UNITED NATIONS
Office on Drugs and Crime

PROBLEM DRUG USE IN PAKISTAN

Results from the year 2006 National Assessment

UNODC's Global Assessment Programme on Drug Abuse (GAP) improves the global information base on patterns and trends in drug consumption through supporting Member States to build the systems necessary for collecting reliable data to inform policy and action; encouraging sharing of experiences and technical developments through regional partnerships; and encouraging the adoption of sound methods to collect comparable data.

For further information visit **www.unodc.org**

UNITED NATIONS
Office on Drugs and Crime

Ministry of Narcotics Control

Anti Narcotics Force

PROBLEM DRUG USE IN PAKISTAN

Results from the year 2006 National Assessment

2007

Acknowledgements

The 2006 National Assessment on Problem Drug Use was conducted under the auspices of the Government of Pakistan's Ministry of Narcotics Control, the Anti Narcotics Force, and the United Nations Office on Drugs and Crime. The technical support in the design, implementation, and data analysis of the study, as well as for writing the report was provided by UNODC's Global Assessment Programme on Drug Abuse (GAP). The Global Assessment Programme on Drug Abuse has been supported during the period of the assessment by the Government of Sweden. UNODC would also like to thank the Narcotics Affairs Section of the Embassy of United States of America in Islamabad for funding the training of field workers.

The success of the study relied on the goodwill and efforts of a large number of individuals whose participation made it possible to implement the assessment on such a large scale. These individuals include not only the research teams in the 23 districts of the country but also those who facilitated and participated in the study at the different levels. The latter include the government functionaries and representatives of drug treatment facilities in each district who gave access to their information. Most importantly, the study would not have been possible without the active participation of the large number of problem drug users and key informants, who agreed to be interviewed. This report acknowledges in particular the individuals listed below whose support and contributions resulted in the successful implementation of the study.

1. Government of Pakistan

Ministry of Narcotics Control
Mr. Ismail Hassan Niazi, Secretary
Mr. Hassan Mahmood, Senior Joint Secretary

Anti Narcotics Force
Major General Khalid Amir Jaffery, Director General
Mr. Anwar Hafeez, Director, Drug Abuse Prevention Resource Centre

2. UNODC

Country Office for Pakistan
Mr. Vincent McClean, Representative
Dr. Nadeem ur Rehman, Programme Officer

Dr. Farrukh Ansari, Deputy Programme Coordinator
Ms. Nabeela Nisar, Programme Assistant

Global Assessment Programme on Drug Abuse

Mr. Kamran Niaz, Epidemiological Adviser, Regional Office for Central Asia, Tashkent
Ms. Katri Tala, Associate Expert, Vienna
Ms. Sevara Karimova, Research Assistant, Regional Office for Central Asia, Tashkent

3. Research team

Fieldwork Supervisors

Mr. Salman Shahzad (Sind)
Mr. Shahzad Akhtar (Central Punjab)
Mr. Syed Kashif Ali Bokhari (Southern Punjab)
Mr. Ajab Khan (Baluchistan)
Mr. Nasir Khan (North West Frontier Province)
Mr. Iftikhar Ahmed (Rawalpindi)

Fieldwork Coordinators

Mr. Tahseen Ahmed (Sind)
Mr. Ayaz Ali Khan (Punjab)
Mr. Bashir Alam Gandapur (Baluchistan)
Mr. Fazal-e-Habib (North West Frontier Province)
Mr. Arshad Mahboob Hamzai, Rawalpindi

Interviewers

Mr. M. Baligh-ud-Din, Mr. Saeed-ur-Rehman, Mr. Kiffayatullah Khan, Mr. M. Bilal, Ms. Romana Jabeen, Ms. Sumera Fareed, Dr. Ariffullah, Mr. Abid-ur-Rehman, Mr. Faisal Jamil, Mr. Farooq Ahmed Afridi, Mr. Gulnawaz Khan, Mr. M.Amin, Mr. Maqsood Ellahi, Mr. Tauqeer Ahmed, Mr. Tajamul Hussain, Ms. Elizebeth Nadeem, Ms. Syeda Taskeen Zahra, Dr. Saadia Iqbal, Mr. Ramzan Ahmed, Mr. Umar Draz Bhatti, Ms. Sana Shafiq, Ms. Saman Khan, Mr. Farhan Ahmed, Mr. Sajid Iqbal Alyana, Mr. M. Nazeef, Mr. Asad Iqbal Chatta, Ms. Rabia Saeed, Mr. M. Asgher, Mr. Ghulam Murtaza, Mr. Ghazi M. Nadeem, Mr. Asif Masih, Mr. M. Afzal, Ms. Zaib-un- Nisa, Mr. Yasir Barkat Ammar, Mr. Nasir Abbas Naqvi, Mr. Qaisar Nawaz Brohi, Mr. Ghulam Umer Panhyar, Mr. Riaz Hussain, Mr. Inam Ali Waggan, Mr. Pasand Ali Khoso Dr. Qasim Brohi, Ms. Syeda Qurat-ul- Ain, Ms. Farheen Siddique, Mr. Mukkarum Beg, Mr. Zahid Sindhi, Mr. Wajid Ali, Mr. Khurram Mehdi, Ms. Zaiba Anjum, Mr. M. Dawood, Mr. M. Hashim Agha, Mr. M. Azam, Mr. Naseer Ahmed, Mr. Haroon Rashid, Mr. Syed-ur-Rehman

Contents

FIGURES

TABLES

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANF	Anti Narcotics Force
ARQ	Annual Reports Questionnaire
ATS	Amphetamine type substances
CND	Commission on Narcotics Drugs
DAPRC	Drug Abuse Prevention Resource Centre
DIC	Drop in Centre
GAP	Global Assessment Programme on Drug Abuse
GOP	Government of Pakistan
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
ILO	International Labour Organization
MARA	Most at risk adolescents
MNC	Ministry of Narcotics Control
NACP	National AIDS Control Programme
NGO	Non Governmental Organization
NWFP	North West Frontier Province
OST	Opioid Substitution Therapy
SDS	Severity of Dependence Score
SES	Socio economic status
STD	Sexually transmitted disease
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Executive Summary

The National Assessment of Problem Drug Use 2006 was conducted in 23 districts to update information on the patterns and trends of problem drug use in Pakistan. For the purposes of this study problem drug users were considered as those who had used opioids[1], i.e., heroin, opium or other opiates[2], regularly during the past 12 months including the past 30 days. Approximately 4000 problem drug users were interviewed for the assessment. Additionally 1,150 key informants were interviewed across the country about their perceptions of drug abuse problems, and their observations of local patterns and trends of drug abuse.

Prevalence of opioid use

The prevalence of opioid use in Pakistan is estimated at around 0.7 (95% CI 0.4 - 1) percent of the adult population or around 640,000[3] opioid users. Similarly, the prevalence of injecting drug users is estimated to be around 0.14% of the adult population with corresponding estimates of around 130,000 injecting drug users in the country. An alarming trend is that the estimated number of injecting drug users in Pakistan has doubled since 2000. The highest prevalence of opioid use is in Baluchistan, followed by NWFP, Punjab and Sind. However in terms of absolute numbers with an estimated number of 200,000 the highest number of opioid users is in Punjab[4].

	Opioid Prevalence	95% CI	IDU Prevalence
NWFP	0.7	0.5 – 0.9	0.06
Punjab	0.4	0.2 – 0.6	0.2
Sind	0.4	0.2 – 0.6	0.2
Baluchistan	1	0.8 – 1.2	0.1
Overall Pakistan	0.7	0.4 – 1	0.14

Table 1: Prevalence of opioid use in Pakistan

[1] Opioid is a generic term applied to opiates and their synthetic analogues with action similar to those of morphine, UNODC, Terminology and Information on Drugs, Second Edition, 2003
[2] Other opiates refer to morphine, codeine, pentazocine, buprenorphine or other licitly produced narcotic analgesics misused in Pakistan
[3] Based on 91 million adult population (15 to 64 years): Source: UN Population Division Data
[4] Detailed information on prevalence of opioid use in section “8 Conclusions and implications”

Social and demographic profile of opioid users

The mean age of opioid users was 35.5 years. Countrywide up to one third of drug users were between 31 to 40 years old, while in Punjab and Sind up to 40 percent of the drug users were between 16 and 30 years old. The majority of opioid users (72 percent) were still living in their homes. However, substantial numbers of drug users were living on the streets. While 38 percent had no education, 25 percent had up to primary and one third up to high school education. Around one third of the opioid users were unemployed, while the remainder had been supporting them selves through casual work (39 percent), or had been working part or full time (15 and 7 percent respectively). Therefore not all opioid users are entirely dysfunctional.

Drug use patterns

The majority of opioid users (77 percent) were using heroin, while the remainder were using opium and other opiates. Most of the opioid users were multiple or poly drug users, i.e., they were using more than one substance at a given time or during a day. Therefore many opioid users were using tranquilisers, antihistamines, and other opiates along with heroin as their primary drug of abuse. On average the opioid users had been using heroin regularly for 10 years, benzodiazepines for 9 years and other opiates for 7 years.

Injecting drug use and sexual risk behaviours

A substantial proportion (29 percent) of opioid users reported having injected drugs in their lifetime, the large majority of these were also currently injecting. A high frequency of injecting was observed, as most of the drug users[5] had been injecting daily and 2 to 4 times a day in the past 6 months. Drugs that were mainly injected include heroin, other opiates, benzodiazepines or a combination of these substances. Also a considerable sharing of injecting and other paraphernalia was reported among injecting drug users. The majority of injecting drug users considered it easy to obtain syringes for injecting. The main sources of obtaining syringes were cited as pharmacies, drug using friends and even local drug dealers. Up to 75 percent of drug users had had sexual intercourse in their lifetime. The person with whom they had sex the first time varied between spouse, boy or girl friend and sex worker. Many drug users reported having multiple sex

[5] The terms drug user, problem drug user and opioid user have been used interchangeably in this report.

partners in the past six months with whom they reported having unprotected sex. Many of their sex partners were reportedly also opioid users.

Treatment and other services

Nationally, up to one third of opioid users, 52 percent in NWPF and 47 percent in Sind had received treatment for their drug problems, while 17 percent had been treated for opioid use in the past 12 months. Most of the opioid users had been treated for dependence on heroin followed by opium, cannabis, other opiates and benzodiazepines. The mean age at first ever treatment for drug dependence was 30.15 years, implying that the drug users regularly used heroin for 7 years, opium for 9 years, other opiates for 12 years, and injected drugs for 4 years before they sought assistance for their drug dependence. The opioid users reported multiple treatment attempts in the various types of treatment services available.

The key informants, in their responses, considered government run treatment facilities as more accessible but considered them less effective than the ones being run by NGOs. Overall, the key informants did not consider most of the services for drug treatment to be very effective. Based on these responses and given the high rate of recidivism, the services provided for drug dependence in the different sectors (government, NGO and private) need to be assessed for their quality, effectiveness and efficacy in providing a continuum of care and meeting the diverse needs of the clients.

