



Ministry Of public health
GD Preventive Medicine
Department of Mental Health and Substance Abuse

COMMUNITY BASED SERVICES FOR TREATMENT OF DRUG USERS

1. BACKGROUND

According to the UNODC survey report in 2009, Afghanistan has about 940,000 addicts. In reference to the report, an increase of 143% in heroin addiction during the 2005-2009 and an increase in the prevalence of communicable diseases such as hepatitis and HIV/AIDS among IDUs pose a serious threat to the public health. The number of drug treatment centres is very low compared to the high number of drug addicts. Currently, 50 drug treatment centres operate throughout the country, staffed with 520 employees who provide drug treatment services to approximately 11,000 drug addicts on an annual basis. This number constitutes 1% of the total addicts in the country. However, 3.14% of opium and heroin users are provided with treatment services¹.

Afghanistan is considered the world's largest producer of opium and heroin and as there are some people have no or limited access to healthcare, some have turned to opium as a means to control pain. A widespread culture of dependency has been established which has serious social, economic and health effects, not just for those who are addicted, but also for their families and communities.

Female drug addiction is also increasing in Afghanistan creating new social problems such as the disintegration of the family unit, addiction in children and neglect of children's basic needs like food, sanitation and education. Addiction among women is more problematic than addiction among males because of the unique nature of women's responsibilities in child care and to the family unit.

Considering different factors such as the lack of skills and technical expertise at drug treatment centres, the lack of effective treatment model coupled with the low quality of services provided by the current treatment centres, and high rate of relapse in ex-addicts, the existing treatment capacity raises questions when compared to average international standards².

¹ Afghan-Drug-Survey-2009-UNODC, Executive-Summary-web

² Afghanistan National Drug Demand Reduction Policy, 1391 – 1395 (2012 – 2016)

WHO report about the importance of community based health services, especially in the field of mental health and treatment of drug addiction stated: "Not only are community mental health and drug addiction services more accessible to people living with severe mental disabilities, these are also more effective in taking care of their needs compared to mental hospitals. Community mental health and drug addiction services are also likely to have less possibility for neglect and violations of human rights, which are too often encountered in mental hospitals".

The concept of the community based health services is to make the services available to the needed population, where they live and work and to progressively reduce the institutional isolation of persons with addiction, relying on a new model of service organization based on integration and networking of services. This will lead to reduce stigma and increase accessibility to care.

There are other different forms of community based health services, it can be through availability of trained health workers in the different locations, where they can early detect the needed cases for treatment and refer them to the allocated treatment centers. Also, they will provide psychosocial support and will do preventive and health education activities for the prevention and promotion of the service. The treatment centers will be available in suitable locations, in MoPH facilities, NGOs facilities and other places to be very near, accessible and close to the clients.

There are some examples of community drug addiction services in Afghanistan. UNODC has a community based programmes for drug addicts especially women and children through detoxification by Buprenorphine plus counseling in the ten priority provinces include Hilmand, Kandahar, Uruzgan, Ghor, Farah, Nangarhar, Laghman, Kunar, Badakhshan, Balkh. Also, Colombo Plan had developed a community based pilot drug addiction approach, the village based programme in Kaldar district (Balkh), which provide detoxification and counselling plus awareness and follow up and an outreach activities through mobile teams.

There will be some organization and management for the transportation of the clients, whom need services to the treatment centres through the NGOs and the local community (Shuras), will involve in all activities related to treatment of drug users, the available transportation of the health facilities. There will be an appointment system, so clients can go according their assigned appointment.

Therefore, Ministry of Counter Narcotics (MCN) in close cooperation with Ministry of Public Health (MoPH) and Ministry of Labour, Social Affairs, Martyrs Families and Disability (MoLSAMD) has formulated the National Drug Demand Reduction Policy that recommends the establishment of drug treatment complexes in regional centres; expand harm reduction services and increase drug prevention and treatment capacity up to 40% in next five years. In addition, MCN together with MoPH will work to strengthen drug addicts' treatment, which is already available in BPHS as an integral part of public health services but it needs to be strengthened

This policy addresses the drug addiction problems at the community level in this country and will tackle the threats caused by this phenomenon to social and human security, particularly the threats to youths and families in Afghanistan. The advantages of the community based services are:

- More accessible to people
- More effective
- Less possibility for neglect/violations of human rights
- Less stigma
- Less deprivation
- Cost effective
- Available
- Reduce the institutional isolation

2. AIMS AND OBJECTIVES

The project is aimed to:

1. Support the development of community-based services for drug users in the different provinces at the national level.

The General Objectives are:

1. Reduce the hospitalization of the drug addicts in the drug addiction treatment centres/wards in the hospitals;
2. Early detection and decrease stigma and deprivation of people with drug abuse;
3. Prevention of mild and moderate drug users to harmful and severe drug use.

