

Integrating Psychoactive Substance Use
Treatment into Primary Health Care and
Community Involvement in Health:

*A Synthesis of Experiences at the
Zimbabwe and Nepal Sites*



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Table of Contents

<i>Acknowledgements</i>	1
<i>Background</i>	3
<i>Introduction</i>	5
<i>Part 1: Basic facts about psychoactive substance use and Primary Health Care</i>	6
1.1 Psychoactive substances and their use	6
1.2 Problems related to psychoactive substance use	7
1.3 Prevention of psychoactive substance use (abuse)	7
1.4 Essential concepts	10
<i>Part 2: Summary of the Case Studies</i>	18
A. Pokhara, Nepal	18
B. Harare, Zimbabwe demonstration project	22
<i>Part 3: Lessons learnt -- Principal activities for integration of substance use treatment into PHC and Community Involvement in Health</i>	27
3.1 Conducting operational research	27
3.2 Major activity areas	32
<i>Bibliography</i>	56

Background

Psychoactive substance use is escalating worldwide. Newer and more menacing substances are joining the supply chain, and consumption modes are changing towards more dangerous patterns of use, such as multiple use and riskier experimentation. A variety of psychoactive substances including dangerous substances, like heroin, cocaine and opium; are now commonly used. These substances cause personal and family distress, and societal problems. In its 1997 World health Report, WHO estimated that use of alcohol and illicit psychoactive substance causes at least 123 000 deaths annually. Psychoactive substance use is a major causative factor in violence and crime, illnesses such as liver cirrhosis; and among individuals injecting drugs, the risk for blood borne infections such as HIV and Hepatitis B and C is high.

With the general increase in the level of psychoactive substance use and the accompanying harm, an enormous strain is being placed on the essential health care, safety and social welfare resources of many communities. The typical responses to problems caused by or associated with psychoactive substance use have been 1) to attempt to control the supply of these psychoactive substances and 2) forceful withdrawal or detoxification of individuals using substances. These approaches are vertical and cannot meet the current health and social demands. Individuals using psychoactive substances often have limited access to health services, both by virtue of their behaviour and the type(s) of substances used. Accessibility to health services becomes even more limited when illicit substances are used. Health care systems in developing countries now face a challenge they are ill prepared to meet. Many lack resources, and service providers do not have the right type of knowledge and skills to meet the challenges brought about by this problem. Moreover, delivery of health services is no longer the sole responsibility of health service workers. Families and communities have a major role to play. Effective approaches to the problems of psychoactive substance use recognize the necessity of creating an equitable integration of various disciplines and sectors of the society, including the target communities, and of garnering the necessary political will and commitment.

In 1996, the World Health Organization (WHO) Programme on Substance Abuse in collaboration with the United Nations International Drug Control Programme (UNDCP) initiated the Project on Psychoactive Substance Use and Primary Health Care/Community Involvement in Health. This project owes its beginnings to resolutions passed by three World Health Assemblies, which proposed integrating psychoactive substance use prevention/treatment programmes into Primary Health Care. This integration was proposed in light of the rapid increase in psychoactive substance use worldwide (in the context of trade liberalization and increased supply), and the rising contribution of substance use to disease causation and social problems. The outcomes from project initiatives provide important lessons for how to effectively integrate psychoactive substance use treatment into primary health care and how to involve the community.

The lessons drawn are of particular interest to the project sites that participated in this project. The information in this document has been put together with the hope that experiences at these sites, though limited in scope and depth, can lead to implementation of more comprehensive and effective interventions. To provide a broader perspective of the approach, the practical experiences are intertwined within the relevant theoretical framework.

Introduction

Three World Health Assemblies (WHA) have passed resolutions that have called for integrated approaches to Primary Health Care (PHC) which fully involve the communities. -- (These are resolution WHA33.27, of the Thirty-third World Health Assembly, passed in 1980; resolution WHA42.20, of the Forty-second World Health Assembly, passed in 1989; and resolution (WHA43.11 of the Forty-third World Health Assembly, in 1990.) In 1996 WHO convened a Working Group to set up model projects on psychoactive substance use treatment, Primary Health Care and Community Involvement in Health, (in accord with the resolutions). The first meeting was held in Harare, Zimbabwe the same year, and the Working Group agreed on an approach consisting of three phases. The first phase entailed developing a local plan of action for each project area. The plan's components include compilation of a country profile; definition of aims of the project; and identification and assessment of two communities, one for developing the demonstration project and the other for comparison purposes. The second phase entailed development of a comprehensive plan for implementing and monitoring local projects for the treatment and care of disorders caused by psychoactive substance use, that are integrated into Primary Health Care (PHC). Components of this phase consist of development of local medical and psychosocial interventions for the management of psychoactive substance use disorders, monitoring and evaluation, as well as dissemination of findings. WHO supported the implementation of local pilot projects in Nepal, Pakistan, Trinidad and Tobago, Vietnam and Zimbabwe. The third phase was the overall evaluation of activities at project sites. This document is based upon the results of pilot project initiatives at two demonstration sites, in Nepal and Zimbabwe. Here basic information about integrating psychoactive substance use treatment into PHC is presented, and examples are given of lessons drawn from the efforts made and the evaluation of these sites. Although project implementers in these sites adopted diverging approaches, in their attempts to meet the project's objectives, there is much to be learned from these local experiences. The information outlined provides a reference point and is of particular value for similar future activities at the Zimbabwe and Nepal project sites.

Part 1: Basic facts about psychoactive substance use and Primary Health Care

1.1 Psychoactive substances and their use

The term "psychoactive substance" is used to include all substances that affect mental processes, for example, thinking and experiencing of emotions. This definition embraces dependence and non-dependence producing substances, as well as illegal and legal substances. Examples of common legal substances are alcohol and tobacco; common illegal substances are heroin and cocaine. There are a variety of ways that substances can be taken. Psychoactive substances may be swallowed (eaten or drunk); chewed and absorbed through the lining of the mouth; sniffed and absorbed through the lining of the nose; inhaled through the lungs; or injected beneath the skin, into muscle or a vein. Evidence has shown that substance use does not occur in isolation. A number of factors influence use. These are factors within or pertaining to the individual (using the substances), the environment (social and cultural) and the availability of the psychoactive substance(s).

1.2 Problems related to psychoactive substance use

Use of psychoactive substances can result in a wide range of problems that have devastating effects on the health of the individual, the family and the community as a whole. At the individual level, problems include intoxication, dependence problems, damage to body organs such as liver, (cirrhosis), cancer of the lungs and mouth, malnutrition due to neglect of good nutrition, mental problems, complications related to pregnancy including miscarriages, retarded growth of the unborn child, and low birth-weight and physical defects. At the family and community levels, problems associated with psychoactive substance use (henceforth also PSU) may include family dysfunction, loss of family income, crime and other delinquent behaviours.

1.3 Prevention of Psychoactive substance use (abuse)

WHO uses the traditional public health model to understand the reasons people use psychoactive substances. The model implies that what may cause a person to use or not to use substances depends a variety of factors that relate to the individual, the substance and the social/cultural context (the environment). Prevention interventions therefore may target:

- The agent (the substance itself) – e.g. tobacco, alcohol, heroin, cocaine, etc;
- The individual (the host) - e.g. biological and social factors; knowledge and attitudes that influence substance use behaviours;
- The environment in which the use of substances occurs – including community norms and cultural aspects that shape behaviour.

