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**Prevention and Treatment of  
Drug Dependence in West Africa**

**WACD Background Paper No. 2<sup>1</sup>**

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# Prevention and Treatment of Drug Dependence in West Africa

## 1. INTRODUCTION

The main objective of this policy brief is to assess the state of drug demand reduction (prevention of use and treatment for dependence) in West Africa and analyze responses to the problem of drug demand in the region. The discussion draws from a diverse array of available information from the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), research published in peer-reviewed journals, and reports and other materials from non-governmental organizations (NGOs). The focus is on illicit drugs though the perspective taken in this brief questions the value of the distinction often made between licit and illicit drugs when addressing dependence on psychoactive substances. This persistent false dichotomy ignores several issues: i) the reality that licit substances such as tobacco and alcohol are usually the first drugs to which young people are exposed; ii) a high proportion of dependent persons use both legal and illegal substances; and iii) dependence on legal drugs is associated with very high health burden and social harm often surpassing the harm attributable to illicit substances.

### *A note on terminology*

The term *drug use* in this brief covers all forms of drug self-administration for the purpose of getting “high”, including use of banned and controlled substances. *Drug abuse* is used as a technical term to refer to dysfunctional drug use as defined in the WHO International Classification of Diseases (10<sup>th</sup> Edition); while *dependence* (or addiction) is characterized by the presence of behavioural, cognitive and physiological symptoms following repeated use. *Drug use disorder* is an inclusive term for abuse (or harmful use) and dependence. When the wider world of drug problems is being discussed, i.e., when licit substances are included, the term *substance* is preferred over *drug*.

## DRUG USE IN WEST AFRICA

There is substantial concern today about the use and abuse of illicit psychoactive substances in West Africa but the problem is not a new one. As far back as the late 1950s there was clear evidence that cannabis was being grown and consumed in some countries. Voices were raised then about the perceived impact of that drug on the mental health of the people, especially those within fringe groups, low skilled labourers in urban areas and, later, students and young professionals.<sup>1-3</sup> Because the early surveys in Nigeria and other countries in the region were conducted among clients in psychiatric hospitals significant attention was afforded to the suspected effects of cannabis on mental illness while little effort was devoted to the epidemiology of the problem in the general population. It is not clear how much the available knowledge about cannabis and its effects influenced legislation in the 1960s but it seems that whatever controls were put in place at the time were developed on the basis of insufficient information about the role of cannabis in psychiatric disorders. The knowledge situation today has changed but not by much: progress has been made in some countries but a lot remains to be known about the relevant characteristics of illicit drug use in the region.

According to UNODC estimates, the number of drug users among adults in Africa is between 22 and 72 million, with a prevalence rate in the range of 3.8 percent and 12.5 percent.<sup>4</sup> We have an emerging picture of drug use in West Africa but it must be noted at the outset that studying the distribution and determinants of illicit drug use is a difficult task in the best of situations and much more so in the low income countries of West Africa. This difficulty is due to many structural and developmental factors and, more important, the fact that dealing in or using illicit drugs attracts stiff penalties which at different times and in different countries has included the extreme penalty of death.<sup>i</sup>

One source of available aggregate data on drug use in West Africa is UNODC's annual World Drug Report which depends on data provided by countries using the Annual Research Questionnaire (ARQ). Unfortunately this source of data is limited in scope as many countries in Africa as a whole sometimes fail to provide their annual estimates. For example, only seven out of 54 countries in Africa completed and submitted the questionnaire for the 2010 data.<sup>4</sup> However, as outlined below, there is some data in these sources that that can be used to describe the epidemiology of illicit drug use in West Africa:

**Cannabis:** The highest prevalence of cannabis use in the world is in West and Central Africa and this drug has remained the most popular illicit substance across the globe. In 2010 some 12.4 percent of adults in West Africa aged 15-64 years had used cannabis compared with 4.2 percent and 5.4 percent in East and Southern Africa, respectively. While the average for our region is certainly much higher than the global average (3.8 percent) or the overall African average (7.8 percent) and has been consistently so for many years, it must be noted that reported prevalence of cannabis use can be much higher within high risk subgroups in some countries, e.g., 65 percent of street children in Sierra Leone reported smoking cannabis.<sup>4</sup>

**Cocaine and heroin:** These relative newcomers to the illicit drug scene in West Africa were unknown in countries across the region before the early 1980s when the first arrests for trafficking were made in Nigeria.<sup>5-6</sup> Many small surveys of drug use involving heroin and cocaine have been conducted in several countries in the region some with financial support from UNODC. What these rapid assessments highlight is that the prevalence of cocaine and heroin use in West Africa is about the estimated African average of 0.4 percent and less than the global average of 0.7 percent.<sup>4</sup> While this estimate is relatively low, there has indeed been a substantial increase in the annual prevalence from the 0.2 percent recorded in 2006. There is sufficient reason to believe that this increase has been sustained in recent years.

