



EADIS First Annual Meeting

**East Africa
Drug Information System**

November 26-28, 2001
Nairobi Intercontinental
Kenya

The contents of this report represent the proceedings of the First Annual Meeting of the East Africa Drug Information System held in Nairobi, November 26-28, 2001, which was supported by the United Nations International Drug Control Programme under the Global Assessment Programme on Drug Abuse (GAP).

For further information visit the GAP website at www.undcp.org, email gap@undcp.org or contact: Demand Reduction Section, UNDCP, P.O. Box 500, A-1400 Vienna, Austria.

This document has not been formally edited.

Maps and country names have been provided by meeting participants and are reproduced as submitted. The boundaries shown do not imply official endorsement or acceptance by the United Nations.

United Nations International Drug Control Programme
Printed in Austria, 2002



Table of contents

Key points	v
Proceedings of the Workshop	1
Introduction	2
Overview of the workshop	3
Participants	3
Update of GAP Activities- Global	4
Introduction to the revised Annual Reports Questionnaire	6
Update on GAP activities in Southern-Eastern Africa	7
INRA Pilot: Mauritius	8
INRA Model Follow-Up: MENDU	9
Drug Information Systems in Eastern and Western Europe: The Pompidou Group	10
Summary of Country Situation Reports	11
Discussion on INRAs: Lessons learnt	15
Focal Point Contracts	16
GAP/LEN joint session	17
Conclusion	19
Country Reports	20
Introduction	21
Burundi	21
Comoros	24
Eritrea	26
Ethiopia	27
Kenya	29
Madagascar	37
Mauritius	39
Rwanda	40
Seychelles	42
Somalia	43
Tanzania	44
Uganda	45
Participant List	62

Key points

The Eastern Africa Drug Information System (EADIS) Annual Meeting is the first reporting session of an ongoing system for gathering information on drug abuse trends in the Eastern Africa region.

EADIS is supported by the UNDCP Global Assessment Programme on Drug Abuse (GAP).

The main drug problems noted in the region were alcohol and cannabis, with several countries also noting abuse of khat. Several countries noted the emergence of heroin use, and reported being used as a transit point for trafficking of heroin and other hard drugs.

Initial discussions at the training workshop focused on how developments towards national Integrated Drug Information Systems (IDIS) were progressing, as a follow up to the training provided at a regional training workshop held earlier in the year that marked the initiation of EADIS.

Information, Needs and Resources Analyses have been conducted in six of the thirteen EADIS countries, with INRA reports from these countries in various stages of development. Although most Eastern African countries had few existing data collection activities or related infrastructure, they were able to identify both people and potential data sources that could form the foundation of a country level IDIS.

An introductory training session in responding to the Annual Reports Questionnaire was provided.



Proceedings of the Workshop

Introduction

The goal of the Eastern Africa Drug Information System (EADIS) is to improve information on patterns and trends in drug abuse across the Eastern Africa region. EADIS aims to provide an ongoing system to allow the cost-effective monitoring of drug problems in a manner relevant to the region.

EADIS is supported by the United Nations International Drug Control Programme (UNDCP) Global Assessment Programme on Drug Abuse (GAP). GAP aims to assist countries in establishing systems to collect reliable and internationally comparable drug abuse data and assess the magnitude and patterns of drug abuse. Such information is of critical value to the developing and targeting of demand reduction programmes. To date, the GAP programme has been initiated in Eastern and Southern Africa, Central and South West Asia and the Caribbean. GAP methods have been configured in accordance with current best practice in drug abuse epidemiology that combines technical expert networks with the ongoing collection and analysis of indicator data. Methods consist of supporting data collection on core topics, provision of a methodological tool-kit to assist countries with developing sound data collection systems, an audit of existing information in each country to develop an information development strategy, facilitating regional networking and providing on-going training where required.

EADIS has been established as a regional epidemiology network on drug abuse based on the expertise and experience of each participating member nation. In turn, this regional network will act as a catalyst for the continued development of similar country level networks. There is considerable value in sharing the experiences of countries facing similar problems and the networking of technical experts has been shown to be of particular benefit.

Member states were invited to participate in EADIS at a regional training workshop in Mombassa, Kenya, in February 2001. At this meeting country representatives, nominated by their national drug control bodies (Inter-Ministerial Drug Control Committees or similar), were introduced to the concept of Integrated Drug Information Systems. Training was provided in how to initiate a drug information system, specifically through the conducting of an Information, Needs and Resources Analysis (INRA). This training was supported by a methodological tool-kit which provided an in-depth guide on how to initiate networks and undertake an INRA. Following on from this training, small grants were provided to enable country representatives to undertake INRAs and initiate drug information systems in their home country.

The initiation of EADIS holds great importance for the region in terms of improving the collection and dissemination of drug abuse information and guiding other demand reduction programmes. To date, there has been no comprehensive or systematic reporting of drug trends in the Eastern Africa region. By way of example, only three of the 13 Eastern African countries submitted the Demand Reduction section of the Annual Reports Questionnaire (ARQ) on drug abuse to UNDCP in 1999. The initiation of EADIS together with revision of the ARQ should improve the reporting of drug trends in the region through the ARQ, and provide information on African drug trends to the global view of the drug situation. Information obtained from EADIS will also be integrated with broader demand reduction programmes, in line with the Declaration on the Guiding Principles of Drug Demand Reduction, which state: "Demand reduction programmes should be based on a regular assessment of the nature and magnitude of drug use and abuse, and drug-related problems in the population." In turn, the formation of national drug information systems under EADIS must be sensitive to local conditions, meeting local needs, as well as being undertaken by states in a comprehensive, systematic and periodic manner.

This report presents an overview of the first EADIS Annual Meeting and its outcomes. For further information on EADIS contact the GAP Regional Epidemiology Adviser, Matthew Warner-Smith [Ph. +27 12 3422424. Fax. +27 12 342 2356, Email: mwarner-smith@odccp.org].

Overview of the workshop

The first EADIS Annual Meeting was conducted over three days, from the 26th to the 28th of November 2001. On the first day an introductory training session in the revised ARQ was provided. Delegates were then updated on the activities of GAP at both global and regional level, and provided with a pilot example of the development of an IDIS in the region, using the Mauritius INRA and the resultant MENDU as a model. On the second day participants presented country reports, describing the current level of progress towards the development of an IDIS in their respective countries, with particular emphasis given to the INRA and the current situation with regard to illicit drugs in their country. The third day involved discussing lessons learned during the INRA process, discussing INRA follow up activities, and a joint session with the Local Expert Network on Drug Demand Reduction (LEN) (UNDCP RAF-66) discussing ways in which EADIS and LEN can cooperate.

Participants

Participation in EADIS was extended to all Eastern African countries. Delegates were previously nominated by Inter-Ministerial Drug Control Committees (IMDCCs), or equivalent organizations, as the EADIS Focal Points for their countries. Twelve countries were represented at the first Annual EADIS Meeting:

- Ethiopia
- Kenya
- Tanzania
- Rwanda
- Burundi
- Seychelles
- Mauritius
- Madagascar
- Comoros
- Somalia
- Djibouti
- Eritrea

Of the countries represented at the Annual Meeting all but three (Somalia, Djibouti and Eritrea) had previously received training in the development of integrated drug information systems at the EADIS Training Workshop, held in Mombassa in February 2001.

Unfortunately the focal point for Uganda, Mr Moses Kamabare, was not able to be present at the Annual Meeting, despite having attended the Training Workshop. In his absence a comprehensive draft INRA report for Uganda was forwarded to the meeting, suggesting that the Ugandan network is progressing well.

Delegates represented a range of backgrounds, including health, research and law enforcement. The Participant List, including affiliations and contact details, is included as Appendix C.

Facilitators for the workshop were the GAP Regional Epidemiology Adviser for Southern/Eastern Africa, Matthew Warner-Smith, and GAP Epidemiologist, Rebecca McKetin. An international consultant, Mr Ruud Bless of the Pompidou Group, was contracted to provide training in the revised ARQ. The coordinator of the Mauritius Epidemiology Network on Drug Use (MENDU), Dr Fayzel Sulliman, was invited to share his experiences in developing MENDU. Administrative and

logistical support was provided by the GAP Southern-Eastern Africa Administrative Assistant, Mrs Florence Kawaza-Musengi. UNDCP Eastern Africa provided substantial professional and administrative support to the EADIS Annual Meeting.

Update of GAP Activities- Global

Rebecca McKetin

Background

In 1998, United Nations Member States adopted a Political Declaration to eliminate or significantly reduce the demand for illicit drugs by 2008. Monitoring progress towards this goal requires reliable and systematic data on drug consumption that was unavailable at a global level. To overcome this problem, the Global Assessment Programme on Drug Abuse (GAP). GAP has been designed to:

- Support Member States to build the systems necessary for collecting reliable data to inform policy and action
- Encourage regional partnerships to share experiences and technical developments
- Facilitate a better understanding of patterns and trends in drug abuse by encouraging the adoption of sound methods to collect comparable

The Guiding Principles of the Political Declaration state that: "Demand reduction programmes should be based on a regular assessment of the nature and magnitude of drug use and abuse and drug related problems in the population."¹ In fulfilling these principles, GAP plays an integral role in providing information on which to base demand reduction policies and the implementation of demand reduction activities.

Activities and Guiding principles

GAP improves the global information base on patterns and trends in drug consumption through a comprehensive framework of inter-linked activities.

Global Level: Disseminate methodological developments and best practices, harmonize indicators, improve reporting standards and increase the quality and coverage of the global information base.

Regional Level: Support regional information systems, encourage networking by countries with similar experiences and concerns and establish training and indicator development utilizing local expertise and resources.

National Level: Provide information, needs and resources analyses (INRAs) to produce strategic action plans, support the establishment of data collection focal points and human networks and provide training and resources to meet key information needs.

GAP methods reflect the following guiding principles:

- Sustainability and ownership
- Developmental partnerships

¹ Special Session of the General Assembly Devoted to Countering the World Drug Problem Together, 8-10 June 1998.

- Sound methods, sensitivity to context and human networks
- Policy relevant and efficient

Harmonizing Global Drug Abuse Data

An international expert forum was held on the principles, structures and indicators necessary for effective drug information systems and hosted by the European Monitoring Centre on Drugs and Drug Addiction in January 2000. Particular consideration was given to development of a set of core epidemiological demand indicators against which Member States could report on their respective situations. The agreed upon indicators are as follows:

- Drug consumption among the general population
- Drug consumption among the youth population
- High-risk drug abuse
- Service utilization for drug problems
- Drug-related morbidity
- Drug-related mortality

A follow-up global workshop was held in 2001 to establish the state of existing data collection networks and to develop a framework for harmonizing indicators and procedures. Deliberations from this meeting have been documented in the report: Drug Information Systems: Activities, Methods and Future Opportunities, and elaborated on in a special edition of the Bulletin on Narcotics.

Annual Reports Questionnaire (ARQ)

The Annual Reports Questionnaire (ARQ) is integral to UNDCP data collection activities because it is the mechanism through which Member States report on the situations in their respective countries. Part II of the ARQ focuses on the magnitude and trends in drug abuse and was recently revised to reflect the above core set of drug abuse indicators. This revised version was adopted from 2002.

Methodological Toolkit

To support capacity to collect high quality data, GAP is developing a methodological toolkit comprised of modules on various aspects of data collection. Modules are currently under development to provide methodological support in the following areas:

- Development of an Integrated Drug Information System (IDIS)
- School Surveys
- Estimation Techniques
- Data Management and Analysis

Further modules are being considered to address issues around treatment reporting systems, focused research studies and drug injecting/HIV risk behaviours. A methodological training resource is also under development to support completion of the revised ARQ (part II).

Building Regional Capacity to Collect Data

GAP is currently supporting the development of drug information systems in four regions:

- Southern Africa
- Eastern Africa
- Central and South-west Asia
- Caribbean

Epidemiological advisers have been appointed to provide technical assistance and coordination of capacity development activities. GAP activities will be extended to other regions as funding becomes available.

- Activities undertaken at the regional level include:
- Development of regional epidemiological networks
- Information, Needs and Resources Analyses
- National Assessment Studies on Drug Abuse
- School surveys
- Focused research studies
- Training in data collection techniques

The activities to date of GAP varied between regions depending on the needs within each region. In the Caribbean GAP activities thus far have focused on data collection through school surveys. In Central and South-West Asia GAP's focus has been on National Assessment Studies, while in Southern-Eastern Africa the majority of GAP's work to date has been in training and support for INRAs and resultant network development.

The regional networks that GAP is supporting include:

- SENDU – Southern Africa
- EADIS – Eastern Africa
- CEUGW – Central Asia
- CARIDIN – Caribbean

Future directions

Global GAP activities planned for 2002-3 centre around and further development of harmonized data collection at a global level, capacity building support around the revised ARQ - part II, continued development of the methodological toolkit modules, and supporting the expansion of field activities.

Introduction to the revised Annual Reports Questionnaire

Ruud Bless

Participants were introduced to the revised ARQ (Part 2). The very low response rate to the old ARQ was perceived to result from a combination of the methods by which the questionnaire is disseminated, the poor design of the questionnaire, and the lack of available data on drug demand in the region. To rectify the two latter hindrances, the questionnaire was substantially modified and simplified, and now provides for different levels of evidence when responding on key indicators.

The revision was based on the principle that the inclusion of all member states in a minimum dataset was preferable to a requirement for near-perfect data which would exclude the vast majority of states. The questionnaire was redesigned, with each question clearly formulated to

improve response rates. To assist member states in responding electronic completion of the ARQ is now possible.

The revised ARQ is structured around a limited number of indicators and can be filled in using either quantitative estimates, where available, or informed expert opinion. The provision for expert opinion has been made to allow member states that may not have formalized quantitative estimates to be able utilise the informal body of knowledge of the drug use situation in their country to meet their reporting requirements. The questions that can be completed using expert opinion ask about the variety of drugs present in a country, the prevalence ranking of each drug, and trends in the use of each drug over the past 12 months.

Delegates received training in how to procure expert opinions. This involves:

- Identifying experts in relevant domains
- Inviting experts to cooperate
- Defining a transparent consultation process
- Allowing reasonable time to implement
- Giving feedback to consulted experts

Experts can be identified by using either a formal approach, selecting individuals based on official functions and positions, or an informal approach, such as through snowball recruiting. Consensus between expert opinions is needed before the ARQ can be completed. This can be achieved through either a consensus seeking meeting, or by using the Delphi approach.

Pitfalls in expert opinions identified include:

- The potential for confusion of expertise and authority;
- Difficulties in restricting responses to the past year; and
- The risk of focusing on incidents, particularly in the context of the recency effect.

Update on GAP activities in Southern-Eastern Africa

Matthew Warner-Smith

The activities of GAP in the Southern and Eastern African regions in the preceding 12 months were reviewed. In the Southern region GAP has been actively supporting the SADC Epidemiology Network on Drug Use, while in the Eastern region it has initiated and been supporting EADIS.

SENDU has been supported through the conduct of INRAs in Lesotho and Malawi by the Regional Epidemiology Advisor and the contracting of the Medical Research Council (MRC) in Cape Town, South Africa, to conduct further INRAs. MRC contracted INRAs have been completed in Namibia and Botswana, with technical support site from the Regional Epidemiology Advisor. As a result of these INRAs, computers have been donated to Lesotho and Namibia, with orders placed for computers for Malawi and Botswana

GAP has been more active in Eastern Africa, due to the absence of any drug information systems in the region prior to the initiation of EADIS. The EADIS training workshop has been previously described. In addition, the Regional Epidemiology Advisor has conducted site visits to provide technical support for INRAs in Kenya, the Comoros and Ethiopia.

Planned support for EADIS by GAP in 2002 includes technical support visits to countries that have yet to complete an INRA, Training workshops in how to complete the revised ARQ plus training in data entry, analysis and presentation, and contracts for the ongoing activities of national focal points.

INRA Pilot: Mauritius

Rebecca McKetin

The INRA for Mauritius was conducted in March 2001 by the then Regional Epidemiology Advisor, Dr Rebecca McKetin. The main collaborating agency was the National Agency for the Treatment and Rehabilitation of Substance Abusers (NATReSA). Other governmental institutions involved in the INRA were the:

- Anti-Drug Smuggling Unit, Police Head Quarters, Port Louis
- Forensic Science Laboratories, University of Mauritius
- Ministry of Health and Quality of Life, Port Louis
- Institute of Health, Pamplemousses
- Brown Sequad Psychiatric Hospital, Port Louis
- AIDS Division, Ministry of Health and Quality of Life

In addition, the following non-government treatment Institutions were involved in the INRA:

- Sangram Sewa Centre, St Paul
- Centre de Solidarite Pour Une Nouvelle Vie, Impasse Larche, Rose Hill
- Centre d'Accueil de Terre Rouge, Residential Treatment and Rehabilitation Centre, Terre Rouge
- Dr Idrice Goomany Treatment Centre, Port Louis
- Help De-Addiction Centre, Hindu House, Cassis

The INRA for Mauritius identified four main sources of drug demand indicator data. Specifically these were: data from specialized treatment centres; hospital separations for alcohol related mortality and morbidity; drug related psychiatric admissions; and, police arrest and seizure data.