The majority of opioid users (70 percent) also considered it difficult to access the treatment services available in the country. They expressed an unmet need for treatment of drug dependence in the course of their drug using career. The majority of drug users mentioned that the main reason for not being able to get treatment was that they could not afford to pay for it.

Services for prevention of HIV/AIDS

Outreach interventions for prevention of HIV are not available in all the districts in the country; however up to 18 percent of the drug users were aware of local outreach workers in their area, while 14 percent were aware of the existence of drop in centres (DIC). Out of these around 70 percent had received services from an outreach worker. In NWFP and Sind most of the drug users had contact with an outreach worker 2 to 3 times

a week, while in Punjab most of them reported daily contact in the past 6 months. Similarly, up to half of the drug users who were aware of drop in centres had also utilised the services they offered. Drug users in the districts of Sialkot, Larkana, Karachi, Lahore and Hyderabad had a high frequency of contacts with drop in centres.

As gathered from the drug users' responses, in Punjab the outreach services are more organised, whereas in Sind the drop in centres or stationary services for prevention of HIV are perceived to be better organised. Additionally, many drug users had not utilised the stationary services for prevention of HIV as they were perceived to be difficult to reach, had complicated rules or procedures, or the drug users were afraid of being registered or being caught and harassed by the police if they went there.

Drug related problems

Up to 38 percent of drug users had been arrested at least once in their lifetime on drug related charges. On average the problem drug users were arrested 7 years after initiating drug use, and after 3 years of regular heroin use. The drug users, on average had been arrested around 4 times for drug related offences and spent up to 2 years in jail. Up to half of the drug users had also been arrested for other criminal offences such as theft and petty crimes.

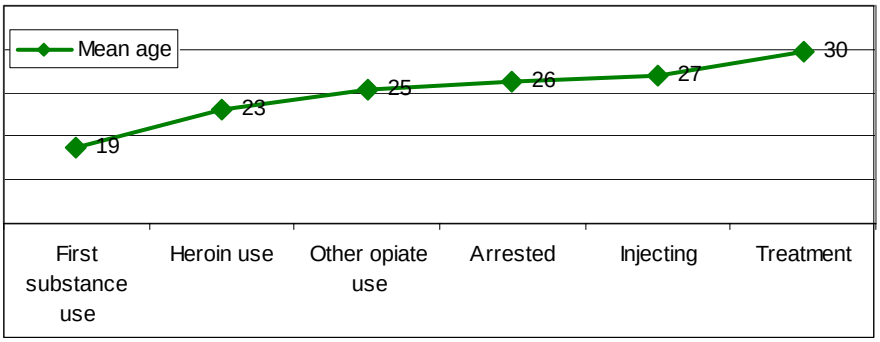


Figure 1: Progression in drug careers

Many drug users reported facing serious health and social problems. Around 8 percent reported having HIV infection, while 18 percent reported having Tuberculosis and 11 percent reported being infected with HCV. The mean score on Severity of Dependence Scale (SDS) among the opioid users was 8.3, indicating a population with need for outreach interventions, and treatment and care to address their drug dependence and other related problems.

Drug use trends

Among the opioid users, cannabis was most commonly the first substance ever used, usually at an age of around 18 years. However, many drug users had also initiated their substance use with other drugs such as alcohol, opium, heroin, benzodiazepines, opiates, tranquilisers, and inhalants.

The key informants also considered cannabis as the most commonly used substance, followed in descending order by sedatives and tranquilisers, heroin, opium and other opiates. Key informants also considered injecting drug use as a common phenomenon among drug users. Furthermore, most of the key informants considered that there had been a substantial increase in the use of cannabis and sedatives and tranquilisers in the past few years. While key informants in NWFP considered that there was some decrease in the use of heroin, opium and other opiates in their province, in the remaining provinces key informants had observed an increase in the use of these substances.

Both the key informants and drug users considered opioids, especially heroin as the drugs causing most harm in the society as well as to individuals. The use of cannabis and other substances was also considered to be causing substantial harm. Ecstasy is considered as an emerging drug especially among the youth belonging to higher socio-economic groups.

Important considerations

Based on the findings of the national assessment, some important issues that arise and need to be addressed in Pakistan by different stakeholders as a priority are:

- There is a population of opioid users, mostly in their mid thirties, who have a history of over 10 years or more of regular opioids use, are also poly drug users, and have had multiple attempts at treatment for their drug dependence.
- There is an increasing population of problem drug users who are injecting drugs, a population that has doubled in the last 5 years or so. Coupled with this is an increasing population of problem drug users with psychiatric and other co-morbidities such as HIV, Hepatitis C, and Tuberculosis.
- Moreover, there is also a younger population of opioid and inhalant users whose needs are to be addressed.

- There is an unmet need for treatment of drug dependence among the problem drug users. The overall availability of treatment services, as well as the range and quality of interventions provided by the existing treatment services are not considered adequate to meet the challenges or the diverse needs of drug dependent persons.
- Use of cannabis type substances continues in large segments of the society along with increasing use of inhalants among adolescents who are primarily street based.
- There is an increasing use of opiates – morphine, codeine, pentazocine, buprenorphine, etc., as well as tranquilisers and sedatives which are being obtained through a black market as well as from pharmacies, ostensibly without prescriptions. Apparently, the dispensation or sale of these controlled substances through the pharmacies is unregulated.

Priority areas for prevention, treatment and rehabilitation

Programmes for the prevention of drug use need to focus on enhancing the protective factors and help reduce the risk factors that promote drug use among adolescents and youth in different settings. Primary prevention programmes therefore need to consider the following three dimensions.

a) Prevention in schools through teaching of "*personal, social and health education*" programmes, that focus on health promotion. Such programmes are based on developing links between knowledge, value and skills and empower students with the appropriate means, information and skills to take greater control of their lives and improve their own health. School based life skills programmes that have corresponding programmes for the parents and families, and encourage them to take better physical and psychological care of children, have proven to be more effective.
b) Community centred prevention aiming at the prevention of substance use such as inhalants, cannabis and other drug use among out of school youth. For instance peer to peer programmes that are lead by young people in which youth can be involved in healthy activities and community service; programmes that would help develop prevention skills within the context of health promotion and healthy behaviours among youth.
c) Prevention programmes for more-at-risk adolescents (MARA) such as those in child labour or living on the streets. These programmes should include

interventions addressing the health and social needs and problems – including drug use and reproductive health – of these at risk adolescents.

For improved delivery of drug dependence treatment services, there is need to review the scope, coverage and delivery of these services to meet the changing and diverse needs of drug dependent persons, especially those with co-morbidities such as HCV, HIV and TB. In this context, it is especially important to consider the introduction of opioid substitution therapy (OST) for opioid dependent persons meeting certain criteria. Opioid substitution therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and societies at large by reducing opioid use, associated deaths, HIV risk behaviours such as injecting drugs, and criminal activity[6]. The coverage and delivery of outreach interventions needs to be expanded for prevention of HIV, especially injecting and sexual risk behaviours, particularly in the districts with high prevalence of injecting drug use such as Lahore, Sialkot, Okara, Kohat, and Karachi.

In order to respond to the increasing use of psychotropic substances a major initiative led jointly by the Ministries of Narcotics Control and Health and with the involvement of other stakeholders, should be to regulate the import, production, supply and sale of psychotropic substances at various levels, but most importantly to regularise their sale by requiring them to be available only through traceable prescriptions.

There is a need to foster research on drug abuse in the country. This could be addressed by developing partnership and linkage with national research institutions and university departments of social and behavioural sciences. In order to continue monitoring the drug abuse situation consideration should be given to establishing a national drug abuse information system. This monitoring system, based on multiple indicators, could provide ongoing information on the patterns and emerging trends of drug abuse. Such an information system could also include indicators to monitor the quality and effectiveness of services and other responses to drug problems at various levels.

[6] WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention, 2004

1

Introduction

In 1998 the member states at the United Nations General Assembly Special Session on World Drug Problems (UNGASS) adopted the "Declaration on the Guiding Principles of Drug Demand Reduction" and a "Political Declaration", in which they recognised “demand reduction as an indispensable pillar in the global approach to countering the world drug problem”. The member states also committed to “introducing in national programmes and strategies the provisions set out in the Guiding Principles of Demand Reduction, to work closely with UNDCP[7] to develop action oriented strategies to assist in implementation of the Declaration”. However, a critical prerequisite to the development of effective demand reduction responses is the existence of a sound knowledge base on the extent and nature of drug problems. Such a knowledge base is also essential for the assessment of progress in respect to the time bound goals of the Political Declaration. A sound understanding of the nature of the drug abuse problem is therefore essential for both the effective targeting of responses and for assessing their impact over time.

The last national assessment on problem drug use in Pakistan, which was conducted in 2000,[8] estimated the prevalence of opioid use as 0.8 percent of the adult population or about 500,000 individuals. The assessment showed that cannabis type drugs such as hashish were the drugs most often reported to be commonly used, followed by heroin, alcohol and tranquilisers. The proportion of opioid users who were injecting drugs was reported to be around 19 percent. While there were reported variations in the type of drugs injected, the commonly injected substances were heroin, opiates and tranquilisers. High levels of injecting risk behaviour – sharing of needles, use of unclean needles, syringes and other injecting paraphernalia among the injecting drug users was also reported in 2000.

[7] The Office for Drug Control and Crime Prevention (UNODCCP) became the Office on Drugs and Crime (UNODC) on 1 October, 2002. The Office on Drugs and Crime includes the United Nations International Drug Control Programmes (UNDCP)
[8] UNODC, Drug Abuse in Pakistan: Results from the 2000 National Assessment, 2000

In 2005 the National AIDS Control Programme (NACP) conducted HIV Second Generation Surveillance[9] which also looked at injecting drug users and reported a high level of injecting and sexual risk behaviours among them.

Considering that the Government of Pakistan was to embark on developing a new Master Plan for Drug Control covering 2007 – 2011, it was imperative that updated information on prevalence, patterns and trends of problem drug use be made available. This information would enable the national counterparts develop a plan based on the evidence, prioritise the interventions and address the needs accordingly,

Objectives of the national assessment

The two main objectives of the national assessment on problem drug use in Pakistan were to provide the policy makers and programme planners with:

- Updated information on the extent, pattern and trends of problem drug use, including injecting drug use and related social and health problems
- Recommendations on key intervention strategies including the need to scale up or diversify current interventions to meet the heath and social needs of problem drug users.

Specifically, the assessment attempted to address the following questions concerning problem drug use in Pakistan:

1. What groups are more vulnerable to problem drug use? (socio demographic profile of problem drug users)
2. What is the prevalence of injecting, sexual and related risk behaviours and other problems among these drug users – including health and social problems, within community settings?
3. What are the characteristics, patterns and recent trends of problem drug use in the country? (determine changes in drug use patterns since 2000)
4. What is the level of awareness, perceived accessibility and utilisation of drug abuse treatment, and services for the prevention of health and social consequences of problem drug use?