**Amphetamine-type stimulants (ATS):** It is well known that ATS (especially methamphetamine) has become a popular drug among traffickers in West Africa and local production has been reported in at least two countries.<sup>7</sup> Though the abuse of ATS has been a problem in South Africa for many years, the effects of these drugs are only beginning to be felt in West Africa. Unfortunately there is hardly any reliable data on ATS use in the region though the estimated annual prevalence for Africa has been placed at about the global average of 0.8 percent. With an increase in trafficking of ATS through the region and what appears to be an emerging local production capacity, use can only be predicted to pick up in the future with harrowing consequences.

**Injection drug use (IDU):** The self-administration of illicit drugs to get high is an old phenomenon. In the 1980s IDU provided some sense of urgency to drug control in western countries because of its association with the transmission of the viruses that cause infectious diseases (AIDS, hepatitis B and C). It is estimated that globally some 16 million people inject drugs (usually heroin but also cocaine and other stimulants) with 3 million of them infected with HIV. In Africa, where the main route of HIV transmission is heterosexual contact, some 221,000 of injection drug users are living with HIV, with the severity of the situation rapidly increasing in coastal East African cities such as Mombassa and Dar es Salaam where prevalence rates are higher than 40 percent; and up to 90 percent in Mauritius. In West Africa studies of IDU have been conducted in several countries showing that the numbers of people who inject drugs vary from a few hundreds to a few thousand.<sup>8</sup> As far back as 1998 IDU was reported in five countries in the region, namely Nigeria, Cote D'Ivoire, Gabon, Ghana and Senegal.

Three rounds of UNODC-funded rapid assessments in Nigeria show that out of the 1,147 street injectors recruited into the survey, 90 (8 percent) were current injectors and 145 (13 percent) had injected at least once in the past.<sup>9</sup> The drugs most often injected were heroin, cocaine, pentazocine

and speedball (a combination of heroin and cocaine). Two groups in the population – female drug users and prison inmates – seem particularly at high risk of being infected with HIV if they inject drugs, hence the need to focus attention on these often neglected groups.

*Prevalence of drug use disorders:* Another source of data on drug use in West Africa is a survey conducted by the World Health Organization which focuses at resources for prevention and treatment. The survey asked for estimates of drug use disorders (abuse and dependence) among males and females aged 15 years and above. Almost all countries provided estimates below 0.5 percent (lower for women than men), with only Ghana and Nigeria reporting a prevalence of about 2.5 percent for males. According to anecdotal evidence (newspaper stories and word-of-mouth), a growing number of families in the region are experiencing the trauma of having a member addicted to a licit or illicit substance.<sup>10</sup>

#### *What does the pattern look like?*

Based on the above, the pattern of illicit drug use in West African countries today is characterized by a very high prevalence of cannabis use and low but increasing rates of cocaine, heroin and ATS use. It is important to stress that the illicit drug scene in any country or region is a dynamic one and influenced by developments in youth culture. Therefore the situation requires regular monitoring and surveillance to identify new substances (or new high risk ways of using old substances), and timely response to prevent rapid escalation in use and reduce the level of harms associated with abuse. While it is difficult to predict what the pattern of drug use will be in the immediate future, we have outlined a few useful pointers that might be helpful in developing and implementing demand reduction policies, which at this stage should be a major focus of attention of policy makers in the region.