It was found that Mauritius has a variety of resources that could support a drug information system. Specifically, there exists a strong infrastructure; a sound skill-base, including expertise in research and survey methods; and computers with database software.

Two primary needs for the development of a drug information system were identified in Mauritius. Firstly, there is the need for the establishment of a coordinated network of professionals. Secondly, assistance and training in the collation of treatment data is required.

The following goals were identified for the strategic development of an integrated drug information system in Mauritius.

Short-term goal

Develop an epidemiological network including representatives from key agencies using existing (indicator) data as the main input to the network

Medium-term goal

The development of a centralized data collection system for drug treatment, specifically:

Develop core set of treatment indicators;

Standardization of data definitions for this;

Develop questionnaire/data entry form; and

Develop system to collate core indicator data i.e., central database.

Long-term goal

Develop data sources, for example:

Overdose (fatal and non-fatal) from opioids;

Hospital data to reflect illicit drug – related admissions

The INRA identified two main follow-up actions that are required in Mauritius in order to establish a drug information system. Firstly, a network of stakeholders and information sources in the drug and alcohol field needs to be developed. Secondly, treatment data needs to be collated, analysed and disseminated in an easily accessible format.

INRA Model Follow-Up: MENDU

Fayzel Sulliman

Following on from the findings of the INRA, NaTRESA, under the direction of Dr Sulliman, established the Mauritius Epidemiology Network on Drug Use (MENDU). The objectives of MENDU were identified as:

- To establish a network of key stakeholders in one or more sites
- To collate existing data
- To share and validate information collected
- To prepare and disseminate reports on the nature and extent of alcohol and other drug use in Mauritius

In order to achieve these goals, a steering committee comprising all the major stakeholders was set up to drive the MENDU project. The existing standardized Southern African Development Community Epidemiology Network on Drug Use (SENDU) treatment data collection questionnaire was then adapted to suit the local context. In addition to the training provided by GAP in Mombassa, a representative of MENDU attended further training provided by the Southern African Development Community (SADC), as part of the SENDU initiative.

Data collection began in the second half of 2001. This data is to be collated, analysed, and prepared into a national report. The report will be presented to representatives of other drug information systems in the Southern African region at the 2002 SENDU Regional Report Back Meeting in April and to fellow EADIS members at the 2002 EADIS Annual Meeting in November.

Drug Information Systems in Eastern and Western Europe: The Pompidou Group

Ruud Bless

The Pompidou group has established a multi-city drug epidemiology network covering both Western and Eastern Europe. The aims of this expert network are to:

- Develop indicators and data collection methodology in the field of drugs
- Exchange expertise, particularly in research
- Collect city data
- Analyze drug trends
- Conduct explorative research

The network operates through a variety of methods. Plenary meetings are held on an annual basis. In addition, project teams work on core activities, while working groups are formed to address specific topics. Finally, the group holds regular training seminars.

Participants in the Pompidou multi-city network are either experts in epidemiology nominated by national permanent correspondents; invited and contracted consultants; or, observers from the European commission, UNDCP or WHO.

The network is a multi-city reporting system, which allows for the annual collection of expert opinion on patterns and trends in drug use. In addition, contextual information, trend analysis and individual city information is reported, as well as ad-hoc reports on specific issues.

Each participating city uses a standard report format, which is consistent with both the national reporting systems of the EMCDDA and the ARQ. The design of the standard report follows that of the new ARQ, in that it is adopted for electronic completion, including automatic data base construction, and incorporates different levels of evidence.

Standardized indicator data is collected from each site. This indicator data is supplemented by expert opinion. Reports describe any new or emerging drug or drug use patterns, the diffusion of drug use, developments in drugs markets, the provision of drug services and socio-economic-cultural context information.

A variety of reasons have been identified which may explain the success of this network to date. Firstly, the network is not linked to individual national governments and is therefore not restricted by political interests nor bound to particular positions or philosophies. Secondly the participants in the network are of a similar vocational background, with the continuity of individuals' participation assured. Finally, regular meetings are held with the content delivered and coordinated by the participants. Finally, the activities of the network have the support of a professional secretariat.

Summary of Country Situation Reports

Delegates presented brief country situation reports. Delegates were requested to focus their reports on progress towards the establishment of their national drug information systems and also to describe any changes in the drug situation in their country that may have occurred since they presented their initial country reports in the Mombassa meeting. These reports were intended to share experiences of conducting INRAs and forming networks between delegates, so that EADIS members could learn and benefit from the experiences of other members. Below is a summary of the overall outcome of these presentations; a summary of individual country reports; and the full unedited text of those reports.

No significant changes were observed in the drug situation in the region since delegates presented at the Mombassa meeting. To recap, all countries cited the use of cannabis as their main illicit drug problem. This cannabis is generally locally grown and in herbal form.

The use of heroin and cocaine, usually at low levels, was reported in a surprising number of countries, and was attributed to countries being used as transit points in the movement of these drugs across the African continent. Countries noting this problem included Uganda, Burundi, Rwanda, Kenya and Tanzania. Of the Eastern African island states, Mauritius noted significant use of heroin, which has been a recognized problem on the island since the 1980s.

Khat continues to be a drug problem noted by several countries, particularly in the context of use in the transport industry. Abuse of solvents and/or inhalants among street children was reported in several countries. Abuse of licit pharmaceuticals also appears common.

Burundi

Burundi has yet to receive the first payment of the INRA grant. Despite this they have made some progress towards the INRA, firstly by identifying potential data sources and relevant agencies. An anti-drugs unit has been established that is currently the only institution that can provide data at a National level. These data are exclusively comprised of arrest and seizure statistics. A psychiatric hospital exists, however the ability of this centre to provide data on drug-related admissions has yet to be determined.

Burundi is seriously concerned about the impact of drug abuse and drug trafficking, however, the war in Burundi presents a major obstacle to establishing routine data collection on drug abuse.

Comoros

The main drugs of abuse in the Comoros are cannabis and licit pharmaceuticals, however no prevalence estimates are available.

Comoros received the first INRA grant payment and has produced a draft INRA report. The first INRA report was apparently written with little consultation with stakeholders in Comoros. As a result the IMDCC replaced it's nominated focal point. While this has disrupted continuity, the new focal point appears highly competent and is currently redrafting the report.

Two sources of data on the drug situation in Comoros exist. The anti-drug authority (BRIMAD) has good data on arrests and seizures which can easily be provided to the focal point. The Ministry of Health has data on the diversion of licit pharmaceuticals for illicit use. These two sources of data can be used in conjunction with expert opinions provided at network meetings to monitor trends in drug use in Comoros. Unfortunately Comoros does not have a university, nor a specialized drug treatment center or psychiatric hospital that could provide survey or treatment data. It was proposed that data could be collected at primary health care centers or at the three regional hospitals. Apparently three psychiatrists and six psychiatric nurses are soon to be trained in the Comoros. The feasibility of these individuals collecting data on drug-related case will be explored.

Ethiopia

As was reported in Mombassa, the main drugs of abuse in Ethiopia are khat, cannabis and alcohol. There have been recent reports of the emergence of heroin and opium use.

Ethiopia has made significant progress towards the INRA. Since receiving the first INRA payment in September they have held a workshop with all stakeholders, reviewed existing survey data and identified relevant institutions and potential data sources. The INRA report is currently being drafted.

The network for Ethiopia will initially involve Addis Ababa as a sentinel site, owing to the very large size of the country (popn 60 million). Relevant institutions which were identified, participated in the workshop and will form the network include:

- The Ministry of Health
- The Federal Police
- Addis Ababa University
- Addis Ababa Hospital
- Emmanuelle Mental Hospital
- NGO-Forum for street children
- Two high schools which have drug free clubs
- The Drug Administration and Control authority.

At the meeting held to introduce these institutions to the concept of drug information systems (held on October 12, 2001) all participants expressed willingness to work together to initiate a drug epidemiology network.

The network will be based on law enforcement data and the Emmanuelle psychiatric hospital. As an example of the type of data able to be provided by the psychiatric hospital, in 1998 43% of inpatients (1086 cases) were admitted because of drug abuse. There are currently no specialized drug treatment centers in Ethiopia.

A number of hindrances to the efficient establishment of a drug epidemiology network in Addis Ababa were noted. These include:

- The lack of an inter-ministerial drug control committee in Ethiopia
- The lack of specialised treatment agencies
- The fact that most data, especially psychiatric data, are raw and there is only limited infrastructure and expertise available for data collation, analysis and presentation.

Two recommendations were made regarding the future developments of the Ethiopian network. Firstly, there was a clearly identified need for infrastructure and training of personnel. Secondly, it was felt that extending the network to other parts of the country in the future may provide a better understanding of the drug situation on a national level.

Kenya

Alcohol and tobacco remain the main forms of substance abuse in Kenya, while abuse of cannabis, heroin and psychostimulants also occurs. A recently released report (WHO, 2001) indicated that a small but significant population of heroin users exists in Nairobi, estimated to number approximately 10,000, with 50% of those being IDU. Consistent with the existence of a heroin using population in Nairobi are psychiatric admission records from Nairobi's Mathari Hospital. Records from 2000 show that opioid-related diagnoses were among the top ten causes of patient morbidity accounting for 7% of inpatient admissions. It is worth noting that a further 9% were attributed to drug-induced psychosis.

A great deal of progress towards the establishment of a drug information system has occurred in Kenya. The Kenyan drug information system will initially be restricted to Nairobi as a sentinel site.

An INRA report has been prepared and is soon to be submitted for government approval and the inaugural network meeting has been held.

The INRA for Nairobi found that there are a number of potential data sources that could contribute to the drug information system. The principle sources of data the network will be based on are:

- Specialized drug treatment centres, which currently do not collect data, but are willing to begin such reporting,
- Police Drugs Unit (CID), which centrally collates arrest and seizure data)
- Mathari Psychiatric Hospital, which is able to provide separations by diagnosis (ICD-10)

Institutions that will be involved in the network include:

- Nairobi Psychotherapy Services Institute (NPSI)
- Mathari Mental Hospital
- Crescent Medical Centre
- Police CID (Drugs unit)

The network will be coordinated by the NPSI, who will convene regular meetings, collate data and prepare an annual report of the findings of the network.

As regards resources, the INRA found that there is a great deal of political will and a good base of human resources in Nairobi that are committed to responding to drug issues. Kenya has a functioning Inter-Ministerial Drug Control Committee and a national agency that oversees drug abuse prevention activities, the National Agency for the Prevention of Drug Abuse (NACADA). However, there is a lack of infrastructure for data collection and a need for training in data analysis and reporting. Similarly, there is a lack of standardization in the data that is collected. This latter issue was addressed in the first network meeting, where it was agreed that members would independently develop data collection instruments and bring these to the next network meeting so that they could be incorporated into a single standardized instrument.

Madagascar

Madagascar has yet to receive the first INRA payment, and as such the INRA has not been commenced. The drug use pattern in Madagascar is typical of that of EADIS member countries, with the main drugs of abuse being cannabis and alcohol abuse. Khat abuse is also common, and heroin and cocaine abuse have also been noted on the island. As was reported at the February training workshop data on drug abuse in Madagascar is manually recorded, as there are no computers available. The resources required to develop a drug information system include training of human resources, information on demand reduction, equipment, and technical support.

Mauritius

Mauritius is unique to EADIS member countries in that it has had a well-established population of heroin users for many years. Substantial morbidity appears to be associated with heroin use with heroin users accounting for a large portion of treatment admissions. HCV prevalence is near 100% among injecting heroin users and there have been anecdotal reports of opioid-related overdose.

An INRA was conducted in Mauritius by the then GAP Regional Epidemiology Advisor, Rebecca McKetin in March, 2001. The report from this has been approved by government and released and has guided the development of the Mauritian Epidemiology Network on Drug Use (MENDU), as described previously. Both the INRA report and the first MENDU meeting report can be obtained from the MENDU contact point (see contact list for details).

Rwanda

Rwanda experienced some difficulties in the initiation of the INRA. While the first INRA payment has been received, it was delayed considerably. As a result the INRA has yet to be commenced.

The Rwandan Focal Point does not have access to a computer and must therefore rely on UNDP Rwanda to allow him to use their computing facilities.

No changes were noted in the drug use situation in Rwanda since the February EADIS workshop. To recap, both the supply and demand for drugs apparently remains high. Transiting of heroin through Rwanda, from Uganda, Kenya, Tanzania and Burundi, was also noted. Vulnerable groups that were noted included street children, unemployed people, and people growing cannabis for export. Two potential data sources were police data on number of arrests relating to illicit drugs, and police informant reports. There was also a facility where drug abusers could receive treatment by a medical officer, which may contribute to a drug abuse information system.

Seychelles

An INRA was also conducted in Seychelles by the then GAP Regional Epidemiology Advisor Dr Rebecca McKetin in March, 2001. The resulting report has been approved by government and released and has guided the development of the Seychelles drug epidemiology network.

Despite the fact that the INRA aided the development of the Seychelles network, it was felt that the INRA could have had more utility had it been contracted to a Seychellois national, rather than by GAP. The Seychelles network is operational and will be presenting data at the 2002 SENDU meeting. Institutions represented in the Seychelles network include NGOs involved in drug treatment, police, schools and prisons.

As was reported in Mombassa, the main drugs of abuse in the Seychelles are locally grown cannabis, imported hashish, alcohol and tobacco.

Tanzania

Tanzania has yet to receive the first INRA payment and has yet not made any progress towards the development of a drug epidemiology network. However, the government has established an Anti-Drug Commission, one of the functions of which is to develop a drug data collection system. To this end UNDCP, through the Capacity Building for Local Government Project, has assisted the ADC by hiring consultant to develop a database of drug statistics. Potential sources of data to feed this database identified by the consultant include:

- Law enforcement data
- Treatment data
- Key informant data
- Licit drug trade information

The report arising from this consultancy has yet to be prepared. The ADC will utilize the findings of this consultancy to develop the Tanzanian drug epidemiology network. Should one still be necessary following the presentation of the findings of the consultant, the consultants report should provide a firm background for an INRA.

As was described in Mombassa, the main illicit drug of abuse in Tanzania is cannabis. Khat is also commonly abused. A limited amount of heroin and cocaine abuse also occurs within Tanzania, and solvent use is commonly observed among street children.

Uganda

Uganda received the first INRA payment and produced a report of the INRA. Unfortunately however, the report could not be presented in person by the Ugandan Focal Point, Mr Moses Kamabare. The GAP Regional Epidemiology Advisor will liaise with Mr Kamabare and the Ugandan drug control body to ensure that the continued development of the Ugandan drug epidemiology network is not compromised.

The main findings from the Ugandan INRA are that the drugs of abuse in Uganda are cannabis and khat, although the latter remains licit. There have been also reports of heroin use (by non-injecting routes).

The principal data sources identified in the INRA for use by the network are:

- Arrest, seizure and purity data provided by various law enforcement agencies
- Psychiatric hospital data (Butabika Psychiatric Hospital)
- Expert opinion.

This would be supplemented by ad-hoc survey data, such as school surveys, one of which has already been conducted in Uganda. Uganda does not yet have any specialized drug and alcohol treatment centers that could contribute treatment data, however one, the Serenity Centre, is currently being founded.

Institutions represented in the network include:

- Anti-Narcotics Unit of the Police Criminal Investigations Department
- Government Analytical Laboratory
- Ministries of Health, Tourism and Education
- Uganda AIDS Commission
- Uganda Youth Development Link
- SOBER, Uganda
- The Serenity Centre
- Butabika Mental Hospital
- Department of Social Work, Makerere University
- Makerere Institute of Social Research

While these institutions have contact with drug users and are able to provide expert opinion on patterns and trends in drug use, data is not routinely collected. Therefore the main development needs were identified as the initiation of data collection activities. This would require training of personnel in data collection and management and the provision of appropriate infrastructure, specifically computers and statistical software.

Discussion on INRAs: Lessons learnt

General lessons learnt from the INRA process included the following:

- It was considered appropriate and beneficial to have national staff conduct the INRA, and using UNDCP personnel rather than national counterparts to undertake the INRA could reduce its efficacy.
- Establishing data sources on drug use in some countries was clearly a very difficult task due to lack of demand reduction infrastructure. The data sources conventionally used by drug information systems (i.e., treatment and hospital admissions, arrest data) were in short supply in these countries. Finding innovative ways to learn about the drug abuse situation and alternative data sources would benefit from collaboration with other countries at a similar level of development.

- One of the benefits noted from having conducted the INRA was the increased awareness of demand reduction activities and the networking between different people within the field. This interaction could be used not only as a mechanism of collecting data, but also as a mechanism to feed-back information on patterns and trends in drug abuse and so inform the implementation of demand reduction activities and policy.
- In terms of the operational aspects, the methodological toolkit (GAP Toolkit Module 1: Developing and Integrated Drug Information System) was seen to provide useful guidance on the INRA procedure. It was still necessary to receive technical support from the Regional Epidemiology Adviser in terms of a site visit during the INRA process, and it was clear that national counterparts would benefit from additional training in the analysis, interpretation and presentation of data. The logistics of providing this support had meant that the INRAs had not been initiated in several countries. Some countries had experienced difficulties with the process of receiving grant payments and this had delayed initiation of the INRA.
- Regarding follow-on activities from the INRA, it was clear that further training and technical support was necessary. Training workshops on data analysis, as mentioned above, were an agreed priority for the region. In fact, this was considered such a priority that members of EADIS agreed to hold 2002 meetings in Pretoria, South Africa, because the cost and logistical benefits of doing this would allow an additional sub-regional training workshop, and training of both Southern and Eastern African countries. Infrastructure needs were also identified as an issue with regard to follow-on activities. Funding constraints meant that an idealized inventory of infrastructure needs could not be met across all countries and it was apparent that a compromise needed to be established between utilizing existing resources and distribution of additional infrastructure support.