In broad terms, prevention aims at ensuring that members of a given community or population do not abuse substances and consequently do not put themselves at risk suffering damage or causing social harm. It is a fact that in some societies use of certain substances is tolerated, and may even be culturally prescribed. In light of this, it is difficult to promote total abstinence. Finding ways to control use and discourage use patterns associated with negative health and other social consequences should be the approach. For example policies that control driving under the influence of alcohol aim at reducing the number of traffic accidents rather than the amount of alcohol consumption. Intervention strategies fall into three basic groups, primary prevention, secondary prevention and tertiary prevention

Primary prevention

Strategies at the primary prevention level are intended to prevent the occurrence of substance use problems by protecting those who have not begun regular use of substances. The target group includes non-users and occasional users. Primary prevention can focus on the elimination of the psychoactive substance, control of the contributing environmental factors, or promotion of skills within individuals that can help them avoid use. Primary prevention strategies include a combination of educational, environmental, community and policy development.

Secondary prevention

Secondary prevention is sometimes called early intervention. The aim is to intervene with individuals who are already affected by substance use. Those targeted are those who use substances regularly and heavily. Through secondary prevention, the duration of the substance use can be reduced, and consequently the degree of health and social consequences can be limited. The success of secondary prevention relies mainly on these basic factors:

- Reliable systems of early identification
- Availability of prompt and effective treatment
- Sensitivity to changing conditions in the community
- Flexibility in modifying responses to meet local needs.

Tertiary prevention

Tertiary prevention includes the treatment and rehabilitation of individuals with substance dependence problems. The goal of this level of prevention is to end dependence problems through treatment, rehabilitation and prevention of relapse.

1.3.1 Key considerations in selecting appropriate intervention approaches

The following points are important to keep in mind when making decisions about the types of interventions to be employed.

- **Early intervention**

Early intervention prevention strategies can help deter individuals who are likely to take the substance or discourage those already using. In the community, this may include direct focus on awareness creation, through information dissemination, and other educational campaigns or through environmental measures, such as promotion of non-substance use reinforcing norms and legal measures.

At the primary health care level, it is possible to provide early intervention by referring those that require specialized care and support to appropriate services and resources.

- **Inclusion of different substances in relation to the local context**

It makes public health sense that all relevant substances are included within the scope of the planned intervention(s). This helps ensure a comprehensive approach. And people who have substance use problems may in fact be using multiple substances.

- **The relevance of the intervention(s) to the target population**

Interventions that are well focused will yield better results. For example, if the target is young people using psychoactive substances in the local community there is no need to focus on physical complications related to substance use, as young people rarely experience chronic conditions related to substance use.

- **The adequacy of a particular intervention for dealing with different substances**

A combination of approaches that are applicable to the types of substance use practices should be employed. Beliefs and attitudes attached to substance use within the given cultural context should also be taken into consideration.

- **Substance use practices**

Substance use trends and practices change over time, depending on the type of substance, accessibility and availability. Decisions on intervention approaches should be guided by current evidence. Priority should be given to targeting patterns of PSU that cause damage to either mental or physical health.

Any intervention that does not take all the factors involved into consideration is likely to be ineffective.

1.4 Essential concepts

1.4.1 Primary Health Care (PHC)

As defined in the 1978 WHO Declaration of Alma-Ata, PHC is "essential health care based on practical, scientifically sound and socially acceptable methods and technology; made universally accessible to individuals and families in their community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". (WHO, From Alma - Ata: to the year 2000: Reflections at midpoint)

PHC remains a valid entry point to comprehensive health care, including substance abuse prevention. For even where the infrastructure exists, millions of people still do not have access to the services offered.

1.4.2 PHC and Community Involvement

Although the word "community" is sometimes used to mean simply a number of people living in the same area, the word also carries the connotations of common interests and fellowship. In general, social groupings cooperate together selectively and in particular contexts. The community is not a homogenous group. Its members can have conflicts of interests, and the sense of commitment to a particular activity can vary according to personal expectations and the social and political context of the activity. In recognition of the important responsibility of health professionals and community members to work together in enhancing the health of individuals and communities, development of PHC and community oriented strategies offers the best option.

1.4.3 Structural advantages of PHC and Community Involvement

- If truly community-based, addressing the problem of psychoactive substance use becomes part of the community's functions;
- There is shared leadership;
- Local wisdom and skills are valued;
- The extension of health service delivery into the community can be achieved in a cost effective way;
- Community access to PHC facilities is increased (i.e. greater access and convenience);
- The possibility of local monitoring and evaluation opens up.

1.4.4 Areas of Community Involvement

There are many areas within the PHC framework that communities can be involved in. Some examples are:

- participation in problem identification and needs assessment
- implementation on the basis of the information gathered
- participation in community activities
- expression of their views and opinions
- evaluation of own actions
- participation in community awareness creating activities on the problems of psychoactive substance use.

1.4.5 Integration of psychoactive substance use treatment into PHC

The design and implementation of PHC programmes is influenced by political and economic factors, as well as the community setting in which they take place. The PHC approach requires intersectoral action and an infrastructure in the form of health centres providing other essential services. When these elements are in place, psychoactive substance prevention can be incorporated. Setting up multiple structures for different health services brings about duplication and inefficiency in the training of staff, in supervision and in logistical support. This also imposes a burden

on community members who have to visit the different health care facilities for various services related to different ailments. When the need to expand health services arises, such as for the treatment of psychoactive substance use problems, integration provides a significant and cost effective means for doing so [OR] expanding PHC services. Though integration sometimes necessitates the employment of new staff or the adding new tasks, this may not be necessary if the workload is spread evenly over a week. Table 1 illustrates the comparative advantages of integration of psychoactive substance use treatment into PHC.

Table1: Two comparative models of response to the problem of psychoactive substance use

"Traditional"	"Integrated"(PHC) Response
<p>Interventions are supply-oriented, seeking to control accessibility of substances often through extreme policing (social control) methods.</p> <p>Health intervention goal is total abstinence sometimes through forced withdrawal and detoxification.</p>	<p>Programme is integrated into the PHC system using existing infrastructure and local resources. Adequate training, material support and referral services are provided. Care is therefore comprehensive from primary prevention to rehabilitation and follow-up.</p> <p>Interventions are demand-oriented, targeting the individual and the environment; and utilizing primary, secondary and tertiary prevention strategies.</p> <p>Social organization is the predominant methodology. Programme avoids criminalization and marginalization, instead seeking total social integration and demystification of substance abuse.</p> <p>Intervention goal may be the reduction of use and abuse, as well as reduction of negative health consequences, rather than total abstinence.</p>

<p>Psychoactive substance use problems are viewed in isolation from the total health and political/socio-economic system, and community and family contexts.</p> <p>Too much dependence on medication.</p> <p>Parallel structures of different health services, via for example, formation of another department or administrative structure. These different services often compete for supplies, transport and political support.</p> <p>Community resources, involvement and empowerment are not considered effective instruments for solving psychoactive substance use problems.</p>	<p>Substance use is viewed in its political and socio-economic context.</p> <p>The family, the community and the society at large are part of the treatment "system", and are actively involved in planning, implementation and evaluation of the programme.</p> <p>There is intersectoral collaboration, use of local resources and appropriate technology. Decision-making is decentralised, leadership is shared and a referral system -- upward and downward -- is maintained.</p>
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1.4.6 The implications of integration

- changes in the training of health workers and relationships between them;
- some workers may need additional skills to enable them to assist in new areas and to enhance their effectiveness within a comprehensive system;
- technical integration at the top and operational integration at the bottom will occur, thus enabling the administrators to see their job as supporting the work of those below them;
- efficient utilization of staff;
- services will have to be responsive to community's needs and efficient in terms of staff, time and resources.

Points to remember

- Prevention should be based on a comprehensive approach, which includes all potentially harmful psychoactive substances (both illicit and licit).
- Treatment services for psychoactive substance use related problems should be integrated into primary and general health and mental health services.
- Intersectoral collaboration needs to be utilized fully, and expanded to health and non-health sectors.

