



# Drug News Africa

Let the Continent Speak Out!

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## Time Ripe in Kenya for Needle and Syringe Programme and Opiate Substitution Therapy

*"Intravenous Drug Users (IDUs) contribute 5.8% of new infections for Nairobi and 6.1% for the Coastal province of Kenya."*

**2008 Kenya Modes of Transmission Study**

**By Saade Abdallah**

The first case of HIV in Kenya was documented in 1984. The country is currently experiencing a mixed and geographically heterogeneous HIV epidemic with a 'generalised' epidemic among the mainstream population, and a 'concentrated' epidemic among specific most-at-risk populations.

According to the National HIV estimates for 2011, an estimated 1.6 million people are living with HIV in Kenya, with about 105,000 adults acquiring HIV infection annually (National HIV Indicators for Kenya 2010, NACC and NASCOP). Recent population surveys have reported a decline in overall, HIV prevalence from 7% for adults aged

15-49 in 2003 and 2007 to 6.4% in 2008-09 (Kenya Demographic and Health Survey, 2008/9). This decline may be attributed to various targeted responses among the general population.

### Injection use & HIV

Despite these achievements, evidence shows there may be a shift in modes and patterns of HIV transmission in Kenya, as in other countries. Heroin has been used in Mombasa for over 25 years and by the end of the 1990s users in Mombasa and other towns were shifting to injection. It is probable that heroin use in Nairobi also began in the 1980s, and that injecting levels increased in the late 1990s. The 2008 Kenya Modes of Transmission Study showed that 3.8% of new infections are attributed to injection drug users who have the highest incidence rate of 256 per 1,000 IDUs due to efficient transmission through sharing

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# Editorial comment:

## It's in Our DNA



We welcome you to our second edition of **DrugNewsAfrica (DNA)** – a quarterly newsletter aimed at stimulating discussion and debate on drug control and related crime challenges on the African continent and the efforts underway to address them.

Africa, like the rest of the world, is grappling with the twin challenge of narcotic drugs and crime and efforts to confront them are often hampered by insufficient understanding of dynamics involved. A multi sectorial and balanced approach between legislative norm setting, law enforcement, and drug abuse prevention and treatment activities, will go a long way in the fight against drugs and crime.

Moreover, because of the scale of the problem and its trans-border nature, African Members States are encouraged to adopt regional approaches. In this issue which mainly focuses on the impact of drugs, we present proposed Continental Minimum Quality Standards for Drug Abuse Prevention and Treatment and Common Position on Controlled Substances and Pain Management in the continent, challenges of drug abuse and prevention, treatment and rehabilitation efforts from three countries including testimonies from recovering addicts.

Elsewhere in this edition are a number of articles aimed at stimulating discussion such as “where to fit the drug problem”, “driving under the influence of cannabis” and “doping in

sports”. Your comments, suggestions and support are appreciated. I take this opportunity to make special a call to our readers to contribute articles on this important subject: scholarly, policy or programme intervention oriented. Let's share our research, good practices, and challenges encountered, all aimed at enriching our response. The spirit in our DNA is to tackle the problem of drugs and crime head on ■

LET'S HAVE YOUR SAY.

**H.E. Adv. Bience Gawanas, AUC  
Commissioner for Social Affairs**

## Feature: Time Ripe in Kenya for Needle and Syringe Program and Opiate Substitution Therapy

*Continued from page 1*

of needles and other risky behaviours. The model indicated that IDUs contributed 5.8% of new infections for Nairobi and 6.1% for Coast. Although injecting drug users comprise a relatively small part of the total population (about 0.3% of the total male population), incidence among injection drug users is extremely high (256 per 1000) and for partners of IDUs 78 per 1000 due to their high HIV transmission potential of 26% (Kenya HIV Prevention Response and Modes of Transmission Analysis, 2009).

Drug users in Kenya are hidden and difficult to reach due to stigma, the illegal nature of drug use, the association of drugs with poverty and crime and the fact that the majority of drug users live in slums and other low income

*Drug users are encouraged to reduce the frequency of injecting, to shift from injecting to smoking, and to consider addiction counseling in order to stop or reduce using drugs. Other strategies include encouraging clients to procure sterile needles and not to share them with other injecting drug users.*

communities. Most substance abusers do not access medical services and if they do, they are likely to conceal their substance abuse from health care providers. In addition, drug and HIV and AIDS prevention and treatment services for drug users are extremely limited. The only public sector facilities providing treatment of addiction in

Kenya is the Mathare Mental Hospital in Nairobi, Coast Provincial General Hospital and Port Reitz District Hospital in Mombasa. Due to high rates of unemployment, family and community stigma, quasi-inexistent social support and poor or no follow up care, relapse rates are high.

Four community based organisations Nairobi Outreach Services Trust (NOSET), Reachout Centre Trust, Muslim Education and Welfare Association (MEWA) and The Omari Project (TOP) with support from the United Nations Office on Drugs and Crime (UNODC) and the Joint Team on AIDS in Kenya, have provided a basic package of HIV and drug abuse prevention, care, and treatment to people who use drugs including inject-

*Continues on page 3*

**Feature: Time Ripe in Kenya for Needle and Syringe Program and Opiate Substitution Therapy***Continued from page 2*

ing drug users in Nairobi, Mombasa and Malindi. Outreach workers, who are often former drug users, including those living with HIV, contact active drug users in the community to deliver HIV risk reduction messages and behavioral skills, and to engage them in HIV and AIDS and addiction care and treatment services. Interventions with IDUs focus primarily on counseling on risks of needle sharing and distribution of bleach, alcohol swabs and water for injection.

**Interventions**

Drug users are encouraged to reduce the frequency of injecting, to shift from injecting to smoking, and to consider addiction counseling in order to stop or reduce using drugs. Other strategies include encouraging clients to procure sterile needles and not to share them with other injecting drug users. According to the WHO, UNODC and UNAIDS Guidance Note on HIV prevention among persons who inject drugs, an effective response to drug and HIV epidemics are needle and syringe access programs (NSPs) and opiate substitution therapy (OST).

Unfortunately these interventions are not currently available in Kenya due to restrictive policies and limited understanding among key stakeholders. Not surprisingly, recent IDU studies and routine programme data indicate that the HIV prevalence among injecting drug users is more than thrice the national HIV prevalence and without additional interventions this may increase and reverse gains made in HIV control among the general population. In December 2010 drug users in

Coast Province experienced a sudden scarcity of heroin which resulted from a firm police crackdown on drug traffickers. This may have been triggered by the US Ambassador to Kenya naming several prominent businessmen and Members of Parliament as drug barons. Many drug users immediately experienced severe withdrawal symptoms that forced them to seek medical treatment and thereby risk arrest. Because of the high demand for treatment by opioid users, the Coast Provincial Commissioner declared that all users should be considered as patients rather than criminals.

**Treatment services**

Stakeholders from Kenya's National Campaign Against Drug Abuse Authority (NACADAA), the United Nations Office on Drugs and Crime (UNODC), and civil society organizations promptly initiated emergency services at the Coast Provincial General Hospital and eleven surrounding primary health care facilities in order to respond to the crisis. Within no time the problem of substance abuse received substantial media coverage. Between January and June 2011, a total 5000 drug users were reported to have accessed drug treatment services from the 14 health facilities.

**Increasing awareness**

According to Dr. Frank Njenga, Chairman of the Advisory Council of NACADAA, before the heroin crisis, substance abuse was considered to be "other people's problem". Many stakeholders from government, NGO, private sector and community simply relied on UNODC and its partner NGOs to address the problem. HIV interventions for injecting drug users were included in GFATM R10 primarily to meet the stringent Global Fund requirements. However, ongoing media coverage on the heroin crisis has increased public concern regarding substance abuse and demand for government intervention.

By the end of October 2011 following attendance to regional conferences on Harm Reduction in Kenya

and Mauritius, a high-level study tour in Spain, United Kingdom, a critical mass of high-level government officials and implementing partners were convinced that the time is ripe to introduce needle and syringe programmes plus methadone therapy. As a result, efforts are underway to educate the HIV Parliamentary Committee on this matter. The just concluded UNODC-funded Rapid Situational Analysis of HIV prevalence and risky behavior among IDUs, plus the CDC-funded Most at Risk Populations (MARPs) surveillance and size estimation will provide the Government of Kenya via NACADAA, the National AIDS Control Council (NACC) and Ministries of Health National AIDS and STI Control Programme (NASCOP) the much needed evidence to advocate for and develop more enabling policies on HIV and drug abuse prevention and control in Kenya.