[9] NACP, HIV Second Generation Surveillance in Pakistan, National Report Round 1, 2005

5. What are the key interventions that need to be up-scaled or diversified in order to assist problem drug users in treatment and community settings?

The assessment comprised of three main components, i.e., a) study of problem drug users in community settings, b) key informants study, c) collection of background and benchmark data for prevalence estimation.

Problem drug users

Problem drug users for the purpose of this study were considered as those who had used opioids, i.e., heroin, opium or other opiates such as codeine, morphine, pentazocine or buprenorphine, etc., regularly, at least in the past 12 months, as well as the last 30 days, and would have experienced problems (medical, social, legal, etc) as a result of their drug use.

Key Informants

Key informants are those individuals who, by virtue of their role or community position, can potentially provide relevant information on drug using patterns, trends, networks, community perceptions of the associated problems and can suggest interventions[10]. The following occupational groups were included for interviews under the key informants' study with the purpose of collecting information on the patterns and trends of drug abuse as well the key informants' perception of the problems:

- Psychiatrists and drug dependence treatment experts
- General practitioners
- NGO representatives and social workers
- Community leaders such as local councillors
- Community outreach workers
- Police and other law enforcement officials
- Recovering addicts

[10] UNODC, Drug Abuse Rapid Situation Assessments and Responses, UNODC Guidelines 1999

Background and benchmark data

The background data consisted of national, provincial and district population estimates, along with breakdown by gender and age distribution. The benchmark data included drug users who were treated in the preceding years in the various treatment centres nationally, as well as those who had been arrested for drug related offences in the past 12 months. All of this data was then used in estimating the prevalence of opioid use in each district, province and nationally. In order to conform to World Drug Report and other UN publications, the population estimates from the UN Population Division data was used for estimating prevalence of opioid use.

Geographical coverage and methodology

In order to build a comprehensive picture of problem drug use in Pakistan, the assessment was conducted in 23 districts. The provincial distribution of the districts where drug users and key informants were interviewed is as following:

1. **NWPF**[11]: Bannu, Chitral, Haripur, Kohat, Peshawar
2. **Punjab**: Dera Ghazi Khan, Faisalabad, Lahore, Multan, Okara, Rawalpindi, Sargodha, , Sialkot
3. **Sind**: Hyderabad, Karachi – districts South, East and Central, Larkana
4. **Baluchistan**: Pishin, Quetta[12]

In addition to these districts, key informant interviews were also held in Attock, Loralai and Qilla Abdulla districts.

Within each district the main city, along with smaller towns or rural locations, were included for interviews with problem drug users and key informants. An arbitrary sample of 200 problem drug users was interviewed in each district – with 100 respondents from the main city and the remainder from the adjoining rural areas or towns of the district. This made a total of 4,000 problem drug users interviewed nationally. Out of these, 28 percent of the problem drug users were interviewed in NWFP, 44 percent in Punjab, 17

[11] In the original study design, a central district such as Mardan or Charsada was proposed, which was not included due to other considerations – and therefore information from this part of the NWFP province is missing

[12] In Baluchistan, originally Turbat instead of Pishin was proposed to have a broader picture of this province

percent in Sind and 11 percent in Baluchistan. Similarly a sample of 50 key informants was assigned to each district, making the total sample of 1150 key informants.

Sampling methodology and sample size

The target group for the assessment were problem drug users that are considered as hidden populations, i.e., because of the illicit nature of their behaviour, they can not be sampled through conventional population based probability sampling methods. Therefore, a snowball sampling methodology[13] was utilised with the aim of achieving a sample that was diverse and to some extent representative of the opioid users in different parts of the country. The particular snowball sampling method also ensured that a broader and more heterogeneous sample of drug users, meeting the study criterion, would be recruited and interviewed. In the snowball sampling new cases are recruited through a process of onward referrals from known cases. Each known case is then asked to nominate 3 to 5 other drug users, out of which one is randomly selected for the interview. In this way the chains are developed ensuring that diverse waves of the chains are followed in each location.

Following the above guidelines, each field worker in his or her area, did an initial mapping of the district to identify the locales where problem drug users were more likely to be found. After the mapping exercise the total quota of drug users to be interviewed in each district was equally distributed within the mapped areas. Thus the interviews with opioid users in these locations were conducted.

The study team in each province comprised a fieldwork coordinator, nominated by ANF, and an experienced researcher as fieldwork supervisor. In Punjab due to the number of districts to be covered, the province was divided between Southern and Central Punjab. In each district two to four field workers were employed. All in all, 54 field workers all across the country conducted interviews with 4000 problem drug users and over a thousand key informants. The entire study team was trained in a five days training workshop which covered the study objectives, familiarisation with the study instruments, field work procedures – mapping, sampling and interviewing techniques and other logistic arrangements.

[13] Council of Europe, Pompidou Group, Handbook on snowball sampling, 1997

Questionnaire development

The questionnaires, broadly based on earlier UNODC Global Assessment Programme assessments, were developed by the GAP Regional Epidemiological Adviser and were adapted in Urdu by a process of translation and back translation. These were then pre-tested before finalisation and application in the field. Similarly, other instruments such as the daily log sheets and sheets for snowball chain referrals and focus groups guide were also prepared by the GAP Regional Adviser.

Ethical considerations

The participation in the study by key informants as well as problem drug users was voluntary, based on the verbal informed consent of the respondents. At the beginning of each interview a general statement outlining the purpose and scope of the study was read out to the respondents, and subsequent to their consent the interview continued. No monetary incentives were provided to the drug users or key informants for participation in the study. However, where needed the fieldworkers offered tea and refreshments to the drug users interviewed.

Prevalence estimation

In order to estimate the prevalence and number of problem drug users, the multiplier benchmark methodology[14] was used. In its standard application, this methodology uses information about the known size of an identifiable subsection of the target population of drug users and generalises from that subsection to give an estimate of the complete target population by applying a multiplying factor[15]. For example the number of drug users in treatment is known, i.e., 1000 and approximately 1 in 10 drug users is known to have attended treatment in that year. Then the treatment figure of 1000 (benchmark) can be multiplied by a factor of 10 (multiplier) to get an estimate of the total number of 10,000 drug users.

For the purpose of current assessment, two multipliers and benchmarks were used. One was the proportion of opioid users in treatment, i.e., those who were interviewed and said that they had been in treatment in the preceding year with the corresponding benchmark data of the total number of drug users treated for various drugs including

[14] UNODC – GAP Toolkit Module 2: Estimating Prevalence: Indirect methods of Estimating the Size of the Drug Problem
[15] Ibid

opioid dependence in the reference year, i.e., 2005. The other multiplier/benchmark used was the proportion of opioid users who said that they had been arrested for drug related offences and the corresponding benchmark data on arrests for drug related charges in each district. For each district the estimates were calculated separately with each benchmark and multiplier and then a mean value and confidence intervals were calculated for the district. These were then used to estimate prevalence within the adult population, i.e., those between 15 to 64 years old in each district. A mean value for all districts' estimates in a province was then used to extrapolate the estimated number and prevalence of opioid use in each province and in a similar fashion nationally.

It should be noted that all estimates were dependent on the quality of information collected during the field work, especially the available districts and national data on treatment and drug related arrests, and the geographical representation of the selected districts. Therefore, the robustness of the estimates that were calculated depends to a large extent on the reliability of the available benchmark data, and other factors listed above.

2

Background

Pakistan in context

The estimated population of Pakistan in 2005 was 153 million[16,17] with a population density of 166.3 per square kilometres[18]. However, the population density ranges from 358.5 per square kilometres in Punjab, to the sparsely populated areas in Baluchistan with a population density of 18.9 per square kilometre. Of the four provinces of Pakistan, i.e., the North West Frontier Province (NWFP), Baluchistan, Sind and Punjab, more than half of the population resides in Punjab, while 22 percent of population lives in Sind and around 13 percent in NWFP. Baluchistan which is the largest province area wise i.e., comprising 43 percent of the landmass is populated by a mere 5 percent of the country's population[19].

	Total population	Adult Population	Population density/sq km
Pakistan	153,451,973	89,716,995	166.3
NWFP	20,936,572	12,351,895	238.1
Punjab	84,813,010	49,802,234	358.5
Sind	35,257,564	21,126,510	216
Baluchistan	7,820,105	4,413,055	18.9

Table 2: Pakistan's population

Drug cultivation and production

Pakistan is a primary transit country for opiates produced in Afghanistan. The trafficking of opiates into and through Pakistan has increased steadily over the 15 years between 1990 and 2007 – corresponding to the period of considerable increase in Afghan opium

[16] National Institute of Population Studies, Population estimates 2005, Pakistan
[17] The UN Population Division data estimates Pakistan's population at 158 million, 15 – 64 population around 91 million and population density 199 per square kilometres
[18] Government of Pakistan, Statistics Division Population Census Organisation, www.statpak.gov.pk/depts/pco/statistics (accessed 13 June, 2007),
[19] ibid

production. The working assumption of Pakistan's Anti Narcotics Force is that up to 36 percent of the opium and heroin exported from Afghanistan transits through Pakistan en-route to Western Europe, Africa and East Asia. In 2005 the reported total seizures of 24,341 kilograms of heroin in Pakistan were the highest worldwide, and accounted for 27 percent of the world's total seizures[20]. Although to date, there has been little evidence, Pakistan is also a possible transit country for precursor chemicals[21] such as Acetic Anhydride into Afghanistan.

While Pakistan was declared poppy free in 2001, there has been a resurgence of poppy cultivation in the federally administered tribal areas (FATA) within the North West Frontier Province (NWFP) and in Baluchistan – areas bordering Afghanistan. In Pakistan the reported area under poppy cultivation in 2005 (3,145 hectares[22]) was equivalent to only 3 percent of the area under poppy cultivation in Afghanistan, but there is a risk that cultivation in Pakistan could increase substantially – especially as a result of displacement from Afghanistan - unless there are sustained efforts of development in those areas and enforcement of the poppy ban.

Drug abuse and HIV/AIDS

In the year 2000 the annual prevalence of opiate use in Pakistan was estimated at 0.8 percent of the adult population. Pakistan along with the other countries neighbouring Afghanistan, have one of the highest prevalence of opioid use ranging from over 2 percent of the adult population in Iran to around 1 percent in some of the Central Asian countries.

Since the National Assessment on Drug Abuse that was conducted in 2000, there have been visible changes in the patterns and trends of drug abuse in Pakistan. The misuse of licit opiates and other psychotropic substances such as sedatives and tranquilisers has markedly increased, and there has been an emergence of inhalants use among adolescents and street children. There is also anecdotal information that drugs such as ecstasy and cocaine are becoming popular among the upper and upper middle classes of the society.