- The use of amphetamine-type stimulants, a class of drugs with high negative impact on users and society, will increase. This is shaping up to be a classic case of supply driving demand due to the increased availability through trafficking and local manufacturing of the drugs.
- Trafficking in cocaine and heroin through West Africa will continue, resulting in higher exposure to and increased consumption of these drugs (including IDU) in the region.
- Prescription medications such as opioid analgesics (as in the case of Benylin with codeine) and benzodiazepines (e.g., valium) will become more popular than they are at present.<sup>4</sup>
- The prevalence of cannabis abuse will remain high and with a growing population of urban youth, will contribute to a rising trend in demand for treatment.
- Without appropriate policies and actual investments in services the negative impact of drugs experienced today in various families and communities will increase.

#### **THE IMPACT OF DRUG ABUSE**

Drug use is associated with a myriad of health, social, employment, security, and family problems with clear and often measurable impacts on the afflicted, the people around them, and society at large. As researchers continue to develop better estimates of drug use, efforts are also underway to capture in finer details the health burden and other problems associated with drugs. Estimates of the economic costs of drug abuse have also been conducted in a limited number of countries (Canada, US, Australia, UK) all showing that the economic losses from drug related crime, violence, health care costs, accidents, etc. make up a substantial percentage of GNP.<sup>11-12</sup>

According to recent analyses of the impact of drugs on health, cannabis remains the primary drug of abuse among people seeking treatment for drug problems.<sup>13-14</sup> In Ghana, Niger, Senegal and Togo (and probably in all countries in the region with no reported data) cannabis was mentioned in at least two-thirds of the cases, and in Africa as a whole cannabis is implicated in up to 64 percent of cases of treatment demand. In Burkina Faso cocaine and ATS were mentioned in 20 percent of the cases. As discussed above, some forms of drug use (especially IDU) have a direct link to infection with HIV and hepatitis B and C. In terms of drug-related death, the Comparative Risk Assessment project drugs globally is about 200,000 and 41,000 in Africa.<sup>4</sup> of the Global Burden of Disease Study<sup>11</sup> shows that the number of deaths attributable to illicit

## PREVENTING DRUG USE

Every country in West Africa and beyond has reported on the introduction of different types of prevention programmes.<sup>14</sup> The challenge to policy makers and professionals is to develop and implement drug demand reduction policies that are based on evidence of effectiveness and not on what feels good. While the selected intervention must be tailored to local needs it must however remain faithful to the effective elements.<sup>15</sup>

Prevention comes in different forms, ranging from school programmes, to community based interventions, and mass media and social marketing approaches. Prevention programmes tend to target adolescents by highlighting the dangers of drugs, provision of accurate information, improving self-esteem, and teaching skills to resist peer pressure.<sup>16</sup> Other approaches include broadly based non-drug focused strategies which target the overall development of the child and which seem to have impact on anti-social behaviour, drug use, overall health and educational performance.

In recent years there has been increasing interest in prevention approaches that target interventions at the developmental and transition stages with attention focused on the risk factors that can have an impact at each of these stages. The argument underpinning this approach is based on the fact that the risks do not suddenly appear during adolescence but exist even at the pre-conception stage. For example, interventions that reduce the risk of unwanted or problematic pregnancies, or improve the quality of early bonding of a mother and child, have the potential of affecting drug use in the adolescent years.

### *What do we know about the effectiveness of different prevention strategies?*

A major systematic review<sup>17</sup> and other comprehensive efforts to summarize current knowledge about prevention of drug use<sup>15-16</sup> have led to the following evidence-based conclusions:

Mass media strategies are generally not effective except if delivered in combination with community involvement.

School based prevention programmes that teach social and coping skills have a slight positive effect by delaying initiation when compared to provision of information about drugs and their effects.

Interventions that seek to change the school environment and classroom management are better than trying to change individual behaviour because factors that predict drug use also predict school failure.

Reducing the civil penalties for some drugs (as happened in the case of cannabis in some western countries) does not seem to increase drug use; instead it reduces the costs involved in incarceration.

Based on current knowledge about prevention, and as noted by Babor et al.<sup>16</sup>, it seems that “[t]he interventions that have the largest effect share two characteristics: they focus on early intervention with the proximal social environment, either the classroom or the family, and they address issues other than drugs by focusing on social and behavioral development”<sup>16</sup> Unfortunately many prevention programmes will continue to fail if the “just say no” approach to prevention remains strong and if the investment needed to sustain the needed effort is lacking.