1.4.7 Importance of District Health Systems in the PHC Framework

The District Health System (DHS) refers to "the local operational framework required for the implementation of PHC. It is an integral part of the national health system, including a population living within a clearly delineated administrative or geographical area, rural or urban". The main features of a DHS are that it:

- is based on equity in relation to need;
- provides accessibility and covers entire populations;
- emphasizes health promotion and disease prevention;
- addresses intersectoral determinants of health, as well as health services, and seeks to involve and empower communities and individuals to assume greater responsibility for their own health;
- uses an integrated approach for more efficient use of scarce resources;
- attends to the creation of incentives and motivation for teams of health workers.

With the DHS in place, community involvement and intersectoral collaboration can take place at various levels. There is also the potential to improve integration of programmes within the health services. In addition, the DHS can also promote more coordinated efforts on the part of various governmental and private voluntary community groups.

Part 2: Summary of the Case Studies

The lessons presented in this document are drawn from two demonstration sites, Harare in Zimbabwe and Pokhara in Nepal. Among the five sites supported under the WHO project "Psychoactive Substance Use and Primary Health Care /Community Involvement in Health", these two sites were evaluated at the conclusion of the project. The summaries of these demonstration sites are as follows:

A. Pokhara, Nepal

The setting and health delivery framework

Primary Health Care has been adopted by the government as the mode of delivery of health services. By 1996/97 the institutions involved in the delivery of health services included 74 hospitals, 117 primary health care centres, 754 health posts and 3,187 sub-health posts. The primary health care centres have a 3-bed inpatient emergency treatment and maternity service; district hospitals have 15 to 25 inpatient beds with basic pathology and radiology services. Primary or basic health care services are mainly provided by sub-health posts, health posts, primary health care centres and district hospitals. There are zonal, regional and central hospitals, medical college hospitals and hospitals run by international non-governmental organizations (NGO's) which provide specialist services. Several primary health care programmes are in effect in sub-health posts, health posts and primary health care centre; and they are manned by paramedical and nursing staff. The sub-health posts and health posts are the first contact point for basic health services. These are also the centres which serve as the first referral points from the village community. Mental health services are not integrated into the general health service, and psychiatric care is not a priority. A National Mental Health Policy and Plan was adopted by the government in February 1997, but it has not yet been implemented. At present, there are 20 Nepalese and 5 foreign expatriate psychiatrists, most of whom are working in Kathmandu valley.

There are no special hospitals or special wards in the general hospitals for the treatment of alcohol or drug-related problems. At the health service sector level within Nepal, these are not recognized as a serious public health problem. Psychiatric services in Pokhara and in other places outside Kathmandu were started in 1988. It is in this Western Region in of Pokhara that the demonstration project is located. There are also several NGOs, in Kathmandu, and one international NGO, in Pokhara, working in the drug education projects.

Operational research

Project implementers at the demonstration site conducted research on local substance use and related problems, as an initial step; using survey, key informant and focus group discussion methods. The research was carried out by eight Village Development Committees representing eight villages in the Kaski district of Nepal, from May 1997 to April 1998. Three of the villages with a total population of 26,933 were chosen as the demonstration model (Sisuwa, Leknath, and Rakhi). These were the sites of the initial key informant survey that was undertaken as a part of phase I of the project development. The remaining five villages, with a total population of 22,633 were taken as the control area (Lamachaur, Hyngza, Armala, Kahun and Bhalam).

Summary of findings

The study found that living conditions within the study area are poor, with a local economy primarily based on rice and maize crops and unskilled labour work. Health services are available through sub-health posts, health posts and a referral hospital. Local village people often consult traditional healers (faith healers) for their physical problems. The traditional healers do not know any indigenous method or herbal medicine to treat alcoholism or drug abuse. Individuals using psychoactive substances do not go to faith healers for treatment. Traditional healers believe ghosts, spirits or witchcraft are the cause of some illnesses, particularly mental illness, which they think they can help. But they do not believe these are causes for psychoactive substance use.

The study showed alcohol use is a problem among males. Home brewed alcohol is the main type used. 80 % of those consuming alcohol start before the age of 20, and the rest before 30. About 13 % of those using alcohol are dependent on it. Alcohol is sold in the villages from early morning until late at night; there is no age bar, and any one can buy alcohol. Most of the people use alcohol for relaxation and enjoyment, and others because of dependence problems. Domestic violence, economic hardship and social problems were associated with alcohol abuse. A few people who are middle-aged or older in the community smoke cannabis. Cannabis is obtained free or at a minimum charge. Traditionally cannabis is smoked or ingested. Young males often smoke or drink cannabis on occasion for enjoyment. In this case study, cannabis smoking and bhang drinking even once was found to cause severe anxiety. Other psychoactive substances are, at present, not commonly used.

Approach adopted at the demonstration site

The study provided a foundation for developing interventions at the Nepal demonstration site. Implementation of the demonstration site project began in 1996. The main objectives of the project were to:

- raise awareness about psychoactive substance use;
- involve the local community and primary health care workers in increasing the utilization of services and increasing the resulting benefits to the client, family and community;
- reducing substance use.

Resources at the demonstration site

These include:

- PHC and general health care facilities (sub-health posts, health posts, and a primary health care centre regional hospital);
- Providers of health services: doctors, paramedical and nursing staff, pharmacists and local traditional healers; Female Community Health Volunteers and other community groups;
- Limited financial support through WHO.

Activities carried out

Project implementers at the demonstration site carried out the following activities:

1. Development of training materials;
2. Training for primary health care workers, local practitioners and Female Community Health Volunteers within the project areas;
3. Administration of AUDIT screening questionnaire and drug screening forms. (AUDIT is a procedure developed by WHO to identify persons whose alcohol consumption has become hazardous to their health);
4. Awareness creation, through information dissemination. In addition, an essay competition on 'alcohol and drug abuse problems' was conducted;
5. Brief interventions about harmful effects of alcohol and drugs by primary health care staff. (Brief intervention is a treatment strategy in which structured therapy of very short duration (typically 5-30 minutes) is offered when assisting an individual attempting to stop or reduce psychoactive substance use);
6. Referral of those using alcohol heavily to the hospital;
7. Treatment and counselling; detoxification;
8. Follow-up.

In the control site, AUDIT screening questionnaires and drug screening survey forms were administered by primary health workers and the research assistant, in the same manner as done in the demonstration site areas.

B. Harare, Zimbabwe demonstration project

The setting and health delivery framework

The Zimbabwe health care delivery system is based on the primary health care model and attempts to provide accessibility, equity and universal coverage; through health care delivery points called "polyclinics" in the cities and "rural health centres" in the rural areas. Community health workers, now renamed "community workers", provide health education, promotion, and mobilization; and first aid care in the rural areas; while urban-based "health promoters" perform similar functions in the urban areas. Community Workers and Health Promoters look after a well-defined number of families and refer cases upward to rural health centres and polyclinics. Traditional Birth Attendants (TBAs) exist and are valued as primary care givers. Zimbabwe also has an enlightened policy toward traditional healers, who are often used in primary health care. A strong association known as the Zimbabwe National Traditional Healers Association (ZINATHA) has assisted in promoting respect for traditional healing practices.

Epworth in Harare was chosen as the demonstration site while St. Mary's was chosen as the comparison area. Epworth was chosen because the information obtained from the initial consultation indicated that community members were concerned about substance use in their community. Another factor that influenced the choice was the felt need, (expressed by key informants), for an intervention, as well as a readiness to take part in the work. Epworth is a community situated about 20 kilometres south east of the capital city of Harare. The population of Epworth is estimated to be between 80,000 and 100,000. The people are generally poor and unemployment is high, particularly among school dropouts.

St. Mary's, the comparison site, is located in Chitungwiza town about 27 kilometres south of Harare. St. Mary's has a population of 54,000, which consists of a small relatively financially "well-off" segment and a larger segment who are poor. Although most homes are brick houses with tile or asbestos roofing, St Mary's is one of the most overcrowded areas in

Chitungwiza. There are numerous buildings that are in substandard condition. There is only one primary health care clinic manned by nurses and a 300- bed referral general hospital for Chitungwiza town.