[20] UNODC, World Drug Report 2007
[21] UNODC, Country Office for Pakistan, Strategic Programme Framework 2007 – 2010
[22] In 2005 the cultivation of opium poppy harvestable after eradication was 2,438 hectares with a potential production of 36 metric tons of dry opium. UNODC, World Drug Report 2007

UNAIDS estimates that with a prevalence of 0.1 percent among adults (aged between 15 and 49 years), there are between 46,000 and 210,000 adult HIV positive cases in Pakistan[23]. Similarly, according to the National AIDS Control Programme's report for March 2007, there were 3,328 confirmed HIV positive cases in Pakistan, of which 27 percent were injecting drug users[24]. These reports suggest that there is currently a concentrated HIV epidemic among injecting drug users in the country. The overall prevalence of HIV among injecting drug users is estimated as 10.8 percent but with variations between cities. The highest prevalence is reported in Hyderabad (25.4 percent), followed by Sukkur (19.2 percent). The reported HIV prevalence among injecting drug users in Lahore is 3.8 percent, in Quetta 9.5 percent and in Peshawar 0.4 percent)[25]. Other studies indicate 23 percent HIV prevalence among injecting drug users in Karachi[26]. The various reports on the HIV/AIDS situation in Pakistan suggest that widespread risk behaviours offer the HIV epidemic scope for future growth, for example the high HIV infection levels among groups of injecting drug users could cross over into other populations, including male and female sex workers[27].

Overall, drug dependent persons have little access to effective treatment services in the country. With a few exceptions the services provided by government-run drug treatment facilities are limited in their range and in many instances comprise only of detoxification or the medical management of acute withdrawal symptoms. The NGOs providing drug treatment facilities in Pakistan also differ in their levels of development and capacity to provide effective services. Generally, NGOs are considered as more receptive to developing new and broader treatment responses and in providing a range of services beyond medical interventions to their clients[28]. However, in most of the NGO run facilities, the staff is often not specially trained. Only a few well established NGO and private clinics offer comprehensive treatment packages including rehabilitation and social reintegration services, but these services are often not easily accessible or are too expensive for the average drug dependent person. Moreover, there is neither monitoring of the quality of services provided nor any studies conducted to determine effectiveness of the interventions provided.

[23] UNAIDS – Pakistan Country Situation Analysis, www,unaids.org (accessed 10 June 2007)
[24] National AIDS Control Programme, HIV/AIDS Surveillance Report, March 2007
[25] National AIDS Control Programme: HIV Second Generation Surveillance in Pakistan 2005,
[26] National AIDS Control Programme/FHI: National Study of Reproductive Tract and Sexually Transmitted Infections - 2005
[27] UNAIDS – AIDS Epidemic Update 2006
[28] UNODC, Study of Drug Treatment Modalities and Approaches in Pakistan,2000 http://www.un.org.pk/undcp/treatment.pdf

In recent years, drug abuse treatment has become more challenging with co-morbidities such as Tuberculosis, Hepatitis C and HIV - resulting primarily from injecting and other sexual risk behaviours among drug users. The need to enhance the skills and competence of drug treatment staff has further increased with the emergence of drugs such as inhalants and amphetamine type substances in Pakistan.

With regard to prisons, there are approximately 90,030 people incarcerated in Pakistan's 89 prisons[29]. It is estimated that approximately 7 percent of Pakistan's prison population has been incarcerated on drug related charges such as drug use, possession of drugs and other similar offences. Many young offenders find themselves in prison because their family members were unable to cope with their drug use and arranged for their imprisonment. Treatment and other interventions for drug users, if available in prisons are limited to medical interventions to bring relief from acute drug withdrawal symptoms. Prison authorities admit that they do not have the capacity to adequately deal with the problems of drug users in prisons.

Status of convention adherence

Pakistan is a signatory to and has ratified the following UN treaties related to drug control:

i. Single Convention on Narcotic Drugs (1961)
ii. Convention on Psychotropic Substances (1971)
iii. Protocol amending the Single Convention on Narcotic Drugs (1972)
iv. Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances (1988).

Legal and institutional framework

The Control of Narcotic Substances (CNS) Act, 1997, effectively covers all aspects of Pakistan's drug control efforts. It deals with cultivation, manufacture, production, trafficking and possession offences as well as with treatment and rehabilitation of drug dependent persons. Chapter VI of the CNS Act deals specifically with treatment and rehabilitation of drug dependent persons, where its different clauses stipulate the following:

[29] Central Jail Staff Training Institute Lahore, Province wise statement of prisoners, 2006

i. Article 52 stipulates that Provincial Governments shall register all drug addicts for the purpose of treatment and rehabilitation while the Federal Government is held to bear the cost for first-time compulsory detoxification or de-addiction of an addict.

ii. Article 53 requests the Provincial Governments to establish as many treatment centres as necessary for detoxification, de-addiction, education, after-care, and rehabilitation, social integration of addicts and for supply of such medicines as are considered necessary for the detoxification of the addicts.

In 1998, the CNS Act was extended to the federally and provincially administered Tribal Areas, but overall implementation of the Act has progressed rather slowly. Up to the present time, no provincial registration of drug users has taken place and the provincial treatment centres referred to in Article 53 are yet to be established.

Pakistan's drug control policymaking and planning is the responsibility of Ministry of Narcotics Control (MNC), which was created in 2003. The Anti Narcotics Force (ANF), which is the implementing agency under the MNC, is responsible for interdicting the production, smuggling, trafficking and abuse of narcotics substances and illicit psychotropic substances. Currently, there are two entities within ANF that deal with demand reduction: the Drug Abuse Prevention Resource Centre (DAPRC) and the Directorate for Planning and Development.

National drug control policies, priorities and plans

The Government of Pakistan, with assistance from UNODC, had prepared a Master Plan for Drug Control covering 1998 to 2003. The financial requirements for the five years duration of the plan were estimated at PKR 2,832 million (approximately US$ 56 million). The Government estimates that only 10 percent or US$ 5.6 million of this amount was made available for implementation of the activities foreseen in the plan. The validity of the plan has now been extended to 2008 and the Government of Pakistan has started work on revision of the plan for up to 2011. In 2005, for the first time, the Government of Pakistan allocated an amount of approximately US$ 1.5 million for interventions such as creating awareness among various population groups, community participation in prevention of drug use, establishment of model drug treatment centres and treatment interventions targeting injecting drug users.

Socio-economic characteristics of Pakistan

Pakistan's human development ranking is 134th out of a total of 177 countries[30]. The life expectancy at birth is estimated at 63 years, while the adult literacy rate (as percentage of ages 15 and older) is 49.9. Although government expenditure on education and health has increased in recent years, the public health expenditure (as percentage of GDP) stands 0.7 percent, with per capita health expenditures as 48 (PPP US$)[31]. Similarly, the public expenditure on education as percentage of GDP was reported as 2 percent. This remains lower than in comparable countries in Asia. Therefore, poor health, illiteracy, and gender and social discrimination are widespread in Pakistan. These conditions are conducive to a societal lack of respect for the rule of law, disregard of human rights, increase in criminality and gross ignorance among the population of their rights, and issues concerning health care. These factors also render a large segment of the population vulnerable to misuse and abuse of drugs including psychotropic substances and to risky practices or behaviours for infections with HIV, Hepatitis C, etc. A number of socio-economic factors such as unemployment, large disparities between income groups, poverty, and urbanisation are generally linked to drug abuse and crime. However, the relationship of these factors to drug abuse problems in Pakistan is yet to be studied.

HDI Rank	134
HDI value	0.539
Human poverty index (HPI – 1) Rank	65
Human poverty index (HPI – 1) value %	36.3
GDP per capita (PPP US$)	2,225
Life expectancy at birth	62.9
Adult literacy rate (% of 15 and older)	49.9
Youth literacy rate (% of 15 – 24)	65.5
Combined gross enrolment for primary, secondary, and tertiary schools (%)	38.4
Public expenditure on education (as % of GDP)	2
Public health expenditure (as % of GDP)	0.7
Private health expenditure (as % of GDP)	1.7
Health expenditure per capita (PPP US$)	48
Physicians per 100,000 population	74
Population with sustainable access to improved sanitation (%)	59

Table 3: Pakistan' Human Development Indicators

[30] UNDP Human Development Report, 2006, Country Tables http://hdr.undp.org/hdr2006/statistics (accessed 10 June, 2007)
[31] Ibid – PPP (Purchasing Power Parity in US$)

3

Patterns of drug abuse

In this section data are presented on the social and demographic profile and patterns of opioids users interviewed in the twenty[32] districts of Pakistan. This section also provides information on patterns of opioids and other drugs used by the respondents.

Social and demographic profile of opioid users

The mean age of opioid users interviewed was 35.5 years which ranged between 14 to 66 years. Within the provinces, the older opioid users were in NWFP and Baluchistan where the mean age was around 37 years and younger drug users in Punjab and Sind – mean ages 34.2 and 33.6 years respectively. Moreover, countrywide up to one third of drug users were between 31 to 40 years old, while in Punjab and Sind up to 40 percent of the drug users were between 16 to 30 years old.

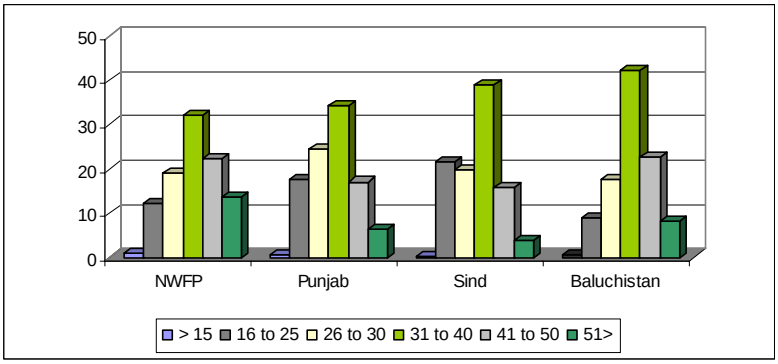


Figure 2: Age groups by province

Compared to the national adult literacy rate of 49.9 percent, countywide up to 62 percent of drug users were literate (38 percent had no education). One quarter of the drug users had up to primary education and more than a third had up to high school, i.e., up to 12 years of education. In Punjab and NWFP significantly[33] more drug users - 43 and 38 percent respectively had up to high school education. Overall up to 3 percent of drug

[32] Key informants were interviewed in 23 districts while drug users were interviewed in 20 districts.
[33] The term significant in the text denotes statistically significant at p<.05 or less

users, more in Punjab, had higher education. This indicates that the literacy level of opioid users in Pakistan is apparently higher than the reported national average.

