Substance Abuse in Somalia

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Introduction

In the Somali Democratic Republic there are 23 Regional Hospitals and 52 District Hospitals. The available beds are roughly 4500. The total number of physicians practicing in the country is around 500.

Development of Primary Health Care (PHC) is a major strategy in the health care policy of the Government. There is a national PHC office in Mogadishu. This has to supervise and coordinate PHC activities at all levels. The Regional PHC Coordinator supervises the District PHC Coordinators who supervise the first level of health facilities. The PHC unit serves 5-10,000 persons while the health post serves 3-4,000 people.

Hospitals at regional and district levels contribute to PHC as referral units for medical care.

By law all the needed drugs which cannot be produced in the country should be imported by the State Agency for the Importation and Manufacturing of Drugs (ASPIMA). Part of imported drugs are channeled to the public sector Government Central Medical Store (DCMS) and main hospitals of Mogadishu. Requisitions for pharmaceuticals and sanitary equipments come from hospitals all over the country to DCMS. Expedition of supplies are directly provided. These drugs are intended for hospitalized patients and are given free of charge.

In the private sector, pharmacies are organized in cooperatives. A presidential law in 1972 abolished the sole ownership of pharmacies. Drugs intended for this sector are directly purchased by pharmacies from ASPIMA Mogadishu or its regional branches.

In 1965 there were in Mogadishu two private pharmacies with qualified expatriates in charge and several retail drug stores operated by laymen (Orphanides 1965). Today no distinction is made among pharmacies. The number of licenced pharmacies in Mogadishiu is approximately 300. Only 10% of these are operated by qualified pharmacists, the rest being in the hands of laymen. This causes serious constraints. All drugs, from antibiotics to psychotropic substances can be dispensed without medical prescription at the patient's request or following the advice of the unqualified dispenser. This is source of serious health and social problems.

Substance Abuse

The Somali population being prevalently nomadic and almost 100% of Islamic faith, has been for centuries almost untouched by widespread and serious problems of alcoholism and drug dependence. Even the use of stimulants such as tea and coffee, which today are widely used throughout the country, were limited to particular areas mostly on the coast.

a. *Tobacco*

Smoking and other forms of tabacco use were once limited to some coastal communities. Tobacco consumption has steadily increased in the last decades. Cigarette smoking is at alarmingly high levels in all settled communities. The habit is strongly growing among children who are also heavily involved in the retail trade of cigarettes.

b. *Khat*

Khat is a stimulant with great social and medical effects. This drug consists of the leaves of *Catha edulis Forsk* which are chewed. Khat chewing started and for centuries remained confined in the north western part of the peninsula. The widespread use of the drug is a phenomenon of the last few decades.

The problems of khat in Somalia have been thoroughly described (Abdullahi S. Elmi 1983, 1984).

In consideration of these serious problems, on the 18th of March 1983, the Government of Somalia passed a law prohibiting the cultivation, importation, marketing and use of khat in its territory.

The 22nd WHO Expert Committee on Drug Dependence which met in Geneva in April 1985, found that cathinone and cathine, the two main compounds of khat, met the criteria for control under the Convention on Psychotropic Substances 1972 and recommended their control (WHO Technical Report Series 729).

The Economic and Social Council of the U.N. in its meeting of February 1986 endorsed this recommendation and definitely placed the two compounds under international control.

c. *Sniffing glues*

Glue sniffing is increasing among adolescents of cities and towns. The phenomenon is notably growing in Mogadishu. It involves mainly children of poor families and the homeless. The continuous increase of glue sniffing is due to the rapid and disorderly urbanization which is typical of many developing countries. This poses a serious problem. The abused substances are plastic cement glue, spray liquid, gasoline, nail polish etc. No epidemiological studies have been carried out, therefore the extent of the problem is not accurately defined.

d. *Cannabis*

Cannabis has a relatively low prevalence in Somalia. Its use is traditional among certain communities of coastal cities. Today's consumers are often young people. The drug is prohibited but it is introduced illegally. Small plantations of cannabis are from time to time discovered by the police and destroyed. After khat cannabis

is the drug most seized by the police especially in the form of marijuana. The increasing seizures of the drug in the last years, is probably a sign of its growing prevalence.

e. *Alcohol*

Alcohol is not illegal in Somalia. Some alcoholic beverages (spirits), are also produced in the country. Most of the consumed alcohol is however imported. Alcohol consumption is not yet a serious problem because of some limiting factors. First of all the large majority of the population being observant muslims regard alcohol drinking as highly despicable. Secondly, alcohol prices are so high with respect to the average income of the population, that it is a luxury that only few can afford. However, because of changes in society, alcoholism may be a problem of the future. Alcohol consumption seems to have slightly increased after khat prohibition (Abdullahi S. Elmi 1984).

f. *Other drugs*

In the last few years, the use of some dependence inducing drugs has markedly increased. Prominent among these are the benzodiazepines especially *diazepam*. The use of diazepam is increasing among the young generation. Unfortunately there are no restrictions in dispensing these drugs. Many people consider and call them « sleeping pills » and make daily use of high doses. The use of these drugs is encouraged by their easy availability and cheap prices in the pharmacies. *Ephedrine* is also highly abused and easily obtained in the pharmacies.