## TREATMENT OF DEPENDENCE

The gap between drug dependence and the availability of treatment services is significant and growing wider as the rate of drug use disorders increases in different countries. In a recent global survey of treatment resources, the data shows a general lack of resources (facilities, personnel, etc.) for treating people with dependence across the world but much more so in African countries<sup>14</sup> and especially in West Africa.

Treatment for drug dependence comes in different forms: specialized (dedicated) services, psychiatric care, the general medical care system, criminal justice/prison system, social welfare system and the voluntary sector.<sup>16</sup> In addition to these orthodox sites, treatment also takes place in traditional and religious healing sites.<sup>18</sup> The latter accounts for a high proportion of people who seek treatment for drug dependence and mental illness in most African countries.

**Availability of treatment:** In a major survey of treatment facilities in Nigeria, Adelekan and Morakinyo (2000) identified the types of treatment operating in the country as follows: purely western orthodox medicine (in psychiatric hospitals); syncretic approaches; purely religious (Christian and Islam) and traditional healing methods; and self help groups such as Narcotics Anonymous using the Minnesota 12-step model.<sup>ii</sup> This classification remains true today and most likely captures the various methods of treating drug problems that have been introduced in other countries in the region.

The proportion of dependent individuals seeking treatment and exposed to the various modalities is unclear but we know that very few of those who need treatment actually get it. And in most cases what treatment they do get is inadequate, in part because there are few dedicated facilities using modern professional approaches to treatment and run by well-trained and qualified staff. The result is poor rate of recovery for a chronic and relapsing condition that by its nature might require several exposures to good professional care and long-term rehabilitation. The only intervention available to most dependent people seeking professional help in West Africa is medical detoxification which is only the initial stage of treatment. Even then, in all countries surveyed, the reported coverage is grossly inadequate. For example, **Table 1** below shows various data on treatment reported by fourteen West African countries.<sup>14</sup> Nine of the fourteen countries have no dedicated budget for treatment services; two (X and X) have budget lines for mental health, which includes substance dependence. Only two countries (Benin and Sierra Leone) reported the availability of some form of national data collection focusing on drug issues. This is an area in which ECOWAS, UNODC and WHO are interested in working together to develop a regional observatory.

**Table 1.** Data on the availability of drug treatment services in 14 West African nations

| Country       | SA Policy exists | Govt. Unit for SUD | Budget Line | Financing Method | Usual Treatment Setting | Medical detox for DUD | SMT available | Specialized Tx available | 3 Most important professionals | National data collection |
|---------------|------------------|--------------------|-------------|------------------|-------------------------|-----------------------|---------------|--------------------------|--------------------------------|--------------------------|
| Benin         | Drugs            | Y                  | Y, drugs    | Tax-based        | Gen health              | Y                     | N             | N                        | Psych, GPs, Nurses             | Y                        |
| Burkina Faso  | N                | Y, alcohol         | N           | Out-of-pocket    | Gen health              | N                     | Y             | N                        | –                              | N                        |
| Chad          | N                | Y                  | N           | Out-of-pocket    | MH service              | Y                     | N             | N                        | Psych, Nurses, GPs             | N                        |
| Cape Verde    | N                | MH                 | N           | Insurance        | MH service              | Y                     | N             | N                        | GPs, Psych, Psy                | N                        |
| Cote d'Ivoire | Y/MH             | MH                 | N           | Out-of-pocket    | MH service              | N                     | N             | N                        | Psych, GPs, Nurses             | N                        |
| The Gambia    | N                | Y                  | N           | Tax-based        | Gen health              | Y                     | N             | N                        | Nurses, PHC workers            | N                        |
| Ghana         | N                | MH                 | N           | Insurance        | MH service              | Y                     | N             | N                        | Psych, Counsellors, GPs        | N                        |
| Guinea        | Y/MH             | N                  | N           | Out-of-pocket    | MH service              | Y                     | N             | N                        | Psych, GPs, Psy                | N                        |
| Mali          | N                | MH                 | N           | –                | MH service              | Y                     | N             | N                        | Psych, Psy, Nurses             | N                        |
| Niger         | N                | MH                 | N           | External grant   | MH service              | Y                     | N             | N                        | Addictologists, Psych, Nurses  | N                        |
| Nigeria       | N                | Y                  | Y/MH        | Tax-based        | MH                      | Y                     | N             | Y                        | –                              | N                        |
| Senegal       | N                | MH                 | N           | –                | MH                      | –                     | –             | N                        | –                              | N                        |
| Sierra Leone  | Y                | MH                 | Y           | NGOs             | MH                      | N                     | N             | N                        | Psych, Nurses, PHC             | Y                        |
| Togo          | N                | Y                  | Y/MH        | Out-of-pocket    | MH                      | Y                     | N             | N                        | GPs, PHC, Psych                | N                        |