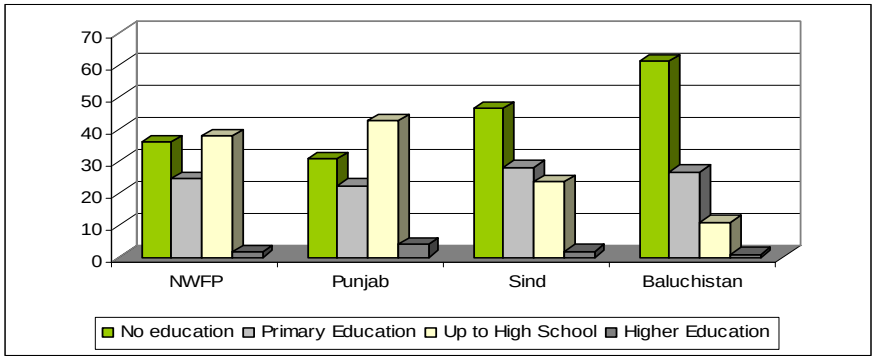


Figure 3: Educational level

While nationally there were no substantial differences between the drug users who were single, i.e., never married or those who had been married, in Sind and Baluchistan significantly higher proportion, i.e., more than half of drug users, were single as compared to the proportion in NWFP and Punjab. Up to 10 percent of the respondents were currently divorced, separated or widowed. In Punjab and NWFP the large majority of drug users (80 and 78 percent respectively) had reportedly been living in their homes in the past six months. Compared to this a significantly higher proportion of drug users in Sind and Baluchistan, 37 and 25 percent respectively, had been living on the streets; a quarter had been living with their parents while one third had been living with their spouses and children – there were no substantial differences within the provinces. In Sind and Baluchistan more drug users were likely to be living with their friends (30 percent) whereas in Sind and Punjab more drug users were likely to be living alone (up to 19 percent). These roughly correspond to the proportion of respondents who had been living on the streets in the past six months

Countrywide 32 percent of the opioid users interviewed had been unemployed in the past six months – the proportion of unemployed drug users was the highest in Sind (47 percent) and lowest in Punjab (24 percent). Up to 39 percent of the drug users had been doing mostly casual work, with higher proportions reported in Baluchistan and Punjab (up to 45 percent); up to 15 percent had been doing part time work while around 7 percent of the drug users interviewed nationally had been working full time in the past six months. This indicates that contrary to popular belief, not all of the opioid users are entirely dysfunctional.

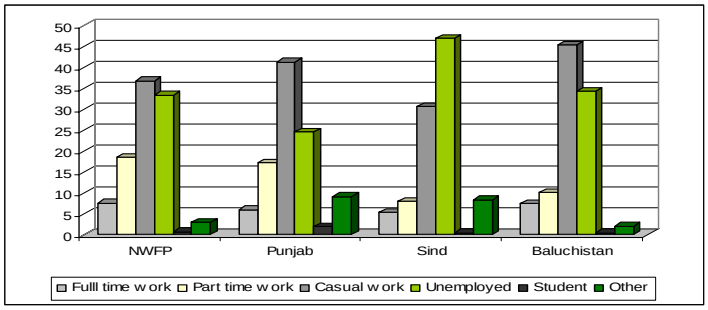


Figure 4: Employment status

Other than earning from employment many drug users also received financial support from their families and friends. A substantial proportion of drug users had additionally supported themselves through theft and begging and a smaller proportion had generated income selling drugs and picking pockets.

	NWFP	Punjab	Sind	Baluchistan
Wages	51%	47%	48%	42%
Family	37%	24%	37%	24%
Friends	33%	18%	25%	18%
Begging	14%	18%	31%	42%
Salary	13%	11%	9%	8%
Theft	11%	10%	26%	14%
Selling drugs	3%	2%	5%	3%
Picking pockets	2%	5%	25%	4%

Table 4: Sources of financial support - 6 months

Drug abuse patterns

All the drug users who were interviewed had been regular opioid users, i.e., they had been using these substances in the past 12 months including the past 30 days. However, the large majority of them had reportedly used a range of other substances along with opioids in their lifetime as well as recently.

Cannabis use

Nationally 87 percent[34] of the drug users nationally, a higher proportion in Baluchistan and Sind, had used cannabis in their lifetime, while the majority of these (78 percent) had used cannabis in the past 12 months as well as recently. The mean age at first use of cannabis was around 18 years. Similarly most of the drug users (86 percent) had used

[34] The number of valid responses for drug use varies for the different drugs as well as for most of the other questions asked during the interview. In this case they were 3576, out of which 87 percent or 3106 had ever used cannabis.

cannabis in the past 30 days, of which up to a quarter had smoked cannabis daily. The remaining had smoked it with lesser frequencies during this period.

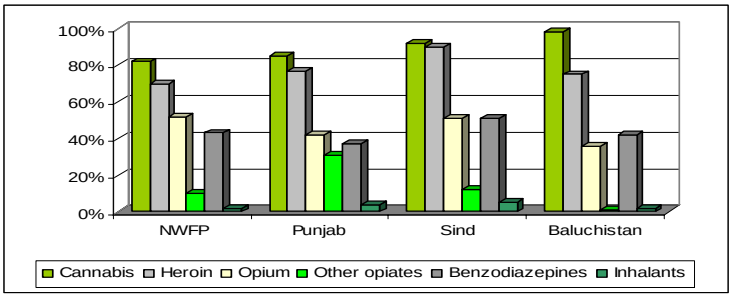


Figure 5: Lifetime use of illicit substances

Heroin use

With regard to heroin use[35] more than two third of the drug users had used heroin in their lifetime – in Sind this was reported as 90 percent. The reported mean age for the first ever use of heroin was 23 years. Up to 90 percent of drug users had used heroin in the past 12 months while more than 90 percent had used heroin in the past 30 days as well. Up to half of them had used heroin daily, while up to a quarter reported using it between 2 to 3 days a week in the past 30 days. While "*chasing the dragon*"[36] has remained the preferred method for using heroin in Pakistan, up to 10 percent of the drug users also reported injecting heroin. The proportion of drug users who had injected heroin was significantly higher in Sind (33 percent) followed by Punjab (9 percent). In the other two provinces a negligible number of drug users were injecting heroin.

Opium use

Up to half of drug users[37] had used opium in their lifetime, whereas up to 68 percent of these, more in NWFP (90 percent) and lesser proportion in Sind (38 percent) had also used it in the past 12 months. In NWFP most of the opium users interviewed were in the Chitral district. Nationally the mean age for first ever opium use was reported as 25 years while in Baluchistan it was around 30 years. Nationally, 80 percent of the drug users reported using opium in the past 30 days as well. Out of these, up to half reported using opium on a daily basis while the remaining had used it less frequently during this period. Oral ingestion of opium was reported as the most common method of using opium (>90

[35] Out of a total of 3,583 valid responses, 77 percent had used heroin in their lifetime
[36] Refers to inhaling the smoke from opium or heroin heated on a foil
[37] These make up to around 1600 drug users interviewed

percent). However, a smaller proportion of drug users especially in NWFP (11 percent) also reported smoking opium.

Opiate use

As for other opiates[38] around one third of the drug users in Punjab compared to 18 percent nationally, had used opiates in their lifetime. The mean age reported for first ever use of other opiates was 25 years. The majority of drug users (68 percent) had used opiates in the past 12 months, while out of these almost all had also used opiates in the past 30 days. More than two thirds reportedly used opiates daily during this period. Except for NWFP where up to one third of the drug users were injecting, almost all the drug users in the remaining provinces reported injecting other opiates.

Benzodiazepine use

Around 41 percent of the drug users, more in Sind, had used benzodiazepines in their lifetime, while the majority within this group (84 percent) had used them in the past 12 months. Similarly, the majority of these drug users also reported using benzodiazepines in the past 30 days (88 percent), of which almost half had been using these substances daily during this period. As for the other opiates, the reported mean age at first ever benzodiazepines use was around 25 years. The most preferred method for use of benzodiazepines was orally (75 percent), however up to one quarter reported injecting benzodiazepines. In Punjab significantly higher proportion of drug users (up to 45 percent) reported injecting benzodiazepines.

	Heroin	Opium	Other Opiates	Benzodiazepines
NWFP	12.4	15.6	10	10.2
Punjab	13.2	13.3	7.2	9.9
Sind	10.4	13.6	5.2	7
Baluchistan	9	11	8	9

Table 5: Mean duration of regular drug use

Finally, smaller numbers of drug users also reported lifetime and recent use of barbiturates (68 persons), amphetamines (50 persons), cocaine (32 persons), hallucinogens (22 persons) and ecstasy (9 persons). As can be seen from the preceding paragraphs, firstly, the drug users have a long history of regular opioids and benzodiazepines use, e.g., on average the drug users had been using heroin for 12

[38] Other opiates here refer to substances such as morphine, codeine, bupronorphine, pentazocine and other narcotic analgesics that are produced licitly.

years, or benzodiazepines for over 9 years. Secondly, during a typical day, most of the drug users have been using multiple substances at different times or in combination with their main substance of abuse. An alarming pattern that has been observed is the proportion of drug users injecting drugs, especially other opiates, benzodiazepines and heroin. Apart from the use of main substances mentioned, a noticeable number of drug users also reported concurrently using a combination of antihistamines, sedatives and tranquilisers, methaqualone and opiates – referred to as "*cocktail*". This pattern of long term, multiple or poly drug use therefore has implications for local level counter narcotics enforcement efforts as well as for treatment of problem drug users.

Initiation of drug use

Cannabis or hashish reportedly is the most commonly used substance in Pakistan[39]. Similarly, the majority of drug users interviewed had used hashish as the first substance in their lifetime. However, smaller numbers also reported initiating their drug using career with alcohol, opium, heroin, benzodiazepines and other tranquilisers, and inhalants. Younger drug users, i.e., those who were less than 25 years old, were more likely to have initiated their drug using career with benzodiazepines or with other opiates. Most respondents had regularly used hashish for more than 5 years before they graduated to heroin or opium use. As the average age of initiation of drug use is 18 years, it is important to introduce drug use prevention programmes and interventions in schools and in community settings targeting young adolescents.

First substance used	Mean age	First substance used	Mean age
Cannabis	18.03	Benzodiazepines	18.90
Heroin	22.38	Inhalants	14.37
Opium	25.20	Ecstasy	19.29
Other Opiates	20.13	Overall	18.63

Table 6: First substance & age at firs use

The reasons given by respondents for using drugs for the first time could be summarised as a) influence of friends or peer pressure, b) social and family stresses, c) sibling or other family member's use of drugs, d) to heighten sexual pleasure, e) to overcome bereavement and f) as pain medication. These reasons for initiating drug use need to be considered along with other risk factors when designing prevention messages for young people.

[39] See key informants' views in the subsequent section "Drug abuse trends",

Injecting drug use

Nationally, up to 29 percent of the opioid users interviewed had injected drugs in their lifetime. This is an alarming trend, as in the early 1990's the proportion of injecting drug users was reported between 2 and 8 percent, whereas in 2000 lifetime injecting was reported among 15 percent of the opioid users.