**Increasing momentum**

The following activities further illustrate how the momentum has escalated for more effective harm reduction interventions within less than 12 months from the December 2010 heroin crisis:

- The Prime Minister and Minister for Medical Services have requested the UNAIDS Executive Director for UN support in addressing the problem of substance abuse in Kenya.
- The Center for Disease Control and Prevention has subcontracted NOSET to implement a pilot needle and syringe program in Nairobi which will complement the five Needle and Syringe Programme (NSP) sites to be established under Global Fund to Fight AIDS, TB and Malaria (GFATM) Round 10 HIV grant.
- The Heads of NASCOP through the Head of Prevention and Programme Manager for MARPs convened a Breakfast Meeting on November 2011 to build consensus with members of the IDU Technical

*Between January and June 2011, a total 5000 drug users were reported to have accessed drug treatment services from the 14 health facilities. "Before the heroin crisis, substance abuse was considered to be - other people's problem."*

**Dr. Frank Njenga, Chairman of the Advisory Council of NACADAA**

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# Taking the Bull by its Horns

## *Mathari Hospital Drug Treatment and Rehabilitation Center, Kenya*

*“Majority of Kenyans are not aware of the existence of treatment and Rehabilitation services for persons with substance use disorders”*

The Mathari drug abuse prevention and treatment Centre was established in May 2003 through a collaborative effort of the Ministry of Medical Services and the United Nation Office of Drugs and Crime (UNODC), with a bed capacity of 15 patients for males, in response to rising demand for drug use treatment and rehabilitation services.

Alcohol and drug abuse in Kenya, as in other countries, permeates every sphere of society. Levels of abuse are worsened by easy access to cheap alcohol and other drugs (both licit and illicit) as well as a permissive society. The National Agency for the Campaign Against Drug Abuse Authority (NACADAA) in 2007 estimated that one in every 10 alcohol or drug users seek help for chemical

dependence related problems.

Mathari national and referral hospital located in Nairobi bore the biggest burden as majority of these patients who were either severely intoxicated or experiencing withdrawal from substance abuse were being admitted at the Hospitals' psychiatric wards as there was no rehabilitation ward. They would present different psychiatric disorders ranging from depression, anxiety disorders, mood disorders, personality disorders, schizophrenia not to mention the many other medical conditions (liver cirrhosis, hepatitis, TB, Ulcers and HIV/AIDS just but to mention a few.

### Capacity

However, after a short period of detoxification and subsequent treatment from the presenting symptoms, these patients would improve and were discharged but sooner than later they would be re admitted with similar problems. This is because, majority of Kenyans are not aware of the existence of treatment and Rehabilitation



A mural at the Mathari Drug Rehabilitation Centre

### Treatment statistics and admission trends, Mathari hospital, 2006-2011;

Drug Type:		2006		2007		2008		2009		2010		2011		Total	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
Alcohol		78	5	98	8	71	2	66	0	100	7	71	0	484	22
Khat and cannabis		40	0	35	2	27	0	34	0	20	0	6	0	162	2
Heroin	IDU	4	0	5	0	4	0	2	0	0	0	0	15	0	
	Chaser	19	0	13	1	2	4	7	0	1	0	2	44	6	
Cocaine		2	0	2	0	1	1	0	0	0	0	0	0	5	1
HIV+		34	0	31	0	33	0	30	0	0	0	0	0	128	0
Multiple Drug		62	2	60	4	55	0	54	0	16	0	24	0	271	6
Total		28	7	200	15	160	6	193	0	137	7	98	1	1,109	37

Total admissions to date is 11441000 97% being males. Access to services by females need strengthening. Anecdotal evidence points to as many female drug users as their male counterparts. Correlation between HIV and drug use has been established to be significantly high with 11 % of those accessing services found to be HIV positive.

(Compiled by Dr. Nelly Kitazi. Superintendent, Mathari national and referral hospital)



services for persons with substance use disorders. Moreover, the capacity of existing drug dependence treatment facilities to deal with the challenge is limited owing to their inaccessibility both physically and financially as majority of them are privately owned.

### Demand

By 2006, there was an increasing demand for these services for both males and females and as a result, patients who were seeking the services at the center were being booked to await a chance to be admitted. Thus, in July 2006, a male wing with a 32 bed capacity, was renovated, leaving the 15 bed capacity initially occupied by males to females patients. This has not been sufficient either as there are always more than 20 patients in the waiting list awaiting admissions to the Drug Unit. The hospital, through the



partnership between the Ministry of Medical Services and UNODC is at an advanced stage of starting an out-patient service.

The treatment center offers detoxification, rehabilitation and treatment of co-morbid psychiatric disorders with a well-refined referral system to those who are physically sick or those who need specialized treatment to include surgery and gynecological treatment. It is a 90-days program based on the matrix model and recently the rehabilitation center has incorporated some of the concepts of the Therapeutic Community (TC) Model. The TC model uses the approach of Community as a method, where members interact in a structured and unstructured ways to influence attitudes, perceptions and behavior associated with drug use.

### Statistics

Most common substances of abuse among the patients admitted in this facility in Kenya generally are alcohol, tobacco, cannabis(bhang), khat (miraa), inhalants(glue), prescription drugs and narcotic drugs in that order. Moreover, 40% of Kenyans aged 15 and 65 years have used one type of alcoholic beverage or another, and at least 13% of people from all provinces in Kenya except North Eastern are current consumers of alcohol (UNODC 2007). There is thus an urgent urgency for the Government to start similar treatment and rehabilitation in other provinces to increase access ■

### Feature story:

#### *Continued from page 3*

Working Group on a coordinated approach and an implementation framework for the needle and syringe program.

- NASCOP is also mapping stakeholders supporting interventions within Kenya targeting most-at-risk populations, including injecting drug users.
- To better address the negative attitude of the judiciary to drug users, the Chief Justice has requested NACADAA and NACC for a curriculum to train the judiciary on petty crimes for substance abuse.
- Substance abuse management is now in the medical curriculum while Psychiatry and Clinical Psychology offer diplomas in substance abuse.
- Development of national harm reduction guidelines which will provide guidance on Needle and Syringe Programme, Opiate Substitution Therapy (OST) and antiretroviral therapy for injecting drug users is in the pipeline
- National Drug Treatment Protocol which includes OST is almost finalized
- Methadone has been included in the ministry of health's Essential Drug List

Close monitoring and documentation of Kenya's progress with implementation is vital to guide future scale up of the Needle and Syringe Programme plus the Opiate Substitution Therapy and to inform other countries experiencing a mixed epidemic of HIV and substance abuse ■

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# Continental Minimum Quality Standards *for Drug Abuse Prevention and Treatment*

The African Union Commission has developed draft continental minimum quality standards for drug abuse prevention and treatment, one of the tenets to strengthen cooperation and coordination in the fight against drugs and crime, as defined by the 4th Session of the AU Conference of Ministers for Drug Control and Crime Prevention (CAMDCCP4) and endorsed by Executive Council Decision EX.CL/615(XVIII) of January 2011.

The need for such standards was reiterated by African members states attending the 21st Heads of National Drug Law Enforcement Agencies (HONLEA), Africa meeting in September 2011, which inter alia discussed need to devote greater attention and resources to the establishment of rehabilitation centers for the treatment of substance abuse.

The draft continental minimum quality standards' document highlights important facets of a national drug control master plan, envisaged elements of Minimum Quality Standards (MQS) for Drug abuse Prevention and treatment; and an evaluation and monitoring component.

This document is aimed at building consensus on minimum standards necessary to provide quality and effective prevention, treatment and care services in Africa. The final document will be presented to the Ministers in charge of drug control during the 5th Session of the AU Conference of Ministers in Charge of Drug Control

*H.E. Mr. Edward Ssekandi, Vice-President of the Republic of Uganda addresses participants during the "Continental Think-Tank Consultation to Fast Track and Facilitate Implementation of AUPA..." in Kampala, October 2011.*



and Crime Prevention, (CAMDCCP5) in September 2012 for consideration and adoption.

Given that development of such a standard require the involvement of a wide range of stakeholders to ensure that it gains support and acceptability, the AUC will organize requisite stakeholder and technical consultations, including validation with the African Union Member State's Bureau responsible for drug control and crime prevention, based in Addis Ababa.