Operational Research

In selecting the project area, efforts were made to better understand local substance use and related problems. A systematic review of relevant police, health and relevant government records was conducted. A survey was also conducted. Factors influencing use included customs and traditions; levels and main sources of income; primary community problems; alcohol and other psychoactive substance use norms, values, practices and consequences; knowledge of these consequences; potential sub-populations at risk for alcohol and other psychoactive substance use; settings in which use typically occurs; and available resources.

Summary of findings

Overcrowding is high, with up to eight people sharing a single room. In the demonstration area of Epworth, alcohol is the most commonly used substance; followed by cannabis (mbanje); stimulants; inhalants, such as glue, petrol and thinners; and Histalix, a cough mixture. Illicit alcohol distilled at home (kachasu), is the most commonly used form of alcohol. It's use is associated with much family and social distress. Other forms of alcohol, such as beer and wine, are also widely used. Mandrax, cocaine and LSD have also recently found their way into the community. Patterns in the types of substance used vary according to age and gender, and social placement. Older men and women drink mostly beer, while younger women drink wine. Inhalants, such as glue, are favourites among street children, and cannabis is used mostly by young out-of-school youth, however, it is also used increasingly among in-school youth. The use of psychoactive substances was observed to adversely affect the individual, the family and the community at large. Health consequences include diseases associated with promiscuity and other high risk sex practices, like sexually transmitted infections including HIV/AIDS. Consequences for the family include loss of employment and income, loss of educational opportunities for children, misconduct among children, marital conflict and divorce. Within the community, outcomes included increases in crime

rates, loss of resources, increases in unwanted pregnancies and sexual abuse of young girls. In psychiatric care, there is a fair amount of intersectoral collaboration such as that existing among the Ministry of Health, the Department of Social Welfare, and the Ministry of Home Affairs.

Several NGOs are involved in mental health, but only two were found to concentrate on psychoactive substance use. The Zimbabwe National Association for Mental Health, ZIMNAMH, was founded in 1981 to safeguard the interests of mental health sufferers, and to advocate for better care, treatment and rehabilitation; as well as promoting mental health in general, in Zimbabwe. There is an urban-based programme in Harare and a rural one located a few kilometres outside Harare (Ruwa) but which serves the whole country. The Urban Rehabilitation Centre focuses on teaching social and technical skills such as industrial work, carpentry and the like. The Ruwa (rural) programme also teaches social skills but concentrates more on agriculture and animal husbandry. A resource unit based at the national association's headquarters does follow-up, trains care providers, and facilitates employment and initiation of self-help schemes for the mentally ill persons under its care. The Zimbabwe Council Against Drug Abuse (ZIMCAD) is especially active in the area of psychoactive substance use; so is an innovative youth-led organization called the Anti-Drug Abuse Association of Zimbabwe (ADAAZ). Formed in late 1998, ADAAZ is an offshoot of a programme called the Youth Against Drug Abuse (YADA) which was run under the auspices of the Freedom from Hunger Campaign, itself a well-known NGO. Recognizing the vulnerability of youth in particular to psychoactive substances, ADAAZ targets young persons through prevention information and education campaigns. It also offers counselling services for those who are already using substances and for their families. Other organizations are variously engaged in prevention of psychoactive substance abuse. Some of these are the Zimbabwe National Family Planning Council, Hope Worldwide, Township Artists Against AIDS and the Zimbabwe Medical Students' Association.

The problem of relapse is serious as mentally ill patients often get

discharged to their homes without adequate follow-up or preparation of relatives and community members for their re-integration. One NGO among a few that acts as a half-way home for persons with mental illness is the Rudo Nyamuswa-Tariro Psychiatric Half-Way Home, located in Glenview, Harare. The halfway home combines occupational therapy, family counselling and chemotherapy to help re-integrate mentally ill persons into society.

Approach adopted at the demonstration site

Interventions aimed at poverty elimination were recommended as the key necessary component in addressing the problems related to psychoactive substance use. Poverty alleviation through income generating activities such as poultry keeping, piggeries, sewing, brick-making and welding; were proposed. It was concluded that poverty was the overarching problem out of which psychoactive substance use related problems emerged. Other envisioned interventions included identification of psychoactive substance use problems, and treatment and rehabilitation of psychoactive substance use disorders. The aim of the Epworth project was to promote healthy life styles through development of models of cost effective Primary Health Care and Community Involvement in Health approaches to the health consequences created by substance use. The two specific objectives were:

1. To prevent and reduce morbidity and mortality due to psychoactive substance use;
2. To ensure that people with psychoactive substance use related problems have access to services and achieve full social integration.

Resources at the demonstration site

- Polyclinics and referral hospital, NGOs;
- Nurses at polyclinics, TBAs, Community Workers, Health Promoters, traditional healers and doctors at the referral centres;
- Limited financial support was also provided by WHO to initiate the project.

Activities carried out

- Household and school survey;
- Focus Group Discussions and Key Informant Interviews were held to establish dialogues and initiate community involvement in the chosen intervention project;
- A planning workshop and the setting of priorities for income generating activities.

Part 3: Lessons learnt -- Principal activities for the integration of substance use treatment into PHC and Community Involvement in Health

3.1 Conducting operational research

The crucial step taken at both project sites was the carrying out research on local substance use and the related problems. This was necessary in order for project teams to gain an in-depth understanding of the local situations.

3.1.1 The main variables considered:

- the risk and protective factors within the communities;
- customs and traditions;
- levels and main sources of income, and other social determinants such as education;
- primary community problems;
- alcohol and other drug use norms, values, practices and consequences associated with use;
- knowledge of these consequences;
- potential sub-populations at risk for psychoactive substance use;
- types of psychoactive substances and methods used;
- available resources.

In addition to determining the extent and nature of psychoactive substance use problems within the target groups, it is necessary to learn about the feasibility of the activity within the larger community. Here are some key guidelines to remember:

- Learn local customs and traditions, and to some extent the language. This helps “outsiders” to get accepted and makes it easier to implement the activities;
- Learn how the community functions and who its leaders are;
- Remember health services must be accessible, (so the people will have the opportunity to use them). Determinants of accessibility may include:
 - distances people will have to travel
 - physical obstacles, e.g rivers, mountains
 - amount of time spent travelling
 - availability and affordability of public transportation.

In Nepal, because some of the areas where people with substance use problems live are in mountainous locations, contact with them was infrequent and depended on whether the health workers had the time to go to these places or whether the clients themselves would seek the services.

3.1.2 Methods of assessment

Secondary data were mainly gathered from health care facilities and police records (desk review). The main methods used to collect primary data were:

- Surveys
- Focus Group Discussions and
- Key Informant Interviews

Both qualitative and quantitative data was gathered using these methods. This information is essential for establishing the actual extent of the problems, the resources available and the needs to be addressed.

Through project efforts a remarkably comprehensive desk review, house survey and qualitative analysis of the problems associated with psychoactive substance use in Zimbabwe, was carried out. This review provides a strong evidential basis for any future work on this subject in Zimbabwe.

3.1.3 Analysis of results of assessment

Research findings, when analysed properly, can form a strong basis for setting priorities. ***Project implementers at the Zimbabwe and Nepal demonstration sites began by conducting research to better understand the local situation.*** Experience has shown that in community work, social action involves a learning process. Communities and funding organizations should be guided by current evidence gathered from the local setting. When determination of the types of interventions to be made comes from funding agencies, research institutions and/or governments, this constitutes a top down approach. And the results of the top down approaches are well known. Because community action is a learning process for all those involved, it can be a very a slow process.