Within the provinces there are significant differences in the proportion of drug users injecting. In Punjab and Sind up to 41 percent of drug users compared to 10 percent in Baluchistan and 8 percent in NWFP had injected drugs in their lifetime. The mean age at injecting drugs for the first time was reported as 26.9 years nationally. However, in Baluchistan the drug users initiated injecting at a significantly older age (35 years) than those in the other provinces. Furthermore, the drug users on average had smoked heroin regularly for up to 5 years before they graduated to injecting.

As for recent injecting, more than 90 percent of the injectors in Punjab and Sind had injected within the past 12 months. In NWFP and Baluchistan significantly lower proportion of injectors (72 and 50 percent respectively) had injected during this period. Out of these, more than half of the injectors in Baluchistan and NWFP and around 88 percent in Sind and Punjab reported injecting regularly in the past six months.

Drug users who had never injected were also asked the reasons for their non injecting behaviour, therefore: a) up to 44 percent had not injected because of fear of injecting; b) more than a third had not injected as their friends did not inject; c) almost one third had not injected as they did not know how to inject; d) up to a quarter of drug users said they had never injected to protect themselves from HIV infection; and e) up to 17 percent had never injected as they considered non injecting methods of drug use to be more convenient.

	Fear of injecting	Friends don't inject	Don't know how to inject	Protect from HIV	Cheaper this way
NWFP	39%	40%	24%	32%	13%
Punjab	46%	31%	33%	19%	16%
Sind	55%	27%	47%	32%	27%
Baluchistan	38%	71%	28%	9%	18%
Nationally	44%	39%	31%	24%	17%

Table 7: Reasons for never injecting drugs

In order to develop a better understanding of the transition from injecting to non injecting drug use, those drug users who had not injected in the past six months were also asked questions to elicit their reasons for not currently injecting. The main reason given for not injecting in the past six months was that the respondents' friends were not injecting. Up to 22 percent of drug users had not injected recently as they themselves were infected either with HIV or HCV and were not injecting to protect others from these infections. This response should be considered as a reflection of an alarming situation with regard to spread of HIV and other blood borne infections among drug users. Up to one third of the respondents had not injected recently to protect their selves from HIV. Less than a quarter of the drug users considered that using drugs by other methods was convenient for them. Finally, up to 13 percent had not injected as they did not have any veins left into which they could inject.

	Friends don't inject	Protect from HIV	Self infected with HIV or HCV	Convenient	No veins left
NWFP	43%	26%	7%	26%	13%
Punjab	58%	32%	10%	20%	13%
Sind	44%	54%	53%	27%	18%
Baluchistan	80%	15%	55%	5%	0
Nationally	56%	33%	22%	21%	13%

Table 8: Reasons for not injecting - past 6 months

Therefore issues such as the influence of peer behaviour and the health consequences of injecting should be borne in mind when designing outreach interventions and peer to peer counselling and support for prevention of injecting drug use.

Summary of main findings

- The mean age of opioid users in Pakistan is 35.5 years. A substantial number of drug users especially in Punjab and Sind are younger, i.e., less than 30 years old.
- The majority are still living at their homes but substantial numbers especially in Sind and Baluchistan are now living on the streets.
- 38 percent had no education, 25 percent had primary and one third had up to high school education.
- Around one third were employed, many had been supporting themselves through casual work
- Poly drug use is commonly reported with many using tranquilisers and other opiates along with their primary drug of abuse e.g., heroin
- Cannabis or hashish is usually the first substance ever used at an age of around 18 years
- Lifetime injecting reported among 29 percent of drug users

4

Injecting and sexual behaviours

Risk behaviours such as unprotected penetrative sexual intercourse, multiple sex partners and concurrent injecting drug use are behaviours which put the drug users at high risk of HIV infection. Such behaviours can also serve as a bridge for the spread of HIV infection from injecting drug users to the general population primarily through their sexual partners. The information presented in this section provides essential insight into the injecting and sexual risk behaviours prevalent among problem drug users in Pakistan. It also helps identify the key interventions needed to reduce the adverse health consequences among them. The first part of this section explores the pattern of injecting risk behaviour, while the second part explores the extent of sexual risk behaviours among drug users.

Injecting patterns

As mentioned in the previous section, up to 29 percent of drug uses interviewed had injected drugs in their lifetime while the majority had continued injecting. The following paragraphs outline their injecting patterns, such as frequency of injecting, commonly injected substances, common places for injecting and frequency of sharing needles and other injecting paraphernalia. Most of this information concerns their practices in the six months prior to the interview.

Frequency of injecting

The majority of injecting drug users, except for those in NWFP, reported injecting daily in the past 6 months. Similarly, with the exception of drug users in Baluchistan, most of the drug users reported injecting with a frequency of 2 to 4 times on a given day that they had been injecting. Smaller proportions of injecting drug users in the four provinces had been injecting more than 4 times a day indicating the severity of their dependence on opioids.

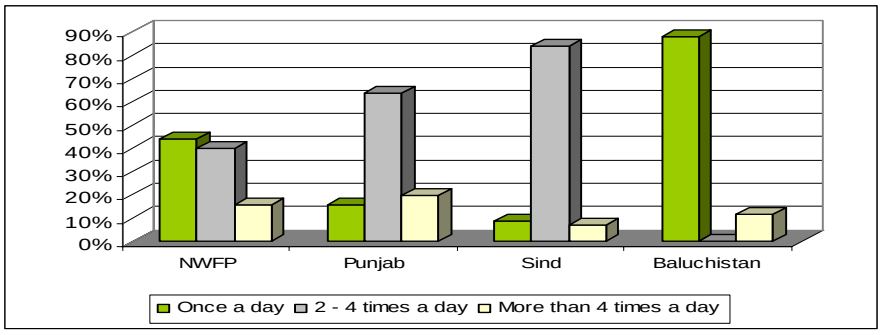


Figure 6: Frequency of injecting on a single day

Substances injected

Nationally, the three main substances that the drug users injected were opiates (56 percent), heroin (49 percent), and benzodiazepines (36 percent). However there were some discernable differences regarding the preferred substance injected within the provinces. In Sind and NWFP the most preferred substance was heroin (90 and 51 percent respectively), whereas benzodiazepines were the main substances injected in Baluchistan. Most importantly, many drug users reported injecting a combination of one or more of these substances with other drugs such as antihistamines.

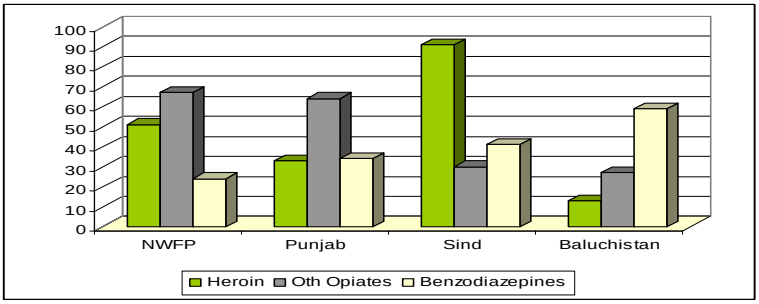


Figure 7: Main substances injected in Pakistan

Injection places

In NWFP and Sind more than a third of drug users reported injecting most often at the place where they lived. The remaining injectors in these provinces and the majority in Punjab and Baluchistan reported injecting mostly at abandoned buildings, public parks, alleys or similar locations. In addition to these places, many drug users especially those in Baluchistan, also reported injecting at a place run by a drug dealer, while some drug users in NWFP and Punjab also reported having injected in jail during the past 6 months. It follows that in order to reach a wider segment of injectors, outreach interventions need to be widely dispersed rather than being focused on one or two more visible locations in a city.

Injecting partners

As a common practice observed elsewhere, most of the drug users are likely to inject in groups. With the exception of injectors in NWFP, the majority of drug users in Pakistan also reported injecting with acquaintances or with a regular injecting partner. The majority of injectors in NWFP and fewer numbers in the other provinces reported injecting "*by themselves"* as their preference. In Baluchistan a substantial proportion also reported injecting in the company of people they did not know.

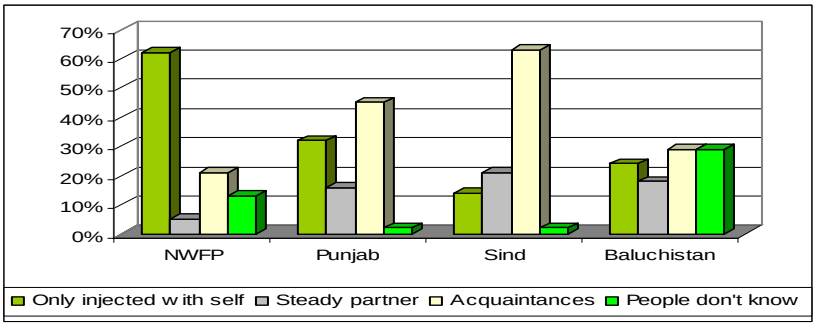


Figure 8: People injected with - last 6 months

Sharing of needles and other paraphernalia

In order to elicit responses on sharing of needles and syringes, the respondents were asked a) if they had used the same syringe[40] after others had used it, and b) if others had used a needle or syringe after the respondent had used it. The majority of drug users in NWFP (around 60 percent) and smaller proportions in Punjab (30 percent or more) reported never having shared syringes either way. Compared to this, the majority of drug users in Sind, Baluchistan (80 percent or more) and Punjab (70 percent) and fewer drug users in NWFP reported sharing their needles and syringes with considerable frequency during the time they had been injecting drugs.

In addition to sharing syringes, drug users also reported considerable sharing of other paraphernalia such as cookers, spoons and similar items for drug preparation as well as the "*rinse water"* used for cleaning such items. Following a similar patter of sharing syringes, the majority of injecting drug users in NWFP had never shared other injecting paraphernalia, while the majority of injecting drug users in Sind, Baluchistan and Punjab reported sharing their injecting paraphernalia with considerable frequency.

[40] The term syringe at this point imply syringe or needle

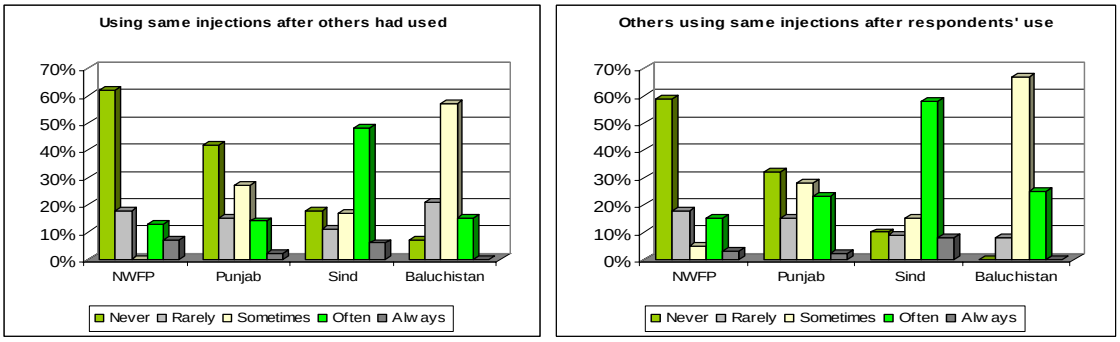


Figure 9: Frequency of sharing injections

This high risk injecting behaviour renders the drug users more vulnerable to blood borne infections such as HIV and Hepatitis C. While earlier reports in Pakistan had suggested near saturation of injecting populations with Hepatitis C infection in some locations[41], recent reports have indicated an increasing prevalence of HIV among injecting drug users in many cities[42]. As a result, injecting drug users could also serve as a bridge for the spread of HIV and Hepatitis C infections among the general population. This will no doubt increase the burden of disease in Pakistan as a large population with AIDS and end diseases of Hepatitis C will have to be cared for.