As a first step, the draft was presented to about 100 experts during the "Continental Think-Tank Consultation to Fast Track and Facilitate Implementation of AUPA..." in Kampala, October 2011. The issues raised by experts on the draft include:

- Need to strike a good balance between prevention and treatment
- Need for comprehensive

prevention strategy to reduce new entries to drug use and prevent progression to problematic drug use

- Review application of minimum standards in mental institutions
- Whole question of drug abuse treatment and care in prisons: what is more practical and desirable, how to deal with those in conflict with the law because of drug use problem, how to treat hard core criminals who are also dependent on drugs, and thus the whole question of alternative sentencing to a drug rehabilitation center, implanting rehabilitation centers in the prison settings, or both.
- Need to link standards with implementation plan and effective funding strategy for implementation
- Well thought out training and training needs assessment for service providers
- Develop a monitoring and evaluation framework ■



*Continental think-tank consultation on AU Plan of Action on Drug Control and Crime Prevention, 12-13 October 2011*

These and other inputs received will be incorporated in the final document. The document can be accessed at [www.au.int/en/](http://www.au.int/en/)

*Lets Have Your Say!*

# Where to Fit the Drugs Issue?

*"The world is gradually awakening to the reality that our current drug policies have failed."*

By Chantel Marais

**D**rugs and drug abuse are controversial, complicated and, more importantly, interesting subjects.

Drugs are absolutely a social issue because drug abuse is a problem that affects not only the person using drugs, but loved ones and friends as well – having a social impact that cannot be denied or ignored.

Above said, drug abuse and addiction are also public health problems that affect many people and have wide-ranging social consequences.

## Drugs and conflict

There is no doubt that drugs and drug abuse are a security issue. The world cannot ignore the clear links between drugs, development and conflict. Unfortunately, conflict and drugs go together very well since poor development fuels conflict, which fuels the drug trade, which fuels conflict, which fuel poverty. Drug lords take advantage of the poor and force them to produce drugs, often leaving them more vulnerable. Drug control agencies must learn to better look beyond the simple realities of drug production, and take into account the social and economic factors that fuel cultivation and consumption.

And then undeniably, drugs are now a criminal issue, due to the approach that drugs should be prohibited through supply reduction. But supply reduction is expensive and, (if done effectively) results in extra pressure on the criminal justice system and overflowing prisons.

The financial value of the global drug trade is estimated at about US\$400 billion per year - untaxed! Add to that the fact that drugs, a consumable, is attractive for criminal organisations because potential profits are significantly more than from other criminal commodities. While much effort goes into negating illegal drugs,



but there are legal drugs that affect far more people worldwide than illegal drugs: tobacco and alcohol. These legal drugs are exponentially more detrimental to the users health, and society. If drugs are harmful, shouldn't it be legalised and regulated? Why would you want cocaine to be illegal, when it can be purchased from a drug dealer who does not ask for ID and sell to minors, who does not know of the potency nor the purity of the drug? Is it not better overall for drug users to buy from places where they could be sure the drugs had not been cut with dangerous, cost saving chemicals.

## Drugs and crime

It would seem that drug abuse has been made a crime, because drug abuse threatens the health of the user, those around them and the wider society. There is also a direct correlation between drug abuse and crime, not merely due to the criminality of the drugs themselves, but by abusers who are attempting to fund their habits. Though it can be argued that legalisation would increase the availability and reduce the cost of such drugs, many drug abusers are unable or unwilling to hold down a job and so would still resort to crime.

From an evidence-based public policy perspective and based on widely available data, drug law enforcement contributes to gun violence and high homicide rates and that increasingly sophisticated methods of disrupt-

ing organisations involved in drug distribution could increase violence. Therefore, since drug prohibition has not achieved its stated goals of reducing drug supply, alternative regulatory models for drug control will be required if drug market violence is to be substantially reduced.

The reality is that the global drug problem is not being contained. Some argue that drugs are not dangerous because they are illegal; they are illegal because they are dangerous. Legalisation and decriminalisation - policies certain to increase illegal drug availability and use among our children - hardly qualify as public health approaches. It is also amoral to expect society and specifically the tax payer to tolerate the social cost of drugs without protest, yet then be forced to pay for the drug abusers treatment.

More effective prevention methods would however be more police and tougher sentences for drug abusers.

Although there exists a correlation between drug abuse and crime, it does not prove causation. The solution is not prohibition, because it creates violence on a much larger scale as profitability becomes reality for illegal drugs ■

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Chantel Marais is a Senior Drug Control Officer at the Department of Social Affairs at the Africa Union Commission (AUC). The views and opinions expressed in the article are those of the author and do not necessarily represent the views of AUC.

# The Union of Sahaida and Shalamar\*

*First hand experiences from the Omari Project Treatment and Rehabilitation Centre, Malindi, Kenya - a report by Outreach Workers*

Sahaida is a lady and Shalamar is a man. The two started a process of recovery from drug abuse separately but now they continue to tread the path together and in awe reflect on a life that was and now is.

We first met Sahaida in 2005 when she was a Commercial Sex Worker, heroin smoker and alcoholic. Though she had been married to a drug dealer previously, her substance use did not start until after his death. The mother of three felt hopeless and was irresponsibly wrecking the lives of herself and her children.

When the Outreach Workers (ORWs) first met her, she had no interest in rehabilitation and recovery but we did not give up on her. Time and time again we visited her, providing motivation and education on risk reduction and HIV and AIDS, including VCT testing until she agreed to take an HIV test and see an addiction counselor. After assessment she was admitted to the rehabilitation center, where she stayed clean for a few months before relapsing. After her relapse, the ORWs and addiction counselors



*Sahaida, six years ago, active injecting drug user.*

designed a targeted approach with ongoing education and motivation to seek rehabilitation and take control of her life. She began visiting the Omari Drop-in Center for addiction counseling until 2008 when she was readmitted to the rehabilitation center. She has remained clean to date.

We also have Shalamar whom we first met in 2002, who was then smoking heroin and by 2004 and graduated to injecting. His deteriorating health, increasing addiction, and hopelessness were a deep concern. The ORWs targeted him with an intensive risk reduction, HIV education and VCT information over a period of time. He eventually agreed to seek treatment, VCT testing and addiction counseling and was admitted to the rehabilitation center in 2005. He managed to stay clean for a year but relapsed in 2006. His relapse did not signal a failure to the ORWs and they contin-

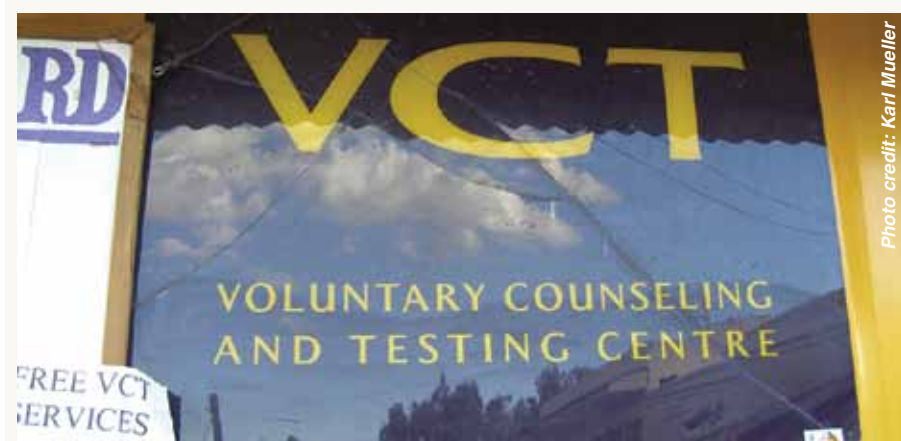
*"We see this couple as a success story not because they are perfect... but because they are an excellent example of the depth of services we provide here at the Omari Centre and what we can do with clients who take their recovery and rehabilitation seriously."*

ued to make contact with him and motivate him to give rehabilitation and recovery another shot, reminding him that recovery is a lifelong process and not a destination. After continued harm reduction education, Shalamar embarked on his rehabilitation process again, and with the help of the VCT, ORWs and Addiction counselor was rehabilitated in 2008.

## Fell in love

Sahaida and Shalamar met through the weekly Narcotics Anonymous meetings at the Drop in Centre, where recovering addicts receive support and motivation each other and from addiction counselor and outreach workers. It was in this environment that a love affair blossomed and the two realized that the support they provided each other is just what they needed to stay clean. They did not take their union lightly and sought support from a number of The Omari Project facilities, both being HIV+ where they were advised on the circumstances of their union, and we gave them some applicable coping tools to help them see how recovering addicts can live together as support systems for each other. Having all of these services in one location was extremely useful to the couple and provided an avenue of support at all times. The couple wedded in 2009.

Soon after, Shalamar wanted children but Sahaida did not, caus-



*Continues on page 9*



ing tension that led to the relapse of Shalamar. ORWs intervened, firstly providing home detox and then the full range of services for HIV and addiction. He was re admitted to the rehabilitation center where he stayed for one month. The couple has managed to reach a mutual understanding, following thorough counseling and adherence to the health protocols for PLWA's and got a baby girl in 2010 through a Caesarean Section (C.S).

### Success story

We see this couple as a success story not because they are perfect...but because they are an excellent example

of the depth of services we provide here at the Omari Centre and what we can do with clients who take their recovery and rehabilitation seriously. We incorporated them as Volunteers into our program. Sahaida has further been trained as an ORW and joined staff of Omari. She is passionate about rehabilitation and recovery. She conducts awareness with schools and religious institutions on risk reduction, HIV prevention, HIV education and human rights. She has become a community icon in the Malindi area. She is an excellent example of how successful rehabilitation can result in productive, responsible citizens.