Some people, especially in the southern part of the country smoke *Datura metel*. Another traditional substance of abuse is a fermented liquid obtained from a palm tree. It is used in the Juba Valley and locally known as « *shalabow* ».

Some episodes of *opium* and *cocaine* seizures have also occured. The general belief is that these drugs were not for use in Somalia but were in transit to Europe and the Middle East.

Existing Laws and their Enforcement

Currently there are two laws for the control and regulation of dependence forming drugs.

The first law enacted in March 1970 regulates the production, use, and trade of narcotics. This law provides for the punishment of all those who without having the necessary authorization buy, sell, transfer, import, export, produce, transform or keep the substances or preparations included in the list of narcotic drugs. Recent amendments give the right to judge on cases on narcotics to the Security Court.

This law needs some improvements and better enforcement.

The second law is the khat law. This law provides for heavy punishments which go up to 10 years inprisonment and heavy fines. This law is strongly enforced.

Suggestions for Prevention and Control of Substance Abuse

In many developing countries there is not sufficient awareness of the gravity of drug related problems.

As in all health problems prevention is the best weapon to tackle drug abuse problems. In some countries, including Somalia, the problem has not the seriousness reached in countries of other geographic areas. Nevertheless it has a growing trend. In such countries the problem should be prevented by bringing to the attention of the population the hazards of drug abuse and dependence.

In Somalia stronger and more specifically oriented interventions relating to change in life style and certain behavioural attitudes are necessary. This could be achieved by:

1) incorporating information on drug related problems in the curricula of intermediate and secondary schools. Since drug dependence is more a problem of adolescence and young people, better knowledge and greater awareness of hazards of drug abuse will certainly help to avoid drug problems;

2) using properly the mass media to promote community awareness and understanding of the health and social dangers of drug dependence;

3) training CHWs and other health personnel to recognize drug related problems in the community and advicing concerned people or refer them to proper centres. CHWs should know how to cope with certain situations and how to get community involvement to help toxic-dependents;

4) improving prescription and delivery systems of psychoactive drugs. Education of physicians, pharmacists and other health personnel on the optimal use and management of these substances is essential. In Mogadishu for example, less than 10% of the pharmacies are run by pharmacists. No record of delivered drugs is kept; physicians very often neglect to limit prescriptions of psychoactive substances to appropriate conditions. All kinds of drugs are dispensed without prescription and by non qualified people. All this calls for immediate reformation;

5) limiting the quantity of imported narcotic and psychotropic drugs to the minimum essential;

6) enhancing the recreational activities by potentiating sport facilities and competitions, encouraging artistic activities and increasing social events. This has shown to be efficacious in Somalia. In fact after the banishing of khat in Somalia, sport grounds and entertainment places were overwhelmed with people;

7) limiting the accessibility to alcohol and certain drugs by reducing the availability and increasing the relative prices. Also punishments for driving under drug and alcohol effects should be made more severe;

8) undertaking research on motivations towards certain behaviours in the community and identifying the risk groups. Combined interventions of health workers, community and religious leaders may help overcome the spread of such behaviour.

Some of the above described measures require action at national level. Nevertheless local communities can organize themselves against drug abuse provided there is sufficient awareness of the seriousness of the problem and its impact on health and social productivity.

Conclusion

Somalia underwent an interesting experience by heavily suffering the problem

of khat chewing and subsequently tyring to overcome it by banishing its use, trade and cultivation.

The existing law against khat and the supporting structure of control are successfully meeting their objectives. Khat consumption dropped by at least 70% especially in the southern regions. The reasons of success are due to:

a) strong enforcement;

b) mass education and increased awareness of the health, social and economic hazards of khat;

c) the high prices due to the collapse of khat supplies following its prohibition.

The use of other drugs is heavily on the increase.

It is highly desirable at this moment to start research aiming at specification of the motivations for use of drugs and identification of the risk groups.

The prevailing trend of increase of drug related problems should be opposed by prevention.

Coordinated actions of health workers, community and religious leaders can get positive results.

The profession of pharmacists should be reevaluated and strict regulations for the dispensing of all the non-OTC drugs in accordance with international standards should be introduced.

Education of pharmacists, physicians and other health personnel, enhancement of creative and recreational activities, enforcement of the existing laws, keeping high the community awareness through mass media, teaching the problem of drugs at schools are crucial steps for the prevention of drug dependence problems.

References

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