3.1.4 Determining priorities for action

Once the health situation and the needs of the populations are known, priorities must be set, together with the community. A clear, transparent and consultative process needs to be established. An atmosphere, in which there is an appreciation of the positive values that underpin the decision-making, should be fostered. This will help lead to the development of a shared understanding of the major problems and options for action. An example of this can be found in the priority setting process followed by the Zimbabwe demonstration site, discussed below.

Following the research, it was essential to develop a "strategic plan" to determine priority needs. This was done during a one day planning workshop held in Epworth in November 1996. Participants of the workshop consisted of two groups of Epworth residents, one adults and the other youths. A plenary session was used to consolidate the discussions. Other participants were representatives from an NGO (Plan International) involved in development work in the area; representatives from the schools, the police and one health centre. The selection of people taking part in the workshop was based on recommendations from preceding group meetings.

Strategic planning involved analysis of the problem with community members, in light of collected data. It also included getting their ideas regarding possible interventions, identifying activities, delineating roles, setting up timetables and discussing finances. The issue of how to sustain the project was discussed at length. As a result, plans for fund raising were drawn up.

The development of projects aimed at alleviating poverty in the ten districts of Epworth, was decided on as the number one priority. The rationale was that without resources for improving their lives, many people in Epworth would find it futile to develop healthy ideas and practices with respect to substance use. Priority number two was the development of public awareness programmes. It was felt that in order to be effective, awareness creating projects needed to be combined with recreational and fund-raising activities.

The “development projects” that were suggested varied and included activities such as poultry or pig raising, sewing school uniforms, brick making and welding. Within the conceived projects, people were expected to work in different groups. The groups would be responsible for developing proposals for funding for the projects. This included submitting drafts to the project team for evaluation. On completion of all the written proposals, a workshop was planned with the aim of seeking funds to support the projects. A community advisory committee was set up. The role of the committee would be to communicate with the project team on the progress of the development of the projects, while that of the project team was to advise the groups as well as to advocate for support of the projects.

The demonstration project in Zimbabwe brought various agencies interested in substance use problems together, and at least created awareness among concerned persons, such as the Ministry of Health and NGOs in the mental health field, about the serious deficiencies in existing services and resources. The project succeeded in mobilizing the community around the issue of substance use, and got the needed participation in and contribution toward possible interventions.

3.1.5 What can go wrong with community involvement in health?

In the two demonstration sites presented in this document, priorities were reached in consultation with the community. In Nepal, alcohol abuse was itself seen as a priority, while in Zimbabwe the priority was poverty alleviation. However, many things can go wrong in developing community-based projects. Some counterproductive factors are:

- lack of cohesion;
- difficulties getting scattered populations together, where social stratification exists or in rural areas;
- lack of basic structures/infrastructures;
- paternalistic attitudes of health workers;
- making unrealistic plans.

The interventions that are chosen should always be those that are relevant, (i.e. addressing priority problems) and feasible. In the Zimbabwe project, the setting of priorities was closely linked to the strategy of health promotion articulated by the 1986 Ottawa Charter on Health Promotion, which treats poverty as an important health determinant. It also asserts that interventions must be comprehensive in order to deal with the interrelated determinants of health. The top priority as expressed by the community was the creation of income generating projects. A crucial point to remember is that communities requires guidance in making choices about the appropriateness and feasibility of proposed interventions. Failure to make feasible choices resulted in a great deal of frustrations at the

Zimbabwe site. This was because while the expectations were reasonable (from an analytic view point), they could not be realistically met. The planned development/ income generating projects, as conceived, were beyond the scope of present available resources.

3.1.6 A checklist list for participatory decision-making

- | |
|--|
| <ul style="list-style-type: none">√ community leaders opinions considered√ discussions held on how to best meet these needs√ discussions held on ways to use the community's own resources√ agreement reached on how to respond√ agreement reached on how services can be provided√ commitments made by all parties concerned√ decisions made on jointly executed projects√ communication process, frequency agreed upon√ roles, responsibilities clarified and agreed upon√ monitoring and evaluation agreed upon. |
|--|

3.2 Major Activity Areas

A well-defined set of activities needs to be carried out in any intervention, in order to achieve the project objectives. Here these sets of activities are called "major activity areas". The demonstration projects did not provide a conclusive or clear picture of the effectiveness of the chosen intervention approaches. However, it is useful to review the activities that did take place, because important lessons can be learnt from them. The main activity areas included:

- Community dialogue
- Community awareness
- Materials development and training
- Screening
- Referral
- Treatment
- Follow-up and monitoring
- Evaluation

These areas of activity form the practical basis for the integration of psychoactive substance use treatment into PHC and Community Involvement in Health, as presented in this document.

3.2.1 Community dialogue

It is always useful to determine the readiness of a given community to respond to and participate in alleviating psychoactive substance use problems. Promoting awareness, commitment and feelings of project ownership will help to harness local resources and ensure the continuity of the approach. Commitment and ownership are usually dependent on:

- how conducive the created environment is to participation;
- the nature and scope of the project activities;
- the project's responsiveness to community needs;
- the project's effectiveness at addressing the expressed needs of the particular community.

It is important to remember that individuals, families and communities can act to improve their health when they are given the opportunity and the means to make appropriate choices. People need knowledge, awareness and skills; as well as access to the possibilities offered by the PHC system. This requires that health care workers be more responsive to the needs of the community. The input of the two communities involved in the demonstration projects in Nepal and Zimbabwe resulted in the two different approaches to the problem of psychoactive substance use. These kinds of dialogues will help ensure that the specific objectives that are sought are clearly understood by all.

3.2.2 Community awareness

A prerequisite for successful community involvement is an understanding of the community's structures and dynamics, and faith in the community's ability to learn and to manage. Communities are encouraged to make decisions about what can be done, how it should be done, and when and where it should be done. The process of involvement implies that community members are able to discuss issues and reach solutions that are agreeable to all. This makes resulting decisions more binding. However, the community must be able to not only make choices, but make *informed* choices. Thus they will need to be given information about the issue or problem to be addressed, and they will need to see the positive value or benefit of proposed interventions. Community participation takes time and dedication by all. An example from the demonstration project sites is given below.

At the Zimbabwe project site, and also to some extent in Nepal, communities recognized psychoactive substance abuse as the social scourge that it is, even though it was not seen (in general) as a health or medical problem. Because of the ready recognition that substance use was a significant problem, it was not difficult in either case to mobilize the communities. When communities are organized around a felt problem, their response is usually positive. Nevertheless, review of these projects highlights the need to educate communities so they can also see psychoactive substance use from a health perspective. This way, substance use may be viewed more seriously and receive the attention, and health and community resources it deserves.

At the same time, because the communities saw the psychoactive substance use problem from a broader social perspective, they also saw solutions that transcend the narrower medically orientated views of the project. Thus in Zimbabwe the communities saw poverty alleviation, not integration into PHC, as the solution to the problem of psychoactive substance use, even while ignoring the medical benefits of early intervention and perhaps referral to specialized care for those in need.

Within the short life span of the demonstration project in Zimbabwe, cooperation from various stake-holding sectors of the society was achieved, and their input taken into account. The Epworth Police, the education sector, social welfare services (the Resource Centre), the district administration, NGOs (e.g. Plan International) and the university joined the community in trying to better understand and address the problem of substance use in the Epworth community.

In Nepal, essay competitions were introduced in the local schools as part of an awareness creation campaign among teachers and students. The evaluation also showed that the administration of AUDIT in control sites contributed to awareness creation. As a result, some individuals dependent on alcohol and their families self-referred themselves to the hospital for treatment.