Together they continue to attend Narcotics Anonymous meetings and continue to receive regular support from our ORWs, VCT counselors and Addiction Counselor. We continue to provide them and other couples (who are recovering drug users) with capacity building and skills training opportunities and help them feel hopeful about their ability to remain productive. We wish them the very best for the future ■

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**\*NB:** names have been changed to ensure privacy and confidentiality.  
(Compiled and edited by: Ahmed Idarus and Said Islam from Omari project)

## Zimbabwe Takes Battle to Schools

### Campaign Against Drug Abuse & Illicit Trafficking

By Dorcas Sithole

**D**rug abuse and illicit trafficking is rearing its ugly head among high school students and out of school youth in Zimbabwe. In a bid to nip the problem in the bud, the country has decided to take the campaign against drug abuse and illicit trafficking into schools.

Zimbabwe's Minister of Health and Child Welfare, Dr Henry Madzorera told a recent campaign against drug abuse in Zimbabwe that cannabis was the most widely abused drug as it was grown locally and also smuggled in large quantities from neighbouring countries. A growing number of young people were being introduced to a life of drugs which prompted the need to respond by providing adequate information about the dangers of narcotic drugs.

At least 16 secondary schools in Harare were earmarked for the campaigns which were also set to be taken to similar educational institutions throughout the country.

The campaign teams comprise staff from the Zimbabwe Ministry of Health and Child Welfare staff,

*"It is absolutely necessary to catch the children young and teach them never to start or experiment with drugs because once they are hooked, it will be difficult to stop and their lives will be ruined"*

**Dr Madzorera.**

Zimbabwe Republic Police (Criminal Investigations Department's Drug Squad), Ministry of Higher and Tertiary Education and Non-Governmental Organisations working in the field of drug abuse prevention.

High school students will be informed about dangers of drug abuse to their health, legal implications if they are caught trafficking and also how police capture those abusing and/or trafficking drugs. The idea behind the campaigns is to inform school children of the dangers of substance abuse and to scare them from using drugs and becoming addicts. Drug trafficking, which was once viewed largely as a social and criminal problem, has transformed in recent years into a major threat to health and security of people and regions. UN Secretary

General, Ban Ki-moon is on record as saying "drug use, at its core, is a health issue. Drug dependence is a disease, not a crime. The real criminals are the drug traffickers."

The United Nations recently established a task force to develop a system-wide strategy to coordinate and strengthen responses to illicit drugs and organized crime by mainstreaming them into all UN activities.

This campaign is aimed at carrying forward the principles of the International Day against Drug Abuse and Illicit Trafficking, commemorated on 26 June, which was set up by the United Nations General Assembly Resolution 42/112 of 1987 in a bid to strengthen action and cooperation to achieve the goal of an international society free of drug abuse ■

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# Drugs in African Prisons

## *An East African Perspective*

*In July-August 2011, UNAFRI commissioned a study on The Situation of Narcotic Drugs in prison systems in Eastern Africa covering Uganda, Kenya, Tanzania and Rwanda.*

**T**ransnational organised crimes pose a global threat to regional harmony, peace and stability. With vast resources, trade in narcotic drugs negatively impacts all sectors including compromising national capacities for developing human resources, good governance practices and criminal justice systems.

Noting weaknesses in crime control, the United Nations General Assembly (UNGA) session through resolution 65/231 on United Nations African Institute for the Prevention of Crime and Treatment of Offenders (UNAFRI) affirmed that “the devastating impact of new and more dynamic crime trends on national economies of African States pose a major obstacle to harmonious and sustainable development in Africa”.

Taking on the legacy from other regions where similar institutes had shown significance in the fight against crime and efforts to strengthen criminal justice administration, UNAFRI was established in 1989. UNAFRI's unique relationship with African member states and related agencies was recognised as a vital component in tackling the problem of crime in the continent. Consequently, the fight against narcotic drugs now involves the African Institute, UNAFRI, in conjunction with the African Union Commission (AUC) and the United Nations Office on Drugs and Crime (UNODC) for its geographic and strategic value.

The UNGA resolution 65/231 commends UNODC, “in strengthening its...relationship with the Institute by supporting and involving the Institute in the implementation of...activities, including those contained in the Revised African Union Plan of Action on Drug

*Control and Crime Prevention (2007-2012) on strengthening the rule of law and criminal justice..., bearing in mind that the Revised AUPA, aimed at encouraging Member States to participate in and own the regional initiatives for effective crime prevention and good governance and strengthened justice administration”.*

UNAFRI's mandate, focuses on realities of identified strategies, emphasising the significance of research-based, home grown and tailored solu-

### *UNAFRI's Intervention Programmes:*

- **Action-oriented research** for threat assessment and effective policy development based on empirical data;
- **Human resource development** to train criminal justice personnel for appropriate capacity building with updates in skills functional operations;
- **Information/documentation** for dissemination of information, findings of research and sharing of good practices;
- **Consultative missions** for technical assistance based on identified needs in crime prevention and criminal justice. Member States are encouraged to incorporate crime prevention measures in national planning mechanisms of governments.

tions and specialized expert support to inform policy making processes. The overall objective is to promote socio-economic development in the continent through UNAFRI's various intervention programmes.

In July-August 2011, UNAFRI commissioned a study on The Situation of Narcotic Drugs in prison systems in Eastern Africa covering Uganda, Kenya, Tanzania and Rwanda. The main objective was



to study drug-related crimes in the region, drawing evidence from prisons. In this respect, profiles were done on drugs and drugs related inmates in terms of demographic data, ascertaining the recidivist rate of drugs and drugs-related inmates; establishment of the nature of drugs-related crime, motivation into drugs and finding out how drugs inmates were managed in the prisons facilities in terms of separation, treatment and rehabilitation.

Below, are some summary findings which can be used to orient policy and programmatic interventions:

- Inmates revealed the role of herbalists and or witch doctors who misled them to chew, swallow or put a substance in their luggage along with the drugs to escape detection by the machines and law enforcers at airports. Some Witch Doctors were said to ‘pray’ for incident-free flight journeys for the traffickers. However, the traffickers were arrested at the airports. Indeed the study revealed that most inmates were not recidivists but first offenders.
- Religious leaders especially Christians and Muslims were also mentioned as not only accomplices to the traffickers, but as being “aware of our business and pray for us not to be caught as we are to travel” and some were “people who train and sponsor us to carry ‘goods’ to their friends abroad”. Muslims led Christians in the numbers of people involved in trafficking, while Christians led

Muslims in the number of people with addiction problems. Others such as pagans trailed the two in both trafficking and addiction.

- The role of high profile government/community personalities who were, more often than not, barons/baronesses, financiers, bosses/god-fathers and the fall back positions in the event of arrests was also highlighted. These officials blatantly did it and rewarded success richly and thus encouraged young people to not only willingly want to traffic drugs but struggle and jostle 'to get the contract'. These officials were said to be people with posh houses in secured and secluded environments of towns they transacted their businesses from.
- Groups/activities/occupations such as mail services, international recruiters, air hosts/hostesses, vehicle importers/exporters and trans-country drivers were also revealed as players in illicit drug trade.
- The criminal justice system through

corruption by the police, judges, as well as airport and immigration officials who were seen to be in league with drug the barons/baronesses of drugs entrenched drug trafficking and related crimes were also mentioned. Respondents indicated that those in prison were 'small fishes' who were not specialized enough, not well connected, amateurs, or those who constituted a threat to the barons by exposing them.

Drugs in particular alcohol and marijuana were reported to be major causes of road accidents, thefts, assaults, rape, defilement, terrorism, and murder.

A trend called 'domiciliary trafficking' (drugs trafficking into prisons facilities) was observed. The drugs were transported into prisons by mainly by: public/visitors through food/drinks; prisons staff for quick extra money; and by the inmates using similar methods used across borders such as stuffing in the

anus and or vagina, swallowing, relay method, hurting method etc. This is mainly possible due to inadequate staff capacity, demand for drugs in prison, lack of classification of inmates, inadequate prevention, treatment and rehabilitation programs.

In East Africa, for example, Rwanda leads in drugs addiction, followed by Tanzania, Uganda and Kenya; while Kenya leads in trafficking, followed by Tanzania, Uganda and Rwanda; and that drugs into Rwanda were from Congo and Tanzania, while the criminalised Ugandan waragi was from Uganda.

UNAFRI continues to receive testimonies attesting to the findings, confirming the need for ongoing research for accurate understanding of the changing nature of drugs and crime for effective intervention ■

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## Doping in Sport: The consequences are dire!