*Notes:*

Y = Yes, available    N = No, not available

MH = mental health    Psy = psychologists    Psych = psychiatrists    PHC = primary health care workers    GPs = general practitioners

SMT = Substitution maintenance therapy

Source: WHO, 2010<sup>14</sup>



### *Harm Reduction (HR)*

Harm reduction comprises several activities and programmes that are directed at reducing the negative consequences of substance use. As a public health and human rights concept, HR seeks to make drug use less hazardous to the user and others. Some of the well-known HR programmes are needle and syringe exchange, supervised injection facilities, outreach services for injection drug users, substitution therapy, prevention of overdose and programmes targeting high risk groups (e.g., people in prisons). Not surprisingly, harm reduction is rarely practiced in the West African region: only one country in the survey cited above engages in outreach services for injection drug users. HR will have to be more acceptable and practiced in the region in response to increasing IDU and as a HIV prevention strategy. This will call for changes in the attitudes of policy makers and the public regarding practices that are seen as encouraging continued use of drugs. Indeed the African Union's first Plan of Action on Drug Control (2007-2012) recognized the role of harm reduction in addressing drug problems by calling on Member States to "conduct training in harm reduction, drug abuse treatment and rehabilitation, and provide services for drug dependent individuals, including street children and child soldiers."<sup>iii</sup> In a declaration of commitment on HIV/AIDS issued six years before this, the UN General Assembly called for "expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counseling and testing..."<sup>19</sup>

### *Does treatment work?*

The question "does treatment work?" continues to be asked by people who genuinely seek answers and those who through personal experience have serious doubts about the long-term effectiveness of treatment in any form. There is consensus today that treatment works and that from a cost-benefit perspective, the return on investment is very high.<sup>20-21</sup> The evidence is overwhelming that the benefits of treatment in monetary terms are significantly higher than the cost expended on providing affordable and accessible treatment services. These benefits accrue from reduced crime rates and unemployment, less workplace problems (including absenteeism), lower levels of drug use, and savings from health care expenses. Treatment for drug use disorders seems to be at least as effective as treatment for other chronic and relapsing conditions like diabetes, hypertension and asthma.<sup>22</sup>

In a major attempt to assess the effectiveness of various strategies for dealing with drug problems, researchers found good evidence that several approaches including opiate substitution therapies, psychosocial treatment, self-help organizations and brief intervention, were all associated with reduced drug use and crime, and improved health and wellbeing.<sup>16</sup> (see Appendix 2). Hence, the debate today should not focus so much on whether or not treatment works and which modalities are the most effective (and cost effective); rather the focus should be on how to make treatment services available to those people who need treatment for a health condition that is beyond their personal control.

What appears to contribute most to successful interventions is the length of time a client remains in treatment. Another factor is comprehensiveness of treatment, with programmes that target several aspects of the client's life (job, social skills, health care, family) more likely to lead to better outcomes than others. The qualities of the treatment system operated within a country are also important factors: effective systems are characterized by equity (treatment should be available and accessible to all), efficiency (there should be a mix of services as already mentioned above), economy (treatment should be cost-effective).<sup>23</sup> In other words a public health approach to drug challenges, one that is guided by concerns for human rights, seems to provide the most effective framework for dealing with substance use disorders.

