and social consequences of drug use and dependence programmes

The key principles and interventions for prevention, treatment and reduction of health and social consequences of drug use and dependence that are already well established and endorsed internationally are listed below:
Prevention of drug use

a) Prevention programmes should enhance protective factors and reverse or reduce risk factors.

b) Programmes should address all forms of drug abuse, alone or in combination including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs; and the inappropriate use of legally obtained substances, prescription medicines, or over the counter drugs.

c) Prevention programmes should address the type of drug abuse problem in the local community, target modifiable risk factors and strengthen identified protective factors.

d) Prevention programmes should be tailored to address risk specific to population or audience characteristics, such as age, gender, and ethnicity, to improve programme effectiveness.

e) Family based prevention programmes should enhance family bonding and relationships and include parenting skills, practice in developing discussing and enforcing family policies on substance abuse, and training in drug education and information.

f) Prevention programmes can be designed to intervene as early as preschool to address risk factors for drug abuse such as aggressive behaviour, poor social skills, and academic difficulties.

g) Prevention programmes for elementary school children should target improving academic and social emotional learning to address risk factors for drug abuse, such as early aggression, academic failure and school dropout.

h) Prevention programmes for middle of high school students should increase academic and social competence skills such as study habits and academic support; communication; peer support; self-efficacy and assertiveness; drug resistance skills; reinforcement of anti-drug attitudes; and strengthening of personal commitment against drug abuse.

i) Prevention programmes aimed at general populations at key transition points, such as the transition to middle school can produce beneficial effect even among high risk families and children.

j) Community prevention programmes that combine two or more effective programmes that combine tow or more effective programmes such as family based and school based programmes can be more effective than a single programme alone.

k) Community prevention programmes reaching populations in multiple settings, e.g., schools, clubs, faith based organizations and the media, are most effective when they present consistent, community wide messages in each setting.

l) When communities adapt programmes to match their needs, community norms or differing cultural requirements, they should retain core elements of the original research based interventions including programmes structure, content, and delivery.

m) Prevention programmes should be long term with repeated interventions to reinforce the original prevention goals.

n) Prevention programmes should include teacher training on good classroom management practices.

o) Prevention programmes are most effective when they employ interactive techniques such as peer education discussion groups and parent role playing that allow for active involvement in learning about drug abuse and reinforcing skills.

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27 These have been adapted by the NIDA publication on “Preventing Drug Use among Children and Adolescents”
p) Research based prevention programmes can be cost effective. Research shows that for each dollar investment in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen.

**Principles of drug dependence treatment**

- **a)** Availability and accessibility of drug dependence treatment including geographical accessibility, distribution and linkages; timeliness and flexibility of opening hours; legal framework; availability of low threshold services; affordability, cultural relevance and user friendliness; responsiveness, criminal justice components; and gender sensitiveness of services.

- **b)** Screening, assessment diagnosis and treatment planning based on comprehensive assessment.

- **c)** Evidence informed drug dependence treatment that offer a range of evidence-based pharmacological and psychosocial interventions of sufficient duration; offered by multidisciplinary teams including: outreach and low threshold interventions, medically supervised withdrawal, maintenance medications with proven efficacy and effectiveness, psychological and social interventions for rehabilitation and relapse prevention, and self help support groups; interventions that are of socio-cultural relevance; with knowledge transfer and ongoing clinical research implemented in different settings; and training of professionals at different stages.

- **d)** Drug dependence treatment services comply with human rights obligations, ensuring non discrimination; include right to autonomy and self determination of patients; and obligation for beneficence and non-maleficence on behalf of treating staff.

- **e)** Drug dependence treatment target special subgroups and conditions including adolescents; pregnant women; people with medical co-morbidities such as hepatitis B and C, HIV and TB; those with psychiatric co-morbidities; sex workers; ethnic minorities; and marginalized or street people.

- **f)** Addiction treatment provided in the criminal justice system through diversion schemes from criminal justice system into treatment; addressing human rights principles of the patients; ensuring continuity of services and continuous care in the community.

- **g)** Community centred interventions, with patients’ active involvement, mainstreaming drug dependence treatment in health and social care settings; linkages between drug dependence treatment services and hospital services, as well as social services, active involvement of NGO and civil society organizations.

- **h)** Clinical governance of drug dependence treatment through: service policies and treatment protocols; delivered through qualified staff; supervision and other support to the staff; provision of financial resources; communication structures and networking of drug dependence treatment and other programmes; monitoring systems to review service delivery, evaluate and provide feedback on service and system performance for quality assessment.

- **i)** Treatment systems: policy development, strategic planning and coordination of services that are based on a treatment policy for drug use disorders; has links to preventions, based and situation assessments provide continuity of care; based on a multidisciplinary

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28 As presented in the UNODC and World Health Organization discussion paper “Principles of Drug Dependence Treatment”, March 2008
approach and capacity of the staff; provide for quality assurance, monitoring and evaluation

Establishing effective measure to reduce adverse health and social consequences of drug abuse\(^{29}\):

Services should provide non-discriminatory facilities that can reduce the harmful consequences of substance abuse to drug abusers.

a) Reliable information and counselling on the physical and psycho-social risks of drug abuse have to be provided including information about the risk of overdose, infectious diseases, driving problems, cardiovascular, metabolic and psychiatric disorders.

b) Low threshold pharmacological interventions (example opioid-agonists and antagonist drugs), not directly related to drug-free oriented programmes, but to immediate health protections, have to be easily accessible.

c) Adequate social assistance should be provided for marginalized drug dependents.

d) Vaccination programmes against Hepatitis should be available to all drug abusers and in all appropriate facilities.

e) Medication and emergency kits for management of overdose in appropriate places should be available.

f) Needle and syringe exchange programmes for injecting drug abusers may be implemented where appropriate under sound medical practice.

g) Voluntary HIV counselling and testing and antiretroviral treatment for HIV infected drug users should be made available and accessible.

h) Prevention and services for the management of sexually transmitted infections have to be accessible to drug abusers and particularly to those involved in sex work.

i) Availability of measures to prevent acute consequences of stimulant abuse in the outlets of frequent abuse of these substances could contribute to the prevention of related emergencies.

j) Interventions in emergency rooms have to be guaranteed.

k) Well equipped street-workers and peer outreach workers units have to be adequately trained to contact drug abusers and dependent individuals in need of assistance.