**D**oping in sport is cheating! It is also extremely dangerous to issues of health and can even kill those silly enough to expect quick rewards on the playing field. It is not playing by the rules of sport and indeed the social rules we expect responsible citizens to engage within their communities. Doping in sport is rife and a menace that is destroying the credibility of sport and endangering the health and well-being of many. It is no longer simply a matter for the world of sport to resolve. It impacts on public health and therefore requires a much more comprehensive and coordinated approach. At the root in addressing issues of doping, is a serious obligation to ensure that our young children receive proper education and information on the subject.

Young athletes and aspiring athletes should realize the implications

of such actions. Professional athletes must know their roles and responsibilities in efforts to eradicate the scourge such as their role and responsibilities in the testing procedure and providing accurate information on their whereabouts. Sports Administrators, doctors, and the myriad of others associated with and assisting athletes, have a critical role in providing athletes under their charge with positive influences, sound advice and strong moral and ethical influences.

Doping is no longer seen as the taking of a substance which is prohibited on the World Anti-Doping Agency's List of Prohibited Substances and Methods. In fact, doping is defined as much more than simply ingesting a banned substance, but includes Anti-Doping Rule Violations such as trafficking in prohibited substances, assisting athletes in taking such a

substance, interfering with the testing procedure and administering a banned substance. The penalties for being caught contravening any of these anti-doping rules are severe and can take those involved and found guilty, out of sport for life. It definitely is not worth it. It is dangerous and it is against everything associated with healthy competition and positive living. Governments, the sports movement, communities, families, all have a role to play in addressing doping and to ensure we uphold the spirit of sport and protect the health of our athletes. Let us work together and let us progress a drug-free sports culture. **Say No To doping!** ■

Rodney Swigelaar is Director at the The World Anti-Doping Agency (WADA) Africa Regional Office



# Type of Parental Attachment and Addictive Behavior in Lomé, Togo

By Professor Simliwa Kolou DASSA,  
Dzodzo Eli Ekploum KPELLE and  
Adama GABA DOVI

## Summary

The reasons for increased addictive behaviors in young adults are not always clearly defined. The objective of this survey was to estimate the index of the relation between types of parental attachment and addictive behaviors. It was conducted as a cross-cutting comparative study based on a sample of 112 randomly selected individuals. In 64.28% of the cases, non-addicted persons have a secure attachment, as against 96.43% addicts who have insecure type attachment.

Detached insecure attachment type is associated with alcohol, tobacco and cannabis abuse, while the

preoccupied insecure attachment type is associated with the abuse of most psychoactive substances. Disorganized insecure attachment is associated with alcohol and tobacco abuse. Addictive behaviors are strongly correlated with type of parental attachment. This confirms the importance of early childhood events in the life of the individual and, in particular, the importance of the quality of the child's first interactions with its environment.

**Key words:** addiction, attachment, upbringing, Togo.

## Patients and Method

We conducted this survey at the Zébé Psychiatric Hospital, the only psychiatric hospital in the country. It was carried out as a cross-cutting descriptive and analytical one-off study from June to December 2010. The population surveyed consisted of the inpatients or out-patients monitored in that facility. The focus were persons of both gender who have been dependent on psychoactive substances for at least 12 months, are not under delirium and have given verbal consent to be so monitored. Not included in the study were cases being monitored for reasons other than drug addiction, individuals that have not given their consent or persons in delirium.

By means ad hoc sampling, four psychologist clinicians duly trained in the use of research tools conducted semi-managerial discussions with 112 individuals of the male gender selected for the study. A reference group of non-users of psychoactive substances was constituted from among those accompanying the patients and visitors to the hospital. Pionné N. and Atger F. indicators of attachment types – secure or insecure – were deployed. The data obtained

Table II: Clinical data

Parameters	Addicts Number (%)	Non-addicts Number (%)
<b>Substances consumed*</b>		
Alcohol	52 (46.43)	00
Tobacco	50 (44.64)	00
Cannabis	21 (18.75)	00
Cocaine	10 (11.20)	00
Heroin	06 (05.35)	00
Crack	04 (03.57)	00
<b>Perception of parental authority**</b>		
Excessive control	04 (28.57)	14 (53.86)
Unpleasant parents	04 (28.57)	04 (15.38)
Absent parents	04 (28.57)	04 (15.38)
Sick parents	02 (14.29)	04 (15.38)
<b>Experience of parental upbringing</b>		
Abandonment/rejection	52 (46.43)	16 (14.28)
Maltreatment/negligence	32 (28.57)	16 (14.28)
Affective, sufficiently good	04 (03.57)	60 (53.57)
Lax, "pampering"	24 (21.43)	20 (17.85)
<b>Type of attachment</b>		
Secure	04 (03.57)	72 (64.29)
Detached insecure	60 (53.57)	20 (17.86)
Preoccupied insecure	20 (17.86)	08 (07.14)
Disorganized insecure	28 (25.00)	12 (10.71)

\*Possible association of several substances  
\*\*Parents living together

were processed on Sphinx Plus 2 software, and test X2 was used for comparison of certain variables, with 5% as threshold of significance.

## Outcomes

Addicted individuals of 18 – 27 years of age accounted for 26.88% as against 13.44% of those not addicted (Table I). As regards family size, 47.04% addicted persons have a family of 7 to

Table I: Socio-demographic data

Parameters	Addicts Number (%)	Non-addicts Number (%)
<b>Ages of patients (years)</b>		
18 - 22	36 (32.14)	20 (17.86)
23 - 27	12 (10.71)	04 (03.57)
28 - 32	16 (14.29)	24 (21.43)
33 - 37	16 (14.29)	32 (28.57)
38 - 42	12 (10.71)	12 (10.71)
43 - 47	12 (10.71)	16 (14.29)
48 - 52	08 (07.15)	04 (03.57)
<b>Size of family</b>		
2 - 6	6 (14.29)	52 (46.43)
7 - 11	60 (53.57)	36 (32.14)
12 - 16	24 (21.42)	16 (14.29)
17 - 21	12 (10.71)	08 (07.14)
<b>Type of family</b>		
Monogamous	06 (05.36)	16 (14.29)
Polygamous	32 (28.57)	16 (14.29)
Single parent	04 (03.57)	10 (08.92)
Reconstituted	14 (12.50)	14 (12.50)
Living together	14 (12.50)	26 (23.21)
Separated/divorced	28 (25.00)	16 (14.29)
Deceased (1 or 2 parents)	14 (12.50)	14 (12.50)

16 members, in contrast to 29.12% for those not addicted.

The substances most consumed were alcohol (31.71%), tobacco (30.48%) and cannabis (25.61%) in various associated ways (Table II). Addicted persons had such parental upbringing experience as abandonment in 29.12% of the cases, as against 17.92% for those not addicted. In contrast, 67.20% of non-addicts had affective relation with their parents, as against 2.24% for the addicted. Non-addicted individuals have secure attachment in 64.28% of cases as against 96.43% for addicted persons with insecure attachment.

## Discussion

The small scope, the ad hoc technique employed and the framework of the study which is limited to

health structures do not allow for generalization of the outcomes. However, the results obtained have the merit of highlighting an important risk factor in addictive behavior, i.e. the insecure attachment acquired by the individual as a consequence of his/her parental upbringing. In this study, the type of family of the parents of psychoactive substance users does not seem to be a determining factor in the etiology of drug addiction. Sévon (2001) found the same result in his study on the "the impact of affective family climate on the personality of the child". The works of Claes and Lacourse (2001), and of Yougbaré (2008) confirm the approach which associates parental attachment and the variables of supervision and conflicts, themselves associated with deviant behaviors as well as alcohol and

drugs consumption. Van Yzendoorn (1997) indicates that parental practices vis-à-vis adolescence act as mediating variables between parental attachment and engagement in deviant behaviors.

In our study, there is a strong relation between the treatment meted out to children by their parents and the addictive comportment observed in the said children at adult age. The drug addict did not experience such secure attachment vis-à-vis his/her parental figures for several reasons (Bowlby, 1978). The child is not sure of being able to always count on the parent or to count on himself. This gap in secure attachment leads the child to get attached to the object "drug", which undoubtedly guarantees for the drug addict, all necessary capacities from attachment figures (Humbert, 2003 ; Noël 2004). The object "drug" replaces the object "attachment figure".

## Conclusion

To repeat the words of Atger, Corcos, Perdureau & Jeammet (2001), addictive behavior may be regarded as the modalities by which the psychic equilibrium of an individual is regulated in the face of the menace of loss represented by the range of problems involved in separation-individuation, problems re-enacted at the onset of adolescence. The factors that intervene in the genesis and perpetuation of addictive behaviors are numerous (biological, psychological, cultural and social); hence the importance of the early childhood events in the life of the individual and, in particular, the importance of the quality of the child's first interactions with its environment.