Frequency of sharing same rinse water					
	Never	Rarely	Sometimes	Often	Always
NWFP	63%	14%	10%	3%	10%
Punjab	42%	12%	13%	25%	8%
Sind	25%	3%	13%	55%	4%
Baluchistan	12%	0%	17%	59%	12%

Frequency of drawing from the same cooker or spoon					
	Never	Rarely	Sometimes	Often	Always
NWFP	83%	8%	6%	3%	0
Punjab	47%	10%	12%	24%	7%
Sind	30%	10%	22%	36%	2%
Baluchistan	20%	20%	20%	30%	10%

Frequency of sharing cotton swab					
	Never	Rarely	Sometimes	Often	Always
NWFP	56%	16%	13%	11%	4%
Punjab	61%	14%	12%	10%	3%
Sind	50%	8%	27%	14%	1%
Baluchistan	19%	0	38%	38%	5%

Table 9: Frequency of sharing other injecting paraphernalia

[41] UNODC & UNAIDS, Baseline Study of the relationship between injecting drug use, HIV and Hepatitis C in Lahore, 1999
[42] NACP, HIV Second Generation Surveillance in Pakistan, National Report Round 1, 2005

Reasons for sharing injections and other paraphernalia

In order to understand further the reasons for sharing injecting and other paraphernalia, based on information from other studies, injecting drug users were asked a series of questions on the possible reasons for their sharing needles and other paraphernalia in the past 6 months. This is important information as it provides insight on the key issues that need to be addressed as part of behavioural change communication for prevention of HIV among injecting drug users. One set of reasons for sharing concerns availability of clean needles and syringes at the time of injecting. Therefore, two main reasons given for sharing were a) there was only one needle present among the injectors; b) the available needle was not usable or c) the needle had been cleaned. The other set of reasons relates to group dynamics of injecting drug users. The injectors mentioned that a) they trusted their injecting friends and therefore did not see any reason for not sharing; b) their friends would get upset if they did not share their syringes and other paraphernalia; and c) either the respondent or his injecting friends needed help in injecting and therefore the same syringe had been used. Similar observations have been made in other studies and publications on injecting drug use[43]

	One needle	Trust injecting friends	Someone needed help	Needed help	Needle not usable	People get upset	Needle had been cleaned
NWFP	44%	14%	14%	17%	6%	11%	19%
Punjab	66%	47%	30%	35%	19%	20%	40%
Sind	79%	72%	69%	69%	35%	39%	43%
Baluchistan	75%	50%	39%	39%	25%	23%	17%

Table 10: Reasons for sharing injections

In terms of targeting interventions in specific geographical locations, it is important to note that these observations were more common in Sind and Baluchistan, followed by Punjab and to lesser extent in NWFP. In NWFP the overall lower prevalence of sharing syringes and other paraphernalia corresponds with the obvious fact that the majority of drug users who reported injecting had been doing so by themselves and not as a group activity. This phenomenon needs to be explored further to have a better understanding of why injecting behaviour in NWFP is different from that in the other provinces.

[43] See for instance chapter on "The Social Context of Injectors' Risk Behaviour", Drug Injecting and HIV Infection, Edited by Gerry Stimson, Don C. Des Jarlias and Andrew Ball, WHO, 1998

Cleaning needles and syringes

The information on practices for cleaning needles and syringes provides additional perspectives on the injecting risk behaviours prevalent among drug users. If drug users are injecting with used syringes, they could still do so safely if these are adequately disinfected with bleach. Therefore, the injecting drug users were asked the method and frequency with which they cleaned their needles and syringes in the past six month prior to their own use or when some else has used it.

Frequency of cleaning needles with water					
	Never	*Rarely*	*Sometimes*	*Often*	*Always*
NWFP	64%	15%	15%	3%	3%
Punjab	46%	11%	13%	17%	12%
Sind	21%	3%	7%	55%	14%
Baluchistan	0%	0%	18%	71%	12%

Frequency of cleaning needles with chlorine					
	Never	*Rarely*	*Sometimes*	*Often*	*Always*
NWFP	100%	.0%	.0%	.0%	.0%
Punjab	85%	8%	7%	1%	0%
Sind	94%	3%	2%	2%	0%
Baluchistan	75%	25%	0%	0%	0%

Frequency of cleaning needles with spirit					
	Never	*Rarely*	*Sometimes*	*Often*	*Always*
NWFP	95%	3%	0%	3%	0%
Punjab	77%	13%	10%	1%	0%
Sind	64%	4%	27%	4%	2%
Baluchistan	63%	38%	0%	0%	0%

Frequency of cleaning needles with boiling water					
	Never	*Rarely*	*Sometimes*	*Often*	*Always*
NWFP	81%	16%	3%	0%	0%
Punjab	64%	14%	12%	6	4%
Sind	47%	5%	44%	2%	1%
Baluchistan	56%	0%	44%	0%	0%

Table 11: Frequencies and methods of cleaning needles and syringes

The majority of drug users in all provinces had never cleaned their syringes with chlorine or spirit, while smaller proportions had cleaned them with plain water on different occasions. If drug users are injecting with used needles and syringes, as part of a comprehensive package of services and as an important step in the prevention of HIV and Hepatitis C infections, they need to be provided with chlorine and taught methods of disinfecting this equipment before use.

Obtaining new syringes

The majority of drug users in all the provinces (75 percent) considered it easy to obtain new syringes when they wanted them. However, up to a quarter of drug users, more in Sind and Punjab considered obtaining new syringes as difficult. With regard to sources of obtaining syringes, not necessarily new, most of the injecting drug users mentioned pharmacies as their main source. Second to these, other drug users, friends, outreach workers and drug dealers were mentioned as additional sources. Notwithstanding that drop in centres do not exist in all the districts in the country, up to 16 percent of the drug users, a higher proportion in Sind (28 percent) had obtained their syringes from the local Drop in Centre.

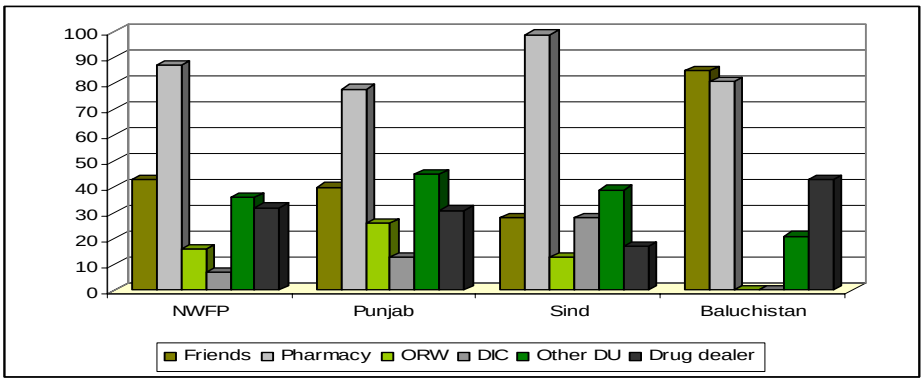


Figure 10: Common sources of obtaining syringes

The majority of drug users on average obtained one syringe per transaction and used it for up to three times before getting another syringe. However smaller proportions of drug users also used their syringes for up to 8 or 10 times.

Considering that many drug users are obtaining their syringes as well as drugs for injecting such as opiates, benzodiazepines and antihistamines from pharmacies, there may be a need to require pharmacies to exercise responsibility in dispensing prescription medicines. Although challenging, pharmacies could be considered as additional outlets

for provision of HIV prevention services, especially to promote safer injecting practices among their drug using customers.

Sexual behaviours

Nationally, two thirds of the drug users had had sexual intercourse in their lifetime. The mean age at first sexual intercourse was around 19 years. It is noteworthy that the majority of drug users, significantly more in NWFP, had their first sexual contact with their spouses. However, up to a quarter of drug users reported having first sexual contact with their girlfriend, while a substantial proportion reported boyfriends, sex workers and transvestites as their first sexual contacts.

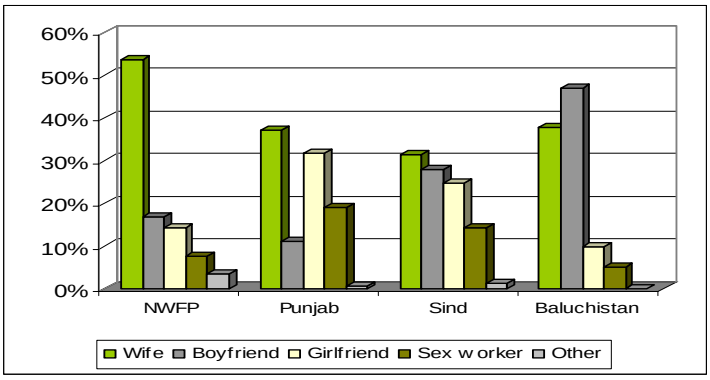


Figure 11: Person with whom had first sexual contact

Most of the drug users (80 percent) said there had been neither an increase nor a decrease in their sexual activities since they initiated drug or injecting drug use. Around one third of the drug users reported having sex once a month, while more than a quarter reported having sex at least 2 to 3 times during a month in the previous 6 months.

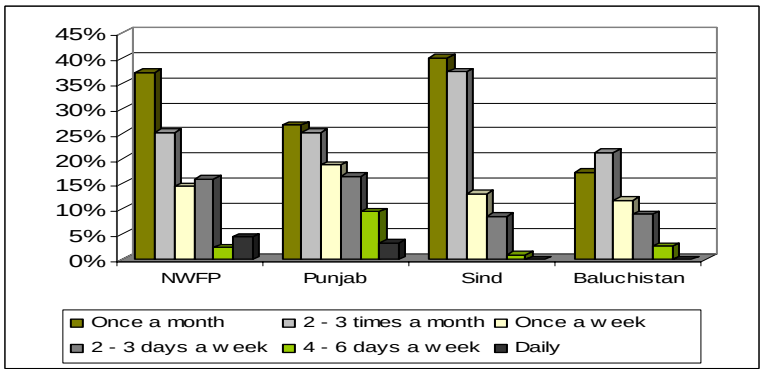


Figure 12: Frequency of sexual activity in a month - past 6 months

Sex partners

The drug users[44] reported having sex on an average, with up to 3 female and one male regular sex partners in the past six months. Around 5 percent said that their regular sex partners were also regular opioid users, while around 4 percent mentioned that *their regular sex partners were also HIV infected*. The drug users also reported having, on an average, 4 non regular or occasional sex partners in the past six months. Concerning drug use by their non-regular sex partners, more drug users described their non-regular sex partners as regularly using opioids (10 percent); around 5 percent reported their non regular partners to be injecting drugs. Less than one percent reported that their non regular partners were HIV positive, and 22 percent said that their non-regular partners also had sex with other men and women.