Outline for an action plan at regional and national level

Since most countries in the South West and Central Asia are facing similar nature of problems with opiate use and HIV among injecting drug users there exists the potential for regional initiatives and cooperation, and the scope of countries benefiting from each others’ experiences and expertise. At the same time, UNODC and WHO are due to launch the joint large-scale initiative on prevention, treatment and reduction of health and social consequences of drug use and dependence\(^{30}\). The joint initiative will cover the period 2009 to 2013 and its focus is to develop concerted action for evidence based prevention and drug dependence treatment services responding to the needs of populations and therefore reaching the maximum number of individuals having the greatest impact at lowest cost. The overall aim of the UNODC-WHO initiative on demand reduction is:


To promote and support worldwide, with a particular focus on low and middle income countries, evidence based and ethical prevention and treatment policies, strategies and interventions to reduce the health and social burden caused by drug use and dependence.

The joint WHO-UNODC action plan is envisaged to be implemented in two stages. Stage I will cover 2009 to 2010 and will focus on: advocacy and engagement of partners, development of programme models and technical tools, dissemination of good practices capacity building and implementation of the programme activities in selected countries. The second stage covering 2011 – 2013 will aim at full implementation of all components including the activities in an increased number of countries with increasing support for the envisaged global and regional activities and consolidated and strengthened international collaboration on demand reduction. The joint initiative will have programmes activities at country, regional and global levels.

Therefore, it is pragmatic and prudent that a regional action plan for South West and Central Asia for prevention, treatment and reduction of health and social consequences of drug use and dependence draws its inspiration and forms part of the joint UNODC-WHO large-scale initiative.

As envisaged in the joint UNODC-WHO initiative, following are the expected outcomes and objectives under this action plan:

**Expected outcomes:**
Improved ability of health and social systems to address effectively prevention and treatment of drug use disorders in populations, ultimately, improving human collective and individual security and enhancing social development.

**Objectives**
1. Strengthen political commitment to support the development and implementation of public health oriented drug treatment and prevention policies in the South West and Central Asia.
2. Form a regional partnership for improving coverage and quality of treatment and care services of people with drug problems in the regional countries
3. Promoting the provision of a continuum of care for drug users, including drug dependence prevention and treatment, HIV and Hepatitis (B and C) prevention and care, and reduction of other health and social consequences in the regional countries.
4. Mainstreaming prevention of drug use and its consequences, and treatment of drug dependence into the health care, social welfare and education systems, lining with NGO at national and local level.
5. Increasing access to care for drug users through development of low cost outreach and treatment services also in rural and remote areas.
6. Supporting training programmes for health care and other professionals involved in provision of treatment and care for drug users.
7. Mapping population needs, legislative frameworks and available services and programmes for prevention of drug use and its consequences and treatment of drug use disorders.
8. Developing and implementing international recommendations, guidelines and standards aiming at the knowledge transfer from research to practice.
9. Supporting regional network of quality service providers, working on substance abuse prevention and treatment, social support services and HIV and AIDS prevention and care.

Some of the regional and country specific issues that need to be taken into consideration for prevention of drug use, treatment of drug dependence, and HIV and AIDS prevention treatment and care have been described in the preceding section.

**Regional initiatives**
The regional level component aims at developing regional support mechanisms for successful implementation of the action plan on the country level. Considering these, the suggested regional and country level action plan is described in this section. Some of the proposed activities would include:

![Regional Initiative Diagram]

**Figure 6: Outline of action plan - regional activities**

1. A regional forum for exchange of information, expertise, and best practices in the region in implementing programmes in all the major areas
2. Establishment of comparable and common systems of monitoring and evaluation of both situation and responses; and sharing of information on the emerging trends and issues.
3. Development of a regional network of drug dependence treatment training and resource centres; and capacity building programmes utilizing the resources within Treat-net phase II.
4. Advocacy, technical assistance and support for introduction of a wide range of evidence-based treatment facilities and programmes, including brief interventions, long-acting opioid agonists and antagonists programmes, short cognitive-behavioural therapy, vocational therapy, job training and rehabilitation in the region.
5. Advocacy, technical assistance and support for introduction and up-scaling of HIV prevention, treatment and care programmes for injecting drug users and in prisons settings
6. Implementation of outreach interventions aiming to improve accessibility to health and social services including voluntary and confidential testing and counselling for HIV, diagnosis and treatment of sexually transmitted infections, and tuberculosis, and ARV for HIV infected persons
7. Advocacy work with international stakeholders for provision of resources especially for prevention and drug dependence treatment projects and programmes in the region.

Country level initiatives
The country level aims at promoting the priority given to prevention and treatment of drug use and dependence in the regional countries by working with the government and appropriate national agencies and organizations for developing public health oriented policies for drug use prevention, drug dependence treatment and reduction of health and social consequences of drug use and dependence. The current and future UNODC programmes and initiatives in each country will be reviewed for the potential to bring them inline with the proposed country level activities. The proposed activities\(^{31}\), keeping in mind the country specific needs and characteristics, some of which have been described in the preceding sections, will include:

![Figure 7: Outline of action plan - country level activities](image)

1. **Strengthening of political commitment at the highest level possible** to develop and scale up evidence based and ethical prevention and treatment policies, strategies and interventions to reduce the health and social burden caused by drug use and dependence.

\(^{31}\) The proposed activities listed here are taken, as the other components, from the paper – Joint UNODC-WHO large scale initiative on drug demand reduction: Prevention, treatment and reduction of health and social consequences of drug use and dependence; Action plan for 2009 – 2013 (draft October 2008).
This activity will include assessment, and if where appropriate support of the existing national interdisciplinary mechanisms with involvement of governmental agencies (such as Ministries of Health, Interior, Justice, and Education, and national treatment agencies), NGOs, academic institutions and other stakeholders, or development of a new coordination mechanism with involvement of different stakeholders including potential or actual service users.

2. **Assessment of existing needs and resources:** including the estimates of population needs for treatment of drug use disorders, structured assessment of existing prevention and treatment systems for drug use disorders using the WHO and UNODC technical tools, assessment of current prevention and treatment policies, barriers for implementation and scaling up of effective prevention, treatment and harm reduction interventions according to the national legislation, needs and priorities. This activity will include also a review of existing protocols and treatment policies, and prioritizing education and training needs. Results of the assessment will be communicated to the national authorities through the coordinating mechanisms described above and serve as a baseline for monitoring progress in development of prevention and treatment interventions for drug use disorders in the country.

3. **Development of supportive policy and legislative frameworks** for increasing coverage of prevention and treatment interventions. This activity includes the review of drug treatment legislation frameworks from public health perspective, and support for development and or revision of policy and legislation frameworks with involvement of relevant stakeholders on the country level and identifying means for implementation of public health oriented policies and plans.