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Table III: Correlations between behaviors and bio-social factors

Parameters	Addicts	Non-addicts	Correlations
<b>Size of family</b>			
2 - 6	16	52	ddl = 2
7 - 11	60	36	X2 cal = 6.86
12 - 16	24	16	X2 lu = 5.99
17 - 21	12	08	DS (S.05)
<b>Total</b>	112	112	C = 0.33
<b>Experience of parental upbringing</b>			
Abandonment/rejection	52	16	ddl = 3
Maltreatment/negligence	32	16	X2 cal = 18,41
Affective, sufficiently good	04	60	X2 lu = 7,82
Lax, "pampering"	24	20	DS
<b>Total</b>	112	112	(S.05) C = 0.49
<b>Type of family</b>			
Monogamous	06	16	ddl = 3
Polygamous	32	16	X2 cal = 5,48
Single parent	04	10	X2 lu = 7,82
Reconstituted	14	14	DS (S.05)
Living together	14	26	
Separated/divorced	28	16	
Deceased (1 or 2 parents)	14	14	
<b>Total</b>	112	112	
<b>Type of attachment</b>			
Secure	04	72	ddl = 1
Insecure	108	40	X2 cal = 23
<b>Total</b>	112	112	X2 lu = 3.84 DS (S.05) C = 0.53

*Continues on page 16*

# Face To Face

## *with a Reformed Drug Addict*

*(First hand experiences from the Omari Project Treatment and Rehabilitation Centre, Malindi, Kenya)*

### Ali Omar – Reformed Drug Addict

Mr. Ali was born in 1964, lived in Malindi throughout his childhood period, where he went to school and trained in Motor Vehicle Mechanics. He moved to Mombasa in 1984 to work with Kenya Airways as a casual mechanic and a year later served as a porter.

His life started to change negatively in 1987, knitted with the threads of drug-life by his brother-in-law who was a drug peddler. Ali would get supplies of heroine (brown sugar) from his brother-in-law to sell; he found out how 'rewarding' it was at that time as he felt the well-heeled of superfluities men and women, spinning their monies into what some of them used to call it a 'spring in your step' but Mr. Ali of that time had not understood the peril behind those placing their currencies into the lay bets of brown sugar.

Ali recalls asking himself several questions: why do people buy drugs? Why do they spend much money on it? How useful are the drugs that people sacrifice for it? While already a heavy alcohol drinker, he also decided to test brown sugar.

An excerpt of an interview with Ali (written consent granted)

#### How did you react for the first time when you used drugs?

"ooh I remember how I vomited copiously but what surprised me is the fact that I was still high!"

#### High? What do you actually imply by this?

"I felt dizzy and could not use the drugs till after three days. I later felt an urge to use daily since I had the supplies with me at the same time working as a porter. This sums up the definition of having enough income to spend".

#### Did this behavior affect your job?

"Not. Initially I had friends selling the drugs on my behalf things until 1990 when got turned down from selling as I used more than I sold. I started messing at my workplace and by 1992 I had to quit, went into hiding in Tanzania till October 1992 when I came back to Kenya for my family. I was arrested in December 1992 and sentenced in July 1993 sentenced to two years at Shimo La Tewa prisons in Mombasa."

#### Were you still using drugs at the Shimo La Tewa prisons?

"No, I worked out myself on quitting drugs".

#### After two years when you were released what happened?

"In October 1994, I was released through Presidential amnesty, got a casual job in Mombasa, earning good income. I started mingling with my old friends who slowly pulled me into selling drugs. It was necessary to test the drugs for quality before purchasing, prompting my relapse".

How long did this last?

"It did not last long. I soon lost my job and found myself back in the dens".

#### How were you supporting yourself after you lost your second job?

"I depended on my wife's income, also stealing items from our house. This stressed her terribly, she had ulcers and died in 1997, leaving me with a daughter and a son".

#### Ooh so sorry, were you able to support them?

"My son was taken by my mother and a daughter by mother-in-law. Living within the family house, I stole and sold off most of the household items except the walls". *Ali continued jokingly,* "and was thinking of how I would even sell the remaining walls of the house".

#### What was the reaction from the family members after you stole every household item?

"I was chased away from home; everyone was really pissed off by me. I tried to talk to them that I personally could not understand what really hinders my efforts in curbing this menace. During the day I was on the streets and at night I went to the caves at the beach, we call them 'ghettos, life was very tough. Till one day I remember I had nothing and had to collaborate with the anti-narcotics in identifying one of the suppliers in order to get money to buy drugs but



was later beaten and had to go back to Malindi”.

### It is now 10 years, and you had to go back to Malindi, for what reasons?

“To run away from the harsh conditions in Mombasa and be with my dad, mum and siblings. They welcomed me knowing that am an addict but they would lock their rooms, hide their belongings, wherever I would I was given an escort. One day I was sitting in the streets with my pals and was caught by anti-narcotics police and sentenced for six months. I am so lucky I was not using drugs at the Mtangani prison in Malindi; was later released.”

### How were you sustaining yourself?

“After release, I remained clean for almost one month, but was still not trusted, had no stable income, had to go to the drug peddlers opting to be ‘employed’ to sell drugs. This tempted me to relapse and continued with the life of a user till 2000 when I met Susan and Megan from Omari Project, who took me to the office to do my first assessment”.

### Were you ready to be taken to the rehabilitation Centre?

“Honestly, I wanted to give it a try and see how my fate would be. I went to The Omari Project, screened, oriented to their services then assessed. However, there was a long waiting list of the clients going to the rehab, it was at its capacity at that time, and had to wait.”

### Did you actually decide to quit drugs then?

“No, but I wanted to give it a try. However as an addict, I was not patient. I continued taking drugs and by January 2001, I was caught and sentenced to two years imprisonment. No one was visited me. I was later in charge of the kitchen where I sold food, bhang and brown sugar to the inmates. I got a lot of money and started to smoke again inside the prisons, but was lucky to be released in December 2001 through presidential amnesty again”.

### Were you injecting drugs?

“No I did not go into injecting. When

the quality was good, I was chasing, and then smoking cocktail, mixing with bhang. I personally considered injecting as being the bane of someone’s existence more than a pain in the neck”.

### Was life after prison this time the message that triggered you into limiting this thorny problem that would even be considered a “pain in the neck”?

“I continued getting supplies to sell and using, even though I went to Omari Project to enquire and still the waiting list was long, but they promised to let me know when my turn was due as they used to visit us in the dens. By 2004, I had health complications, and was taken to the hospital. This made me evaluate my real problem.

After I left the hospital, I went straight to the Omari Project offices with anger. I remember shouting “why isn’t my time ready? Or am I very vulnerable?” Mr. Dilmua, who was an assistant Coordinator at that time summoned me into his small office, asked me to sit on his chair and ordered a soda and food for me.

Afterwards, I cooled down and was able to explain that I was assessed and how I was so impatient to wait any longer. Dilmua contacted the supervisor, re-assessed and was taken to the rehab that same day without even contacting my family members”.

### When you started your drug dependency treatment at The Omari Project’s rehab Centre, were your families visiting you?

“No they were not as I didn’t not inform anyone that I would be going to the rehab, but after completing the first two months, I felt that I missed them for the first time in my life. I explained to my individual counselor who then arranged for family therapy meetings once every month till I finished my sixth month program.”

### After graduating what was next?

“We assessed the environment in Malindi. My individual counselors, Mr. Shosi and Dilmua advised me not stay there. I told them that I had a brother working in Arusha, but they insisted on

*“an ongoing cloud of tranquility started to envelope as I was enrolled as a volunteer in Omari Project.”*

assessing the place beforehand. I then settled there from June 2005 to June 2006, after a year I quarreled with my brother and I relapsed for two and half months then I came back in Malindi, realized my mistake and sought for assistance from Omari Project.

I went to Omari Project drop in Centre, assessed before undergoing a detox program, later on Narcotic Anonymous meetings, and having no other place I opted to be at the drop in Centre for further counseling and meetings.”

### Did you find yourself to be away from the urge of using drugs?

“Of course, an ongoing cloud of tranquility started to envelope as I was enrolled as a volunteer in Omari Project. Together with two colleagues, we started the Narcotic Anonymous (N.A) meetings, and at the same time was going to the rehab Centre, in Msabaha, as a support worker.

In May 2007, Omari Project sent me for an Outreach and Drug Dependency Program Training sponsored by United Nations Office On Drugs and Crime (UNODC) in Mombasa and subsequently employed as a full time outreach worker by The Omari Project in July and in October 2007, transferred to Lamu Drop in Centre to initiate N.A and outreach under the supervision of Mr.Shosi (who is also my individual counselor).

