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**5TH SESSION OF THE AFRICAN UNION
CONFERENCE OF MINISTERS OF DRUG CONTROL
ADDIS ABABA, ETHIOPIA
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CAMDC/EXP/4(V)

**THEME: *PROMOTING GOOD PRACTICES IN DRUG POLICY
DEVELOPMENT AND IMPLEMENTATION***

**PROPOSED
CONTINENTAL MINIMUM QUALITY STANDARDS FOR TREATMENT
OF DRUG DEPENDENCE**

TERMINOLOGY USED	
addiction	: Defined as compulsive physiological and physical craving for a habit-forming substance, addiction is a chronic and progressive disease usually characterised by physiological symptoms upon withdrawal. The term "dependence" is often used synonymously to avoid the pejorative connotations of addiction.
AUPA	: The Africa Union Plan of Action on Drug Control and Crime Prevention (AUPA) (2007-2012)
best practice	: The best application of methodology to current activities in the field on drug control: <ul style="list-style-type: none"> • methodology which is understandable, transparent, reliable and transferable; • experiences in implementation which are recorded and made available; • issues such as effectiveness and sustainability have been reflected upon; • supporting evidence and contexts are relevant to the problems and issues affecting those involved.
CAMDCCP4	: 4th Session of the AU Conference of Ministers for Drug Control and Crime Prevention
client/patient	: An individual who has a drug use problem, for whom intake procedures have been completed, and has been admitted to a treatment facility for either inpatient or outpatient care.
community-based treatment	: Treatment in a non-residential setting, or outpatient treatment, where counselling and aftercare services are provided.
drug use	: The use of psychoactive substances, licit or illicit, which might result in physical, mental, emotional, and/or social impairment.
Primary drug use prevention	: Activities which are directed towards avoidance of drug use. It entails drug awareness and education, and addresses alternatives to drug abuse, e.g. healthy lifestyle promotion, recreation opportunities, incentives not to use psychoactive substances ("loading" alcohol prices, to "subsidise" soft drinks prizes down) etc.
Secondary drug use prevention or early intervention	: Actions that seek to provide early intervention in order to prevent regular drug use among persons who have started experimentation with drugs, or who are exposed to substance usage continuously, to encourage them to lead a drug-free life. Secondary drug use prevention addresses availability of substances ("off-limits" issues), "care-frontation" or constructive confrontation or motivational counselling, and involvement of "buddies" for active engagement in alternatives to drugs.
Tertiary drug use prevention or treatment	: Treatment commences when substance users come into contact with a health provider or any other community service, and may continue through a succession of specific interventions to assist them to acquire skills to live without psychoactive substances and skills to re-integrate into society again. Trained counsellors are needed, and a variety of social support services.
evidence-based programmes	: Interventions that show consistent evidence of preferred outcomes based on the application of defined methodology and techniques.
logical framework model	: The graphic depiction of the components of a programme/initiative.
needs assessment	: Collection of data on needs of the community and on resources available to address identified needs. Common indicators of need for substance use prevention services often include high incidence and prevalence of alcohol and drug use in the community, and presence of associated risk factors such as crime and violence, economic

		dislocation, families in poverty, school drop-out rates, and the like. In the context of substance use prevention, the inquiry into resources usually focuses on human resources and ways that these resources might be strengthened through training.
performance monitoring	:	The measurement and communication of the results of strategic plans and treatment services designed to address substance use.
process evaluation	:	An evaluation to determine whether procedures were followed, which can also be called quality assurance.
qualified medical (professional)	:	A licensed physician, nursing practitioner or registered assistant.
substance dependence	:	Symptoms indicating that the individual continues use of the substance despite significant substance-related problems.
treatment facility	:	An organised service system which addresses treatment needs of clients.