Focal Point Contracts

Matthew Warner-Smith

In 2002 GAP will be offering small grants to national focal points to assist them in network development and reporting. These small grants are expected to cover, as a minimum, three core activities:

- the holding of a network meeting;
- the production of a national report based on the data presented at the network meeting, and;
- acting as a liaison point for UNDCP on drug epidemiology in their country.

While the initial INRA training workshop and the accompanying tool-kit clearly explain what is involved in network development, including network meetings, a clear need was identified for an explanation of the rationale for, and format of, standardized national reports

The purpose of national reports is to provide a clear concise description of the national drug situation in a manner that is accessible and comparable across countries. National reports have been used successfully in many countries to disseminate information on drug epidemiology, and thereby inform policy and programme development and evaluation. The advantages of national reports are that they bring together multiple agencies thereby promoting communication and cooperation in the field of drug epidemiology; that they are inexpensive, as once they have been produced they can be easily updated; and that they take advantage of many levels of expertise. The standardization of national report formats is advantageous because it increases the comparability of information related to use and abuse of drugs between countries and facilitates the production of regional reports.

The structure of national reports should be along the following lines:

- Preface & Acknowledgements

- Executive summary
- Introduction
- Information sources on drug trends
- Overview of drug situation/trends
- Development proposal/future directions
- Conclusion and recommendations
- References & Appendices

National reports should be as clear and specific as possible. National reports will be used as tools to inform policy. As such the perspective of policy makers should be taken into consideration when drafting the report. It should be remembered that the target audience is not likely to have scientific training and will require a clear and concise presentation of patterns and trends in drug use in their country.

A model report will be produced and provided to focal points to assist them in the preparation of national reports.

Upon completion of INRAs, GAP will be initiating focal point contracts in each EADIS country. These grants will be to the value of \$2000. An additional \$1000 may be made available to focal points that are able to provide technical assistance to their government in completing part 2 of the Annual Reports Questionnaire.

GAP/LEN joint session

The final session of the meeting was held in conjunction with the Local Expert Network on Demand Reduction (LEN) meeting. EADIS members were introduced to the LEN project, its role, objectives and most recent activities. LEN members were then updated on the activities of GAP in the preceding months, having been introduced to GAP at the first LEN meeting in Nairobi in July 2001.

All participants agreed on the need to establish strong linkages and cooperation between EADIS and LEN. Although the two networks have different mandates and act at different levels, they can certainly, through the reciprocal collaboration, add value to each other work. The data and information produced by EADIS/GAP should inform the activities undertaken by LEN, which in return can give important inputs to EADIS/GAP in terms of additional data and/or feedback on the concrete utilization of the information from the point of view of practitioners.

Integrated drug abuse and HIV/AIDS prevention was regarded as one important area where synergy should be addressed. There are several efforts being made in the region in the field of Drug Abuse and HIV/AIDS prevention and LEN recognized the importance of more research on Drug abuse and HIV/AIDS and more qualitative and quantitative information, which could, in larger part, be provided by EADIS/GAP. GAP is currently exploring the possibility of including in the Annual Report Questionnaire specific indicators that could shed more light on the link between drug abuse and HIV/AIDS. A methodological tool for data collection on drug abuse and HIV/AIDS is currently being developed, but there is still a need to analyse the type of information that are available at the moment.

Members of the Eastern African Drug Information System (EADIS) and the Local Expert Network on Drug Demand Reduction (LEN).

The following proposals were made by meeting participants to improve EADIS-LEN reciprocal collaboration:

- Ensure constant cooperation and communication between the two networks at country and regional level and in Vienna headquarters.
- LEN and GAP focal points from the same country to establish formal and informal regular contact and liaison (where this does not already occur).
- UNDCP to provide GAP and LEN with lists of contact addresses for members of both networks.
- Sharing of INRA reports and documentation with LEN members at country level.
- LEN members to share the protocol Instruments developed for the two main thematic areas (Peer-to-Peer Youth Preventing Education and Treatment and Rehabilitation) with EADIS/GAP.
- Develop Networks of data stakeholders at country level (activity driven by EADIS/GAP).
- Extend, wherever possible, the LEN membership to other Eastern Africa countries so as to ensure better cooperation with GAP at country level.
- All UNDCP and UNDP project focal points to meet on a regularly basis with the purpose of sharing information (periodicity of the meeting to be decided by each country individually).
- EADIS/GAP and LEN to undertake joint activities (advocacy and awareness raising) based on solid data provided by GAP.
- The Newsletter produced under project RAF/E15 to be used as one of the main tool for communication together with the web-site to be developed by GAP.

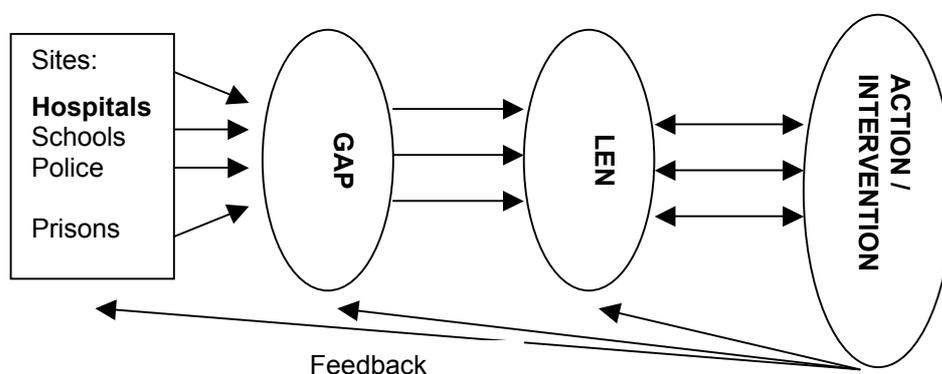


Figure 1. Model for GAP-LEN cooperation

LEN and GAP participants were of the opinion that collaboration between GAP and LEN should be ensured at regional and country level.

Proposals have been made for LEN and GAP participants to be invited as members of Interministerial Drug Control Committees in their respective countries. However it has been observed that this is not feasible everywhere, since some Eastern African countries still do not have very structured drug regulatory bodies.

All participants to the meeting noted that a constant flow of communication should be ensured with the Drug Control Regulatory Bodies (wherever they exist) or institutional drug control focal points in the Eastern African countries. To that effect one of the tasks of LEN and EADIS/GAP members could be to organize formal or informal briefing with drug control officials after each regional meeting, upon request or whenever deemed necessary.



Figure 2. Members of the Eastern African Drug Information System (EADIS) and the Local Expert Network on Drug Demand Reduction (LEN)

Conclusion

The first annual EADIS Report Back Meeting successfully documented the ongoing development of national drug information systems in Eastern Africa. All thirteen countries of the Eastern African region were represented at the meeting, indicating a high level of support for this initiative.

Activities planned for EADIS in 2002 include the completion of INRAs, network development activities, and a second report back meeting. These activities will be supported by the UNDCP GAP project. This support will be in the form of small research grants for INRAs, focal point contracts for network development activities, the hosting of the annual report back session and training in data entry, analysis and reporting.



Country Reports

Introduction

The following country reports were provided by participants of the meeting, and in many cases they report on the progress made toward carrying out Information Needs and Resources Analyses (INRAs). The information contained in these reports does not necessarily reflect the viewpoints of the respective governments of these countries. The reports have not been formally edited, however, they have been re-typed and/or reformatted and in some cases translated into English. Djibouti provided a verbal country presentation only as it was their first time participating in the EADIS network.

In addition to the following country situation reports, Information, Needs and Resources Analyses (INRAs) on the Seychelles and the Republic of Mauritius can be found elsewhere. These INRAs were conducted by UNDCP in collaboration with national counterparts, and have been approved by the national government drug control agencies of the respective countries.

Burundi

Laurent Dondo

Geographical Situation:

Because of its geographical situation, Burundi is known as the “HEART OF AFRICA”. Burundi covers 27 834km² and is situated between Central Africa and Eastern Africa, in the middle of the Great Lakes District, between latitude south 2° 45 and 4° 28, longitude Eastern 28° 50’ and 30° 53’30. Burundi shares its borders with the following two countries: in the North, Rwanda and in the West, the Democratic Republic of Congo, and together, they form the Economic Community of the Great Lakes District (CEPGL, in French). On the Eastern and on the South, Tanzania – its neighboring country – and Burundi itself form part, together with Uganda and Rwanda, of the Organization for the Development of the Basin of the River Kagera (OBK, in French).

Relief and Climate:

Most of Burundi is covered with mountains with slopes over thrust by the great Ridge, which separates the Nile Basin from the Congo Basin. Throughout the territory, the landscape is extremely varied. The interior consists of a triangular plateau that reaches an altitude of 1540m and then drops down towards the river Maragarazi. Despite the proximity of the Equator, Burundi enjoys a rather temperate climate due to its altitude and the average temperature is 23°C throughout the year. Both altitude and relief have a role to play in determining four main climatic zones and a multitude of micro-climates, thus creating a flora which is exceptionally rich. Starting from the western side of the country, one can record four distinct zones:

- The Lowlands of Rusizi and Tanganyka Lake, known as Imbo, situated in the North and South of Bujumbura, with an average height of 850m. This is a tropical climate area.
- The Congo-Nile Ridge where one finds the high summits, with a mild and temperate climate, which shelters the Kibara forest. The highest point of the country – HEHA – forms part of that ridge (2 670m).
- The Central Plateau with its rolling hills reaching an average altitude of 1 600m.

- The Eastern Zone, known as Kumuso, with an average altitude of 1 400m and a tropical climate.

Hydrography:

Burundi belongs to the hydrographical Basins of the Congo and the Nile. From North to South, the Congo-Nile Ridge splits the waters of Burundi between the basins of these 2 great rivers. The streams situated in the Eastern part of the Ridge, the Ruvubu and its affluent – the Kanyaru and the Kagera – drain into the Nile Basin. The rivers flowing in the West like the Risizi, and the Malagarazi – which constitutes a part of the border with Tanzania – drain into the Congo Basin. Lake Tanganyika constitutes the border on the western side of the country, with an area of 32 000 km² and a maximum depth of 1 470m. Other lakes are found in the North-Eastern depression like COHOHA (75 km²), RWERU (55 km²), KANZIGIRI and GACAMIRINGA.

Population:

Burundi has a population of about six million inhabitants. It seems to be one of the most highly populated countries of Africa. The annual birth rate is 2,6%. The population of Burundi is not equally spread out and can be found mostly in the hills of the Central Plateau where the density reaches 300 inhabitants/km² in some areas like the Ngozi Province. The main characteristics of the population of Burundi are its extreme youth and rapid growth (2,6% per annum). Young people below 18 years old represent half of the population (49,5%); adult – between 18 and 59 years old – constitutes 48% of the total population and among those, the young adults, fewer than 40 years of age, is the absolute majority. 90% of the population in Burundi is to be found in rural areas where they live on agriculture. The inhabitants are disseminated on the hills, either alone or in groups of 4 to 5 people. The fact that the population of Burundi is not gathered in villages creates serious problems to the countries who are trying to bring basic services to rural communities.

Administration organization:

For administration purposes, Burundi is subdivided into 16 provinces, 1 Town Council, 115 Communes, some Zones, Local Areas and Districts. Each Province has a Police Station in addition to the Police Station situated in the Administrative Centre of the Rumonge Commune. Provincial administration falls under Provincial Governors who are the representatives of the Head of State and of the Government in their respective Provinces. They are responsible for the coordination of all political, economic, social and cultural activities taking place in their Province and send reports to the relevant Governmental Authorities. The Commune is a decentralized administrative entity with a legal and financial autonomy. An Administrator appointed by the President of the Republic manages it. The communes are divided into Zones, which are in turn subdivided into Local areas, or in the case of urban zones, divided into Districts whose number and delimitation are stipulated by an Order of the Minister of Home Affairs. The Sector or the District is the basic unit of the Administration in Burundi and consists of a variable number of geographical hills or streets depending in whether it is a rural or an urban Commune.

Facts concerning drugs in BURUNDI:

Analysis of Needs and Resources

In Burundi, a Drug Control Unit was created and is responsible for controlling the traffic, cultivation and commercialisation of drugs at the National level. This unit falls under the authority of the General Commissioner of the Criminal Investigation Department within the Ministry of Justice. It is practically the only Department one can turn to, at the National level, as far as data collecting on Drug consumption is concerned. Still today, this Unit does not have the capacity to collect the minimum data necessary for treatment, as they do not have the necessary material and human means.

In the other sectors, Prisons, Hospitals, Schools, Ministry of Public Health, one does not find any data on file dealing especially with drug consumption. The various Police Departments – Documentation, Public Security Police, Airport, Border and Foreign Police, sometimes the Customs Department – compete to control Drug traffic, cultivation and consumption but the coordination of all their actions has shown itself to be practically impossible as the Inter-Ministerial Committee for Drug Control does not exist yet despite constant promises in the political arena.

At the National level, the only Centre, which might possess some data concerning the patients they treat for Drug consumption, is the Neuro-Psychiatric Centre of Kamenge. Such data had not yet been examined and captured as the Director of the Centre who would be able to give authorization for that work to be undertaken was on holiday in Europe until the end of December 2001.

We do not have enough personnel in the Public Service to be able to stay in regular contact with Drug users. Drug consumption being a scourge among the youth in Burundi, quite a few organisations involved in training the youth could take part in collecting information about Drugs, if the financial means were available. As mentioned above, at the National level, the only place where one can retrieve some information on Drug consumption is with the Criminal Justice Department, based on the number of seizures and arrests made.

Unfortunately, this data does not give a proper picture of reality as there is no coordination between the various Police Departments regarding the seizures or arrests and because of the war situation which has affected all sectors of life in the country for almost 9 years now. This explains why, in the year 2000, only 8 Police Stations out of (illegible) were aware of Drug Trafficking and Cannabis Cultivation. In July, a record was set with seizures and arrests made in 5 Provinces.

The Province of Muyinga, on the border with Tanzania, came first during that year with seizures and arrests in March, June, July, August and September, and a total of 12 suspects and 2,3kg of Cannabis. During the year 2000, 26 suspects, among whom a woman, were stopped for questioning, an estimated amount of 8,2kg of Cannabis were seized and 20 plants pulled out. In 1999, between March and November, Bujumbura was kept busy with cases of Drug Traffic and use, as well as a seizure of 267 doses of Heroin known as "KIKETS" in Users and Drug Dealers' jargon and 8 kg of cannabis. In the Ruyigi Province, 10kg of cannabis and in the Cankuzo Province, 1kg of cannabis were seized. Both these Provinces are situated on the border of the United Republic of Tanzania. On the other hand, the previous year, 1998, could be described as a "dead year", only 2 cases of drug use having been reported at the police station of Bujumbura.

Conclusion:

Although we do not have all the necessary data on drug consumption, cultivation and traffic, cannabis is a reality in Burundi.

The following figures, for example, taken from the Report of 11th Anniversary of the International Day for Drug Control in the Yr 2000, are proof enough of that state of affairs:

Heroin:

3,895 kg
1,074 kg
11,5 kg
31,5 kg
6 g

Cannabis:

30kg coming from Burundi were seized at Charles-de-Gaulle International Airport, in France, on 23/12/1986.

75 kg coming from Burundi were seized at Zaventem International Airport, in Belgium, on 15/11/1987.

1 2774 kg of cannabis and 87 plants were destroyed in 1990.

603 kg of cannabis and 7 700 kg of cannabis seeds as well as 65 plants were destroyed, in 1991.

8 320 kg of cannabis were seized in the Town Hall of Bujumbura, in 1998.

45, 8 kg of cannabis were seized in 1999 and 156 people involved.

Comoros

Mohammed El Badaoui

Introduction

The creation of this information network and analysis of consumer needs and resources would set the political and religious authorities in a convincing direction, as it would provide data on the more or less exact situation regarding drugs used by consumers as well as the consequences inherent to their use.

The lack of correct data on these products comes, on the one hand from a lack of personnel and on the other hand, insufficient knowledge and a lack of collaboration with those concerned with drugs. It is for this reason that INRA decided to concentrate its efforts on training National capacities to enable people to collect data and process them in a country where this kind of work does not exist.

Data on the country

The Comoro Islands constitute an archipelago of 4 islands, on a North-West, South-Eastern axis, at equal distance between Madagascar and the African Continent.

Population: 510 000 inhabitants
Official Language: French and Arabic
Regional hospitals
17 Districts Centres
1 Central point where medicine is bought
80 Dispensaries

Existing data sources

Whether drugs or psychotropic substances, it is through the Ministry of Health, Department of Pharmacy, that one can find the imported quantities.

Illicit substances: Data on these substances are found through the Joint Drug Control Unit and the Justice Department.

Patients: There are no Psychiatrists in the country and as a result, no Psychiatric Units exist within the National Hospitals. Patients are sent to the Regional Hospitals where they are treated by General Practitioners.