Convincing the community to take collective action in respond to the problem of psychoactive substance use requires patience and commitment. A number of issues to be considered are:

- Creating an enabling environment;
- Creating equal opportunity for all;
- Allowing the community to choose the services to be provided to meet their needs;
- Encouraging community members to help with the delivery of services, wherever appropriate;
- Allowing the community to help promote services and evaluate them;
- Letting the community contribute according to their means;
- Paying attention to gender participation;
- Taking care that all participation is on a voluntary basis;
- Not loosing sight of cultural context(s) in promoting involvement;
- Working with community members and not simply giving them what you think they need;
- Helping the community use its own resources to overcome the problems of psychoactive substance use.

3.2.3 Development of materials and training

Development of materials

Integrating PSU treatment into PHC and implementing any new approach will require reorientation or training. Support mechanisms and materials are important in this regard. When developing educational (etc.) materials, the following should be taken into consideration:

- the knowledge and skills needed by the target group
- general characteristics of the target group (e.g. level of literacy, etc.)
- cultural acceptability

- language
- relevancy
- clarity and simplicity.

In Nepal training materials developed for the project were:

- a manual on alcohol and drug abuse problems and management;
- educational brochures for clients;
- AUDIT screening questionnaires.

Both service providers and clients in the project site found these to be useful educational and reference tools.

Training

No matter what the level of activities, training should be an integral part of any intervention related to psychoactive substance use. Although integration of services can ease problems associated with the expansion of services, human and financial resources remain crucial factors. Integration of substance use treatment should be done in conjunction with the integration of all other services, to maximize the efficient use of support services and staff. Identifying responsibilities and assigning them to specific people is an important part of the process of creating an integrated system. Integration into PHC requires close coordination of efforts and decision-making among all those providing health care. A team approach is critical to ensuring that all the health priorities are appropriately addressed. Service providers such as general practitioners, primary health care workers, pharmacists, social workers, medical and psychiatric assistants and other community service providers; can be trained. Community involvement provides opportunities for building confidence; obtaining a better understanding of local conditions; and for getting to know individuals and families, and the community as a whole.

Health workers gradually become part of the life of the local community. In order for this to happen, whatever work is being done in the community should be carried out from start to finish by the same group of workers.

We also learnt from both Nepal and Zimbabwe that integration of PSU treatment is not only possible but also cheaper, in that local human resources already working in the PHC system can be accessed. The usual practice when addressing the problems associated with PSU has been to erect externally funded vertically structured projects, which tend to wither away with the scaling down of donor support. The use of existing systems and infrastructure is important for project sustainability.

In Nepal training of all of the following was conducted: primary health care workers and orientation of Female Community Health Volunteers, mother's group (women's group) members and traditional healers. A total number of 136 persons were trained at 7 community locations within the project site.

Training should go beyond mastering skills necessary for delivering messages related to substance use, but should also include related subjects such as general communication and organizational skills, and methods for motivating the community to take collective action. In general, PSU treatment service providers should be taught how to screen and to encourage individuals using substances to seek help, and how to make appropriate referrals, including proper record keeping.

The training package at the Nepal site included training on the health, economic and social hazards of using alcohol and other psychoactive substances, and AUDIT interview. In fact, the Village Community Health Volunteers that were trained acknowledged that before training they had felt that they would not be able to help individuals using alcohol. In addition, information on the consequence of poor nutrition, which had not previously been linked to alcohol use, became an important health education message.

Better prepared personnel are able to more effectively plan and take into consideration the particular needs of the community. This consequently facilitates lobbying for resources. Training must therefore be an integral part of service provision. To be effective workers in the PHC facilities must:

- understand the actual health needs related to psychoactive substance use in the communities they serve;
- gain and maintain the confidence of the people;
- where possible, reside in the community where they are working;
- be chosen by the community;
- look at those who use substances and the community positively.

In Zimbabwe, it was possible to get information on the skills needed by the PHC workers in order for them to manage and treat PSU problems. It was revealed that nurses and other PHC workers lacked basic skills in handling problems associated with psychoactive substance use. Most nurses only received information on psychoactive substances during basic training. No continuing education or routine update was provided to equip them with skills to handle PSU problems.

In Nepal, training of PHC workers and Female Community Health Volunteers helped to raise awareness about psychoactive substance use and to improve referrals. Better training of PHC workers also promotes greater respect for them within the community. This may make others in the community more likely to heed their counsel.

Determining training needs

The training needs for the implementers of activities, largely depends on the objectives of the project. For example, is the focus on primary, secondary or tertiary prevention? Consideration should also be given to the needs of the implementers and the community, and the requirements for sustaining the activity over the long term, at a satisfactory level.

What training methods can be used?

Training methods need be adapted to the learning objectives. In principle, for skills acquisition individuals being trained require supervised practice until the agreed on standard of skill level or competence is attained. Conditions for practice should be similar to the actual conditions in which trainees will be expected to work.

In Nepal, for example, the training of PHC workers on AUDIT screening procedures took place in a local health facility. During training PHC workers were given the opportunity to administer the AUDIT instrument among clients at the health facility.

It is always useful to combine theory with practice under realistic conditions. The problem-solving approach, when used skilfully, is highly productive. It requires that under appropriate supervision, individuals being trained work out a solution or manage certain types of problems that they will encounter later in their work. A variety of instructional modalities, such as role-play, demonstration, simulations and group discussions; should be used.

As was the case in the Nepal demonstration site, those being trained should be treated as active collaborative learners and not mere passive recipients of information and ideas. This is the adult education approach.

Conducting training in circumstances comparable to the expected working conditions should be the ideal. For the most part, the duration of training should depend on the objectives and expected roles of those being trained. In the demonstration sites, it was deemed necessary to extend the training of both health care workers and Village Community Health Volunteers over a longer period of time, in order to accommodate the other demands of their routine work at home or of work at the health facility.

Who should be the trainer(s)?

The trainer should be competent in the area of psychoactive substances, have skills and prior experience in training, be familiar with the structure and dynamics of the target population, and be sensitive to the sociocultural and economic determinants of PSU problems. This makes it easier to address these issues as they influence local circumstances.

The regional psychiatrists in Phokara, and the Senior District Public Health Officer for Kaski, were instrumental in the training of workers in this project. Engaged already in community work, these trainers were easily accepted and respected.

Support groups

Such groups are essential to ensuring that the project is accountable to the people being served. These groups must have representation from all social and political sectors. This will help sensitize the entire community. Such groups will require an understanding of the different strategies for responding to PSU problems.

In Nepal, it was strongly recommended that support groups within the community be formed. The support groups proposed were mothers' and fathers' groups. These new groups were to augment the existing village groups that represent the local political and traditional leadership, and groups comprised of those directly affected by psychoactive substance use problems (mainly alcohol dependence). Village Development Committees were instrumental in initiating and organizing most of the activities for demonstration project.

The problem of high turnover of service providers

It is not always easy to keep the motivation of community members participating in community related interventions. Close contact, supervision and training can contribute to sustaining community support.

In the Nepal demonstration site, numerous problems were experienced maintaining workers who were trained and engaged in the activities related to the project. The problems cited were:

- transfer of trained staff to other areas or programmes;
- staff at the PHC facility had limited time to offer to any one programme;
- volunteers became overwhelmed with domestic affairs.

In Zimbabwe, changes in the staff positions and staff turnover within the organization primarily coordinating the project also contributed to the difficulty in moving the project forward. Because of these changes, the time allocated to the project was drastically cut. It became more difficult to achieve the required visits, which resulted in reduced contact with the community. Project implementation stalled considerably, creating apathy among community members and a lack of interest in coming forward to participate during the evaluation of the project.

3.2.4 Screening

Screening is a procedure directed at people who may or may not have the specific health ailment, such as psychoactive substance dependence. Screening is a way of assessing health status by partially using the normal diagnostic procedure. In the Nepal demonstration site the screening procedure known as AUDIT was used extensively to identify people having alcohol dependence problems.

What is AUDIT?