1. Introduction and Background

An evaluation of the drug situation in Africa indicates that:

- Africa has become a major global transit point for cocaine and heroin and is developing the capacity to produce synthetic drugs;
- The levels of drug consumption continue to grow in Africa while there is a tendency toward stabilisation in North America and Europe;
- An in-depth revision of current drug policies has become necessary (in Africa) in view of the increasing human and social costs and threats to democratic institutions.
- In order to turn the tide on drug use, provisions should be made towards treatment of drug users which was instrumental in stabilising drug consumption in the West.

The criminalisation and marginalisation of drug users has increased drug-related health problems and contravened universal fundamental human rights. In these difficult economic times, Governments may see an opportunity to review drug control laws, strategies and programmes to make the most effective use of resources and achieve the fundamental objective of drug policy: to maximise human security, health and development.

Global debate on quality prevention and treatment (as an alternative to law enforcement/criminal justice solutions) is becoming more prominent. Increasingly, it is common opinion that minimum standards provide an important tool for improving the effectiveness and efficiency of treatment of drug dependence. Drug dependence treatment should be evidence informed, human rights based, gender responsive and youth friendly for maximum efficacy.

The development of a set of minimum quality standards and benchmarks for the African Union is still ambitious given national differences in terms of drug use challenges as well as the differences in the organisation of public health care systems, and cultural and socio-economic factors. Nevertheless, there is considerable scope to improve the quality of interventions, programmes and services.

The 4th Session of the AU Conference of Ministers for Drug Control and Crime Prevention (CAMDCCP4) (endorsed by Executive Council Decision EX.CL/615(XVIII) of January 2011) defined as one of its priority actions for 2011 and 2012, the need for a Continental training facility for drug dependence treatment and that the AU Commission consults with Member States in this regard.

Hence, the Commission developed the Continental Minimum Standard for treatment of drug dependence as a guide to Member States.

1.1 International and Continental Milieu

Successful drug use prevention and treatment strategies must be placed within a policy framework addressing both drug supply and demand reduction. Treatment and prevention responses are critical dimensions that support successful implementation of a balanced demand reduction response. Prevention policies must

be developed hand in hand with treatment policies in order to achieve a balanced approach.

Agreement already exists among Member States of the United Nations to invest and develop prevention and treatment activities through the Declaration on the Guiding Principles of Drug Demand Reduction¹ which states that “*Demand reduction programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse. They should embrace information, education, public awareness, early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration. Early help and access to services should be offered to those in need.*”

While the UN’s international drug control treaties provide the legal foundation for drug control, in Art. 36 of the 1961 Convention, Member States are also encouraged to promote the training of personnel in the treatment, aftercare, rehabilitation and social reintegration of drug users.

According to UN drug control conventions, the primary concern of the drug control system is “health and welfare of mankind”. Drug control bodies and measures are bound by overarching obligations created under the 1945 UN Charter, which promote universal respect for, and observance of, human rights and fundamental freedoms which stem from dignity and worth of the individual. They are universal, interdependent, interrelated, indivisible and inalienable, and cannot be taken away from a person because they might be a drug user or grower, or a person living with HIV. Human rights are not only a statement of principle. All states have binding obligations under international law to respect, protect and fulfil them. This means that they should adopt appropriate legislative, constitutional, budgetary and other measures so that the human rights of all their citizens are fully realised.

Most African Union Member States have developed national drug master plans or broader national policy frameworks or strategies to organise and guide how the country addresses the drug problem. Since problems with drug use affect most sections of society and lead to health, social and legal problems, drug control master plans should preferably be integrated with existing policies (justice, education, health, labour, agriculture, economic and social). Criminalising users estranges them from health services out of fear of stigmatisation, arrest and incarceration. This can disrupt lives more than drug dependence itself and further reduces the possibility of long-term recovery. Reduced sentences or alternatives to prison should be sought, particularly for those involved at lower levels, who have no organising responsibility, receive minimal earnings, and are connected to the illicit market due to economic necessity or their own drug use. Holistic drug dependence treatment and effective harm reduction offers a greater diversity of treatment options, less stigmatisation, prevention of disease and overdose, and reduction of crime while alleviating social harms, particularly in reducing levels of drug-related violence.