Here my recovery process was also monitored as I would be going for burn-out sessions and further clinical supervisions. In October 2008, I was transferred back to Malindi and a few weeks later, after I handed over my work to the incoming outreach leader, I went for a refresher course in Malindi. Every year, till now in 2011, I have been part of the team (alongside other 11 recovering users employed by The Omari Project) sent for the refresher courses

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under the United Nations Office On drugs and Crime (UNODC), NACADA, NASCOP, NACC among others”.

**Is there any other training that you have received from Omari Project or anywhere else that has been the key to your recovery?**

“Yes, in 2009 there were people from Real Medicine Foundation from Hawaii that came to Omari Project, and I was one of the staff members to be selected for the training on auricular acupuncture and Yoga. With this I have been able to administer it to my clients and received positive feedback as it reduces their urge to use drugs. In 2010, they came back again and trained us on Indian Head and Body Massage and they promised to come and train us on Reflexology in December 2011.

In February 2011, I went to Mombasa to represent Omari Project for a training sponsored by the National Campaign Against Drug and Alcohol Abuse (NACADAA) which was basically for the faith based organizations on drugs demand reduction, among other many drug dependency treat-

ment trainings and am now promoted as a Senior Outreach Team Leader”.

**How would you summarize your success in your life?**

“I would say I thank ALLAH for giving me another chance to live. My gratitude to the Omari Project for not giving up on me, especially Mr. Dilmua and the entire Projects staff (together with the eleven other recovery users employed at Omari Project) for their long lasting contribution to where I am now. I am HIV positive and no one despise me. I got married in December 2008, sponsored by Dilmua who catered for all the wedding expenses. I am now living with my two daughters and a son who is now in High School-form two. My first daughter completed form four and went to study accounts (CPA). I am still an Omari Project's employee and a life member as I owe my life to it”.

**What would you consider to be your mission to be accomplished?**

“I am aiming to stay clean and be drug free. From the little knowledge I have acquired I am determined with all my heart to help others who are suffering from drug addiction and working

with the organization that is mainly concerned with tackling drug demand reduction. My utmost mission is to live happily with my family members without breaking any bond, I know I had let them down a lot.”

*Ali started to cry for almost three minutes; I had to pause, patted his back twice and whispered to him, “we are all proud of you, brother. Mistakes are part of our lives, committing them is like missing a step on a ladder, you have found a way to step on the very ladder without any imbalances, never regret as you would never have imagined if you would have taken the ladder up your life, but you did elevate higher and others are now asking for your hand. Keep your head up, brother”.*

Ali had really put up with an old image of himself channeling another piece of life as an outfit of his next best chance left in him, dedicating his much time as a senior outreach officer in The Omari Project, in Malindi, Kenya, with full pride. He is now opting to pursue further course in Addiction Counseling to help others ■

Compiled and edited by: Said Islam and Ahmed Idarus.

## Type of Parental Attachment and Addictive Behavior in Lomé, Togo

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**References**

1. Atger F, Corcos M, Perdereau F, Jeammet P. Attachement et conduites addictives. Annales de médecine interne 2001 ; 152 (3) : 67-72.
2. Bohm K. Psychopathologie et drogue : facteurs associés à la reprise des conduites addictives chez les toxicomanes. Lomé (Togo): Mémoire de maîtrise en psychologie, Université de Lomé ; 2008.
3. Bowlby J. Attachement et perte : L'attachement (vol. 1). Paris : PUF ; 1978.
4. Claes M, Lacourse N. Pratiques parentales et comportements déviants à l'adolescence. Enfance 2001 ; 53 : 379-399.
5. Dassa SK, Bassoti E, Djassoa G, Ahyi RG. Usagers de substances psychoactives illicites. Etude descriptive rétrospective des patients suivis entre 1990 et 2002 au CHU-Campus de Lomé, Togo. Alcoologie et Addictologie 2008 ; 30 (4): 367-370.
6. Dassa SK, Mbassa-Menick D, Karfo K, Djassoa G, Ahyi RG. Les troubles psychopathologiques associés à l'abus de substances psychoactives à l'hôpital de psychiatrie Zébé (Togo). J. Rech. Sci. Univ. Lomé (Togo) 2008 ; série D, 10 (2) : 155-160.
7. Dassa SK, Mbassa-Menick D, Karfo K, Talbikpéti EA, Djassoa G, Ahyi RG. Les difficultés psychosociales des toxicomanes. Etude dans des ghettos de Lomé (Togo). Alcoologie et Addictologie 2009 ; 31 (1): 21-26.
8. Humbert P. Le premier lien, théorie de l'attachement. Paris : Odile Jacob; 2003.
9. Noël L. Je m'attache, nous nous

*Continued on page 17*

## 21st Meeting of Heads of National Drug Law Enforcement Agencies, Africa

Addis Ababa, 5 to 8 September 2011;

Bringing together 22 African States, the 21st meeting of Heads of National Drug Law Enforcement Agencies, Africa, discussed and considered the current situation with respect to regional and sub-regional cooperation in countering drug trafficking; implementation of the recommendations adopted by the Nineteenth Meeting of Heads of National Drug Law Enforcement Agencies, Africa; follow-up to the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem; with the highlight being working group discussions and recommendations.

The working groups discussed the following pertinent topics (a) Controlled delivery operations; (b) Being proactive in counter-narcotic operations; (c) Precursor control — Africa's developing challenge; and (d)

Special session on drug courts. The groups made requisite recommendations which included the establishment of necessary legal frameworks, bilateral agreement with neighboring states, designation of focal points, improving access to reliable crime information, multi and inter agency responses measures to control precursor chemicals, including use of the online PEN system. The special session on drug courts on the other hand discussed the methods and procedures, sentencing and their impact to improve legal mechanisms against drug trafficking, with an expert from Canada presenting the Canadian experience

The meeting noted that statistics on drugs in Africa were not accurate and up to date; hence need to improve on data collection and analysis. Moreover, the meeting also discussed the issue of the quality of law enforce-

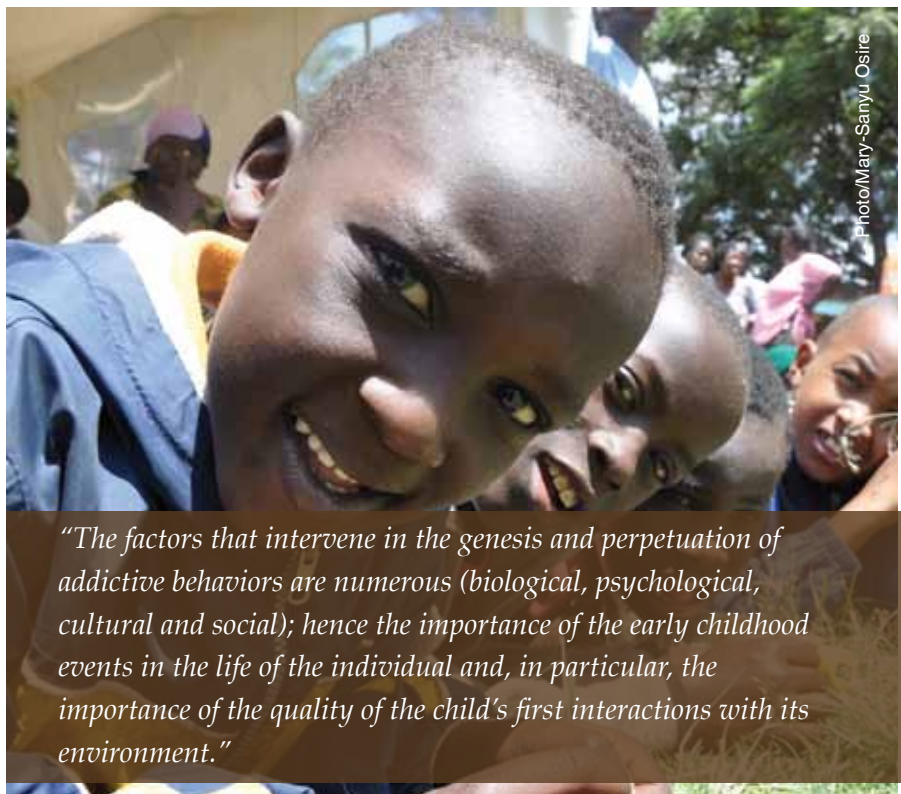
ment-related information and the need for real-time exchange of intelligence to support drug law enforcement efforts.

The meeting further expressed its support for the African Union Plan of Action on Drug Control and Crime Prevention, 2007-2012, noting current implementation status and priority activities to 2012, calling for closer cooperation between the African Union Commission and UNODC in launching a joint fund raising strategy for its implementation. In this regard, the need for more attention and resources by donors and Member States to be devoted, inter alia, to the establishment of rehabilitation centers to facilitate the treatment of drug dependent persons, capacity-building for the judiciary and support for alternative development programmes was underscored.