### *Why bother?*

Related to the question of effectiveness (whether or not treatment works) is the question of why a society (a country) should be concerned about addiction to psychoactive substances. Why bother with a condition that is non-communicable and in most instances willfully initiated by an individual? Why not just focus attention on keeping the drugs “off our shores” (even if we have been notably unsuccessful with this strategy)? The quick answer is that from a cost perspective alone, treatment provides wider social benefits than no treatment, and comparative analyses have shown that punishment as a driving force in drug control is more costly to society than providing services to drug users.<sup>24</sup> Whether the response requires methadone maintenance or psychosocial therapies (as in cognitive behavioural therapy for cocaine addiction) or a combination of therapies, treatment and a general shift from punishment to rehabilitative or non-punitive services for addicted users will reduce the many “externalities” associated with drug use – violence, crime, disease and death.<sup>16</sup> Thus far, the dominant response has been in-patient psychiatric hospital-based care but there is sufficient evidence to suggest that out-patient care, drop-in centres and service at primary health care systems where the addicted come in contact with professional care can all be effective responses. In this regard, lessons can be garnered from the experiences of countries such as China, Iran, Tanzania and Kenya where initial rejection of evidence-based treatments like methadone maintenance resulted in costly delays and a worsening of the HIV situation in those countries.<sup>25-26</sup>

## **2. RESPONDING TO DRUG PROBLEMS IN WEST AFRICA**

What has been the response to drug problems in the West African region? By all measures of development in the substance abuse prevention and treatment fields, West Africa has been the least developed region for many years. In terms of drug policy orientation the focus has tended to be predominantly on law enforcement, in some cases with severe punitive measures. In addition, drug control bodies tend to fall under the responsibility of Ministries of Justice, and success is generally measured in terms of number of arrests. Policies, when they exist, tend not to be guided by evidence of effectiveness, a problem that is not limited to West African countries where policies are often driven by external considerations and not the public interests of citizens.<sup>16</sup> Other challenges to effective responses in the region include a very weak empirical base underpinning existing policies; an underdeveloped capacity for research and treatment; more reliance on supply reduction than demand reduction; and cultural beliefs and practices that help sustain the perception of the “addict” as a criminal, social outcast or moral failure.

As noted above, Table 1 shows in some detail the current state of response to drug problems in almost all the countries in the region. One glaring deficiency highlighted in the responses provided by countries is the lack of substance abuse policy. More than half of the countries had no policy on this issue; and where policy was defined, it was as a “written document containing goals of prevention and treatment activities related to use, abuse [of] and dependence [on] alcohol, prescription and non-prescription (including illicit) drugs.” Four of the countries (Cote d’Ivoire, Guinea, Nigeria, and Togo) reported that substance abuse was part of the government’s mental health policy. Only one country (Sierra Leone) reported having a substance abuse policy as defined. Related to the availability of written policy, few countries (Niger, Nigeria, Sierra Leone, Togo) reported the presence of special legislative provisions for treatment and rehabilitation and/or compulsory treatment for people with SUD. Two countries (Cape Verde and the Gambia) had established drug courts, an innovation that can be used to divert drug dependent persons into treatment instead of jail. The table also presents data on financing treatment, availability of services, and the usual setting for treatment services.

While the table demonstrates that the current situation is inadequate in many ways, certain recent developments may lead to some shift in emphasis from fighting a “war on drugs” to creating space

for drugs in the public health and social welfare agenda. The following are a few examples of noteworthy developments.

- Both the Economic Community of West African States (ECOWAS) and the African Union have developed Action Plans to address some of the prevention and treatment needs of the region, including HIV prevention among IDUs.<sup>27-29</sup>
- As part of its action to improve on data availability, within the framework of its 2008-2011 Action Plan, ECOWAS is planning a project on treatment demand indicators.<sup>iv</sup>
- A UNODC/WHO observatory project in Senegal is currently under discussion.
- The European Union, Nigerian Government and the UNODC have finalized a plan for work in various areas of drug control including treatment and prevention, etc.

### 3. CONCLUSION AND RECOMMENDATIONS

In summary, while much is lacking in evidence-based drug demand reduction services in West Africa there are positive signs of a growing interest in preventing an upsurge in illicit drug use and dependence. This is a propitious time to act to maintain or reduce the current relatively low consumption, crime and violence levels in the region not least because the knowledge base for action is there and the region is some distance away from what could be described as an epidemic. In order to prevent such an undesirable outcome, West African countries will however, need to engage in the following actions:

1. Develop and implement broad-based policies that recognize the relationship between some forms of drug use, HIV/AIDS and other blood borne infections.
2. Invest more financial resources in implementing effective prevention and treatment services for problem drug users.
3. Recognize that drug dependence treatment is a multi-faceted intervention and that addiction is a public health matter which should be managed by trained professionals.
4. Encourage greater civil society participation in prevention and treatment service delivery by providing grants and other forms of support.
5. Implement a sustainable data collection, monitoring and surveillance system that will help identify trends in drug use and drug-related problems and inform policy.