Research: No specific research has ever been made in this field, and it is only in the Casualty Department that certain figures can be obtained.

Data from the Police Department: The joint Drug Control Unit gathers all the data on illicit drugs and seizures made. These various drugs are either imported or cultivated and they consists mainly of the following:

CANNABIS	:	imported and cultivated
ALCOHOL	:	imported
CANNABIS RESIN	:	imported
DATURA METELE	:	cultivated
TEPHRISA CANDIDA	:	cultivated
KHAT	:	cultivated
NUTMEG	:	cultivated

As far as arrests due to the possession of illicit drugs concerned, most of these are due to imported Cannabis.

Data on prisons:

Prisons do not really play the role they are supposed to, as prisoners are allowed to leave the prisons camps and come back at any time.

Through its National AIDS Programme, the Department should be able to give information concerning the relationship between AIDS sufferers and Drugs.

Available Resources

The Department of Pharmacy owns a small data bank on licit and illicit substances but it is still at an embryonic stage. However, some effort has taken place since 1998, giving Private and Public Pharmacies Statutory instruments to collect data on users of psychotropic substances. There is some expertise available in order to carry out a survey at a National level and to create a National Data Bank on the consequences of Drug consumption.

What are lacking are time – because of the political instability – as well as specific knowledge on the Epidemiology of Drug Consumption. One could use the Regional Hospitals and the Districts Centres to establish Data Collection Centres on Drugs and contribute to the development of a network on the Epidemiology of Drugs Consumption.

Other competent people, organisations or Departments do exist within the country and these should combine their efforts in order to improve the network. They are:

- the Sociologists who are doing some research work in this direction;
- the Information and Statistical Department of the Ministry of Public Health;
- the National Centre for Research and Training in the Public Health sector;
- the NGOs

Proposal for a Development Strategy for the Network

The Development Plan for Human Resources has advocated the training – before the year 2006 – of 3 doctors in Psychiatry and 6 Nurses. In the meanwhile, one can make use of existing resources to organize the network. These resources are among others:

- 3 Regional Hospitals
- 17 District Centres
- The existing NGOs
- The Ministry of Health
- PNLs
- GNFRSP
- The Joint Drug Control Unit
- The Pharmacy and Medical Practitioners Associations

The main Needs are:

- Training
- Logistic Equipment

Conclusion:

The main drugs used in Comoro Islands are cannabis and alcohol. No appropriate research exists to prove how prevalent the consumption of these drugs is. The success of the network will only be reached when an open cooperation between the various actors (Health, the interested parties, Customs, Foreign Affairs) does take place.

Eritrea

Andom Mehari Yoel

Counter Drug department was established in late 1994 and now it is functioning within the ministry of Local government. Drug abuse and trafficking was increasing especially up to mid 1998. The most abused drug is herbal-cannabis. The sources were from neighbouring countries. In addition to this there was very small-scale plantation that was discovered.

The consumption and trafficking of herbal-cannabis reaches its peak during the summer season. This can be attributed to the number of people who comes from abroad for recreational purposes. Another factor, which contributes to the increase in herbal-cannabis sales, is that of traffickers who try to illegally cross the border to Saudi Arabia. They hide in the Red Sea coast area until they get small boats, which can take them across illegally. These traffickers may stay there for a minimum of one month. So when they finish food staffs and other necessities before their departure time or if unforeseen events occur they are forced to sell all or part of the herbal cannabis they have in different cities of the country.

In general, due to the low standard of living it is very difficult to afford hard drugs. However the increasing number of deportees with abuse of hard drugs is going to be a potential threat. They seized two kilos of cocaine in 1997. They have also found opium poppy, which was grown in flowers in recreational parks but it seemed to have been planted unintentionally. They sent a sample of it to US for analysis and they were informed that the sample was found to be pods from the opium poppy (*Papaver somniferous*) with Morphine base content of 0.1 percent.

Another type of illicit drug, which is encountered, is Phenobarbital tablets. Besides this we also encounter khat. Khat is grown in the country on a very small scale.

Their experience they have found drug abusers who try to strengthen the effect of herbal-cannabis by soaking it in butter, honey or whisky and then they sun-dry it before they smoke. A stick of herbal-cannabis, which is prepared in this manner, has more effect than the naturally grown one as the users stated it.

Though currently illicit drug abuse and trafficking is not a major problem in Eritrea, there is a great concern on drug abuse and its related problems by the government and the society. So, every possible effort is being undertaken by the department to combat it.

They hold seminars and workshop with different law enforcement bodies and National NGO's to create awareness and strengthen the existing cooperation. In addition to this common understanding has to be reached with the ministry of justice to refine preventive measures for illicit drug abusers and traffickers since the sanctions at present are too lenient.

Ratification of the three conventions on Narcotic drugs and psychotropic substances are on process and will soon be signed.

In future drug abuse and related crimes may increase:

- When the movement of people to and from neighbouring countries and from different corners of the world increases.

- If sea patrol are not strengthened (the red sea coast stretches about 1200km with more that 300 small and big islands and archipelagos).
- If the department does not overcome the existing limitations namely human and technical resources as well as if do not develop and strengthen coordination and exchange of information with their counter parts.

Ethiopia

Albdoo Abdulrahman

The following summary outlines the structure and progress made on the INRA for Ethiopia.

Objective of the INRA:

A report that documents the existing information sources, resources and needs related to drug abuse data collection within Addis Ababa and a proposed framework for the development of EADIS. Working reference document on information and resources within the country relating to drug abuse epidemiology.

INRA involves assessment of:

- Information on drug abuse
- Infrastructure and resources (data collection activities)
- Need for development, and proposing a strategic plan for the development of INRA.

Establishing Information on drug abuse:

Identification of relevant institutions and individuals:

- Ministry if Education
- Federal police
- Addis Ababa university
- Community health department
- Sociology department
- Psychology department
- Emmanuel mental specialized hospital
- Forum for street children
- Black lion and Menilik High School
- Ministry of Health, drug administration and control authority

Assessing information and resources available:

Activities to date:

- Meeting on October 10, 2001
- Situation of drug abuse and illicit trafficking

- Information, needs and resource analysis (INRA), EADIS and GAP

Questions:

- National survey of drug abuse
- School survey on drug abuse
- Registry of treatment admission
- Police keep statistics on arrest

For each data source:

- Method of data collection
- Data categories
- Method of data collation
- Mechanism for data retrieval and analysis

Discussion points:

- Khat, cannabis and social drugs
- AA Police commission – problem of heroin and opium 1/8 of population of AA aged 13-40 Sub abuser
- Advertising of alcohol by media
- Interministerial committee
- Extending the study to other part of the country
- Survey done by Aauand Emmanuel Hospital
- Extent of drug abuse qualitative and quantitative study by AAU Emmanuel Hospital

Identifying resources and needs

Resources:

- Data Source
- People to partake in a net work
- Expertise and technical skills

Needs:

- Infrastructure (database software, internet/email)
- Staffing and financial support

Analysis of data sources:

- Treatment data
- Survey
- Rapid situational analysis
- Arrest data

Existing information on drug consumption in Ethiopia

Some correlates of poly-drug use behavior among street children (Forum, 1998): The highest consumption rate was reported for khat use (56.2%) followed by alcohol and tobacco (51.9% and 46.8% respectively). The other two drugs, benzene and hashish, constituted 28.9% and 18.8% respectively.

The prevalence and impacts of drug abuse among 1780 randomly selected students from 30 senior secondary high schools in Ethiopia, the investigator found out that from the total number of respondents 20.7% (M=257, F=112, Total=369) are tobacco users, 49.6% (M=565, F=318, T=883) alcohol users, 39.8% (M=456, F=253, T=709) khat users, and 11% (M=129, F=67, T=196) hashish users.

Emmanuel psychiatric hospital: In its 1998 annual report, the hospital has treated 1686 drug related cases. Among these the majority were alcoholics. Besides, in a survey conducted in the hospitals in 1993 it was found that 43.0% of psychiatric in-patients admitted were for drug abuse. According to the study the most frequently abused drugs were khat, alcohol, and cannabis. The report also indicated that between January 1, 1993 and August 30, 1994, 2176 (out patients out of total of 23, 507) were treated for drug abuse related problems.

A report on the rapid assessment of the situation of drug and substance abuse in selected urban areas in Ethiopia in 1995 indicated that 82% (N=1880, male=1080; female=800) of the respondents (respondents were street children, commercial sex workers, and street vendors) admit of having used addictive drugs.

A study on the prevalence of problem drinking and khat chewing in Addis Ababa in 1993 was found to be 2.7% and 7.4% respectively.

Kenya

Able Ndumbu

Most African countries have today discovered that in addition to the proverbial triple enemies of poverty, ignorance and disease first described at independence they have to deal with other problems that have been emerging since independence. One of these emerging problems is the issue of substance abuse. In the case of Kenya, the Government has been aware of the damage that drugs can do to the youth, to the whole labour force and to the economy in general. For instance, the Traditional Liquor Licensing Act (First promulgated during the colonial period) and the Chiefs Act were, among other things, aimed at ensuring that traditional brewing and consumption of traditional liquor was restricted to authentic ceremonial purposes.

Soon after taking office in 1978, President Moi, citing the dangers that chang'aa and other local brews pose to wananchi banned the brewing and consumption of local brews. The proscription however has not prevented episodic catastrophes arising out of potent brews. Notably, in 1999, illicit brews killed 30 people in Kiambu, and the following year, a brew originating in Murang'a killed 130 people in far-flung parts of the country who consumed it. More recently, earlier this year, (2002) 'kumikumi' another highly potent local brew led to the deaths of several people in one of the slums in Nairobi. Perhaps the potency of these brews is best illustrated by the story in April 2001, of a man who sustained serious injuries after the chang'aa he was drinking in Siaya, burst into a ball of flames. He had lit a match to check how "conc"(concentrated) his drink was.

A consistently high rate of fatal road accidents, a high crime rate and a number of serious riots, fires and other violent disturbances in educational institutions have caused a great deal of public concern. The most common explanation for the frequent occurrence of these problems has been

to associate them with the consumption of drugs. In particular, several fatal incidences in schools have brought an added urgency for the Government and the public in general to deal with the influence of drugs on youth. In 1991, 19 girls of St. Kizito Secondary School in Meru died in an orgy of rape and subsequent stampede after boys from a neighboring school evaded their dormitory; in March 1998, 23 students of the Bombolulu Secondary School died, and 18 were seriously injured when a night fire engulfed their dormitory; in May 1999, another school tragedy occurred in Nyeri High School where fellow students attacked and killed four prefects. The most recent of these tragedies occurred in March 2001, at Kyanguli Secondary School, Machakos, where 58 students died in another night inferno, lit with petrol, by some of their colleagues. These are only some of the major incidences. There have been numerous others throughout the country.

Acting in line with the relevant stipulations of the United Nations, and as part of its own efforts to protect the citizens of the country from the harmful effects of drug abuse the Kenya Government has ratified the three major United Nations Conventions on Narcotic Drugs and Psychotropic Substances. These are the Single Convention on Narcotics, (1961); the Convention Against Illicit Trafficking on Narcotic Drugs and Psychotropic Substance, (1968) and the Convention on Psychotropic Substances, (1971). The latest legislation against drugs in Kenya is The Narcotic Drugs and Psychotropic Substances (Control) Act, 1994.

The promulgation of the act in 1994 was followed soon by the appointment of an Inter-ministerial Drug Security Committee charged with the responsibility of evaluating drug policy issues in the country. This committee produced a Drug Master Plan, which was approved by the Government in 2001. Responding to the hue and cry about increased rates of drug abuse, particularly among the youth, the Government took further action against drug abuse with the formation of the National Agency for the Campaign Against Drug Abuse (NACADA) whose major objective is the co-ordination of programmes on the fight against abuse.

This task can only be carried out effectively with a full knowledge of the magnitude and associated circumstances of drug abuse in the country. The author of this paper is a member of a Technical Working Group established in October 2001 to plan and implement a national baseline survey on substance abuse. The questions the survey will seek to answer relate to: the proportion of Kenya's population taking drugs, what drugs they are taking, when and where are the drugs being used, why does the individual concerned take drugs and where do the drug abusers get their drugs from?

In general term, drug abuse in Kenya is a much-studied subject. For instance many Master of Medicine (Psychiatry) theses at the Department of Psychiatry, University of Nairobi, have dealt with various aspects of this problem. There has, however, not been much emphasis on research intended for application in solving socio-economic problems.

A survey team carried out an Information, Needs and Resources Analysis (INRA) for Kenya in July, 2001. The team which was led by Professor of Psychiatry at the University of Nairobi and Director of Nairobi Psychotherapy Services & Institute (NPSI) composed of research staff and research associates of NPSI: Dr. Donald A. Kokonya, Dr. Francisca A. Ongecha, Mr. Able Ndumbu, Ms. Victoria Mutiso and Mr. Leonidas Musafiri. Two UNDCP personnel Dr. Rebecca Mcketin and Dr. Mathew Warner Smith provided facilitative and training support. The survey team found a situation where, despite the existence of many organizations working on the drug abuse portfolio, information and statistics on drug abuse are extremely scanty. Where such data is available, it relates to every small sections of the population and cannot therefore be justifiably by generalized to the total population of Kenya. Another drawback in the existing data was that it had been collected on a rather ad hoc basis. The survey team found that since late 1970s a number of studies have been carried out to assess various aspects of drug abuse in Kenya. Most of these studies have been carried out for academic purposes. However, their scope has been rather limited, so much so that it would not be prudent to rely entirely on such data for project planning and implementation of projects on demand reduction.

The earliest effort to study substance abuse in Kenya is apparently a study carried out in 1983 by Dr. Mauri Yambo and Professor S.W Acuda (then associate Professor of Psychiatry at the University of Nairobi), The study report, **Epidemiology of Drug Use and Abuse: Final Report of a Pilot Study of Nairobi City and Kyaume Sub-location**, among other things, recommended that together with a campaign to change the attitudes of youth towards drugs, there was "potential to manipulate the availability in Nairobi, of such drugs as cannabis, khat and amphetamines to

prevent access to them becoming any easier than it is at the moment.....” Many years later, in 1996 a doctoral thesis by Anne Atieno Obodo of the Department of Psychiatry, University of Nairobi dealt with the socio-economic impact of one of the most commonly abused drugs in Kenya, entitled: **The Socio-economic Effects of Alcoholism on the Kenyan Family**, her thesis like the previous study, pointed out that there is a need to take various actions to minimize the occurrences of alcoholism (and by implication, other forms of drug dependence) and the socio-economic problems they cause in the family. In 199, a Master of Medicine (Psychiatry) dissertation, at the University of Nairobi by Dr. Mary Wangari Kuria found that the most commonly abused drugs in Kenya were alcohol, tobacco, inhalants, cannabis, amphetamines, opiates and cocaine.

On behalf of the United Nations International Drugs Control Programme, (UNCP). Dr. Halima Abdalla Mwwenesi carried out a survey in 1995, whose report – **Rapid assessment of Drug Abuse in Kenya: A National Report** indicated that, “although the drug problem in Kenya was still in its infancy in Kenya, however, especially because of Kenya’s good communication links with other countries and the pressure from drug manufacturers and traffickers regularly seeking new markets, the degree of risk of the problem taking root is high”. From the interviews carried by the survey team and from newspaper reports it would appear that the problem has indeed been taking root in Kenya but the actual prevalence of drug abuse cannot be ascertained without a full-scale national survey. Every respondent the survey team interviewed, particularly those providing the drug and rehabilitation services spoke of having noticed an increasing trend but could not give an accurate figure for the rate of increase.

In 1997, Prof. D.M. Ndeti and his team at the Department of Psychiatry at the University of Nairobi carried out a study under the auspices of UNDCP **Economic-Social-Political Aspects of Illicit Drug Use in Kenya**. This little publicized study is so far the most comprehensive study supported by data. The major objective of the study is so far the most comprehensive study supported by data. The major objective of the study was to evaluate the epidemiology of illicit drug trade in Kenya. The study was designed to focus on the illicit drug trade in Kenya as the central focus, and thereafter evaluate the peripheral economic-social-political environment the drug trade thrives in. The findings of this report provided a major input into the preparation of the **Drug Control Master Plan** drafted in 1998, and approved by the Government in 2001. With regards to the economic aspects of illicit drug trade, the study found that illicit drug production in Kenya involved the growing of cannabis sativa (bhang). This is mainly done in remote unsettled areas, but there was a small proportion inter-planted with regular crops. Other supplies emanating from Uganda increased the supply. Khat (miraa) which contains a controlled psychostimulant (cathinone) is freely grown in Kenya. Significantly, the major motivation for drug production was the financial gain from the trade. Concerning distribution, the report says that the drugs of illicit use most commonly trafficked in Kenya are cannabis, sativa, heroin, mandrax and cocaine. Other significant psychotropic drugs include benzodiazepines, barbiturates, and volatile hydrocarbons as well as illicit ethanol local brews. The main target groups of the illicit drug trade are youth especially in urban centres, students in schools, matatu touts, prostitutes, hawkers, criminals, a few adults, some foreigners – particularly tourists and some religious cults. With regards to the social aspects of illicit drug trade, the study noted that cannabis production in Kenya is rampant which points to the existence of a strict code of secrecy surrounding operations in the trade. Although it is largely grown in state land, in the remote unsettled areas there has to be a considerable size of networks to harvest, packages, transport and finally retail the finished product.