The Specific Objectives are:

1. To define, implement and evaluate a model organisation for community-based services for drug users ;
2. To strengthen proper referral systems according to the reorganisation of integrated mental health/drug dependency services at a community level;
3. To establish/mobilize community support groups (Shuras) for effective delivery of services and program sustainability;
4. To conduct training courses on the management of treatment of drug users for the approach staff (CHW, CHS, MDs and PSC), local volunteers/ NGOs and shuras (community support groups);
5. To build a village/local capacity for future, promoting people centred prevention, and rehabilitation;

6. To plan psycho-social support activities for drug addiction patients leading to de-hospitalisation, family support and community integration;
7. Promote awareness in the communities to reduce stigma, discrimination and social exclusion of the mental health/drug addicts.

Mental Health and Drug Demand Reduction Department, MoPH, will initiate/coordinate the approach in coordination with relevant local village administration. The MoPH will provide the necessary technical support while working with the Ministry of Counter Narcotics to allocate the needed fund. The program will start in selected districts of selected provinces for one year.

3. ACTIVITIES:

The activity will start as an approach in some selected villages in different provinces. The selected village should be near to a BPHS facility (e.g. CHC, DHS, DH) where psycho-social counsellors are available and trained physicians and nurses about mental health and SUD.

The activities of the community based treatment programme will lead to increase the involvement of the community leaders, volunteers and the community will help on follow up the clients, and help in reducing the relapse rate.

The preparation consists of: conduct a rapid situational analysis, needs assessment, planning and implementation including identification of target and vulnerable groups about the drug use in the selected villages/provinces.

The intervention includes three-phases: I) Pre-treatment, II) Primary Treatment Activities, III) Aftercare and rehabilitation

I. Pre-Treatment Phase: 3-4 months:

A. Form new village shura from existing shuras, if health shura is existing the activity will be added to its activities, and if not a new village shura will be selected: 8 to 10 members (teacher, village head, mullah, women, community health worker (CHW), community health supervisor (CHS) from nearby health facility, village elder, police or local security people, ex-drug addicts and their families, representative from business/agriculture trades and people motivated and interested in addressing drug related problems).

B. Identify the village treatment team and a village focal point, who can lead the shura. The team will be formed from the CHW, CHS and one doctor from the nearest CHC, BHC or the nearest clinic in the province, in addition to a nurse (if female clients – all staff will be females). The team needs some short term training regarding drug addiction, and will work under the supervision of the PPHD. This activity will be linked through focal point with any available drug addiction activities and developmental projects in the village/area eg Solidarity projects and shuras.

C. Introducing the community based model to SHURA team, conducting a orientation/training sessions to explain the treatment program.

D. Awareness campaign and community mobilization in the community: The aim is to involved the community throughout the all project and to build awareness among the population that drugs (particularly opiates) are not medicine, not a babysitting tool, and can cause harm to people and those using opiates are dependent and should seek treatment. Also, to provide psycho-social support, as several actions will be implemented to promote community awareness on mental health/drug addiction issues, reduce stigma and discrimination, and uphold the rights of persons with mental health disturbances. Additionally, the shura member especially the religious leaders will use Islamic teachings to motivate and mobilize community for their support.

E. Selection of client – screening for addiction, medical check-up, following the basic of the motivational interviewing, preparation of client and family, referral if needed, documentation to reflect all the activities.

F. Selection for community based service site/camp: The MHD/PPHD, Shura and local NGO will take lead role in identification and provision of place/venue for conducting the activity. It will be in nearby health facility or it can be in a school, NGO building or mosque, takyakhana or it can be in the form of a camp, which should be secured and located in an easily accessible area for the local community.

II. Primary treatment phase/activities:

The bio-psychosocial approaches also measures to improve quality and effectiveness of interventions will be used with focus on other health problems of the clients. During this period clients in multiple groups pass through the treatment as per below:

A. Motivation Phase: Develop a motivational support to prepare the addicts for the detoxification phase including risk assessment and risk reduction;

B. Detoxification and drug treatment therapy for 7-14 days: Detoxification can be done in either home under the supervision of the team or if needed it will be done in the nearest addiction centre using the right medication. The medications will be secured from the nearest CHC/BHC;

C. Psycho-education sessions and group therapy sessions daily, started at the beginning of the treatment phase till discharge;

III. Aftercare and Rehabilitation Phase:

A. Follow up phase - intensive up to 90 days – will be done by shuras, volunteers, community health workers and supervisors;

B. Follow up for 1 year with relapse prevention, self-help group initiation and support group and recognition of recovery.

C. Outreach activities: The treatment team will conduct home visits to follow up the clients during the detoxification/treatment and the follow up periods. The aim of these visits is to provide psychosocial support to the clients and their families and early discovery of any relapse or complications. Other activities such as awareness and behaviour on HIV/AIDS, harm reduction, behaviour change will be conducted.

D. Promote school visits or madrasas, peer support initiative, Friday prayer campaigns and sermons, public gathering speeches, local prison visits (if available).

There are some activities will be addressed during and after implementing the approach such as:

1. Record keeping;
2. Monitoring and supervision;
3. Evaluation and reporting of the activities