4. **Support for development of effective models of intervention and service delivery** to improve access to treatment and treatment coverage through the following interrelated and coordinated ways:
   a. Mainstreaming prevention and treatment interventions for drug use disorders into primary health care.
   b. Development of decentralized low-cost substance abuse treatment and HIV, Hepatitis B and C prevention services involving NGOS and the health care system in a coordinated local network of services that are diversified to respond to patients’ clinical needs.
   c. Integrating and linking of prevention and treatment interventions with treatment and care of other health conditions associated with high prevalence of drug use and drug use disorders like HIV and AIDS, Tuberculosis, and sexually transmitted infections.
   d. Evaluation of new models of service delivery in different health care, cultural and resource settings. This activity envisages scientific evaluation of new models of service delivery to strengthen evidence base for future service developments.
   e. Provision of essential medicines for treatment of drug use disorders.
   f. Open access community based and other services including self help groups.
   g. Provision of interventions in primary health care and specialized health care settings like STI and HIV and AIDS clinics, mental health care settings, TB services and services for patients with hepatitis B and C with training support and supervision from specialized centres.
h. Basic addiction treatment centres, low-cost and decentralized drug dependence treatment services are mainstreamed into the health care systems and therefore are more available, accessible and affordable.

i. Specialized addiction treatment centres at a district or provincial level. These include a multidisciplinary approach, treatment of dually diagnosed patients in collaboration with mental health services and in patient facilities.

j. Adapt and rigorously evaluate evidence based prevention interventions in a variety of settings (in particular schools, families, religious institutions), building on regional cultural specificities and including specialised interventions for especially vulnerable groups (e.g. carpet weavers, street children, refugees).

5. **Strengthening of human resources and improving quality of preventive and treatment interventions.** Qualified staff at different levels of service provision, supported by adequate supervision and training opportunities, is key for improvement of provision of prevention and treatment interventions. This activity will include:
   a. Improving the ability of drug prevention and treatment service providers to deliver evidence based interventions through capacity building (training)
   b. Promotion of national standards of care, quality indicators and accreditation which are developed in line with the best available evidence and international recommendations, guidelines and standards.
   c. Development of an improvement plan for compliance with quality standards.
   d. Support for dissemination of evidence-based psychosocial interventions (cognitive behavioural therapies, motivational enhancement interventions), both in community-based and residential setting, and linkage to vocational training and job facilitation services.
   e. Support for an adequate in-service training, national curricula development and undergraduate and postgraduate training of health professionals within existing structures and organizations at the national level.

6. **Implementation of appropriate diversion schemes from criminal justice system into public health care system and provision of quality prevention and treatment interventions in prison settings.** This activity aims at ensuring continuum of care between communities and closed settings and will be built upon previous work and linked to other activities particularly to development of supportive policy and legislative frameworks.

7. **Monitoring and evaluation:** This activity will focus on implementing at the country level the monitoring and evaluation tools developed as a part of the implementations of the joint UNODC-WHO global initiative on drug demand reduction.
Annex I - DRAT: Demand Reduction Action Teams

Among the different projects that have been implemented in the region, one important initiative that needs further consideration are the Demand Reduction Action Teams (DRAT) in Afghanistan. The teams were established in 2004 under the UNODC project that aimed to build government capacity in drug demand reduction, and to ensure sustainability and continuity of services in six targeted provinces namely, Kabul, Balkh, Heart, Badakhshan, Nangarhar, and Kandahar. Each team comprised medical staff from the Ministry of Public Health and educationists from the Ministry of Education. The team members were trained to provide quality services to their clients in their area of work. The teams were located in the provincial health departments and provided with transport, computers and other office equipment to function efficiently.

DRAT have provided a range of services in their communities including, identification, motivation, referrals and treatment and aftercare to drug dependent persons. They have also been engaged in conducting drug awareness and prevention activities among at risk and vulnerable groups including women. Although there has not been an outcome or impact evaluation of the DRAT, it has shown promising results. For instance in 2007 the DRA Teams working in six provinces provided motivations counselling to 2,768 drug dependent persons and facilitated treatment for 2,133 and referred 331 out of these for vocational training. Through 69 training workshops the teams have trained 1,776 social multipliers in concepts of drug abuse prevention who have in turn reached 27,869 people that were considered vulnerable and informed them about the harmful consequences of drug abuse through various community meetings and social mobilization events. After the project’s closure in May 2008, arrangements have been made with the Afghan Ministry of Public Health and the Colombo Plan Bureau that DRAT will be financially supported by the Colombo Plan while UNODC will continue to provide technical and advisory support to the DRAT and the Ministry of Public Health.
Annex II - Summary table of current legislation, assessment methods, prevention, treatment and reduction of health and social consequences of drug use and dependences

Afghanistan

Current Legislation
The Law on Narcotics, drafted by the Counter Narcotics Directorate with UN assistance in 2002/3 is the major law on narcotics related offences.

National institutions
Ministry of Counter Narcotics and Ministry of Public Health – Demand Reduction Section and National AIDS Control Programme.

Assessment Methods
The main assessment on drug use was conducted with the assistance of UNODC in 2005. No systematic data on the drug abuse and prevalence of HIV/AIDS or other sexually transmitted infections (STI) are available due to absence of surveillance in Afghanistan. The two current sources of data on HIV/AIDS are the Central Blood Bank Kabul and the Voluntary Counselling and Testing Centre at Kabul started in 2005.

Prevention, treatment and rehabilitation of health and social consequences of drug use and dependence
In January 2006, the Afghan government inaugurated an eight-pillar National Drug Control Strategy (NDCS) calling for coordinated action in the areas of Public Information, Alternative Livelihoods, Law Enforcement, Criminal Justice, Eradication, Institutional Development, Regional Cooperation, and Demand Reduction. The NDCS includes rehabilitation and demand reduction programs for drug abusers.

Political commitment as well as efforts towards prioritizing and implementing national drug demand reduction programmes is intensifying, yet endeavours in connection to HIV prevention and care are still limited and hardly any specifically meet the needs of women. Local experience suggests that female drug users -especially female injecting drug users- represent a small segment of Afghanistan drug user's population, yet their situation is of particular concern. The stigma and discrimination they face is particularly intense, and keeps them from accessing health services.