Significantly, deprivation (obviously arising from rampant levels of poverty) was noted as a major contributor to illicit drug use. On the political front, the study report notes that although Kenya had put in place the fundamental relevant statutory elements for the regulation and control of trade in psychotropic drugs via **Kenya Gazette no. 41-1994** there were inadequate resources to reinforce the law effectively. Further, there had been two serious impediments in the reinforcement mechanism. First, the interpretation of the law courts had at times been at variance with the written stipulations thereby confusing the law enforcement personnel, and secondly there had been cases of manipulation of the law to favour the law breakers (specially the influential drug dealers) within the ranks of the law enforcement groups. These then are the prevailing conditions of secrecy and connivance which personnel working on data collection and consequent intervention programmes have to contend with. The study report indicated that the major drugs of choice by abusers in Kenya continue to be alcohol, tobacco, cannabis and miraa (khat), but the real hard drugs such as heroin have made some inroads.

The INRA survey team found that two organizations in Nairobi have made considerable efforts to initiate a systematic collection of data. These are the Anti-Narcotics Unit of the Criminal Investigations Department, Kenya Police, which is maintaining a relatively detailed database on seizures of illicit drugs by type and quantity, and Mathari Hospital. Their limited data highlights the need for an improved, systematic data collection and categorization of data by its sources such as arrest and seizures data, psychiatric data, treatment data, data from school counsellors, data from Non-governmental organizations, and data from primary health care centres and from social workers.

Adolescent Drug Use and Abuse in Kenya: Impact on Reproductive Health is a briefing book based on research by Dr. Tony Johnson at population Communication Africa, Nairobi, funded by Pathfinder International. Johnston's research sought to empirically establish the truth regarding what he considers to be sensational reporting on the part of daily newspapers and wild claims on the part of Kenyan politicians, administrative, educational and religious leaders. In particular, Johnston is scornful of a newspaper report that said "Most Form I students in Nairobi are forcibly or unwillingly injected with cocaine before they are accepted into their peer groups". According to Johnson, false beliefs in the public had come from media reports of "wild, extravagant and mostly erroneous statements". Some of these were the notion that drug use and abuse within Kenyan adolescent/ young adult population has now reached alarming proportions and has in 'recent years' doubled or tripled (or in some way multiplied) and thus become rampant, widespread, or uncontrollable; that drug use and abuse among Kenyan youth has been the direct cause of poor school performance in national examinations, and students riots (which have caused considerable damage to school and other public buildings as well as loss of life) and growing rates of crime within many Kenyan communities. Johnson's data showed that a quarter (25.4%) of all Kenyan adolescents and young adults (16-26 years) report (previous and current) regular use of drugs, that the most prevalent drugs regularly used by youth in Kenya are cigarettes and alcohol (commercial beer and spirits). These account for 87.65 of all regular use. 18.5% of Kenyan adolescents and young adults reported one or more episodes of drug addiction. Johnston calls for sobriety in reportage of drug use and abuse among Kenyan youth and admits that the country has a problem that is associated with narcotics. "Within the larger urban universities, and in some of our coastal tourist centres, there are youngsters, who, today, inject narcotics....." But even as he called for a proper perspective, significantly he noted the seriousness of the problem. He wrote "as this briefing goes to press, (2000) and illegally "brewed alcoholic spirit (chanáa) has in one week taken the lives of over 130 Kenyan (men and women of all ages) and the death toll is expected to increase. Over 400 Kenyan consumers of this "batch" of changáa are presently in hospital. Of those that might survive, many will be blind for life."

At the time that the INRA survey was getting off the ground in July 2001, a "Rapid Assessment and Response Report" carried out under the aegis of the world Health Organization was nearing completion. Among the key findings of this report were: there is rampant and well-established injecting drug use in Nairobi; that according to anti-narcotics reports, heroin is the most trafficked and also the most abused hard drug in Kenya. The report further said that non-injecting use of heroin (brown sugar) began in the late 1970s in the coastal, tourist town of Mombasa, and later on moved to Nairobi. On the other hand, injecting drug use began in the early 1990s with the introduction of "Thai white" brand of heroin; the drug of choice for injection is white heroin. Brown sugar is preferred for non-injection, which includes what are known as chasing, smoking and sniffing methods. One of the merchandising efforts on the part of dealers was the introduction of a one tenth of a gram instead of the previous measure of one gram. This in addition to the discovery by the abusers that injected heroin lasts longer in the body, is reported to have caused a rapid increase in the number of injectors

With regards to treatment data, Kenya has one specialized referral hospital for treatment of mental diseases – the Mathari hospital certainly one of the largest and oldest such institutions in Africa having been opened in 1911. There is a psychiatric unit in all the provinces of the country, which refer the more complicated cases to Mathari. Psychiatric units have not been opened in all the district hospitals but the current director of mental health informed the survey team that plans are underway to institute mental health care in these hospitals, as well as in health centres where possible. The survey team found that Mathari Hospital has a Department of Health Records and Information Services whose ambitions, for the future, at the time of the visit included:

Acquire a computer and a printer to enable easy access of well-processed data readily consumable by all stakeholders such as Hospital Management, Ministry of Health, postgraduate students, researchers and other stakeholders.

Institutionalise the use of accurate and timely information in decision making within the hospital.

Some of the statistics available at Mathari hospital relate to the “top ten” causes of in-patient morbidity in accordance with ICD-10 categories. While these statistics have entries for “Mental Disorders due to opioids” and “Drug-Induced Psychosis” drug abuse receives no further scrutiny, neither are patients probed further for type, source and method of acquisition of drugs or demographic characteristics. The administration of the hospital accepted to maintain more detailed information on drug abuse in the future.

Treatment data in the NGO and private establishments that the INRA survey team visited do not isolate drug abuse as a special category for data purposes. These organizations, which have accepted to join the proposed network-notably Avenue Hospital, Brightside Alcohol and Drug Abuse Rehabilitation Centre, Dapar Centre for Alcohol and Drug Abuse, the Raphaelites, and the Crescent Medical Aid clinics – will be part of the network’s efforts to maintain a drug abuse databank of standardized, internationally comparable data.

General Hospital records are maintained as part of the treatment data on the total populations of in-patients but these do not specify information on drug abuse. Financial constraints have in recent years led to a situation where outpatient records are maintained in exercise books purchased by and kept by the outpatients. Part of the tasks of the network in its co-operation with the Ministry of Health will be the acceptance of the use of standardized treatment/ data collection that can feed information into the databank on drug abuse.

The type of drug abuse problems that social workers face most frequently are related to the consumption of alcohol and cannabis. Unfortunately, there is no centralized system data collection. The survey team considered that one of the tasks of the proposed network, once fully operational, would be to co-operate with the ministry responsible for social services, as a potential contributor to the databank through the operations of social workers.

As regards data from law enforcement agencies, both the Narcotics Unit of the Criminal Investigations Department, Kenya Police, and the Prisons Department manifested to the survey team a rare degree of openness and co-operation. The Narcotics Unit maintains regularly updated statistics on seizures by type of drug and quantity. These two, will participate in the network as their operations are not only useful in data collection, but also crucial for the success of demand reduction activities.

The type of data currently available from educational institutions, of necessity comprises information of a qualitative nature. Although there have been many newspaper and anecdotal reports on the consumption of drugs in schools, hard data has been very difficult to come by. However, one of the organizations visited by the survey team – Welfare and Allied Services had been doing considerable work on both advocacy and rehabilitation in high-cost schools in Nairobi and had already prepared a project proposal for the expansion of the services. The university students’ organization **Nairobi University Association for a Drug-Free Society (NUADS)** had also done some advocacy work and was planning to extend its advocacy working by co-operating with students in other universities in the country, both public and private.

The Director of Education expressed concern about the paucity of accurate information on accessibility and rates of drug abuse in schools. The same concern was expressed by NACADA – the newly established National Agency for the Campaign Against Drug Abuse. It is evident from these concerns that one of the major activities of the proposed network will be to seek ways in which to support both the Ministry of Education and NACADA with reliable data and the necessary interventions.

Discos and nightclubs are regular haunts of drug dealers and users. Subsequent enquiries after the survey indicated that in the Kenyan case, these should not be considered as viable sources of data other than information of an anecdotal nature. This is largely because of the secrecy with which dealers and abusers operate. Moreover proprietors and managers consider action against drug users in their premises as invasive of their business. Nonetheless discos and nightclubs have always been potential grounds for police arrests, seizures and information gathering on drug abusers and their sources.

With regard to Policy Issues the Kenya Government has ratified three major United Nations Conventions on Narcotic Drugs and Psychotropic Substances. These are: the Single Convention on Narcotics, 1961; the Convention against Illicit Trafficking on Narcotic Drugs and Psychotropic Substances; 1988, and the Convention on Psychotropic Substances 1971. The latest legislation against drugs in Kenya, is The Narcotic Drugs and Psychotropic Substance (Control) Act, 1994. This enactment was followed soon by the appointment of an inter-ministerial committee on drugs. The general opinion at every relevant corner that the survey team visited is that the inter-ministerial committee, the lack of support notwithstanding, was the production of the Drug Master Plan in 1998. The Drug Master Plan was approved by the Government in 2001. There is however, a general consensus that some of the recommendations of the Drug Master Plan., such as the recommendation that the President should chair meeting of the committee every six months, are unworkable in the Kenyan context. Concerns about increasing rates of drug abuse particularly among the youth, led to the formation of the National Agency for the Campaign Against Drugs (NACADA). NACADA, formed by the President in 2001 and still in its early formative stages, is responsible for coordination and evaluation of programmes on the fight against drug abuse as well as the stimulation of intervention projects.

The Current directory of NGOs involved in drug demand reduction and rehabilitation programmes includes 22 NGOs of varying capacities and strengths. The general observation of the survey team was that the NGOs involved in programmes against drug abuse are generally under-funded. With the exception of a few, their resources do not match the enthusiasm of their staff. While the majority of the NGOs profess to be involved in awareness campaigns and rehabilitation, only a few have been able to establish rehabilitation centres and programmes – notably, Dapar Centre for Drug and Alcohol Abuse, Brightside Alcohol and Drug Abuse Rehabilitation Centre and the Raphaelites, whose impressive rehabilitation centre is situated in Red Hill, Limuru, on the outskirts of Nairobi. All the three Organizations provide residential rehabilitation services at a fee. One NGO – the Healing Fountain Centre had made plans to start a 24-hour counselling service on abuser, HIV/AIDS teenage pregnancies and other social problems affecting the youth in particular, especially in metropolitan Nairobi. All the organizations visited reported an escalating rate of drug addiction as a result of the merchandising activities of drug dealers and peddlers. Of particular concern was the reported increase of drug abuse incidence in schools. The survey team heard reports of peddlers who were trying to create demand for their drugs by lacing sweets and other food and snacks with drugs. Certainly this method has been used by thieves who offer drug-laced sweets and other snacks to fellow travellers in buses or trains with the intention of robbing them their belongings once they are drugged.

Turning now to resources and needs we find that Kenya is well endowed with a wealth of human resources who have the necessary expertise to deal competently with the socio-economic problems associated with drug abuse. One of Aftocan's leading psychiatric institutions, Mathari Hospital is situated in Nairobi. In recent years a number of centres dedicated to drug rehabilitation has been established by private organizations and Non-Governmental Organizations. The function of coordinating programmes and projects against drug abuse has been vested in NACADA, the National Agency for the Campaign Against Drug Abuse, since 2000. There is therefore an ample pool of qualified manpower in Kenya to provide the technical support and coordination for data collection and networking activities on drug abuse among the various stakeholders. There are more than twenty NGOs involved in advocacy against drug abuse while a few are involved in advocacy and rehabilitation work. Many potential contributors of data to the network do not have computers and those few who have computers either do not have the necessary software or personnel trained in data collection and management.

While the Government has recently provided an umbrella organization for the coordination of programmes against drug abuse, NACADA, (National Agency for the Campaign Against Drug Abuse) and of the major needs remains the initiation of a system for sharing information and data among the various players in the fight against drug abuse. There is also the lack of a standardized method of data collection, as it becomes available from clients in a manner that makes that data internationally comparable to other similar sources of data. Currently there are many organizations that are potential sources of data but none of these sources are adequately developed up to the point where they can contribute regularly to a national data bank on drug abuse. Many of these sources lack computers others have computers but they do not have the necessary software nor are their staff properly trained in the creation and maintenance on an epidemiological databank.

There is great willingness on the part of the organizations visited during the course of the survey, but many are handicapped by the lack of resources.

The main proposal at this stage put forward for strategic development was the inauguration of a drug abuse network. The advisory committee of the network held its first meeting on 15th August 2001. The advisory committee endorsed the establishment of a secretariat at NPSI. The advisory committee charged NPSI with the responsibility of not only ensuring effective data collection but also ensuring that the network plays an important role in meeting NACADA's national objectives. In particular the network should be able to assist NACADA with the provision of the necessary training of trainers, the development of project proposals and in carrying out research activities.

It was agreed that members of the network will, at an appropriate seminar, approve a timetable. The timetable will include the merger and adoption of a standard format or standardized forms as data tools for the different sources. The organization represented agreed to prepare different data collection tools that they considered most appropriate for their purposes. These would then be discussed and merged into standard tool.

The members emphasized that they are looking forward to a results-oriented network that will organize training of drug abuse counsellors for its membership to carry out research and serve as a resource centre. The members have accepted to await the results of the NACADA national baseline survey in order to ensure that its activities are implemented in random with NACADA and are supportive of national priorities.

From a regional perspective, information obtained from the Anti-Narcotics Unit of the Criminal Investigations Department, Kenya Police is extremely relevant to EADIS. The Director of the Anti-Narcotics Unit explained that his unit was part of a regional East African Network that also included Rwanda, which was co-operating on operations against drug trafficking. Pakistan is understood to be the main source of drugs, which are stockpiled in Kenya on transit to other countries. The unit has 23 stations, which are strategically situated in the country's transport network. Five of these are in Nairobi. Seizures and arrests are entered in a 'daily crime and incidence report' and in a special form-C8. This gives a description of the suspect but does not indicate the occupation or the age (bracket), neither does it specify whether the suspect is a consumer, a courier or a small time peddler. The statistics are maintained in a computer at Police Headquarters. Constraints include the fact that the data has to be collected manually and with only 100 officers the unit is understaffed, the law treats petty crimes casually and therefore some relevant fingerprints and statements do not reach the unit's network and this may lead to under-reporting. Drug traffickers are using many ways to avoid detection, for instance, some traffickers from Nigeria and other West African countries cohabit with rich Kenya women to camouflage their activities. The normal estimation is that a roll or one stick of cannabis (bhang) weighs 5gm.

There have been plantations of cannabis on Mt. Kenya but two operations carried out by the unit in co-operation with forest officers and guards with the aerial support of the Kenya Wildlife Services, going as far as 25 kilometres in the forest at the foot of Mt. Kenya in Central Kenya have destroyed 90% of the crop. The plantations were large and the enormity of the supply problem this would cause can be gauged from the fact that an acre of cannabis accommodates 10, 000 plants and each plant will yield leaves of up to 2 kilograms. This does not include the seeds and the stems, both of which are abused. Cannabis farms in the Gwasi Hills and Nandi Hills in the western highlands of the Valley have also been destroyed. A major problem remains at the porous Kenya-Uganda border, particularly around Busia where on the Ugandan side of the border many people "grow the plant up to the doorsteps". At the Kenya-Tanzania border around Isebania greater surveillance on the Kenyan side has led to a situation where Kenyan businessmen contract Tanzanians border at Namanga, there has been a seizure from a woman who had wrapped the drug around the body of her young child. Some parents carry drugs across the border by using innocent children. Trafficking on the international routes is trickier to deal with. Some couriers traffic drugs by swallowing pellets, others pack drugs in suitcases. Major East African or European couriers use containers shipped by sea or by air. Like the land borders, the coastline is also porous.

Mr. Jakobam considers that the best way forward on demand reduction is by sensitising the people. Kenya needs to invest heavily on strategies for drug control since traffickers and peddlers are now using newer and more complicated methods to conceal drugs. Kenya cannot work in isolation to deal effectively with the problem but needs to work in co-operation with the

neighbouring countries on policy formulation and operation. The anti-narcotic unit he said is already carrying out a restructuring of its operations to cover all the geographical areas of the country.

Madagascar

Raobijaona Bruno

Madagascar is considered as the 4th biggest island in the world and situated in the Indian Ocean South – East of the African continent. Its area covers 587 041km² and stretches over 1600km from North to South and over 500km from West to Eastern, with a coastal range of about 5000 km. Madagascar is divided into 6 autonomous provinces, on two levels (28 regions and 1 391 communes). Malagasy is the only language, spoken and understood by the whole population. However the French language is used for administrative matters.

In 1998, Madagascar was ranked 141st over 174 countries in the world in terms of human development. The struggle against poverty thus became one of the prime targets in the same way as economic growth. With that in mind, the strategic document of Poverty Reduction and Economic Growth was elaborated. Political stability, re-established since 1997, encouraged a dynamic growth in the economy in general.