The AUDIT procedure was developed by WHO to identify persons whose alcohol consumption has become hazardous to their health. The term AUDIT stands for "the Alcohol Use Disorders Identification Test". Conducting the AUDIT is particularly useful because brief interventions such as educational and counselling interventions are the first approach recommended to persons engaged in harmful use of alcohol. PHC workers should therefore play a role in the early management of harmful alcohol use.

Audit interview in the villages in phase II of the project helped to raise awareness and activated local women groups. This was the most likely reason that individuals who use alcohol and other psychoactive substances, and who sought medical treatment were often accompanied by their spouse and/or friends.

3.2.5 Referral

Referral should form an integral part of the comprehensive response to PSU problems. A well-developed network of appropriate services is required. It is also important to have the basic skills needed to be able to identify the problem and refer for appropriate care and support. In most developing countries problems with referral systems include:

- the remoteness of the community;
- lack of training of community-based workers in assessing, identifying and referring individuals with PSU problems;
- unaffordable transportation costs;
- social distance (class, cultural or status differences);
- poor opinion of the health facility to which referrals are made;
- domestic commitments.

In both Nepal and Zimbabwe PHC is the accepted government health policy, but the PHC system has not been prepared to integrate psychiatric health problems. During the course of the project, however, it was learnt that it is possible to utilize primary level health care workers in making diagnoses, providing advice and in referring cases to more specialized institutions for treatment and counselling. According to primary health care workers and Female Community Health Volunteers, the number of cases that were referred to the hospital for consultation and treatment was high, and only some of them agreed to attend for treatment.

A strengthened district health care system

Communities may themselves maintain long-term activities through local enthusiasm and organization. However, there must also be a well managed relationship between the more peripheral services and the health care system. There needs to be a joint support group for guidance and coordination of PSU work in the community, appropriate referral arrangements and a supply system. To maintain the link with community-based PHC, close interaction is required with the DHS (District Health System). This helps to avoid:

- community-based services running on their own without direct support and uncertain about referral;
- hospitals functioning in isolation not knowing, and having no way of knowing, the relevance and effectiveness of their services in relation to the surrounding populations.

Strengthening the DHS may involve new organizational mechanisms for addressing psychoactive substance use, new collaboration and a larger scale of action. Above all, the referral system should be well stocked with the necessary supplies. Referral centres without the supplies needed for dealing with PSU problems (for example, detoxification), will make it impossible to build needed trust in the services.

It was noted in Nepal that clients referred to the health post by community volunteers, were reluctant to attend. Only those with severe health problems followed through on their referral. This fact was attributed to the stigmatization of the health posts as being facilities for women and children, and feared isolation from the community.

However, individuals with PSU problems opted to go to the regional hospital in Phokara as medicines used in detoxification were known to be available there.

When community-based workers are involved in the referral of clients with PSU problems, this provides an opportunity for them to learn and to discuss the referral cases and reports. This creates an excellent opportunity for increasing knowledge and updating skills.

In Zimbabwe, well-trained nurses run the PHC units, but persons with mental health problems have to await the periodic visits of psychiatric nurses. The shortage of psychiatric nurses means that an important rung in the referral ladder is missing. As a result, relatives take persons with acute PSU problems, and especially those who present with overt psychiatric problems, directly to specialized units. Without any follow-up system in place upon discharge, a "revolving door" situation regularly develops. (This is one in which a patient goes in and out of the psychiatric unit.) The lack of a "filtering" mechanism and follow-up at the PHC level leads to congestion at the psychiatric units and inevitably to poor care. Most nurses working at the PHC facilities do not make any attempt to identify people who may have psychoactive substance use problems, although there is follow-up in some clinics. Discharged patients have regular visits from psychiatric nurses.

3.2.6 Treatment

Treatment "is a process that begins when an individual using a psychoactive substance comes into contact with a health provider or another community service provider, which may continue through specific interventions until the highest attainable level of health and well-being is achieved". In most communities, people do not believe that PSU problems, such as alcohol dependence, can be treated. The properties of psychoactive substances produce a change in feelings and actions. Providing treatment can reduce the adverse social, economic and health consequences that the individual, the family and community can experience. Provision of treatment is not only the task of health workers, families and the individuals themselves should actively be involved. The challenge is convincing community members with PSU problems to accept the services being offered as substance use is often clouded by stigmatization.

Only the Nepal project got to the stage of providing health interventions against the problem of psychoactive substance use. The lack of recognition of substance use as a medical problem -- and therefore the reluctance to bring substance use related problems to the health posts and sub-health posts; is considered by the project implementers to have been a major obstacle to the achievement of the project's goals. Even the AUDIT screening at the Outpatient Department (OPD) level was not considered entirely successful because alcohol use was not viewed as a health problem. However, making investigations about alcohol abuse was in itself a motivating factor, as it helped to raise awareness and to activate women's groups. The research investigation promoted the use of health workers and referrals. And clients who showed improvement were seen to be strong motivators for others using alcohol. This points to the effectiveness of peer interventions in countering substance use.

Treatment involves specific activities directed at individuals who have PSU problems in the hope of improving their status. Some programmes may offer only one form of treatment; others may offer more. In general goals of treatment are:

1. To reduce dependence on psychoactive substances;
2. To reduce the morbidity and mortality caused by, or associated with, the use of psychoactive substances;
3. To ensure that individuals using substances are able to maximize their physical, mental and social abilities; and have access to services and opportunities, and achieve full social integration.

Treatment of people with PSU problems is essential and forms a key component of an integrated response to psychoactive substance use, PHC and community involvement. Key considerations to remember when helping people with PSU problems are:

- individuals using psychoactive substances are at different levels of use and experience different kinds of problems;
- their engagement in a process of change is of primary importance;
- rejecting individuals using substances is not helpful;
- help should be given to all those using the substances (those using them in a harmful way and those who are not);
- there is no likelihood that a single cause will be identified for all instances of PSU problems;
- there is a likelihood that the range of causes that interact to produce PSU problems in a population can be identified;
- PSU problems are a result of various interactions of different etiological factors in different individuals;
- although treatment is more effective when the cause of a PSU problem is known, treatment without such knowledge is also possible.

Settings for treatment

Treatments for PSU problems range from community responses, such as those provided by traditional healers and community development workers, to those offered by specialized services. ***In the demonstration projects, one site reported the overwhelming consultation of traditional healers by individuals with substance use problems.*** This suggests that settings for treatment vary. At the same time, there is no evidence that any one particular setting or modality of treatment produces better outcomes. Hospitals, residential settings and Out-Patient Departments(OPD) are among the settings that can be used for treatment of PSU related problems. Most of the treatment for alcohol abuse can be carried out in the OPD with only a few cases requiring admission. Therefore the primary care physician should be equipped with the necessary skills and tools to handle such cases, (e.g. for brief intervention, detoxification and early detection of substance abuse among regular patients). It is essential to view treatment as part of the prevention continuum – (primary, secondary and tertiary prevention), if a meaningful outcome is to be realized.

Integration was not considered feasible because individuals using psychoactive substances did not come to the PHC service centres for care.

In Nepal individuals using substances still did not come to the PHC unit even when referred (from the community) during the course of the project. Instead they preferred to attend the hospital ostensibly due to better facilities there.

Stages of treatment

Types of treatment interventions vary in terms of their time requirements. The diversity of treatment approaches raises the possibility of major variations among facilities providing care. Although settings for treatment vary, the processes of treatment may be similar and these are presented below.