National Interventions
The key responses to prevention, treatment and rehabilitation of health and social consequences of drug use and dependence, based on the national strategies are:

1. To provide maximal harm reduction coverage to IDUs in communities and prisons, with the aim of covering 80% of IDUs with Harm Reduction programs.
2. To strengthen strategic information to guide policy formation, programme planning and implementation. Revise the national drug treatment, drug abuse prevention and harm reduction guidelines, strategies and protocols
3. To gain political commitment and mobilize resources necessary to implement the national HIV/AIDS/STI strategy.
4. To ensure development and coordination of a multi-sectoral HIV response and develop institutional capacity of all the sectors involved.
5. To raise public awareness on HIV and STI prevention and control, ensure universal access to behaviour change communication on HIV, especially targeting most at risk and vulnerable groups.
6. To ensure access to prevention, treatment and care services for most at risk and vulnerable populations.
7. To strengthen the health sector capacity to implement an essential package of HIV prevention, treatment and care services within the framework of BPHS and EPHS.

8. Upgrade and improve capacity of the DR directorate of MCN in monitoring, coordination of the drug demand reduction programmes.


10. Establishment of a National demand reduction training and resource centre in Kabul.

11. Expansion of drug treatment facilities, both community-based and centre-based to a further 12 provinces. Currently 40 facilities are available in 21 provinces. Strengthening of follow up and aftercare and also provision of vocational training in marketable trades/skills and job placement programme for recovering addicts.

12. Improvement of coordination and networking between services providers and development of referral system.

13. Establishment of Drop-in day-care centres and harm reduction programmes for IDUs and non IDUs, provide HR services (e.g. NSP, OST, and PHC).


UNODC Interventions

UNODC is developing and supporting the following interventions:


2. Institutionalization of drug abuse prevention through development of drug abuse prevention programme in Afghanistan.

3. Development of a drug treatment system through primary health care programme to ensure the accessibility of the client groups to the treatment.

4. Development of selective program for special groups, carpet weavers’ women and children (Turkmen and Ismaili communities).

5. Advocacy for tackling drug abuse problem in the Afghanistan from community development perspective.

6. Mental health and drug abuse.

7. Conduct Survey on opiate abuse in Afghanistan and setting up a drug abuse information system.

8. Establishment of a national training and resource centre in Kabul.
Pakistan

Current Legislation
The Control of Narcotic Substances (CNS) Act, 1997, effectively covers all aspects of Pakistan’s drug control efforts. It deals with cultivation, manufacture, production, trafficking and possession offences as well as with treatment and rehabilitation of drug dependent persons. Chapter VI of the CNS Act deals specifically with treatment and rehabilitation of drug dependent persons, where its different clauses stipulate the following:

1. Article 52 stipulates that Provincial Governments shall register all drug addicts for the purpose of treatment and rehabilitation while the Federal Government is held to bear the cost for first-time compulsory detoxification or de-addiction of an addict.

2. Article 53 requests the Provincial Governments to establish as many treatment centres as necessary for detoxification, de-addiction, education, after-care, and rehabilitation, social integration of addicts and for supply of such medicines as are considered necessary for the detoxification of the addicts.

National institutions

Assessment Methods
1. Treatment reporting in selected cities as part of Treatment Demand Indicator implemented by Anti Narcotics Force, Ministry of Narcotics Control supported by UNODC.

2. National Assessment of Problem Drug Use 2006 implemented by Anti Narcotics Force, Ministry of Narcotics Control supported by UNODC.

3. Sentinel surveillance on HIV among different risk groups conducted by the National AIDS Control Programme.

Prevention, treatment and rehabilitation of health and social consequences of drug use and dependence
The goal of the National Drug Control Master Plan (2008-12) is “to reduce the health, social and economic costs associated with drug trafficking and substance abuse in Pakistan.” More specifically, the drug demand reduction objective of the Master Plan is “to check the increase in drug demand and achieve reduction in the number of drug addicts through prevention and treatment and rehabilitation measures.” The overarching goal of the National HIV and AIDS Strategic Framework (NSF) 2007-11 is to halt / reverse the spread of HIV infection by 2011 by providing each of the target groups (general population and most at risk populations) with a minimum package of prevention services.

National Interventions
The key national interventions in the areas of prevention, treatment, rehabilitation and reduction of social and health consequences of drug use and dependence are as follows.

1. NGOs working in the field of drug demand reduction and HIV/AIDS prevention are to establish national and provincial umbrella organisations.

2. District Governments to establish District Drug Abuse and HIV/AIDS Prevention Committees in at least forty districts.

3. The Ministry of Education, Curriculum Wing, in collaboration with Ministry of Narcotics Control and UNODC will incorporate drug abuse and HIV/AIDS prevention material in curriculum for classes 8 to 14. Teacher training courses on drug abuse prevention to organize at provincial teacher training institutions.

4. The Ministry of Religious Affairs and Dawa Academy in collaboration with Ministry of Narcotics Control to develop special courses for madrassa students and for religious teachers undergoing training at the Academy.
5. The provincial health departments, in collaboration with Ministry of Narcotics Control/ Anti Narcotics Force to upgrade twenty existing drug treatment centres in public and private sectors, throughout the country, to provide quality drug treatment and rehabilitation services.
6. The staff working in the network of drug treatment centres in 20 cities will be trained in data collection and local reports generation on treatment demand and drug related arrest data.
7. The Anti Narcotics Force to establish four new Model Drug Abuse Centres.
8. The Anti Narcotics Force to coordinate training of drug abuse treatment staff and other institutions through national, regional and international courses.
9. The Ministry of Narcotics Control / Anti Narcotics Force in collaboration with the National Prison Staff Training Institute Lahore to develop special training packages on drug abuse and drug-related HIV/AIDS prevention and rehabilitation of drug addicts for prison staff trainees at the institute.
10. A specially designed programme for street children with solvent abuse problems will be developed in five major cities.
11. Home based and specialized treatment facilities will be established in five cities for the drug treatment and rehabilitation of drug addicted women.
12. A coordinating body will be established comprising of Ministries of Narcotics Control, Health, Social Welfare, Education, relevant provincial departments and civil society organisations. The body will design and monitor the demand reduction programmes.
13. The Ministry of Narcotics Control / Anti Narcotics Force and provincial governments will train and support NGOs/CBOs and students from Psychology/Sociology/Anthropology departments of universities to mount small-scale drug abuse assessment studies.
14. Over the next five years government plans to provide comprehensive HIV prevention services to 45,000 IDUs (36%) through its own sources, 10,000 (8%) through ‘One UN’ initiative and 28,000 (23%) with financial assistance of international donors and programmes vis-à-vis Global Fund for AIDS, Tuberculosis and Malaria.
15. Establishment of the pilot oral substitution treatment programme in the selected cities.