GENERAL CHARACTERISTICS OF THE COUNTRY	1997	1999
Total population men/women	13 500 000 49.8% 50.2%	14 670 000 49.4% 50.6%
Average Age: 47% under 15 years old		
Urban population	21.6%	22.2%
Life expectation at birth men/women	54.2 54	55.1 56
71,3% of the population lives below the threshold of poverty		
Demographic growth rate	2.68%	2.65%
Growth rate of the GNP	3.9%	4.7%
Inflation rate (% of consumption)	5.4 %	7.9%
Percentage of children in primary school		
Boys	100.97	
Girls	99.25	

ILLICIT TRAFFICKING

On the basis of data provided by the National Police Force, the National Gendarmerie and the Department of Customs, cannabis is the only drug that can be considered as a drug being the subject of illicit traffic in Madagascar. This substance, with its continuous increase in quantity, comes from illicit cultivation occurring in the inaccessible areas of the country.

In short, five (5) provinces out six (6) are hit with high scale production of cannabis, turning Madagascar into one of the big producers of this substance. However, the local authorities, through their repressive departments, have tried to solve this problem. In the course of the different operations carried out by the National Police Force (Central Drug Unit and outlying Departments), they have:

- seized 3 836 500g of cannabis
- pulled out or destroyed 700 000 cannabis plants
- Questioned 236 people; 4 for cultivation, 61 for trafficking, 51 for selling and 39 for drug consumption.

At the same time, the National Gendarmerie has also undertaken:

- the seizure of 176 597 kg of cannabis
- the destruction of 89 643 cannabis plants

- the questioning of 421 people

As for the Department of Customs, it has not been aware of any case of illicit drug trafficking or abuse. On the other hand, in the course of the various seminars organized by the International Technical Cooperation Department of the French Police in the sub-regions of the South-West of the Indian Ocean, the representatives of various delegations from neighbouring island maintain in their presentations that the totality of cannabis confiscated in their countries come from the Great Islands.

ANALYSIS OF EXISTING DATA SOURCES

Through lack of financial resources, the study on the analysis of data sources was not carried out efficiently. However, an informal encounter, following a meeting on the elaboration of a National Drug Control Master Plan at the ODCCP's headquarters, with a few responsible persons concerned with the problem, allowed us to draw up the results of a rough evaluation concerning the information sources – a study which will be of course expanded later on. These results are shown below.

	ARRESTS AND SEIZURES BY THE POLICE FORCE AND THE GENDARMERIE
Present situation	Repression as far as abuse and traffic are concerned if the responsibility of the Police Force and the Gendarmerie, each of them having a separate Central Drug Unit. Data is kept at the Inter-Ministerial Commission for the Coordination of Drug Control. There is still no computer system for data collection. Data is captured manually. The information sources are too widely spread out. There is no standard form for data collection.
Coverage	National, Regional
Compatibility with ARQ	Data is not compatible with the reports included in ARQ
Planned development	Short and medium term.
Priority	Average
Sustainability	Average
Training needs and support	Computerization of data collection Electronic information network Need for software or a standard form for data collection Training of technicians for data management
Equipment	Software packages for data banks Standard forms, printed matter for data collection
Key Institutions	Central Drug Units, ODCCP
Proposed Development Strategy	To have at one's disposal an Internet connection To have a National Data Bank To offer staff training on the ways and technique necessary to fill in standard forms

	UNIVERSITY AND PSYCHIATRIC HOSPITAL CENTRES
Present situation	Existence of a Register of Admission and Release. Data consists of admission of drug abuse but is not regularly recorded. In most cases, patients linked to Drug abuse are treated in the same hospital centre than mentally ill people. Data is not reliable.
Coverage	National, Regional
Compatible with ARQ	The Ministry of Health has made some efforts in order to ensure data compatibility with the reports included in ARQ.
Planned Development	Short and medium term.
Priority	High
Sustainability	High
Training Needs and Support	Training in specialized human resources. Financial aid and support for the equipment of researchers in the drug arena. Need to use raw data for a better understanding of the problem regarding drugs.
Equipment Needs	Software packages for data Banks. Standard forms, printed matter for data collection.
Key Institutions	Ministry of Health, ODCCP
Proposed Development Strategy	To heighten the awareness of various officials in the Ministry of Health about the importance of understanding the data on drugs. To heighten the awareness of the population on the IEC section on drug related problems and their consequences. Paramedic activities to become more professional. Improved coordination of drug related activities.

Mauritius

Refer to: Information, Needs and Resources Analysis for the Republic of Mauritius. (2001). Southern African Office for Drug Control and Crime Prevention, Pretoria.

Rwanda

Réverien Rugwizanoga

Political will and commitment

Rwanda is conscious of the problems and negative implications of drugs economically and socially at national, regional, continental and world level. It has already signed the International Conventions of 1961, 1971 and is on the point of ratifying the one of 1988. In its efforts of fight against drugs, it has created within the National Police an Anti-narcotic Division.

Rwanda takes part in meetings against drugs at regional, continental and world level. It supports any initiative of fight against drugs. Rwanda falls under the program of the United Nations of elimination or at least significant reduction of drugs in the World in the Year of 2008.

Assessment of drug problem in Rwanda.

The drug problem in Rwanda is becoming a real threat on all levels: individual, family and country. In addition, the problem is much more serious among youth, the sharp forces and the hope of the Nation.

This takes advantage in the geographical position of the country, technological rise and the recent historical events of genocide. Although no thorough study has been conducted, the facts show that requests and offers for drugs are growing constantly in Rwanda.

Cannabis comes mostly from Congo, Uganda, Tanzania and Burundi, which have a common border with Rwanda. It takes the first place in the drugs consumed in Rwanda.

Heroin, previously considered as transient from Asia towards Europe and the United States, has started to be consumed within Kigali town, the Capital. All the types of drugs are available on the local market for the local consumers. All the modes of consumption meet there: to smoke, sniff, oral consumption, and intravenous injection with all the risks of contamination of HIV/AIDS.

The consequences of the genocide and the bad economic performances increase the number of vulnerable groups. The latter take refuge in the drug abuse or are recruited in the illicit network of drug trafficking in the process of drug routing and distribution. Indeed, surveys already report that 50% of youth traumatized by the genocide consume drugs.

From January until September 2001, a quantity of heroin 1.3 kg were seized, 450 kg of cannabis were seized and 457 people were arrested in connection with the planting, trafficking and the consumption of drugs.

Whereas the problem is becoming very extensive, the country does not have an adequate infrastructure nor of personnel entitled for the processing of the drug addicts. This remains a challenge for the country.

For treatment of drug problems, drug addicts go to a psychiatric hospital (psychiatric Hospital of NDERA) and a psychosocial centre (psychosocial centre of Muhima), or the general hospitals.

Institution building

The Anti-narcotic Unit created within the National Police force coordinates the activities of prevention and the fight against the abuse and the trafficking of illicit drugs. Within this framework the National police force, Direction of immigration, the Management of the Control of the Airports,

the Directorate of Post Office, the Directorate of Customs and Excise, are working in close collaboration and have a project to sign a Memorandum of Understanding.

Until now a certain local NGO did modest work in the fight against the drug abuse. Very recently the UNDCP offered to give a support to a local NGO/FACT (Forum of the Activists against Torture), which has a project with Anti-narcotic Unit of mobilization against the drug abuse, especially in youth.

The Anti-narcotic Unit of the National Police is setting up a network of the integrated system of information on drug abuse with the support of the UNDCP/EADIS (East African Drugs Information System). Rwanda is member of the Forum of East African Operation Meeting on Drug made up of Rwanda, Kenya, Tanzania and Uganda. They meet every six months to exchange information, to evaluate the situation, and to make up common strategies.

a. Development of human resources.

A few personnel from the National Police got training in drugs through regional and continental cooperation. Also a few personnel attended UNDCP seminars.

The Anti-narcotic Unit, in collaboration with the NGO/FACT, soon will appoint focal points in all the provinces of the country in the framework of the prevention and the fight against the abuse and the illicit trafficking of drugs. The National Police have a programme to provide training regarding the Anti-narcotic fight in the National Police up to the Stations level. It already introduced a course on the Anti-narcotic fight into the basic training of the National Police Forces.

b. Suppression of the illicit drug Traffic.

During the time of January – September 2001 the cases of arrest recorded in connection with the illicit traffic, culture and, consumption of drugs amounted to 457. Heroin (1300 g) and 450 kg of cannabis were seized.

The national legislation envisages a five years penalty for infringements in connection with drugs. The anti-narcotic unit within the National police force is represented in all the terrestrial provinces and borders and airports. It has a deployed permanently a canine section at the International Airport of Kanombe.

Four terrestrial borders posts got the blue Kit of UN. This was done with the aim of stopping illicit drugs. The political good-will is there but the efforts remain blocked by the lack of human resources and the material insufficiency.

c. Reducing illicit demand for drugs

The extent of the demand for illicit drugs in Rwanda is not yet known. The few studies undertaken by the university, social institutions, local NGO, and the information collected by the National Police during the arrests brings back a constant increase in the illicit demand of drugs.

There is a programme for preventive education in the primary schools and secondary, creation of the focal points for prevention and the fight against drugs in the different provinces of the country. Campaigns against drug abuse and drug illicit trafficking pass through the national radio, national television and local newspapers.

We deplore the fact, however, that there is not yet suitable place for processing drug addicts. They are treated in psychiatric hospitals or the general hospitals. They are treated by personnel without training in this field with the corollary consequences.

d. International co-operation

At the regional, continental and international level, Rwanda takes part in various activities of fight against the abuse and the illicit traffic of drugs.

- In 1999, Rwanda joined the forum against drugs, which includes countries of East Africa (Tanzania, Kenya, Uganda and Rwanda).
- In February 2001, Rwanda sent a representative in the workshop of prevention and fight against the drug of the EADIS (East African Drug Information System) of Mombasa.
- In March 2001, the Anti-narcotic unit of Rwanda National Police force exchanged experiences with those of Tanzania during three working days at the International Airport of Dar-es-Salam.
- In June 2001, Rwanda reached the 10th operational meeting against drugs for the Forum of the countries of East Africa, which was held in Kampala and included Tanzania, Kenya, Uganda and Rwanda.
- In July 2001, Rwanda was represented in the 1st meeting of the coordinators of the Inter-ministerial Drug Control Committees from Eastern Africa which was held in Nairobi.
- In September 2001, Rwanda accommodated the 4th meeting of the EAPCCO which had entered in its agenda a chapter on the fight against drugs.
- Recently the UNDCP offered to extend to Rwanda its projects falling under the program of the United Nations to eliminate or reduce to a significant degree drug in the year 2008.

e. Community mobilization.

- Community mobilization is done through the broadcasting of the National Police at the national radio, national television and interviews in the newspaper.
- The Anti-narcotic unit and the local NGO/FACT have a project to establish Focal Points of prevention and fight against drug abuse in twelve provinces of Rwanda before the end of 2001.

Seychelles

Refer to: Information, Needs and Resources Analysis for the Seychelles. (2001). Southern African Office for Drug Control and Crime Prevention, Pretoria.

Somalia

Sid Ahmed Abdirahman

Introduction

Today there is no doubt that hunger and man-made disaster have been felt in every Somali house due to the unbelievable war clan based conflicts, and as a result of the past serious set back of trauma, war victims, and a long term continued problems, which have uprooted and collapsed totally all public institutions social – economical infrastructures. As a matter of consequence, the up-rising of several problems with negative impact have occurred, such as the illicit drug business in connection with cultivation of marijuana.

Hence, the anti-drug department conducted an inquiry survey in selected rich agricultural areas purported to be the zone of big production of illicit drug such as central Jubba and Lower Shabelle. According to this assessment, and investigations carried out by the anti-Narcotic, department we have confirmation of existing cultivation of illicit drug in these areas. After only one month of hard work we succeeded to sequestrate 50 Kg of Marijuana seeds and more than 800 Kg of marijuana plants.

The drug department was set-up 6 months ago but is working in a poor place and under conditions that impede performance, including lack of money that caused the non-payment of salary to the policemen in this last 3 months. However, in order to achieve an efficient kind of programme, the above mentioned department needs a medium seized laboratory well equipped with all instruments, chemical products, skill technicians (2 Persons) and all necessary in order to come into use. All those called upon to enhance the interest of international communities to assist urgently the newly formed drug department of Somalia Police Force both financially as well as to shape a special training course for members of the Drug Department.

We are all aware that the activities of this department must be one of the main target points and more influential problems needed to be resolved in order to ensure the community well-being and community self-reliance, paving the way for general regeneration and recovery of socio-economic balance of the Somalian life pattern.

Methodology of Activities

As we are aware, Somalia is a cross-road of international drug trafficking and areas of drug cultivation. After the 11 years of civil war the lack of infrastructure, (like governmental institutions and networks for monitoring the drug traffic control, permitted the growth of illicit business including drug trafficking. Hence, the police drug department meet more problems in implementing this program, due also to the lack of rules and means. The drug unit, in order to achieve this programme, need to adopt the following methods:

Monitoring: is the means to measure the effectiveness of drug activities monitoring is conducted every day in order to know the real consistence of the above phenomena and monitoring results will be carried out by specialized anti-drug team. There is also the supervision to be conducted on daily bases by the team chief.

Evaluation: is to ensure the goal of this programme. That evaluation will be conducted at the end of every month and carried out by skilled team.

Considerations

We have a growing sense of hope by taking note of the social consciousness which signals a transparent rapprochement that has epitomized the historical national reconciliation that took

place recently. This will be a cornerstone of a long lasting peace and stability based on social equity and benevolent co-existence that binds together all Somalia Communities.

Therefore, in the hope to back up these noble reconciliation peace efforts, the drug reduction program, headed by the anti-narcotic department may include prevention, treatment, after care, rehabilitation, social reintegration and education that will be in practice often linked and overlapped, and must be one of the priority objectives.

As we are aware, the geographical strategic position and the actual bad financial situation of Somalia, call upon a coordinated joint effort and adequate and timely international financial assistance in order to implement the above mentioned programme, avoiding that this country become an easy cross-road for the unlawful traffic of drugs and an area of illicit drug cultivation.

Tanzania

Asheri Wimile

The Government of Tanzania established an Anti Drug Commission for the purpose of defining, promoting and coordinating the policy of the Government on the control of drug abuse and trafficking. One of its functions is to establish a viable data collection and analysis system at national level on drug abuse and drug trafficking. The Commission is to prepare and publish a yearly report describing the situation and developments regarding the supply and demand of drugs. It also has to formulate proposals to promote anti-drug activities and such report shall be laid before parliament. The UNDCP through the Capacity Building Project has hired a consultant for the purpose of establishing a database for the commission including a database application programme. After February's workshop we decided to wait until the consultant finish his assignment then we will see how we can harmonize his findings with the EADIS requirements. To date a draft report of that consultant is out and we are waiting his final report.

The consultant also developed a computer programme that is to be installed in the commission's software but he is still working on it in cooperation with the commission's computer analyst. The consultant conducted training of the commission's staff to create awareness on matters relating to data and information systems. They were led to understand the role information plays in decision making (i.e. information guides policy formulation) that the system must be carefully handled to ensure that data that is used genuine and accurate and the information that comes from the system has been produced using correct procedures.

The focus of the consultant was to build a database that will provide information and insight to the commission on a range of issues and activities relating to drug trafficking and abuse on one hand and their socio-economic effects on the other. The database will focus on collecting information that addresses a wide range of aspects from traditional customs, cultivation of plants, their exportation, traffic, sale and consumption, mental health statistics (including rate of admissions, diagnosis, mortality rates) and other social consequences. The database is also to provide mechanisms for predicting trends so as to guide policy formulation.

The consultant suggested many information requirements for the database, here are some of the proposed requirements:

- Information for analysis of drug- related data from the law enforcement indicating whether or not there is a decrease in drug supply
- Data that can provide indications of reduced related medical consequences as determined by admissions to major hospitals, treatment centres and rehabilitation centres, morbidity and mortality data.

- Information from key informant surveys of formal and informal community leaders and other survey data indicating positive shifts in anti-drug attitudes and drug use behaviour.
- Information that indicate sufficiently the control of the licit trade and the use of narcotic drugs and psychotropic substances.
- Alcohol consumption rate throughout the country.
- Information that can help describe the extent to which the society is consuming illicit psychotic substances e.g. alcohol and tobacco.
- Information that can help assess the appropriateness and strength of the provisions of law in combating drugs.
- Information that can describe the pattern of deployment of resources for drug control. This information may indicate funds received from the Government, Donor Agencies and projects to which they were directed.
- Information that can describe the contribution of other Non-Governmental Organizations on combating drug abuse.

This database is also expected to provide information to other organizations within and outside Tanzania e.g. UNDCP, INCB, SADC drug database, Eastern Africa community and other stakeholders.

The consultant in his work visited various stakeholders collecting their views on how they were going to contribute to the database. He was also looking at whether they are collecting various data at their centres. It was observed that the Ministry of Health has large and comprehensive management information system. We are looking at how we are going to incorporate our requirements into their system. Other institutions are collecting their data in a very crude form, because they lack resources. However, most of the stakeholders of the database are institutions established by various legislations and there are no legal requirements for them to bring their information to the database and the consultant proposed that they should amend their laws to arrest that discrepancy. In complying with that advice the commission has started to prepare regulations which when passed will be binding on all stakeholders to bring their information to the commission.