1.2 Cultural Milieu and Financial Reality

However complex and integrated prevention and treatment is, policies, responses and programmes should remain flexible to respond to changing conditions in the nature and effects of drug use. These responses should be appropriate and realistic and within the realities of community. For instance, the treatment of intravenous drug users is expensive and Member States might want to target interventions to

focus on the drugs of use in their communities while centralising the treatment of intravenous drug users.

1.3 Population Groups Vulnerable to Drug Use

Some societal groups are often marginalised or overlooked or at a statistically higher risk to fall victim to drug use. They therefore deserve special attention.

Box 1: Population Groups Vulnerable to Drug Use	
Young people and children	: Strategies need to consider how best to provide services to young people and children who may have, or who are at risk of developing, drug-related problems. There are demographical features that make young people and children especially vulnerable to become drug users. Indicators are conflict and post-conflict situations; environments with high levels of drug use; orphans; children of migrant workers; young persons in conflict with the law; unemployment; peer pressure; in the care of welfare authorities; poor or no attendance to school; street children; under-age children in the labour market.
Women	: There are fewer female patients seeking treatment, for a variety of reasons (such as cultural roles). As a result, some services may be less sensitive to women's needs and less able to respond appropriately.
Seniors	: While vulnerability to drug use is highest among young people, older people should not be ignored.
Current and previous users of psychiatric services	: People with substance use problems and co-morbid psychiatric disorders appear to have a relatively high contact with medical services and may require more intensive treatment as there is proof that people with drug use and severe mental illness will not respond well or comply with traditional care plans and arrangements.
Homeless people	: The most common health related problems cited by people who sleep rough concern psychological issues, alcohol consumption and drug use.
Racial/ ethnic minorities	: Many minority people live far away from urban areas and may differ from majority people in numerous ways, for example, ethnicity, language, culture and beliefs.
People in conflict with the criminal justice system	: Many people in conflict with the criminal justice system have drug use problems. There are issues involving the detection and management of drug users in police custody, in prison and within probation services.

In Africa, most communities are still resistant to treatment of drug use. Treatment is expensive, and often involves the removal of those who seek treatment from their families, communities and places of employment, hence treatment must take into account cultural contexts, community institutions and traditional treatments as solutions to challenges as well as involve the family and the community as part of the treatment.

Community based treatment and prevention stems from the need for a departure from specialised institutions to more preventative and cost effective approaches with a wider reach.

1.4 Levels of drug use prevention:

Community based treatment and prevention intervenes on three basic levels, namely:

Box 2: Levels of drug use prevention	
Primary drug use	: Activities which are directed towards the avoidance of drug use. It

prevention		entails drug awareness and education, and addresses alternatives to drug abuse, e.g. healthy lifestyle promotion, recreation opportunities, incentives not to use psychoactive substances ("loading" alcohol prices, to "subsidise" soft drinks prizes down) etc.
Secondary drug use prevention or early intervention	:	Actions that seek to provide early intervention in order to prevent regular drug use among persons who have started experimentation with drugs, or who are exposed to substance usage continuously, to encourage them to lead a drug-free life. Secondary drug use prevention addresses availability of substances ("off-limits" issues), "care-frontation" or constructive confrontation or motivational counselling, and involvement of "buddies" for active engagement in alternatives to drugs.
Tertiary drug use prevention or treatment	:	Treatment commences when substance users come into contact with a health provider or any other community service, and may continue through a succession of specific interventions to assist them to acquire skills to live without psychoactive substances and skills to re-integrate into society again. Trained counsellors are needed, and a variety of social support services.

Equally important is employment creation which is an important aspect to ensure a balanced community as it allows for meeting individual and family needs, while there is also need for recreation as an alternative to drug use.