**UNODC Interventions**

UNODC is developing and supporting activities in the following areas.

1. Assist government institutions to collect and analyze data to inform policy deliberations on prevention and treatment of drug abuse and HIV/AIDS.
2. Test new approaches to promote application of best practices in relation to vulnerable populations.
3. Develop capacity in government institutions and civil society organizations for prevention of drug abuse and HIV transmission and treatment and rehabilitation of drug users.
4. Assist women with substance abuse problems.
5. Provide assistance for street children abusing drugs and solvents.
6. Increase the capacity of prison staff and NGOs to undertake drug abuse and HIV/AIDS prevention work in prisons.
8. Increase awareness of the risks attached to drug abuse and the need to scale-up HIV/AIDS prevention and treatment services of injecting drug users, prisoners and other high risk groups such as street children.
9. Reduce drug abuse and related health and social consequences by advocating and providing support for comprehensive HIV/AIDS prevention and treatment services.
Islamic Republic of Iran

Legislation

The Fourth Economic, Social and Cultural Development Plan of the Islamic Republic of Iran refers to the need for an expansion and systematisation of drug prevention, treatment services, together with programmes of education and social harms prevention. The Iranian Expediency Council, endorsed a policy paper entitled “Islamic Republic of Iran General Drug Policy” which highlighted the need to address the problem of drug use as a main policy of drug control in terms of drug prevention, treatment and rehabilitation as well as reduction of harm associated with drug use (2006).

National institutions

Drug Control Headquarters (DCHQ), Ministry of Health and Medical Education; the Ministry of Education; the Ministry of Culture and Islamic Guidance and the Organisation of Prisons and Penitentiaries.

Assessment Methods

During the past decade a number of surveys have been carried out to assess the situation of drug use in the Islamic Republic of Iran. From all these the only officially published survey is the Rapid Situation and Response Assessment on the drug use Situation in the Islamic Republic of Iran conducted in 1998.

Prevention, treatment and rehabilitation of health and social consequences of drug use and dependence

The Fourth Economic, Social and Cultural Development Plan of the Islamic Republic of Iran refers to the need for an expansion and systematisation of drug prevention, treatment services, together with programmes of education and social harms prevention. In order to expedite the reintegration of drug users and their families into society it also obliges the government to undertake all necessary steps to control the HIV epidemic through required prevention, treatment and care services.32

In 2005, an Executive Order from the Head of Judiciary was issued advising judges at all courts of justice and prosecutors’ offices throughout the country to consider the lack of malicious intent in the implementation of harm reduction interventions like provision of needles, syringes as well as methadone maintenance programs for drug addicts and asked the judicial authorities not to impede the implementation of such essential programmes.

In 2006, the Iranian Expediency Council, the highest policy-making entity under the Supreme Leader, endorsed a policy paper entitled “Islamic Republic of Iran General Drug Policy” which highlighted the need to address the problem of drug use as a main policy of drug control in terms of drug prevention, treatment and rehabilitation as well as reduction of harms associated with drug use.

In 2007, following the policy of reducing the prisons’ population, the head of Judiciary issued an advisory instruction indicating that the drug use per se could not be considered as a crime and therefore no one should be sentenced to imprisonment merely for this reason; however, the drug users must be directed to drop in centres and drug treatment centres.

National Interventions

National programmes and activities are as listed below.

1. Ratification of the Narcotic Drug Control (NCD) macro policies in eleven articles, one of which on Harm Reduction, in the senior law-making bodies.

2. Revision and modification of the NDC law with the aim of facilitating the Harm Reduction programmes.
3. Advocacy for the Harm Reduction programmes among high ranked officials from Judiciary, Military, and Police forces.
4. Allocation of more than 40 million USD from 2003 to 2007 to implement and support the Harm Reduction programmes and measures including Methadone Maintenance Treatment (MMT), NGOs running Drop In Centres (DIC) centres and other related NGOs and outreach services.
5. Operating a Treatment and Harm Reduction committee in DCHQ headed by the deputy to the health minister.
6. Reviving of the NDC coordination council under DCHQ in all provinces to monitor performance of medical schools, welfare organization, prisons organization, and NGOs.
7. Formulation and incorporation of HR programmes in the National Twenty Years Development Preview as well as in the fourth National Development Plan of the Islamic Republic of Iran.

The Iran HIV/AIDS National Strategic Plan (NSP) has been designed as a three-year plan (2007 – 2009) in order to coincide with Iran’s National Development Plan. Based on its goals, by the end of the three-year implementation, the following are to be expected:

1. Improvement in the attitudes regarding HIV/AIDS among the general public as well as means of transmission and non-transmission.
2. Reduction of the probability coefficient of contamination of transfused blood.
3. Increase in the rate of compliance with standard precautions among healthcare and treatment providers and professionals.
4. Increase in the rate of identification of infected pregnant women.
5. Increase in the percentage of identified cases of PLWHIV.
6. Increase in the rate of compliance with harm-reduction techniques among injecting drug users.
7. Increased rate of condom-use in youth sexual contacts.
8. Increased rate of coverage of standard counselling, care and treatment services for PLWHIV.
9. Increased rate of coverage of standard counselling, care and ARV treatment services for known AIDS cases.
11. Increase in the rate of coverage of support services for people living with or affected by HIV.

**UNODC Interventions**

The main thematic areas envisaged by UNODC are prevention, treatment and reintegration, and alternative development, which include the main objectives as:

1. Reduction of opportunities and incentives for illicit activities and gains, and reduction of drug abuse, HIV/AIDS (as related to injecting drug abuse, prison settings and trafficking in human beings), criminal activity and victimization with a special focus on women and children, as well as dissemination of information and successful practices in those areas.
2. Effective prevention campaigns, care and reintegration into society of drug users and offenders, and assistance to victims of crime.
3. Foster and strengthen international cooperation based on the shared responsibility principle in sustainable alternative development, including, where appropriate, preventive alternative development.
Central Asia

Current Legislation
The current legislative regulations on drug abuse prevention and treatment and HIV prevention, treatment and care are generally based on the three UN conventions on Narcotic Drugs (1961), on Psychotropic Substances (1971) and on Countering Illicit Drug Trafficking (1988) as well as the Declaration of Commitments to Fight HIV and AIDS adopted at 26 Special Session of the UN General Assembly on 27 June 2001. Each national strategic programme is approved and put in force by Presidential decrees.