In preparation for the database the commission has started collecting information from Non Governmental Organizations dealing with drug abuse especially on what they are doing, research done by them, their experience and constraints. The commission also employed a computer analyst to deal with day-to-day data entry.

The work being done by the consultant has to be harmonized with the requirements of EADIS to ensure effective use of resources and to avoid duplication.

Uganda

The following report represents a draft Information, Needs and Resources Analysis which was prepared by Moses Kamabare during his time as the EADIS focal point for Uganda. The INRA report is currently being finalised for approval from the Ugandan government.

Information, Needs And Resources Analysis For The Republic Uganda, October 2001.

Supported by the: UNDCP Global Assessment Programme on Drug Abuse (GAP)
Forwarded by Mr. KAMABARE MOSES

Preface

In the Political Declaration adopted at the 1998 Special Session of the UN General Assembly on Drugs, Member States agreed to eliminate or significantly reduce the supply and demand for illicit drugs by the year 2008. This is the first time that the international community has agreed on such specific drug control objectives. However reliable and systematic data to monitor and evaluate the progress towards achieving these goals are presently not available. For this reason, the UN General Assembly requested the United Nations International Drug Control Programme (UNDCP) to provide Member States with the assistance necessary to compile reliable and internationally comparable data. Furthermore, UNDCP was asked to collect, summarise and analyse these data and report to the UN Commission on Narcotic Drugs on global trends in drug production and abuse.

To respond to this request, UNDCP has developed two global programmes: first a global programme to monitor the cultivation of illicit crops and second, a global programme to assess the magnitude and patterns of drug abuse. Both programmes, will hence be at the core of a credible international follow-up to the Political Declaration of Member States to reduce the production and abuse of illicit drugs.

The main objective of the **Global Assessment Programme on Drug Abuse (GAP)** is to develop and establish one global and nine regional systems to collect reliable and internationally comparable drug abuse data and assess the magnitude and patterns of drug abuse at country, regional and global levels.

At the **global level**, the programme will develop a set of internationally accepted indicators on drug abuse and develop practical and cost-efficient methods of collecting and assessing data on drug abuse. The global support sub-programme will further be responsible for the synthesis of national and regional data and aggregate them globally in order to report on global trends of drug abuse to the UN Commission on Narcotic Drugs.

At the **regional level**, the programme will adapt data collection methods to the respective regional, cultural, and social environments, strengthen existing regional institutions, and promote a regional network for drug abuse analysis, thereby supporting sound policy information.

At the **country level**, the programme will develop and establish national capacities to collect, assess and report on drug abuse data for the development of national demand reduction policies and programmes.

Gap will deliver an improved and more timely understanding of the extent and patterns of the global drug abuse problem. Information will be available from developing countries that are increasingly severely affected by illicit drug problems. Standardization of indicators and the wider adoption of sound methods for data collection will result and enhanced analysis of trends in drug abuse in both the industrialized and developing world.

ACKNOWLEDGEMENTS

The following individuals and institutions participated in the meeting through which information was obtained to complete this INRA

1. Dr. David Basangwa: National Mental Hospital, Butabika
2. Mr. Johnson Ayela, Head of Anti-Narcotics Unit, Uganda Police Force
3. Mr. Rogers Kasirye, UYDEL
4. Mr. Fred Kakembo. UYDEL
5. Mr. Deus Mubangizi, Kusemererwa, Ministry of Education

6. Mr. Emmanuel Kusemererwa, Ministry of Educaiton
7. Dr. Fred Kigozi, Senior Cousultant Psychiatrst: National Mental Hospital, Butabika

ABBREVIATIONS

ARQ	-	Annual Report Questionnaire
AIDS	-	Acquired Immuno -Deficiency Syndrome
GAP	-	Global Assessment Programme
HIV	-	Human Immuno-Deficiency Virus
INRA	-	Information, Needs Resource Analysis
NADAC	-	National Alcohol and Drug Addiction Council
NDA	-	National Drug Authority
NGO	-	Non-Governmental Organizations
UNDCP	-	United Nations Drug Control Programme and Crime Prevention.
UYDEL	-	Uganda Youth Development Link

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

ABBREVIATIONS

EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 BACKGROUND

1.2 COUNTRY INFORMATION

1.3 INRA FOR THE REPUBLIC OF UGANDA

2. INFORMATION ON DRUG ABUSE

2.1 EXISTING DATA SOURCES

2.1.1	Law Enforcement data
2.1.2	General hospital data
2.1.3	Treatment data
2.1.4	Psychiatric hospital data
2.2	SPECIALISED STUDIES
2.2.1	Crime and Drug Abuse
2.2.2	Drug Abuse in Secondary Schools
2.2.3	HIV/AIDS and drug Abuse
3.	RESOURCES
4.	NEEDS
5.	STRATEGIC ANALYSIS
5.1	ANALYSIS OF DATA SOURCES
5.2	EPEDEMIOLOGICAL NETWORK
5.3	PROPOSAL FOR STRATEGIC DEVELOPMENT
5.3.1	Short-Term Goals
5.3.2	Medium-Term Goals
5.3.3	Long-Term Goals
6.	CONCLUSION
7.	APPENDIX 1. CONTACT LIST
8.	APPENDIX 2. RESOURCE LIBRARY
Table....1	AMOUNT OF DRUGS SEIZED, BY YEARS
Table....2	NUMBER OF PEOPLE ARRESTED WITH DRUGS, BY GENDER

Executive Summary

Information, Needs and Resource analyses (INRAs) are being conducted with the support of the UNDCP Global Assessment Programme on Drug Abuse (GAP). The purpose of the INRA is to establish country capacity for collecting information on drug abuse. The INRA involves auditing existing information on drug abuse, auditing infrastructure and resources available to support data collection activities and identifying key "needs" for development of a drug information system. The INRA is the first step in establishing ongoing drug abuse surveillance. The list of data sources and resources relating to drug abuse presented in this report is not exhaustive, and is intended to serve as a resource to stimulate discussion on drug abuse information, directing the reader towards potential data that can be used to monitor drug abuse.

Information, available on drug abuse in Uganda is that although alcohol is most abused, Cannabis in its herbal form, is of major concern. This drug can be grown in any part of the Country and thus easily available and cheap. There is evidence, however, of growing use of Heroin by the unemployed youth and among prostitutes which is contributing to the growing problem of HIV/AIDS. Cocaine and amphetamines are least consumed and available in Uganda.

There is need of technical support to various institutions, to enable staff collect, collate and analyse information on drug abuse in their possession. Support in area of equipment and software packages are of crucial importance. There is also need to carry out a baseline survey on drug abuse in Uganda. There is need to have a treatment and rehabilitation centre in the Country. There is potential in Uganda in terms of human resources, which if given additional training would be a resource in the area of contributing to the epidemiological network. The already active Anti-Narcotics Unit could provide the needed information on arrests and seizures and NGOs would provide key informant and social workers.

Although a number of institutions have information on drug abuse, the information is not recorded in the form that would be useful and easily retrievable. Assistance could be obtained through UNDCP-GAP to obtain the necessary training on both quantitative and qualitative data analysis.

1 Introduction

1:1 Background

The purpose of this report is to serve as a resource for discussion when developing an information system on drug abuse. The report is directed towards establishing a sound information base, as the first step in establishing ongoing drug abuse surveillance. The data sources and resources are not exhaustive, but provide a starting point, directing the reader toward potential data that can be used to monitor drug abuse.

Information, Needs and resource Analysis (INRAs) are conducted under the UNDCP Global Assessment Programme on Drug Abuse. The purpose of INRA is to establish country capacity for collecting country information on Drug Abuse. The INRA involves auditing existing information on drug abuse, auditing infrastructure and resources available to support data collection activities and identifying “Needs” for development of a drug information system. The INRA also puts forward a strategy for developing a drug information system, outlining the short-term, medium-term and long-term goals.

The basis of the INRA for Uganda was on the GAP tool kit module which explains how to conduct an audit of resources for development of drug abuse epidemiology and how to write an INRA report that can be used to guide development of an Integrated Drug Information System (IDIS)

1.2: Country Information

The Republic of Uganda is situated in East Africa, bordering Sudan to the North, the Democratic Republic of Congo (former Zaire) to the West, Republic of Rwanda to the South-West, United Republic of Tanzania to the South and Republic of Kenya to the East. Uganda covers an area of 241,038 square kilometres, with 17% of this area being covered by swamps and open waters. It is mostly a flat plateau of between 900 and 1500 metres (84%) above sea level. It lies on the Equator, and has a pleasant climate and fertile soils conducive for the growth of Cannabis. Uganda’s population is growing at a rate of 3. Per cent, with current estimated population of 22 million people.

The country’s economic growth has strongly been tied to the political atmosphere and good governance. The present National Resistance Movement (NRM) government, after take-over in 1986, introduced an economic recovery programme geared towards monetary stabilisation and structural adjustment. English is the official language and the adult literacy rate is 64%.

Unemployment in Uganda is relatively high resulting in a larger number of unemployed youth rushing to the rapidly developing urban centres. It is these unemployed youth, commercial vehicle drivers, together with those in schools that are mainly involved in Drug Abuse.

The main drug of abuse in Uganda is Cannabis, followed by Khat (*Catha edulis*), though the latter is not outlawed yet. Heroin inhalation is also slowly taking root among the urban youth. Cocaine and Amphetamine – related substances are least known to be consumed in Uganda.

1.3: INRA for the Republic of Uganda

The information contained in this report was compiled by Moses Kamabare. During the compilation of this report, members of the National Alcohol and Drug Addition Council (NADAC) were consulted. Some members of NADAC were consulted individually for information on the various studies they have carried out.

The institutions that were consulted are the following:

1. The National Alcohol and Drug Addiction Council (NADAC)
2. The Anti-Narcotics Unit, Criminal Investigations Department of Uganda Police.
3. Government Analytical Laboratory
4. Ministry of Health
5. National Drug Authority (NDA)
6. Butabika Mental Hospital
7. Uganda Aids Commission, UAC
8. Uganda Prisons Service
9. Non-Governmental (Advocacy) Organisation:
 - a) Uganda Youth Development Link (UYDEL)
 - b) SOBER Uganda
10. Ministry of Education and Sports
11. Serenity Centre
12. Slum Aid Project

2 Information on Drug Abuse

Information obtained from various sources available in Uganda is outlined in this section, according to the type of data. It is important to note that there has not been a National Survey carried out on either alcohol or illicit drug consumption.

2.1: Existing Data Sources

2.2.1: Law Enforcement data

The Anti-Narcotics Unit of the Uganda Police Force is the one responsible investigation of drug Related crimes in Uganda. The data provided include the number of drug cases handled, that is, Arrests for unlawful possession, and cultivation of illicit drugs. The Unit also investigates cases pharmaceutical narcotics and psychotropic substances brought to its attention by the National Drug Authority.

Drug – related arrests and seizures

The data provided by the Anti-Narcotics Unit is as indicated in tables 1 and 2. The indication is that, on the whole, there has been increased seizure and involvement of more people with me. The largest seizures are with Cannabis, and the explanation is that it is locally cultivated in Uganda, Heroin, Cocaine and Mandrax together with Hashish (Cannabis resin) are imported into the Country from the Indian Sub-Continent, for Heroin and Mandrax, and from South America and Sudan for Cocaine and Cannabis resin respectively. A glance at the people arrested shows that more males than females are involved in illicit drug trade and cultivation.

Purity of Drugs

The drugs interdicted at ports of entry into the Country are analysed by the Government Analytical Laboratory, for purity. On average, the purity of Heroin and Cocaine is 50 – 70%. The Heroin which is obtained or seized from the drug users, in peri-urban Kampala usually range between 5 – 15%.

2.1.2: General Hospital Data

There are Nine general hospitals in Kampala. The data on alcohol related disorders, is however not collated for easy retrieval and analysis. It was therefore not possible to obtain data on hospital admissions related to alcohol-related diseases.

2.1.3: Treatment data:

Kampala, and Uganda at large does not have a single treatment centre for drug – related diseases. Most of the admissions related to drug abuse are sent to the Psychiatric, hospital – Butabika Mental Hospital.

2.1.4: Psychiatric data:

The National referral mental hospital in Uganda is located in Kampala. It is called Butabika Mental Hospital. Data related to drug abuse and alcohol-related admissions could, however, not be easily obtained. There is no special system for collating, collecting and recording of such data. Information obtained from Dr. David Basangwa, a Psychiatrist at the hospital estimate that 20% of the total admissions to the hospital are either related to alcohol or drugs abuse. Further, that 50% of these use only alcohol and 54% use both alcohol and other drugs of abuse.

2.2: Special studies and other data

2.2.1: Crime and Drug Abuse

Information obtained from Criminal Investigations Department of Uganda Police indicate that there is an emerging and strong correlation between drug abuse and commission of serious crimes as Rape and Defilement, Domestic violence, Violent robberies and gruesome Murders. It is estimated at about 85 – 90% of the people involved in these crimes are drug users. The commonly used drugs are Cannabis and Heroin. The latter is administered by both inhalation and injection. Vitamin C injection is also administered by Heroin users, to avoid detection, according to the drug users.

2.2.2: Drug use in Secondary Schools

The study carried out by Dr. David Basangwa of Butabika Mental Hospital, indicates that drug abuse is prevalent in these schools. About 68% use alcohol, and about 10% of the students use Cannabis, Cocaine and stimulants of all kinds. It is interesting to note that the majority of the students have their exposure to these drugs as early as at 15-16 years of age. (See attached Fig.1 & Fig.2)

2.2.3: HIV/AIDS and Drug Abuse data

The study carried out by Dr. Fred Kigozi, a Senior Consultant Psychiatrist at Butabika Mental Hospital and Mr. Rogers Kaisrye, a specialist social worker point to a strong link between increased abuse of drugs and alcohol and HIV transmission. Although there is a general Awareness about HIV/AIDS scourge and its transmission through unprotected sexual intercourse. Most of the people interviewed confirm that they are unable to use condoms during a sexual Intercourse, even when they have the condoms with them at the time of intercourse. This is because due to the level of intoxication by the alcohol of drug abuse, these people are unable to correctly put on the condom, or at all.

3 Resources

Uganda's infrastructure for data collection is almost non-existent. There would be centres for collection of this information do not have, computers for collection and storage of this data; although there is a sufficient number of personnel in all these centres, that would collect this data. The Country, fortunately has skilled manpower in area of research and survey methodology, although resources have not been available for the carrying out of the research or survey.

Uganda also is endowed with medical or other expertise relevant for the treatment and rehabilitation of drug users. Unfortunately, there is no treatment or rehabilitation centres to talk of. There is a place, Serenity Centre, that is in its infant stage of treatment of drug users.

The data on law enforcement activities, related to drugs, that is drug types, seizures and trends could be collated on the computerized database. These data however, is not fully computerised due to lack of relevant computer programmes for this purpose.

Institutions that would be in a position to contribute to drug abuse epidemiology network include the following:-

1. Anti-Narcotics Unit, Criminal Investigations Department,
2. Government Analytical Laboratory
3. National Drug authority
4. Ministry of Health, Pharmaceutical Department
5. Ministry of Industry and Tourism
6. Ministry of Education and Sports
7. Uganda Aids Commission
8. Non-Governmental Organizations:
 - a) Uganda Youth Development Link 9UYDEL
 - b) SOBER, Uganda
 - c) Serenity Centre
9. Psychiatric Institutions:
 - Butabika Mental Hospital.