Finally, policy makers in the region must recognize the role of alcohol, tobacco and other psychoactive substances as potential stepping stones to illicit drug use and the health and social costs associated with them. In order to capture this reality and other related issues it is highly recommended that substance abuse policy be anchored in a broad public health perspective,<sup>30</sup> rooted in the social and cultural realities of each nation.

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i Today only a small number of countries in Africa (Egypt, Somalia, Zimbabwe) still apply the death sentence for drug related offences. Nigeria abolished the death penalty for drug trafficking in 1986; Gambia in 2011.

ii The philosophy behind the Minnesota 12-step model was developed by people recovering from alcohol addiction. The philosophy comprises a belief that addiction is an emotional, physical and spiritual problem and that the goal of treatment should be lifetime abstinence which can be achieved through affiliation with a self-help group and spiritual reawakening.

iii AU, (2007, p. 9). While the overall aim of the follow-on Draft Plan of Action (2013-2017) is more progressive, it does not include a direct mention of harm reduction.

iv Success of the project will however, be contingent on whether the project is adequately funded and if it is underpinned by sound baseline data.

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## **APPENDIX 1: RELATED BIBLIOGRAPHY**

World Health Organization (2006). *Basic principles for treatment and psychosocial support of drug dependent people living with HIV/AIDS*. Geneva: WHO.

Lists and discusses the following principles:

Principle 1. Human rights of drug dependent people with HIV/AIDS

Principle 2. Evidence-base for treatment, care and psychosocial support

Principle 3. Appropriate treatment and psychosocial support

Principle 4. Equitable access to HIV/AIDS care and treatment including antiretroviral therapy (ART)

Principle 5. Supportive environments to enable and facilitate treatment, care and psychosocial support

Principle 6. Client participation

Principle 7. Participation of community and other stakeholders

WHO/UNODC (2008). *Principles of drug dependence treatment*. Geneva: WHO.

Principle 1: Availability and accessibility of drug dependence treatment

Principle 2: Screening, assessment, diagnosis and treatment planning

Principle 3: Evidence-informed drug dependence treatment

Principle 4: Drug dependence treatment, human rights, and patient dignity

Principle 5: Targeting special subgroups and conditions

Principle 6: Addiction treatment and the criminal justice system

Principle 7: Community involvement, participation and patient orientation

Principle 8: Clinical governance of drug dependence treatment services

Principle 9: Treatment systems: policy development, strategic planning and coordination of services

**UN Agencies (2012). Joint Statement on Compulsory drug detention and rehabilitation centres. Geneva: UNAIDS.**

*Items 1, 2 and 3 are available online at [www.who.int/substance\\_abuse](http://www.who.int/substance_abuse)*

Obot et al. (eds. 2012). *Substance abuse and HIV/AIDS in Africa*. Uyo/Abuja: Centre for Research and Information on Substance Abuse (23 papers on the topic; complimentary copies available on request)

Special issue of the *African Journal of Drug and Alcohol Studies* (Volume 5, Number 2, 2006) on "Substance abuse and HIV/AIDS in sub-Saharan Africa". (Abstracts available online at [www.crisanet.org](http://www.crisanet.org))

Dua, T., Barbui, C., Clark, N. et al. (2011). Evidence-based guidelines for mental, neurological, and substance use disorder in low- and middle-income countries: summary of WHO recommendations. *PLoS Medicine*, 8(11), e1001122.

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United Nations Office on Drugs and Crime (2010). From coercion to cohesion: treating drug dependence through healthcare, not punishment. Vienna: UNODC.

**WHO/UNODC/UNAIDS (2004). *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: position paper*. Geneva: WHO.**

*From the position paper:*

No single treatment modality is effective for all people with opioid dependence. Adequate access to a wide range of treatment options should be offered to respond to the varying needs of people with opioid dependence.

Substitution maintenance treatment is an effective, safe and cost-effective modality for the management of opioid dependence. Repeated rigorous evaluation has demonstrated that such treatment is a valuable and critical component of the effective management of opioid dependence and the prevention of HIV among IDUs.