National institutions
Tajikistan: Drug Control agency, Ministries of Health and Education, Republican AIDS Centre.
Uzbekistan: State Commission on Drug Control under the Cabinet of Ministers, Ministries of Health (Drug treatment, Republican AIDS Centre), Education.
Turkmenistan: Drug Control Agency, Ministries of Health and Education.

Assessment Methods
1. The drug abuse monitoring is based on drug users registered by health and law enforcement agencies and reported as aggregated data.
2. HIV cases are reported as those registered after being tested HIV positive.
3. National assessment of problem drug use and school survey on alcohol, tobacco and drug use among secondary school students conducted by Ministries of Health and Educations with support from UNODC (with the exception of Turkmenistan).
4. Treatment reporting in selected cities as part of Treatment Demand Indicator implemented by national focal persons from Ministries of Health and supported by UNODC.

Prevention, treatment and rehabilitation of health and social consequences of drug use and dependence
The governments in the region, as stated in their respective National Programmes to counter trafficking of illicit drugs and prevention, treatment and rehabilitation of drug abuse as well as for the National Strategic Programmes to address HIV and AIDS, are committed to providing services for prevention treatment and rehabilitation of health and social consequences of drug use and dependence through a) expanding the services, b) improving the delivery of services, and c) building capacities of the professionals rendering these services or interventions. The key features of the national priorities in this area and UNODC interventions in the Central Asian countries are listed below:

National Interventions for Uzbekistan
In December 2006, the Government of Uzbekistan approved its “State Program of comprehensive measures to address drug demand and supply reduction” covering 2007. The “Strategic Programme on Responses to HIV Epidemic in the Republic of Uzbekistan” covering the period 2007 and 2011 has also been approved. Some key interventions are listed below.

1. Monitoring of drug abuse situation.
2. Training and improvement of professional skills of experts working in the field of drug prevention, treatment and rehabilitation.
3. Implementation of healthy life style program and improvement of quality of other prevention programs and an active use of the mass media.
4. Realization of measures on employment and social protection of drug users.
5. Revealing of children and teenagers with risk behaviour.
6. Improvement of treatment services through implementation of new diagnostic and treatment methods, medical and social rehabilitation.
7. Strengthening of cooperation between narcologists, school teachers, law enforcement bodies and social workers.
8. Training for decision making government officials on HIV issues.
9. Studying of influence of HIV epidemic on social and economic development of the country, prognosis and development of strategy on mitigation of consequences of epidemic.
10. Involvement of civil society in the realization of HIV preventive program.
11. Upgrading the legislation with regard to HIV.
13. Implementation of preventive measures among high HIV risk groups.
14. Expansion and improvement of HIV prevention programs among youth.
15. Strengthening of preventive measures on HIV transmission from mother to child in medical organizations.
16. Provision of good quality treatment for HIV-positive patients, including laboratory diagnostics, medicinal help, etc.

**National Interventions for Kazakhstan**

The Strategy on Struggling with Drug Abuse and Drug Trafficking in the Republic of Kazakhstan for 2006-2014 and the national programme on counteracting the AIDS epidemics in the Republic of Kazakhstan for the period 2006-2010 years envisage the following activities.

1. Strengthening of propaganda on healthy life styles.
2. Improvement of prevention measures, early revealing, effective treatment and social rehabilitation of drug users.
3. Improvement of services provided by government medical organizations for drug users.
4. Improvement of prevention educational programs at schools and universities.
5. Ensuring the cooperation of national and international partners in the field of HIV/AIDS.
6. Involvement of the mass media in HIV prevention and allocation of grants for journalists.
7. Supporting the NGOs working in the field of HIV/AIDS.
8. Provision of training for specialists on monitoring and evaluation in the area of HIV/AIDS and psychosocial counselling and anonymous HIV testing services.
10. Involvement of IDUs in needles exchange programs, counselling and anonymous HIV testing.
11. Implementation of the pilot projects on substitution therapy in Karagandiyskaya and Pavlodarskaya regions.
12. Provision for IDUs, CSWs and prisoners with high quality condoms and free of charge anonymous STI treatment.
13. Equipping laboratories of AIDS centres with diagnostic equipment.
14. Expanding the network of trust points.
15. Preventing HIV transmission from mother to child.
17. Ensuring preventive antiviral treatment among HIV infected pregnant women.
18. Ensuring chemoprophylaxis of secondary, opportunistic diseases, tuberculosis among HIV infected.
19. Constant control over blood and its components at blood transfusion centres.
20. Improvement of specialized medical help to PLWHA at inpatient and outpatient levels.
21. Ensuring access of people with HIV to ART.
22. Developing a national database on HIV/AIDS.

**National Interventions for Kyrgyz Republic**

The fifth National Program of the Kyrgyz Republic on Countering Drug Use and Illegal Turnover of Drugs will last until 2010. This Program
was approved by the Kyrgyz President’s Decree on 22 December 2004. Additionally, the State Program on Prevention of HIV/AIDS Epidemics and its Socio-Economical Consequences in the Republic of Kyrgyzstan (for 2006-2010) is also in effect. Some of the key interventions under the programmes include the following.

1. Monitoring of drug abuse situation.
2. Creation of governmental fund on social support and rehabilitation of drug users.
3. Establishment of Training Centre on drug prevention under the Drug Control Agency.
4. Improvement of legislative base in the field of drug control.
5. Involvement of mass media in drug prevention.
6. Supporting of public and non-governmental organizations working in the field of drug abuse.
7. Improvement of treatment, rehabilitation and diagnostics.
8. Conducting activities on involving religious leaders in explanatory and prevention work in local communities.
9. Conducting research on spread of HIV/AIDS, sexually transmitted infections among injecting drug users and CSW.
10. Conducting trainings for specialists who work with drug users and HIV-positive individuals in order to provide services for the youth.
11. Conducting TV programs on healthy lifestyle for the youth (including sign language for people with hearing impairment).
12. Strengthening cooperation with foreign law enforcement agencies and international organizations (UNODC, UNDP, WHO, EU, OSCE, NATO, ECO, CACO, CSTO, SCO, the Fund "Soros-Kyrgyzstan", etc.) on drug prevention, drug trafficking, transnational crime, terrorism, human trafficking and so on.
13. Development of new anti-drugs projects and submission to international organizations and countries which provide grants.
14. Implementation of an international project on common information reporting system and information sharing.
15. Strengthening of drug control cooperation within the framework of Inter-state Commission “Central-Asian Cooperation”.