Individuals within these institutions would have the necessary expertise:-

1. School of Pharmacy, Makerere University
2. Mulago Hospital – National referral Hospital
3. Department of Social work and Social Administration, Makerere University
4. Government Analytical Laboratory
5. Makerere Institute of Social Research

Figure 1. TYPE OF SUBSTANCE USED

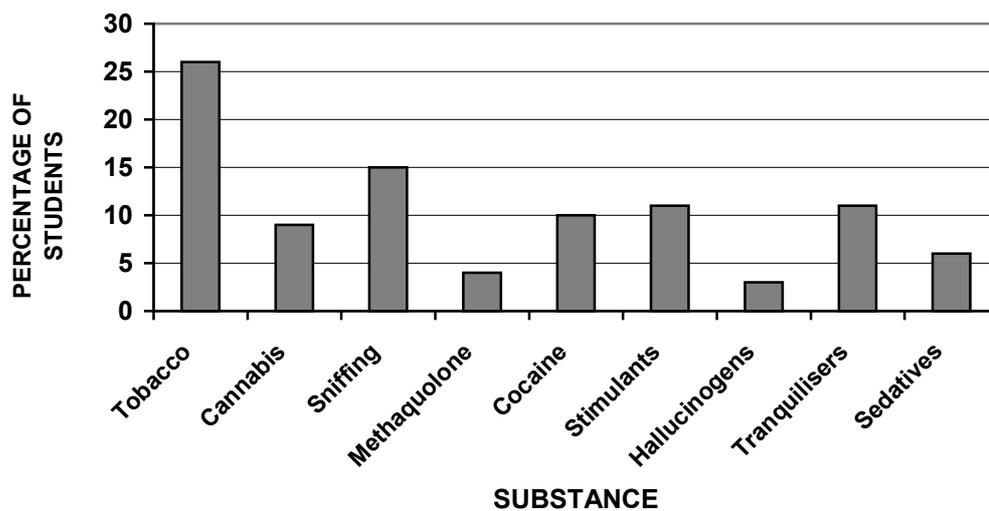
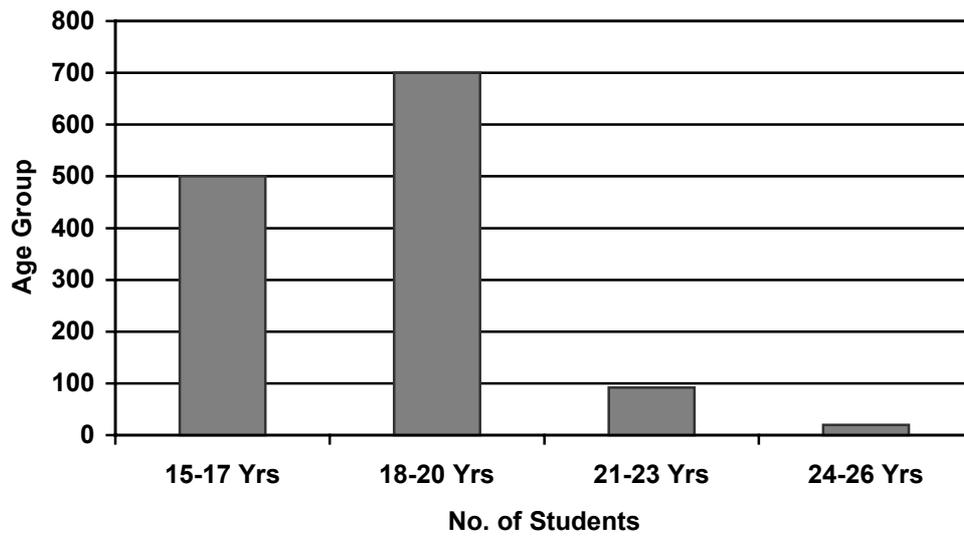


Figure 2. AGE DISTRIBUTION



Note. Figures 1 and 2 have been reproduced and may not represent the exact figures represented in the original document.

4 Needs

There is no doubt that the most important need in Uganda is upgrading of the existing data sources to feed into the epidemiology network on drug abuse. Several potential data sources have not been exploited. The recording of relevant data on drug abuse, other than for law enforcement is virtually none existent. There is therefore need for and by all the members of the epidemiology network to agree the data to be collected, at what level and by which institution to enable collation and analysis of this data.

Although there is wide knowledge about the problem of drug abuse amongst various institutions in Uganda, many of these institutions had, until the contact made during the compilation of this report, not appreciated need to systematically and regularly record this data. There is, therefore, need for more sensitisation and support to those institutions to enable them capture and report relevant data in their possession.

There has not been a single baseline survey done in Uganda. There is therefore need to carry out this survey.

The need to provide hardware and software to the institutions required to collect, collate and analyse the data, and in addition training for the relevant personnel cannot be overstated.

5 Strategic analysis

5.1: analysis of data sources

There exists various potential sources of information in Uganda. The ones reported on here under do not in any way exclude other potential sources of data.

Data Source	Psychiatric data
Current Development	Can be analysed by gender, age whether its due to alcohol or drugs or both
Coverage	Potentially 100%
ARQ Compatibility	Compatible in terms of reporting gender, age and categories of drug use
Development potential	Short-term
Priority	High
Sustainability	High
Training and Support need	Training required and software packages needed
Infrastructure needs	None
Key Institutions	Butabika Mental Hospital
Proposed development strategy	<ul style="list-style-type: none"> - Encourage systematic and regular reporting - Training of personnel on relevant software packages.

Data Source	Arrest and Seizure
Current development	Aggregate figures available from 1996 to 2000
Coverage	Potentially 1000%
ARQ Compability	Includes all illicit drug categories but does not include licit narcotic drugs and psychotropic substances.
Development potential	Short term for illicit drugs but Long term for licit ones.
Priority	High
Sustainability	High
Training and Support needs	Train the personnel on the software packages
Infrastructure needs	Provide Hardware and software packages to Anti-Narcotics Unit of Uganda Police.
Key Institution	Anti-Narcotics Unit, Uganda Police Force
Proposed development Strategy	Provide technical assistance to data entry assistance

Data source	Non-Governmental Organizations (NGOs)
Current development	Data exists at level of NGO but not collated centrally
Coverage	Potentially 100%
ARQ Compatibility	Not Applicable
Development Potential	Medium term
Priority	High for UYDEL SERENITY Centre and NADAC
Sustainability	High
Training and Support needs	Train staff in data entry and analysis
Infrastructure needs	Need of Hardware and data entry software
Key Institutions	UYDEL, SERENITY Centre and NADAC
Proposed Development strategy	<ul style="list-style-type: none"> - Initiate data collection and entry system for - UYDEL NADAC and SERENITY Centre. - Train staff in data entry and analysis

5.2: Epidemiological network

The epidemiological network for Uganda would include Non-Governmental Organizations, Government Institutions related to Health, Social work and Education. There is need to the foregoing with the Police Force, and Prison data. Thus, the agencies are the following:-

Uganda police Force – Anti-Narcotics Unit

Non-Government Organisations: NADAC, UYDELand SERENITY Centre

Ministry of Education

Ministry of Health

National Drug Authority

Uganda Aids Commission

Ministry of Gender, Labour and Social Affairs

Butabika Mental Hospital

The following data will form the basis of the network

Police arrest and seizure data

Psychiatric hospital admission data

Expert opinion from NGOs and social workers.

Further information from the following sources would enrich the network.

Data from Intensive Care Unit

Prison data

Inclusam of licit pharmaceutical drugs which are abused

NGO data

Data from Makerere Institute of Social Research

5.3: proposal for strategic development

Short term goals

Set up a drug abuse network

Hold network meeting of various relevant institutions

Training staff of various relevant institutions for data entry purposes;

- (a) Acquire relevant Hardware and software packages
- (b) Train staff in data entry and analysis

Develop Psychiatric data

Sensitize personnel at Psychiatric hospital on need for collecting and recording relevant data

Develop and pilot data collection forms

Train staff in data entry and analysis

Medium Term Goals

Carrying out a Baseline Survey on Drug Abuse

Secure finding for the survey
Train staff for collection of data
Reporting the findings from the data

Training of NGOs on need to collect and report relevant data

Sensitisation of staff of NGOs
Training the staff on data entry and analysis

3. (a) Development quantitative data from Schools and Prostitutes

Train social workers in data collection methods

Sensitising the public on dangers of drug abuse and need to seek help or treatment;

Make annual programme of the education
Train staff in hospitals and NGOs on how to handle drug users and the information to obtain

Long – Term Goals

Acquire a treatment and Rehabilitation Centre for drug addicts:

Plan for the centre
Solicit for funding for the centre

(Develop the capacity of Police Anti-narcotics Unit to handle licit drugs which are abused.

Increase collaboration with National Drug Authority
Obtain relevant training for Police personnel in identifying, investigating and recording cases of abuse.

Develop School Curriculum with Drug Abuse component

(a) Obtain consent of Ministry of Education and Curriculum development Centre

Agree on the information to be included in the curriculum.

Table 1: Summary of Drug Seizures

Type of Drug	1996	1997	1998	1999	2000
Herbal Cannabis	1,500 (Kg)	4, 900 (Kg)	5, 500 (Kg)	5, 520 (Kg)	2, 651 (Kg)
Cannabis Plants	7, 500	12000	9411	35,000	15,000

6 Conclusion

This report is an attempt at eliciting a discussion among various institutions, on how much has so far been achieved in the area of the over growing problem of illicit drugs in Uganda. The report therefore looks at both demand reduction and supply reduction efforts.

It is important to note, however, that most of the Country's efforts have been directed at supply reduction, which explains why data collection and analysis is more developed, as compared to demand reduction efforts. It should be noted, also that there has not been any direct link between demand and supply reduction and also with other institutions and people that have been working on other areas of drug abuse.

Alcohol use still dominates in abuse in Uganda, both as local brew and that made from factories. Among the illicit drugs abused, Cannabis is most widely used. The wide use of Cannabis could be explained by the fact that it is widely grown in any part of the Country. Heroin abuse however is taking root among the prostitutes and unemployed youth. Catha edulis (Khat) is also another drug that is mostly abused by drivers of commercial vehicles, especially commuter taxis. Cocaine and amphetamines are the least used in Uganda.

Uganda government is concerned that all the achievements it had made in the efforts to reduce HIV/ AIDS might be eroded by Drug Abuse amongst the sexually active age groups. Drug abuse is also known to contribute to other crimes as murders, robberies, domestic violence, rape and defilement.

With the government's determination to enact a new piece of legislation to deal with the over growing problem of drug abuse and drug trafficking it is envisaged that the provision of an Interministerial Committee, with a multisectoral composition will provide a sustainable central point of effectively dealing with the drug problem and its social, economic and political ramifications. The support given to Uganda by UNODCCP will definitely come in handy, to this effort.

APPENDIX 1

CONTACT DETAILS

Dr. David Basangwa
Psychiatrist
National Mental Hospital, Butabika
P.O. Box 7017, Kampala – Uganda
Tel: 077-430825

Mr. Emmanuel Araali Kusemererwa
Senior Education Officer
Ministry of Education and Sports
P.O. Box 7063, Kampala – Uganda
Tel: 077-430825

Mr. Mukasa Rashid
Banker/ Chairman
Sober Uganda
P.O. Box 1104, Kampala – Uganda
Tel. 256-041-530228

Dr. Fred Kigozi
Senior Consultant Psychiatrist
National Mental Hospital, Butabika
P.O. Box 7017, Kampala-Uganda
Tel. 221376/7

Mr. Kasirye Rogers
Social Worker
Uganda Youth Development Link
P.O. Box 12659, Kampala-Uganda
Tel: 256-041-234823

Mr. Ayela Johnson/ Sociologist
Head, Anti-Narcotics Unit
Uganda Police
P.O. Box 2973, Kampala
Tel. 256-041-234823

Professor Rwomushana
Uganda Aids Commission
Tel: 258538

Mr. Bernard Wandera
Social Worker
Department of Social Work and Social
Administration
Makerere University
P.O. Box 7062, Kampala.
Tel: 256-041-534114

Mr. Martial Magirigi
Director/ Social Worker
Serenity Centre
P.O. Box 25210, Kampala-Uganda
Tel: 077-613832

Mr. Martin Otebba
Principal Pharmacist
Ministry of Health
P.O. Box 7272, Kampala
Tel. 251-041-231563

Ms. Rose Gwaya
Educationist
Slum Aid Project
P.O.Box 10388, Kampal
Tel: 532769

Mr. Lugudo Ally
Assistant Commissioner
Government Analytical Laboratory
P.O. Box 2174, Kampala
Tel: 251-041-250470

Dr. Stella Mema
Makerere Institute of Social Research
P.O.Box 16022, Kampala-Uganda,
Tel. 554582

Mr. Deus Mubangizi
Chief Inspector of Drugs
National Drug Authority
P.O.Box 23096, Kampala
Tel: 251-041-347391/2

Mr. Moses Kamabare
Pharmacist – Police Force
P.O. Box 2973, Kampala
Tel. 251-77-418090

Inventory of resources on drug and alcohol abuse: 2001

Dear Sir/ Madam,

INTRODUCTION

This is to guide you in compiling the information on Drug and Alcohol Abuse in your area of operation/work. It will be used to compile a country report that will be represented to UNDCP in November, 2001.

We kindly request you to take some time off your busy schedule and provide us the necessary information.

SURVEY DATA

Have you undertaken a Drug substance Abuse Study/ Research/ Report on any of the following:

Alcohol.....YES/NO

Marijuana (Bhangji)/ Cannabis.....YES/NO

Mairungi.....YES/NO

Others (Heroin, Cocaine,etc).....YES/NO (Specify)

IF YES, Kindly attach a copy of the study

EXISTING DATA

Nature of study/data collected

How data was collected, e.g. questionnaire, etc

- Coverage/area of study

How data was recorded

How record is kept

- How data collected was disseminated

Resources needed for data collection activities

QUALITATIVE DATA

- Type of drug used
- Demographic characteristics of drug users ie. Sex, Age, Tribe, Profession/ Occupation, Religion.
- Frequency of use
- Is drug used together with other drugs above?
- How is drug consumed/used e.g. smoking, injection, drinking.
 - Where and with whom do they use drugs
- Why use the drug
 - Problems experienced with use of the drug
- What risks are the users exposed (take) in using the drugs.

5.0 RESOURCES AVAILABLE – IN YOUR ORGANIZATION

- People/ expertise
- Nature and level of technical know-how of the people involved in work
- Availability of infrastructure e.g. computers, telephones, etc. at office.
- Finances to undertake data collection and other activities related to drug abuse.

6.0 NEEDS

- Any training needs for the staff?
- IF YES, in which areas?
 - Infrastructure – need for computer, vehicles, etc
- Communication/ Networking needs e.g. Internet; e-mail
- Any other needs related to data collection activities

STRATEGIC DEVELOPMNT PRIORITIES

- Short term needs and goals
- Medium term needs and goals.
- Long term needs and goals

INFORMATION PROVIDER

Name

Position

Organization

Address

Phone

Fax

E-mail

Date of Compilation



Participant List

Burundi

Mr. Laurent Dondo
L'Officier de Police Judiciaire
Bujumbura
Fax +257 223799
Email C/- jean.kabahizi@undp.org
chantal.sindayigaya@undp.org

Comoros

Dr. Mohammed El Badaoui
Ministry of Health
Ph. +269 73 21 70
Fax +269 74 40 72
elbadaoui@yahoo.fr

Ethiopia

Mr Albdoo Abdulrahman
Division for the Prevention and Control
of Drugs of Abuse
Ministry of Health
PO Box 1234
Addis Ababa
Ethiopia
Ph. +251 1 151793, +251-1-151790
Fax +251 1 512691, +251-1-519366

Kenya

Mr Abel Ndumbu
Prof David Ndeti
University of Nairobi
P.O. Box 19 676
Nairobi
Kenya
Ph. +254 2 72 43 39
Fax +254 2 72 60 30
Email k0033@maf.or.ke

Madagascar

Mr. Raobijaona Bruno

Gouvernement Comisión Interministerielle de
Coordination de la Lutte contre la
Drogue
Maison de Produits
4^{eme} Etage 67ha
BP 5029
101 Antananarivo
Madagascar
Ph. +261 20 22 36766
Fax +261 20 22 35573

Mauritius

Mr. Vedant Naik
Executive Director, NATReSA
3rd Floor, Atchia Building
Cnr. Suffren and Gonin Street
Port Louis
Republic of Mauritius
Ph. +230 210 6775/1389
Fax +230 210 8015
Email na251996@intnet.mu

Dr Fayzal Sulliman
SENDU Representative for MENDU
Dr. Idiile Goomany Treatment Centre
Ph. +230 242 3016
Fax +230 242 6098
Email goomany@intnet.mu

Rwanda

CIP Réverien Rugwizanova
OC Narcotics Unit
Rwanda
Ph. +250 86267
Fax +250 87532
Mobile 085 055 92

Seychelles

Benjamin Vel
Tate House
Victoria, Mahé
Seychelles
Ph. +248 22 42 59
Fax +248 22 4626 / 32 4242
Email: dac@seychelles.net

Tanzania

Mr. Asheri Wimile
State Attorney, IADC
C/- Ministry of Home Affairs
PO Box 9223
Dar-es-salaam
Tanzania
Ph. +255 2211 2035/4 Ext. 276 /22
Fax +255 741 211 723
Email: awimile@hotmail.com
Ph. +256 41 234823
Fax +256 41 347429
Mobile 077 41 8090

Somalia

Prof Sid Ahmed Abdirahman
Consultant of Anti-Narcotic Dept
Somalia Police Force
B.P. 5400 Mogadisciu, Somalia
Ph. +252 1 2155552/543041/44055
Fax. +252 1 221573/643038/43619
Email profsid@hotmail.com

Djibouti

Mr. Mohamed Aden
Office Centrale de lutte Anti-drogue
B.P. 2506 Djibouti
Ph. +253 355886
Fax. +253 356830
Email harbi.omar@undcp.org

Eritrea

Mr. Andom Mehari Yoel
Drug & Narcotics Law Enforcement
Ph. +291 1 123026
Fax. +291 1 126242
Email epnug@gemel.com.er

UNDCP

Florence Kawaza-Musengi
GAP Project Assistant
UNODCCP South Africa
P.O. Box 12673
Hatfield, 0083
South Africa
Ph. +27 12 342 2424
Fax. +27 12 342 2356
E-mail fkawaza@odccp.org.za

Matthew Warner-Smith
GAP Regional Epidemiology Adviser
UNODCCP South Africa
P.O. Box 12673
Hatfield, 0083
South Africa
Ph. +27 12 342 2424
Fax. +27 12 342 2356
Email mwarner-smith@odccp.org.za

Rebecca McKetin
GAP Epidemiologist
UNODCCP Vienna
Rm E17
Vienna International Centre
Ph. +43 12 6060 4110
Email Rebecca.McKetin@undcp.org

Pompidou Group

Ruud Bless
Quinx Research
In de Poldermolen 3
1115 GR Duivendrecht, Netherlands
Tel. +31 20 6008760
Fax. + 31 20 600 6521
Email bless@quinx.nl