There is mounting evidence that improved outcomes from opioid substitution maintenance therapy arise from timely entry into treatment, longer duration and continuity of treatment, and adequate doses of medication.

Individuals with opioid dependence benefit from substitution maintenance therapy through increased stability and improved well-being and social functioning. People receiving substitution therapy can make significant progress in their physical and emotional life, as well as in their relationships with others and their ability to contribute meaningfully to their community and society at large.

Society as a whole benefits from substitution maintenance therapy through reductions in the incidence of criminal behaviour, reduced health and criminal justice system costs, reduced risks of transmission of HIV and other blood-borne viruses, and increased productivity. There is a strong case for investing in opioid substitution maintenance therapy, as the savings resulting from treating an individual far exceed the costs.

Provision of substitution maintenance therapy of opioid dependence is an effective HIV/AIDS prevention strategy that should be considered for implementation – as soon as possible – for IDUs with opioid dependence in communities at risk of HIV/AIDS epidemics... Provision of substitution maintenance therapy should be integrated with other HIV preventive interventions and services, as well as with those for treatment and care of people living with HIV/AIDS.

The practice of substitution maintenance therapy must be guided by research evidence and supported by adequate training and evaluation. Possible adverse consequences need to be minimized by adhering to best clinical practices, monitoring treatment quality and outcomes, and instituting adequate control measures and regulations to avoid diversion of the medicines into illicit channels.

**APPENDIX 2: EFFECTIVENESS OF SELECTED STRATEGIES AND INTERVENTIONS (From Babor et al. 2010, *Drug policy and the public good*)**

| Intervention                          | Effectiveness  | Comments   |
|---------------------------------------|--|--|
| <b>PREVENTION STRATEGIES</b>          |  |  |
| Family/parenting programmes           | A few studies in the US show effectiveness in reducing the onset of drug use               | Target non-users, adolescents, parents, the public |
| Affective education                   | No evidence of effectiveness   |  |
| Information/knowledge only            | No evidence of effectiveness   |  |
| Mass media                            | No evidence of effectiveness   |  |
| Social marketing                      | Insufficient evidence of effectiveness   |  |
| Drug testing in schools               | No evidence of effectiveness   |  |
| <b>TREATMENT SERVICES</b>             |  |  |
| Methadone maintenance                 | Good evidence for reduced heroin use, other drug use, crime, HIV infection, and hepatitis  | Target people with substance use disorders         |
| Buprenorphine maintenance             | Good evidence for reducing heroin use, other drug use, crime, HIV infection, and hepatitis |  |
| Opiate antagonists (e.g., naltrexone) | Some evidence of reduced opiate use but problem with compliance                            |  |
| Needle exchange programmes (NEP)      | May reduce drug-related infections and facilitate treatment engagement                     |  |
| Psychosocial treatment                | Good evidence for reducing drug use, drug related problems, and criminal activity          |  |
| Self help (e.g., NA)                  | Good evidence for reducing drug use, crime, and infections                                 |  |
| Brief interventions                   | Good evidence for reducing drug by at-risk drug users                                      |  |
| <b>SUPPLY CONTROL</b>                 |  |  |
| Alternative development               | No known instance of effect on drug use  | Target   |



|  |   |  |
|--|---|--|
| Crop eradication                                 | Can create temporary market disruption  | producers and traffickers  |
| Precursor chemical control                       | Good evidence for temporary disruption in drug market                               |  |
| Interdiction                                     | May disrupt supply chain and increase cost  |  |
| High enforcement through criminal investigations | Limited evidence of dose-response effect  |  |
| Street-level enforcement                         | More evidence of ability to modify market than reduce availability                  |  |
| Imprisonment                                     | There may be diminishing returns to expansion of imprisonment beyond certain levels |  |
| <b>CRIMINALIZATION AND DECRIMINALIZATION</b>     |   |  |
| Changing the level of criminal penalties         | Moderate or no effects on cannabis use  | Target drug, especially cannabis, users                          |
| Diversion to mandated education or treatment     | Little effect on cannabis-related problems  |  |
| <b>REGULATORY INTERVENTIONS</b>                  |   |  |
| Restrict over-the-counter (OTC) sales            | Some evidence that OTC restrictions prevent health problems with analgesics         | Target inadvisable use of drugs, doctor and pharmacist behaviour |
| Require prescription                             | Support for some effect   |  |