The meeting ended with the government of Ghana offering to host the next HONLEA meeting in September 2012 ■

attachons - le lien entre un enfant et ses parents. Bruxelles : Éditions Science et Culture; 2004.

10. Pionné N, Atger, F. Attachement et Psychopathologie. Perspectives Psy 2003 ; 42 (2) : 129-133.
11. Sévon K. Impact du climat affectif familial : cas du toxicomane de Lomé : Mémoire de Maîtrise en psychologie, Université de Lomé ; 2002.
12. Van Yzendoorn MH. Attachment, emergent morality, and aggression: Towards a developmental socioemotional model of antisocial behavior, International Journal of Behavioral Development 1997; 21: 703-727.
13. Yougbaré S. Catégories d'attachement et Délinquance juvénile chez les mineurs du Bureau International Catholique pour l'Enfance. Lomé : Mémoire de maîtrise en psychologie, Université de Lomé; 2008.



*"The factors that intervene in the genesis and perpetuation of addictive behaviors are numerous (biological, psychological, cultural and social); hence the importance of the early childhood events in the life of the individual and, in particular, the importance of the quality of the child's first interactions with its environment."*

Photo/Mary-Sanyu Osire



# Proposed African Common Position on Controlled Substances and Pain Management

*WHO estimates that 5 billion people live in countries with little or no access to controlled medicines that are used to treat moderate to severe pain.*

Pain is a common medical symptom prompting patients to seek care. Recent medical advances have improved the capacity for pain relief. Patients suffering from cancer, HIV/AIDS, and other conditions have been able to find relief from incapacitating chronic and acute pain. However, despite these developments, adequate management of pain remains a global challenge, particularly in developing countries. The result is that for millions of people around the globe, excruciating pain is an inescapable reality of life.

## Pain management

Pain of all types is undertreated in African society. Experience has demonstrated that adequate pain management leads to enhanced functioning and quality of life, while uncontrolled chronic pain contributes to disability and despair. Paediatric and geriatric populations are especially at risk for under-treatment. Physicians' fears of using opioid therapy, and the fears of other health professionals, contribute to the barriers to effective pain management.

The failure of national governments to prioritise access and the complex socioeconomic, cultural, and regulatory factors contributing to the under-utilisation of pain medicine in developing countries, have been widely observed. However, notably, there has been no scholarly consideration of the global drug regulatory environment or how international law and international institutions either interfere with or can contribute to national efforts to strengthen pain management. Patients in the end stages of AIDS are in great pain, but very few have access to pain

relieving drugs because of insufficient knowledge among physicians, inadequate health systems, fears of addiction, antiquated laws, and unduly strict regulations. This lack of access undermines the right to health and the right to be free from cruel, inhumane, and degrading treatment or punishment for the tens of millions of people who need narcotic drugs to treat pain.

## Growing recognition

There is growing recognition on the part of health care providers, government regulators, policy makers and the public that the under-treatment of pain is a major societal problem. During the 4th Session of the African Union Conference of Ministers for Drug Control and Crime Prevention, held in Addis Ababa in September 2010, the Ministers agreed "that Member States, in cooperation with AUC, INCB and other Partners, actively address the control of precursor chemicals and that AUC assist in the sourcing of training, expertise and equipment as requested by Member States." (CAMDCCP/MIN/Report(IV))

This decision was again reiterated at the Continental Think-Tank Consultation to Fast Track And Facilitate Implementation of the AU Plan Of Action On Drug Control And Crime Prevention (AUPA) 2007-2012 at Continental, Regional And National Levels held in Kampala, Uganda, in October 2011 where experts recommended that action should be taken to "improve legitimate access to narcotic drugs and psychotropic substances for medical and scientific purposes".

The United Nations international



drug control regime, including the Single Convention is a mechanism to provide a global framework to advance medical availability of opioids. A more balanced approach to the international implementation of the 1961 Single Convention on Narcotic Drugs – one that weighs the Convention's dual goals of controlling abuse and ensuring availability – can have an important, albeit limited, influence on states in encouraging medical availability of opioids.

## Control of illicit trade

The twin aims of the Single Convention are to control the use and trafficking of substances with abuse potential while also assuring the availability of these drugs for scientific and medical purposes. The Single Convention establishes four schedules for controlled substances, with Schedule 1 containing substances that are subject to all of the control provisions of the treaty. The Single Convention seeks to control illicit trade and abuse through stringent regulation of all phases of the supply of drugs. Government authorisation is mandatory for participation in any phase of narcotics trade, and each individual international transaction requires an export or import license. A centrepiece of the Single Convention is a global "estimates" system designed to limit

the total quantities of drugs, whether produced domestically or imported, available in each country on an annual basis, to that needed for medical and scientific purposes. The treaty also requires that every participant keep detailed records of all transactions in drugs and submit annual and quarterly statistical reports. Substances such as opium is in fact

also legally produced for processing into various medicines and are useful in managing severe acute or chronic pain. For instance, any country can formally apply to the UN's Commission on Narcotic Drugs to cultivate, produce and trade in licit opium, under the auspices of the UN Single Convention on Narcotics Drugs 1961 and under the supervision and guidance of the

International Narcotic Control Board (INCB).

### Prescription monitoring

What is needed is to institute operational prescription drug monitoring programmes (PDMP) in all African Union Member States. Prescription drug monitoring programmes to facilitate the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances. The PDMP further provides data and analysis to law enforcement and regulatory agencies to assist in identifying and investigating activities potentially related to the illegal prescribing, dispensing, and procuring of controlled substances.

PDMP's have several challenges, such as educating the public and policymakers about the extent of prescription drug diversion and abuse and the benefits of a PDMP, responding to the concerns of physicians, patients, and pharmacists regarding the confidentiality of prescription information, and funding the cost of programme development and operations. On the other hand, PDMP's will lead to reductions in the time and effort required by law enforcement and regulatory investigators to explore leads and the merits of possible drug diversion cases ■

### *The Member States of the Africa Union supports the position that:*

- physicians who appropriately prescribe and/or administer controlled substances to relieve chronic and/or acute pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the position of the Africa Union that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection;
- education of medical students and physicians to recognise addictive disorders in patients, minimise diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and
- the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of physicians in the use of opioid preparations.



Photo/ICAP-Global Health Action

*"It is the position of the Africa Union that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection."*



AFRICAN UNION

# Driving under the influence of cannabis

*"Common perception indicates the cannabis is linked to tens of thousands of serious traffic accidents. This is not the case."*

Excerpt from:

<http://www.drugwardistortions.org>

A number of studies on the effects of cannabis on driving have been conducted over the past few decades. While driving under the influence of any controlled substance is a matter of concern, there is no evidence that cannabis use alone is a significant cause of motor vehicle accidents.

Probably the best study of cannabis and driving was conducted for the Road Safety Division of the UK's Department of the Environment, Transport and the Regions, by the Transport Research Laboratory, Ltd., in 2000. They concluded that, *"Overall, it is possible to conclude that cannabis has a measurable effect on psycho-motor performance, particularly tracking ability. Its effect on higher cognitive functions, for example divided attention tasks associated with driving, appear not to be as critical. Drivers under the influence of cannabis seem aware that they are impaired, and attempt to compensate for this impairment by reducing the difficulty of the driving task, for example by driving more slowly."* (Source: Sexton, BF, RJ Tunbridge, N Brooke-Carter, et al., *"The Influence of Cannabis on Driving,"* Prepared for Road Safety Division, Department of the Environment, Transport and the Regions, UK, by Transport Research Laboratory, Ltd., TRL Report 477, 2000, p. 4.)

The report further notes that alcohol has a more severe, negative effect on driving than does cannabis: "In terms of road safety, it cannot be concluded that driving under the influence is not a hazard, as the effects on various aspects of driver performance are unpredictable. In comparison with alcohol however, the severe effects of alcohol on the higher cognitive processes of driving are likely to make this more of a hazard, particularly at higher blood alcohol levels." *"The Influence of Cannabis on Driving,"* p. 29.

Importantly, the TRL report concludes that it is possible for law enforcement to determine whether a person is impaired by cannabis, though they do recommend that more work be done to refine the techniques: "On the basis of these observations, the general medical examination and standardized impairment testing applied by the police surgeons were judged to be effective in determining both impairment and establishing condition due to a drug. Preliminary conclusions were drawn by the police surgeons on the number and combination of impairment test failures which would allow a conclusion that the driver was 'impaired'. Further refinement and calibration of these techniques in the field, for use by both police officers and police surgeons, is however desirable and is planned."

*"The Influence of Cannabis on Driving,"* p. 29.

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*Feedback and contributions are welcome from all stakeholders and in particular African Member states. Please note that contributed articles should not exceed 1500 words.*

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