National Interventions for Tajikistan

The task-oriented Program on Drug Abuse Prevention and Countering the Illicit Drug Trafficking in the Republic of Tajikistan for 2008 – 2012, and the National Program for Prevention and Fight against HIV/AIDS and STDs in the Republic of Tajikistan foresee the following activities.

1. Development of common national database on drug abuse.
2. Development of a monitoring system on the drug abuse situation in the country and improvement of the statistical reporting system.
3. Conducting of “Regulations on drug prevention in educational system”, “Regulations on rehabilitation of children and teenagers who use drugs” and “Regulations on certification of experts and accreditation of establishments which work in the field of drugs.”
4. Strengthening cooperation between governmental and civil society organizations.
5. Permanent training of professionals involved in drug treatment and rehabilitation.
6. Development of drug prevention measures among target groups and the entire population, (including rural areas and also prisoners).
7. Organization of psychological help through the crisis telephone lines.
8. Healthy life style lessons at schools.
9. Reflection of state anti-narcotic strategy in mass-media.
10. Dissemination of Government grants for youth organizations for the implementation of prevention programs.
11. Permanent training of teachers.
14. Improvement of legal policy and the social environment in order to expand access to prevention treatment, care and support for HIV-positive people.
15. Implementation of programs on Anti Retroviral Therapy (ART) and treatment of opportunistic diseases, palliative treatment and care of people living with HIV.
16. Implementation of programs on social support of people living with HIV.
17. Development of epidemiological surveillance, including monitoring and estimation of retaliatory measures.

National Interventions for Turkmenistan
The National Programme on Fighting Illegal Drug Trafficking and Assistance to Drug and Psychotropic Substance Addicts for 2006 – 2010 was approved by the Decree of the President of Turkmenistan on April 24, 2006. The key activities under the national programme include the following.

1. Working out a national strategy on narcotics control on the basis of annual analysis of drug abuse situation.
2. Improving the regulatory legal acts governing drug abuse and HIV prevention.
3. Working out new forms and methods of drug use prevention among youths.
5. Conducting epidemiological and social surveys with the purposes of an assessment of the extent to which consumption of narcotic and psychotropic substances has spread among various population groups, especially among the youth.
7. Development of educational materials related to a campaign promoting healthy life styles and prevention of illegal use of narcotic and psychotropic substances.
8. Opening new narcology and rehabilitation centres.
10. Preparation of proposals on opening a mandatory treatment centres for female drug users.
11. Conducting medical examinations of employees in organizations/agencies in order to identify persons consuming narcotic and psychotropic substances.
12. Improvement of trainings for narcologists, psychiatrists, family doctors, psychologists, and social workers involved in prevention, treatment and social rehabilitation of drug users.
13. Promoting the involvement of public associations in drug prevention activities.

UNODC Interventions for Central Asia
The key UNODC interventions for Central Asia are as listed below.

1. Development of school based life skills education and family based skills programme.
2. Development of structured programmes as alternatives activities for development of life skills and health promotion.
3. Effective school and community based prevention programmes implemented through trained local leaders, educationists, NGOs and media personnel.
4. Advocacy and awareness on prevention of drug use and HIV/AIDS among educationists, local leaders and policy makers.
5. Enhanced partnership with local leaders and civil society organizations for the implementation of prevention programmes.
6. Media campaigns linked with community prevention initiatives implemented at local and national levels.
8. Enhanced coordination within and partnership developed among different stakeholders and service providers for delivery of services.
9. Improved quality and coverage of comprehensive package of services through trained and skilful service providers at various levels.

10. Lessons learned and case studies of effective intervention and programmes documented and disseminated.

11. Advocacy and awareness among programme planners and service providers for the need to develop effective, accessible treatment and rehabilitation services meeting the diverse needs of drug dependent persons.

12. National stakeholders supported in developing and implementing effective and accessible treatment and rehabilitation services that offer a continuum of care in various settings with emphasis on community based interventions and community support to drug dependent persons through involvement of NGO and civil societies in the delivery of services.

13. Improved quality and coverage of drug dependence treatment and rehabilitation services offered based on clients’ needs through trained and skilled service providers at various levels.

14. Development of national resource centres supported that foster linkages and partnerships with different institutions and service delivery outlets as a comprehensive treatment and rehabilitation system.
# Annex III – UNODC Response to Drug Demand Reduction and HIV/AIDS challenges in the region