- **Acute Treatment**

This concerns emergency treatment for physical, social and psychological crises. This type of treatment may include detoxification and withdrawal, and is a gateway for individuals to enter a treatment course. Screening for PSU problems is important at this stage. At an outpatient department of a PHC facility or hospital, for example, many individuals who present with repeated traumatic fractures may be using psychoactive substances. Unfortunately most of these individuals go unrecognized as such in these settings. Even when patients are referred from other PHC settings, screening is still essential. Brief interventions can be provided as part of screening and assessment. (Brief intervention is a treatment strategy in which structured therapy of short duration, typically 5-30 minutes, is offered to an individual attempting to stop or reduce psychoactive substance use.) Although brief interventions may not necessarily be useful for dependence problems (e.g. to alcohol), they are a useful starting point for general treatment and awareness raising.

- **Active treatment**

Assessment, intervention and stabilization are all important during active treatment.

Assessment

Through assessment a comprehensive and objective understanding of the nature and severity of the problems, and the strengths and weaknesses of the individual can be determined. These can be used as a basis for selecting the best treatment. The evaluation of the health status of the individual is crucial here.

Intervention

Intervention means that specific treatment is provided. They may be simple or complex, brief or extended over a period of time.

Stabilization

Stabilization entails the consolidation of gains achieved through intervention, for example, in the transition from hospital to the home.

The availability of brief interventions and treatment services coupled with a well-sensitized community, which can make use of them, can reduce PSU problems. Services such as these also require the provision of clinical interventions such as detoxification and sustained counselling for individuals using substances and their families, especially the spouses.

Project implementers in Nepal conclude that education of women may be a critical intervention. Clients who presented with co-morbidity tended to be better motivated to stop alcohol use and to comply with treatment and follow-up advice. Similarly patients suffering from depression or anxiety and treated with amitryptiline and fluoxetine, in addition to chlordiazepoxide, tended to comply better with the treatment procedures if the initial treatment elicited a good response.

Examples of specific psychoactive substance use related problems

- **Acute intoxication**

This can be dealt with within the community in any other appropriate setting. However, it is important to note that acute intoxication can be followed by various health risks and complications related to the properties of the substance used, contamination of the substances, the dosage, the individual, the route and rate of administration, the context of use, and/or the behaviours associated with use. Professional assessment and care is always needed in cases of overdose or other serious reactions. It is possible that pharmacological methods to reverse the intoxication can be used in the PHC setting if personnel have been appropriately trained. Psychosocial support is essential in order to motivate recovery, to improve dangerous patterns of consumption and to identify the next steps that might be appropriately taken.

Within the community, peers, family members and others can participate in the interventions. Supervision of an intoxicated person is essential. They must be guarded against accidents due to disturbed behaviour, and even death from overdose.

- **Dependence syndrome**

While pharmacological management of dependence syndrome is essential, psychosocial and behavioural interventions aimed at a substance free lifestyle are also needed. With an attempt to stop use of a substance, a withdrawal state can occur. Appropriate supervision is needed especially in the presence of confused mental and emotional states and cerebral seizures.

Detoxification Procedures

Detoxification is the process by which an individual is withdrawn from the effects of a psychoactive substance. Detoxification may or may not involve the administration of medication. The facilities in which detoxification takes place may also vary. Detoxification needs to be seen in the context of broader social and cultural interventions, including initial social stabilization and extended social support. Community-based detoxification is therefore possible. Detoxification may result in unpleasant experiences. Withdrawal is the state that occurs within the individual when intake of a psychoactive substance is discontinued either spontaneously or via thin detoxification procedures. The reactions which occur during withdrawal state may include depression, tremors, chills, muscle cramps and sometimes convulsions. Management of withdrawal and all detoxification procedures should take these risks into consideration.

3.2.7 Follow-up and monitoring

Follow-up and monitoring provide a good opportunity for gaining an overview of all the activities carried out by project implementers. It also provides an opportunity for continuing education and training needs assessment, discussion of problems and the exchange of information.

To avoid inconsistencies and contradictions it must be made clear who will do the follow-up and monitoring. Time and to some extent funds should be devoted to these activities, and a clear strategy should be adopted. A checklist for activities is a good preliminary tool for conducting follow-up and monitoring. In an integrated system of health service delivery, visits to the community by other health care personnel can serve as points for integrating activities such as these. Careful documentation of every intervention is useful. It will also help in the outcome evaluation.

As was evident in the Nepal demonstration site, workers at the health posts and those in the community valued the opportunity to be visited by the focal persons in this project. These visits had a powerful incentive effect. The main constraint against regular visits such as these were lack of transportation and work overload, especially on the part of the supervisors.

In Zimbabwe apart from the community management committee, the community members involved in developing the project were all employed (formally and informally), by the school, the clinic or elsewhere. For those in the formal sector, time committed to the project competed with time for earning income, for their daily living, and this impacted significantly on the progress of the project. In addition, because of the lack of telephone service and the general mode of life in Epworth, a number of visits to the community was usually needed in order to plan for one meeting between the committee members and other key community members.

Follow-up and monitoring should not only focus on the performance and activities of service providers, but also on the clients and their families as well. Individuals and families with problems related to psychoactive substance use require a lot of support and encouragement. Most will have to deal with the problems of discontinuing consumption of a particular substance. Awareness that community work requires patience and innovation, especially in making and sustaining contact with people, is essential for successful follow-up and monitoring.

3.2.8 Evaluation

Evaluation implies looking back on all that has been done over a period of time. Evaluation includes a review of available information on the nature and extent of the problems to be addressed or the behaviours to be encouraged; the methods and means available; and the setting of relevant and realistic, measurable objectives and targets. Information (data) obtained from evaluation can be used to refine the implementation of initiatives related to psychoactive substance use within PHC settings and within the larger community. Evaluation should not be seen as being judgmental, but rather as a prerequisite for success in the future planning and implementation of activities. Both monitoring and evaluation should be participatory, with health workers and community members being involved in all phases of the process. Evaluation and reporting of results should use language that is appropriate to the subject matter. Without sacrificing scientific soundness, evaluation should be carried out in the simplest, most straightforward terms.

Table 3 gives examples of what can be evaluated.

Table 3. Variables for evaluation

Project element	Variables
Input	<ul style="list-style-type: none"> • Community <ul style="list-style-type: none"> - main characteristics - health knowledge about psychoactive substances - beliefs about psychoactive substances and their use - practices related to psychoactive substance use - health and social problems resulting from psychoactive substance use. • Service providers (PHC and other community-based) <ul style="list-style-type: none"> - knowledge about substances, their types, use and consequences - skills - values - their acceptability to the community - awareness of their limitations and the constraints faced, e.g. resource allocation, such as educational materials on substance use; ambiguity in the definition of their roles, inadequate support. • Training <ul style="list-style-type: none"> - Timing - Use of resources - Comprehensiveness - Impact of training.
Activities and implementation	<ul style="list-style-type: none"> • Time <ul style="list-style-type: none"> - How much time is spent on activities related to psychoactive substance use - How much time is spent recording and reporting.

Project element	Variables
	<ul style="list-style-type: none"> • Services - Integration of services - Community involvement - Intersectoral collaboration - Effectiveness of services offered.
Outcomes	<ul style="list-style-type: none"> - Knowledge and skills base of providers - Utilization of resources, e.g. educational materials - Extent of use - Individuals with psychoactive substance use problems - Problems associated with psychoactive substance use - Utilization of services - Referrals - Community decision-making - Intersectoral cooperation and health team involvement.

3.2.9 Cost and financing

The evaluation of this project did not focus on determining the cost effectiveness of the interventions, but rather on the process of implementation of activities. This is largely due to the lack of defined cost items. It must be reiterated, however, that planning and cost assessment are required. Even with community-based activities, training, follow-up and supervision, materials development, and transport; can be expensive. Careful planning can help in making realistic and feasible goals. In addition to financial support from the government and NGO's, community financing is also possible. Community contributions towards project resources increase self-reliance and are an important ingredient in community involvement. Feasible and culturally appropriate means of funding and resource gathering can be agreed upon with key community members.

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