In order to achieve effective drug use prevention, initiatives should (i) be in alignment with national legislation, policies and strategies, (ii) be in partnership with the community, (iii) be supported by qualified prevention personnel, and (iv) include monitoring and evaluation parameters.

Box 3: National drug strategies should always be based on five core principles:

- 1) Drug policies should be developed through a structured and objective assessment of priorities and evidence.
- 2) All activities should be undertaken in full compliance with international human rights.
- 3) Drug policies should focus on reducing the harmful consequences in addition to the scale of drug use and markets.
- 4) Policy and activities should seek to promote the social inclusion of marginalised groups.
- 5) Governments should build open and constructive relationships with civil society in the discussion and delivery of their strategies.

<http://idpc.net/policy-advocacy/idpc-drug-policy-guide-html>

2. Minimum Standards for Treatment of Drug Dependence

Drug dependence is not a crime but rather a health issue. Drug dependence treatment can be an effective avenue towards addressing drug dependence, reducing drug-related harms and minimising social and crime costs. Studies in a range of social, economic and cultural settings confirmed that a wide range of drug-related health and social problems – including family breakdown, economic inactivity, HIV and petty street crime – can be successfully addressed in a cost-effective manner through the widespread provision of scientifically sound drug dependence treatment.

It is important that treatment regimens respect human rights and the principle that it is always the individual's choice whether to enter a treatment programme, and

whether to comply and continue with it. This will not only comply with human rights obligations but also ensure programme effectiveness.

There are a number of potential routes through which individuals can access treatment programmes¹:

- **Self-referral** by the individual or family.
- Identification **through general health and social service structures** Existing health and social care services will often be in the best position to recognise symptoms of dependent drug use and encourage the drug user to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role.
- Identification **through specialist drug advice centres or street outreach services** These services can offer food, temporary housing, harm reduction services, and the encouragement and motivation to engage with drug treatment – at which point direct access to a more structured treatment can be facilitated.
- **Identification through the criminal justice system** Through the illegal nature of their drug use, and the need to fund it, dependent drug users often come into contact with the criminal justice system. A number of successful models of intervention have been developed for criminal justice systems to identify and motivate dependent users to accept treatment.

Treatment programmes

Treatment programmes include outpatient treatment, which encompasses a wide variety of programmes for patients who visit a clinic at regular intervals – mostly involving individual or group drug counselling, but often also including cognitive behavioural therapy, family therapy, motivational interviewing and incentives and self-help support groups. Treatment programmes also include residential treatment and treatment within the criminal justice system to address the twin problems of crime related to drug use and the treatment and care needs of drug dependent persons. Social support interventions, such as employment programmes, vocational training and legal advice and support have been demonstrated to be effective in facilitating social inclusion and should be included in treatment.

Treatment programmes² must be **integrated and systematic**, since many people with drug use problems require the provision of several different types of treatment service over time. Those supports are important elements in an effective package of care services that can evolve over the course of treatment of an individual.

Treatment programmes must have a clear and concise **mission** statement, and **description and objectives characterising** the client group served by the programme.

¹ <http://idpc.net/policy-advocacy/idpc-drug-policy-guide-html>

² <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1124>

Box 4: Principles of Effective Drug Dependence Treatment:

- Addiction is complex but treatable. It affects brain function and behaviour.
- Treatment needs to be readily available. Forcing someone who needs addiction treatment to wait for it when he or she is ready for it may mean losing that person to care.
- Matching treatment settings, interventions, and services to an individual's particular problems and needs is essential to the end-result and recovery.
- Effective treatment attends to several needs of the individual, not just drug use. To be effective, treatment must address the individual's drug use and any related medical, psychological, social, vocational, and legal problems. Treatment must also be tailored to age, gender, and culture.
- Recovery from drug addiction is a long-term route and frequently requires multiple instalments of treatment. Therefore, remaining in treatment for a sufficient period of time is critical, as is allowing patients to have as many rounds of treatment as necessary.
- Counselling and other social therapies are the most universally used forms of drug use treatment. Participation in group therapy and other support programmes during and following treatment assists abstinence.
- Medications are often a core element of treatment, in particular when linked with counselling and other social therapies. Treatment of opiate addiction using methadone, for example, even over a long period, is highly effective for many patients.
- Individual treatment plans must be evaluated frequently and adapted as required.
- Accessible and affordable treatment for mental disorders may be crucial to ensure effectiveness of treatment for drug dependence.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Patients should be encouraged to continue drug treatment following detoxification. Ongoing support, motivation and encouragement must also be included.
- While the voluntary nature of treatment is a central principle, family, friends and colleagues can often help by urging and encouraging entry into treatment.
- Drug use during treatment must be monitored to prevent lapses.
- Treatment programmes should assess patients for infectious diseases and provide support and counselling to help patients modify activities that place them at further risk.
- Treatment and rehabilitation services should play a key role in reducing the social stigma and discrimination against drug users and supporting their reintegration into society as healthy and productive members of the community.

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Executive/Governing Board and Management: Based on its mission and objectives, the treatment facility will have fixed criteria pertaining to admissions or refusals and will keep the right of refusal should a potential patient not meet the admission criteria. Both the policy and the procedures of the facility must be clearly described and explained with all parties concerned well before admission. Facilities must have concrete policies and workplans which are accomplished and revisited bi-annually. Moreover, facilities will have written procedures and protocols for both patients and staff to abide by. Information should be available regarding the governing body which must have full legal authority for operating the facility. In the case of public organisations, an organisational chart which reflects the treatment facility's placement within a government agency shall be provided, while private organisations should provide documentation of the legal authority for the formation of the agency.

- Every facility must have a clear description concerning its unique identity and mode of treatment offered. As a result, patients are able to make informed choices on their rehabilitation and care.
- The facility will have clear, concise and in writing fixed house and behavioural rules for staff, patients, family and other persons concerned.

- As acceptance and understanding of the rules must be confirmed in writing in a legally binding document, prior to admission, while patients and their families must, at all times, abide by these prescribed house and behavioural rules
- A signed copy of the agreement to abide by the fixed house and behavioural rules will be kept in the patient's file.
- Offences toward behavioural rules must carry clear consequences and must be contained in a transparent manner while respecting the right to privacy and confidentiality. All serious behavioural problems and committed interventions are reported in writing to Executive/Governing Board and the patient file. Patients may lodge confidential complaints in a complaint register must be kept up. The complaints procedure must be clearly defined. The centre will have a clear policy and procedures to customers imposing and/or isolate restrictions.

Training of the staff: The facility must have expert qualified employees who are supported to offer the best possible treatment. The centre will maintain a training and development plan for the staff which connects to the needs of the institution and is coordinated with evolving needs of patients.

Employees must have skills and training in the following:

- to assess aptitude of the patients to successfully complete the programme,
- conducting an initial interview,
- design of a treatment plan in order to measure progress
- ability to assess, individual and group-counselling,
- case management,
- crisis intervention,
- consultation with other professionals concerning the treatment.

Facility: The centre must be safe, alcohol and drug-free (except for medications used in scientifically sound medication-assisted therapies) and support efficient residential care and treatment in order to promote a positive self-image with patients customers and protect their human dignity. There are facilities suitable for special medical treatment accompaniment and care.

Family support and involvement: The centre must encourage the support and participation of the family and/or in-laws of the patients as an essential and integrated component of treatment, rehabilitation and re-socialisation. The centre involves the family as much as possible in the treatment process and makes every attempt to reincorporate clients into their social system. If necessary the family (the social system) will also receive treatment. Policy and procedures must be in writing, with the aim to lead, regulate and encourage the involvement of family and/or in-laws in treatment.