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<tr>
<td><strong>I. AFGHANISTAN</strong></td>
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<tr>
<td>AFG/H09</td>
<td>Capacity Building for Drug Demand Reduction in Afghanistan (Ongoing)</td>
<td>Canada, Germany, Italy, Ireland, Netherlands, Norway, Sweden</td>
<td>2003</td>
<td>2008</td>
<td>2,339,800</td>
<td>0</td>
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<tr>
<td>AFG/H87</td>
<td>Drug Demand Reduction Information, Advice and Training Service for Afghan Communities Living in Refugee Camps in Baluchistan and North West Frontier Province (NWFP), Pakistan (Ongoing)</td>
<td>Italy, Norway, Sweden</td>
<td>2004</td>
<td>2008</td>
<td>631,282</td>
<td>0</td>
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<tr>
<td>AFG/J56</td>
<td>Development of a Drug Dependence Treatment and Rehabilitation System in Afghanistan-Demonstration in Eight Provinces: Badakhshan, Balkh, Herat, Kabul, Kandahar and Nangarhar Kunduz and Ghazni (Planned)</td>
<td>Unfunded</td>
<td>2008</td>
<td>2011</td>
<td>2,249,200</td>
<td>2,249,200</td>
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<tr>
<td>AFG/J68</td>
<td>Development of Drug Abuse Prevention Programme in Afghanistan (Planned)</td>
<td>Unfunded</td>
<td>2008</td>
<td>2011</td>
<td>2,572,300</td>
<td>2,572,300</td>
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<tr>
<td>AFG/J76</td>
<td>HIV/AIDS Prevention, Treatment and Care for Female Injecting Drug Users and Female Prisoners in Afghanistan (Ongoing)</td>
<td>Norway</td>
<td>2008</td>
<td>2010</td>
<td>1,117,600</td>
<td>534,300</td>
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<tr>
<td>AFG/J82</td>
<td>Survey on Opiate Abuse in Afghanistan and Setting up a Drug Abuse Information System (Planned)</td>
<td>UK</td>
<td>2008</td>
<td>2010</td>
<td>339,000</td>
<td>3,245</td>
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<tr>
<td>To be determined</td>
<td>Provision of Comprehensive HIV Prevention and Care Services Afghan Refugee Drug Users in Iran and Pakistan and Returnees Afghanistan (Planned)</td>
<td>Unfunded</td>
<td>2009</td>
<td>2011</td>
<td>4,151,020</td>
<td>4,151,020</td>
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<td>Project Number</td>
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<td>End Date</td>
<td>Budget (USD)</td>
<td>Funding Shortfall (USD)</td>
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<tr>
<td>PAK/I33</td>
<td>Drug Abuse Treatment &amp; HIV/AIDS Prevention for Street Children (Ongoing)</td>
<td>Sweden, Austria, Switzerland</td>
<td>2006</td>
<td>2009</td>
<td>580,000</td>
<td>-5,223</td>
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<tr>
<td>PAK/I35</td>
<td>Counselling &amp; Treatment of Women with Substance Abuse Problems (Ongoing)</td>
<td>Italy</td>
<td>2006</td>
<td>2008</td>
<td>270,000</td>
<td>-</td>
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<td>H-13</td>
<td>Prevention of Transmission of HIV among Drug Users in SAARC Countries (Pakistan component) (Ongoing)</td>
<td>AusAID</td>
<td>2008</td>
<td>2012</td>
<td>1,071,000</td>
<td>657,748</td>
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<tr>
<td>PAK/J85</td>
<td>HIV/AIDS Prevention, Treatment and Care for Female Injecting Drug Users and Female Prisoners in Pakistan (Ongoing)</td>
<td>Norway</td>
<td>2008</td>
<td>2010</td>
<td>1,167,900</td>
<td>559,450</td>
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<td>To be determined Provision of Comprehensive HIV Prevention and Care Services to Injecting Drug Users Returning to Afghanistan from Iran and Pakistan (Planned)</td>
<td>Unfunded</td>
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<td></td>
<td>To be determined Drug Abuse &amp; HIV Prevention Targeting Youth in the Selected Districts of Pakistan (Planned)</td>
<td>Unfunded</td>
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<td></td>
<td>To be determined Pilot Scientific Study on Oral Substitution Treatment in Pakistan (Planned)</td>
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<tr>
<td>III. CENTRAL ASIA</td>
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<tr>
<td>GLO/J71-UZB</td>
<td>Partnership for Action on Comprehensive Treatment (PACT) - Treating drug dependence and its health consequences (Ongoing)</td>
<td>Central Asian segment funded by the US</td>
<td>2008</td>
<td>2011</td>
<td>1,490,000</td>
<td>890,000</td>
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<tr>
<td>Project Number</td>
<td>Project Name</td>
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<td>End Date</td>
<td>Budget (USD)</td>
<td>Funding Shortfall (USD)</td>
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<tr>
<td>RAC/I29</td>
<td>Effective HIV/AIDS Prevention and Care among Vulnerable Populations in Central Asia and Azerbaijan (Ongoing)</td>
<td>Ireland</td>
<td>2006</td>
<td>2009</td>
<td>4,000,000</td>
<td>556,560</td>
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<tr>
<td>RER/H36</td>
<td>Drug Demand Reduction and HIV/AIDS Prevention and Care Policy Advice to Central Asian Governments (Ongoing)</td>
<td>Italy, Sweden</td>
<td>2004</td>
<td>2008</td>
<td>400,000</td>
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<tr>
<td>RER/H37</td>
<td>Drug Abuse and HIV/AIDS Prevention through Mass Media, NGOs and Civil Society (Ongoing)</td>
<td>Italy, Sweden and USA</td>
<td>2004</td>
<td>2008</td>
<td>700,000</td>
<td>0</td>
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<tr>
<td>TJK/J77</td>
<td>Prevention of Drug Use Among Youth in Tajikistan (Planned)</td>
<td>Unfunded</td>
<td>2009</td>
<td>2011</td>
<td>406,800</td>
<td>406,800</td>
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<tr>
<td>TKM/J78</td>
<td>Prevention of Substance Use and Crimes among Youth in Turkmenistan (Planned)</td>
<td>Unfunded</td>
<td>2009</td>
<td>2011</td>
<td>350,000</td>
<td>350,000</td>
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<tr>
<td>UZB/J79</td>
<td>Community Centred Prevention in Uzbekistan (Planned)</td>
<td>Unfunded</td>
<td>2009</td>
<td>2011</td>
<td>450,000</td>
<td>450,000</td>
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<tr>
<td>To be determined</td>
<td>Community Centred Prevention in Kazakhstan (Planned)</td>
<td>Unfunded</td>
<td>2009</td>
<td>2011</td>
<td>350,000</td>
<td>350,000</td>
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<tr>
<td>To be determined</td>
<td>Community Centred Prevention in Kyrgyzstan (Planned)</td>
<td>Unfunded</td>
<td>2009</td>
<td>2011</td>
<td>350,000</td>
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</tr>
</tbody>
</table>

**IV. ISLAMIC REPUBLIC OF IRAN**

<p>| IRN/I54        | Drug abuse treatment in the Islamic Republic of Iran (Planned)                | Unfunded                       | 2009       | 2011     | 2,490,000    | 2,490,000              |
| IRN/I55        | Nationwide Drug Prevention Measures in the Islamic Republic of Iran (Ongoing)  | Italy, Sweden                  | 2008       | 2010     | 900,000      | 441,373                |
| IRN/I56        | Addiction and rehabilitation and HIV/AIDS prevention in the Islamic Republic of Iran (Planned) | Unfunded                       | 2009       | 2011     | 2,237,000    | 2,237,000              |
| IRN/I57        | Advocacy and Regional Cooperation in Drug Demand Reduction (Ongoing)          | Sweden, UK                     | 2007       | 2010     | 749,900      | 172,534                |</p>
<table>
<thead>
<tr>
<th>Project Number</th>
<th>Project Name</th>
<th>Current Donors</th>
<th>Start Date</th>
<th>End Date</th>
<th>Budget (USD)</th>
<th>Funding Shortfall (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be determined</td>
<td>Promotion of HIV/AIDS Prevention and Care Programmes for Female injecting drug users and female prisoners in the I.R. of Iran <em>(planned)</em></td>
<td>Netherlands</td>
<td>2009</td>
<td>2010</td>
<td>170,000</td>
<td>170,000</td>
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<tr>
<td>To be determined</td>
<td>National Assessment of Problem Drug Use <em>(Planned)</em></td>
<td>Unfunded</td>
<td>2009</td>
<td>2010</td>
<td>600,000</td>
<td>600,000</td>
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