Documentation, monitoring en evaluation: Treatment and other service activities are fixed and documented to monitor the progress of the treatment periodically and evaluate the quality of care. All patients will have a separate confidential file containing the details of the treatment and recovery. The centre will monitor its performances by an annual internal audit during which qualitative and quantitative data are collected and reported to the oversight authority, referring and other relevant agencies.

Access to treatment: Services must be available on demand while the centre will have a written policy and procedures relating to the admission process and regulate. The centre will accept people who meet the admission criteria. The centre will

ensure that employees responsible for the admission process and including appraisal are trained in: the determination of the types of drugs used the duration of the use, a psychiatric screening, identification of the need for detoxification, short description of the social history and the appraisal of the needs. The centre must have a mechanism for monitoring wait times or improving availability when wait times exceed a certain level.

Affordability and availability of services: Dependence treatment services should be affordable. Centres should monitor the refusal of potential patients because of lack of ability to pay as well as refer patients to government sponsored and more affordable treatment centres. Services need to be equally available (and of comparable quality) to people living in poverty and others, to people of all ethnic groups, to homeless people and those with stable shelter, to men, women and transgender people, to people in all occupations including sex work. There must be mechanisms for filing complaints in these areas that guarantee prompt and fair hearings of these complaints. Services should also be tailored to the needs and situations of women, including pregnant women and women with children.

Patient assessment: Initially all patients must receive a holistic appraisal including a medical exam performed by a doctor followed by regular check-ups for the duration of their treatment in order to appraise progress. Appraisals are placed in the patient's file and may be discussed with the customers and with the family to ascertain progress.

Individual treatment plan: All patients must have a confidential file and an individual treatment plan which supports treatment and is regularly monitored. Patients must voluntarily agree to this plan before treatment commences. If possible, patients must have insight regarding specific treatment options, risks, and advantages and play a personal role in treatment plan selection. The treatment of patients will relate specifically to the nature of their addiction and/or psychiatric and/or social situation, their personal preference, strength and properties, social needs and circumstances.

Evidence-Based Approaches to Drug Addiction Treatment: Depending on the legality of opiate substitution therapy, several examples of treatment approaches have an evidence base supporting their efficacy. These approaches are designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. Some of the approaches are intended to supplement or enhance existing treatment programs, and others are fairly comprehensive in and of themselves. Pharmacotherapy (methadone, buprenorphine, and naltrexone) used for mainly opioid addiction could be combined with behavioural treatments such as cognitive-behavioural therapy, community reinforcement, contingency management, and motivational incentives. Medicine and other medical care must be rendered in an accessible and legal manner with the wellbeing of the patient being paramount. The centre must have 7 days per week, 24 hours per day medical, mental health care and emergency aid available (e.g. by telephone consultation or access to emergency services). Medication received must be recorded in each patient's file in conformity with legal regulations (names of medicine; amount, frequency, method of administration, and details of the prescribing doctor). Patients must be monitored by trained employees who are able to respond to emergencies.

Structured residential treatment programmes and daily activities: Patients must participate in a range of treatment programmes designed to be safe and effective in treating drug dependence. Treatment programmes must be assessed regularly and adjusted to conform with internationally accepted standards. Treatment programme include group-therapy and/or counselling, individual and family therapy and/or counselling and organised group activities such as sport, health education, recreation and creative activities. Treatment programmes should cover at least 40 hours per week including therapeutic and counselling activities. Patients may be involved a maximum of 8 hours of non-exploitive (including training of professional competences) labour activities (e.g. construction of meals, cleaning the centre) activities. Patients must receive at least three (3) meals per day.

Aftercare, release and readmission: Suitable programme must be available for reintegration into society in order to be well-prepared to return to everyday life.

Fiscal Management: Treatment facilities must have written budgets including income and expenses, and that lists all income by source, as well as lists all expenses by facility component or type of service. Treatment facilities must develop a standardised fee structure and use this structure uniformly and transparently.

- Each treatment facility shall develop a reporting mechanism which indicates the relation of the budget to actual income and expenses to date.
- Each treatment facility shall maintain written policies and procedures that govern the fiscal management system (e.g., purchasing authority, accounts receivable, cash, billings and cost allocation).
- Personnel responsible for signing cheques and performing other accounting activities shall be cleared to handle financial and accounting assignments.
- A fiscal management system shall provide for an audit of the financial operations of the treatment facility at least every two years, either by a public accountant who is not a staff or Board member or by the funding agency.

Patient rights: The treatment and care facility will, at all time, respect the **basic human rights** of patients, with specific regard to dignity, suitability of treatment and care, and human rights.

- The patient will be provided with comprehensive information, in writing, regarding the facility, its regulations, and operations, rights of patients and duties of both the facility and patients.
- During pre-submission, the patient or his/her legal guardian will agree, in writing, to these terms setting out the rights and duties of both parties.
- Should the patient be less than 18 years of age, this agreement will be entered into by either his/her parents or legal guardian.
- The patient will be entitled to (at minimum) healthy and sufficient food, safe drinking water, medication, rest and safety.
- The patient has the right to treatment in accordance with the "African Charter on Human and Peoples' Rights", sanitary supplies, personal hygiene and care.
- The patient has the right and is also obliged to actively participate in the treatment programme availed by the facility.
- The patient is obliged cooperate/contribute to the overall maintenance of the facility.
- Patients always have the right to express discontent to the management of the facility, being either an executive or governing board.

3. Evaluation and Assessment

Conceptual framework for monitoring and evaluation of treatment and prevention programmes

Inputs	: Resources used to provide a treatment or service. Can be financial, staff, infrastructure, equipment and materials. Inputs make the services possible.
Outputs	: Level, amount or volume of activities undertaken as result of the inputs. Usually workload expressed in terms of time or cost. Outputs do not necessarily indicate whether the objectives have been met or the extent of being effective, rather it is an indicator of efficiency.
Quality measures	: The extent to which the service meets the desired standards and expectations.
Outcomes	: Results of activities.

Essential elements of a performance and outcome monitoring system

Performance and outcome monitoring is an integral part of effective and efficient treatment and prevention. Information sheds light on scope for improvement in service, access, assessment, impact, and gaps.

Some universal features of effective outcome monitoring systems are:

- “keeping things simple” by using a small number basic indicators of outcome;
- commitment to monitoring progress and impact; and
- linking financial support to results.

Information required for recording are:

- Concise information about all prevention activities, referrals and assessments conducted;
- Demographical information and drug use profile of all clients/patients, including previous treatment information;
- Details of the comprehensive treatment regime for each client/patient;
- The status of the client/patient at the end of treatment under the programme.

All services should record a basic set of information about the client referral, assessment and treatment activity of the programme for a specified reporting period (for example, per annum). That information should include the number of people: referred to the programme for assessment; referred to another service; who commence treatment; and who complete treatment.

Managing information and communicating results:

Information helps to augment treatment and prevention services and facilitates effectiveness and efficiency.

4. Concluding Remarks

The nature and complexity of drug dependence treatment in Africa have changed over time. The traditional use of cannabis has been compounded by the use of newer types of drugs such as heroin, cocaine, and amphetamine type stimulants. Injecting Drug Use has added another dimension to this complex situation, given its nexus with HIV. While progress has been made in the last decade by several

countries to provide quality drug dependence treatment, we are still far from reaching the minimal critical mass both in terms of qualified health personnel and dedicated treatment services.

It is hoped this document will fill a critical gap in defining minimum quality standards for treatment of drug dependents and provide M/S with an important tool in improving their services and ultimately evaluating them.

Essential additional reading:

- <http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>
- http://www.who.int/substance_abuse/activities/msbatlaschsix.pdf
- http://dl.dropbox.com/u/64663568/library/IDPC-Drug-Policy-Guide_2nd-Edition.pdf

ⁱ General Assembly resolution S-20/3