Condom use

As for using condoms, out of the drug users who answered these questions, more than one third had "*never"* used a condom, while the remaining had used a condom "*rarely*" (around half) or "*sometimes*" while having sex with their regular partners in the previous six months. Similarly, less than half of these drug users had never used a condom, while the remaining had either used it "*rarely*" or "*sometimes*" while having sex with their non regular partners in the previous six months.

Money or drugs for sex

Some drug users also reported exchange of money or drugs for sex with different partners in the past six months. More than a quarter of the drug users had given money, while 5 percent had given drugs to up to 5 different partners in exchange for sex. Similarly, 3 percent of the male and 29 percent of the female drug users reported receiving drugs in exchange for sex while 2 percent of men and 19 percent of women who reported receiving money to have sex with up to 8 different partners in the past six months.

[44] Due to cultural constraints and personal inhibitions not all respondents answered questions on sexual behaviours. The total number of valid responses, as in the other sections, varies in these paragraphs, and therefore the proportions reported here should be taken as indicative

At their last sexual contact, the majority of drug users (62 percent) reported having sex with their regular or steady partner (including their spouses), while the remainder had sex with casual (22 percent), charging (12 percent) or paying partners (4 percent)[45]. Only 12 percent of these drug users reported using a condom in the course of their last sexual contact.

Overall, the information on sexual behaviours among drug users indicates a high level of risky sexual behaviour with multiple sex partners both male and female with whom they have had mostly unprotected sex. These issues also need to be addressed as part of behavioural change communications and other interventions with drug users.

Summary of main findings

- Up to 29 percent of drug users had injected drugs in their lifetime
- A high frequency of injecting observed, most of the drug users had been injecting daily and 2 – 4 times a day in the past 6 months.
- Heroin, other opiates, benzodiazepines, tranquilisers and their combinations are the main drugs injected
- Most of the drug users normally inject in public places, alleys and parks, but many especially in NWFP also injected in the places where they lived
- Considerable sharing of syringes and injecting paraphernalia was reported among injecting drug users.
- Most of the drug users consider it easy to obtain syringes for injecting, with pharmacies, drug using friends and even drug dealers cited as the main sources.
- Up to 75 percent of drug users had had sexual intercourse.
- The person with whom they had sex the first time varied between spouse, boy or girl friend and sex worker.
- Many drug users reported having unprotected sex with multiple sex partners in the past six months.
- Many of the sex partners were reportedly opioid users
- Community based outreach interventions for drug users that address the injecting and sexual risk behaviours observed, need to be implemented widely in the country.

[45] A paying partner would the one who pays to have sex, while a charging partner would the one who charges money to have sex with the person.

5

Treatment and other services

In this section data are presented on the treatment history of drug users along with their utilisation of different services for treatment of drug dependence and for prevention of HIV (wherever such services are available). This section also provides information from key informants' interviews on their perceptions of the nature of services offered by various facilities for treatment of drug dependence, as well as the perceived effectiveness of these services in Pakistan. This section provides essential information on how various drug dependence treatment, and HIV prevention and care services for drug users could be made more effective in providing a continuum of care, that meet the diverse needs of drug dependent persons.

Treatment for drug dependence

In NWFP and Sind significantly higher proportions of drug users (52 and 42 percent respectively), than in Baluchistan or Punjab (22 and 19 percent respectively) had been treated for their drug problems at least once in their lifetime. Furthermore, many of the drug users had been treated for multiple drugs in their lifetime. It is important to note that along with heroin, opium, and other opiates, a substantial proportion of drug users, especially in Baluchistan also received treatment for their cannabis and benzodiazepines use - a trend which needs to be monitored further through a national "*treatment reporting system*".

	Heroin	Cannabis	Benzodiazepines	Opium	Other opiates
NWFP	80%	20%	18%	29%	6%
Punjab	77%	29%	17%	19%	31%
Sind	91%	7%	17%	12%	13%
Baluchistan	74%	35%	33%	12%	1%

Table 12: Substances treated for in lifetime

Out of the drug users who had prior treatment, more than 90 percent had been treated for opioid dependence. The mean age when the respondents had their first treatment for opioid dependence was reported as 30.15 years. However, the drug users in Baluchistan and NWFP had their first treatment at significantly later ages, i.e., around 32 years and

those in Punjab at younger ages, i.e., 27.7 years. On average most of the drug users experienced at least 2 treatment attempts while a substantial proportion (up to 20 percent) had experienced up to 10 attempts. The last treatment episode for most of the drug users was around 20 months prior to interview.

It is noteworthy that on average the drug users had spent around 7 years regularly using heroin, 9 years of regular opium use, 12 years of regular use of other opiates, and up to 4 years regularly injecting before their first treatment for opioid dependence. The lag period of 7 years, i.e., the period between first use of heroin for instance, and seeking treatment for the first time, has also been observed in other places. Nevertheless, instituting outreach interventions can actually shorten this period as well as assist many drug users to avoid serious health and social problems related to their drug use.

	Heroin	Opiates	Opium	Injecting
NWFP	7	17	10	7
Punjab	6	8	9.2	3
Sind	6	14	9.2	3
Baluchistan	4	5	3	4
Nationally	7	12	9	4

Table 13: Mean lag period (in years) between use of substances and first treatment

Places for treatment for drug dependence

In the course of their drug using careers, the respondents had tried different options for treatment of their drug dependence. Most of the drug users, especially in Sind and Baluchistan, had treatment in government run treatment facilities. Many drug users, especially in NWFP and Punjab, had treatment in private clinics, in addition to being treated at NGO run centres or in their homes. However, it should be noted that the drug users would have used the type of services in their area which were most commonly available, accessible or perceived as effective.

	Government Centres	Private clinics	NGO Centers	At home
NWFP	37%	41%	46%	18%
Punjab	42%	55%	25%	26%
Sind	67%	30%	30%	26%
Baluchistan	51%	35%	15%	17%
Nationally	46%	41%	35%	22%

Table 14: Places treated at - lifetime

Recent treatment

Nationally, around 17 percent of drug users interviewed had been treated for opioid dependence in the past 12 months. The reported pattern of utilisation of drug treatment services in the past 12 months is quite different from lifetime utilisation of services. More drug users in NWFP had treatment in Government centres in the past 12 months than in NGO centres or private clinics. In Punjab drug users continued to utilise the services of private clinics, but were also treated in Government run treatment facilities. In Sind the NGO centres and Government run facilities were utilised more in the past 12 months. Finally, in Baluchistan private clinics followed by Government facilities, were preferred for recent treatment of drug dependence. Based on this information, however, it can not be deduced that one or the other type of services is used preferentially by drug users in Pakistan.

	Government Centres	NGO Centers	Private clinics	At home
NWFP	46%	30%	12%	9%
Punjab	23%	9%	38%	10%
Sind	25%	21%	5%	18%
Baluchistan	25%	0	40%	0
Nationally	35%	21%	19%	11%

Table 15: Places treated at - past 12 months

On average the drug users who had been treated in the past 12 months, had at least one treatment episode and most of them had spent up to 10 days in treatment. When asked about the different services drug users had received at their last treatment episode, to the extent they were able to describe the services, most of them mentioned being detoxified with various medicines, followed by receiving counselling and relapse prevention training. Smaller proportions of drug users also reported participating in twelve steps programmes, or having received aftercare, or social rehabilitation services.

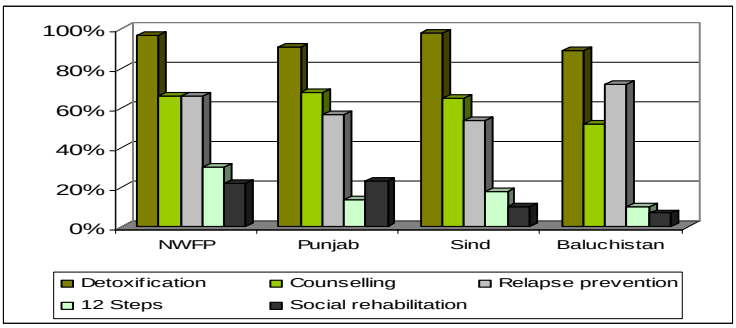


Figure 13: Services received at last treatment

However, given the time it takes to stabilise a person after initial withdrawals from opioids, the effectiveness of such interventions provided within the span of 10 days needs to be ascertained.

Unmet need for treatment

Up to 70 percent of the drug users interviewed, significantly less in Punjab (59 percent) and more in NWFP (82 percent), expressed an unmet need for treatment, i.e., they were unable to get treatment when they needed it. The main reason given by the majority of drug users was that they could not afford to pay for treatment. The other noteworthy reasons given were a) the drug users did not trust government facilities; b) there were no inpatient treatment facilities available locally; and c) they did not know about local treatment services. The latter two reasons are more valid for those districts in Pakistan where drug treatment services are not as widely available. Most of the drug users considered that it was quite difficult to get local treatment for their drug dependence. These issues need to be considered in future planning to ensure drug treatment services are widely available and more accessible to drug dependent persons.

	Very easy	Somewhat easy	Unsure	Somewhat difficult	Very difficult
NWFP	3%	6%	15%	30%	46%
Punjab	3%	5%	26%	19%	47%
Sind	2%	12%	16%	38%	33%
Baluchistan	0%	1%	40%	12%	48%
Nationally	3%	6%	23%	24%	45%

Table 16: Perceived ease or difficulty in accessing local treatment

With regard to current need for treatment, more than half of drug users indicated an "*urgent need*" and around one third "*somewhat need*" for treatment or assistance for their drug dependence. Only 7 percent of the drug users indicated that they did not need any treatment. Knowing that many drug users themselves had expressed *need for treatment* can help outreach workers in communities to "*ready*" their drug using clients to enter treatment. However this could only work in situations where there are matching services available as well to address the needs of drug users.

Availability of services for treatment of drug dependence

In the course of interviews with key informants they were asked if they were aware of Government, NGO run or private drug treatment centres functioning in their areas. Their responses are indicative of the extent and coverage of such services in Pakistan. This information is presented by districts in the table below[46].

	Government	NGO	Private treatment	Drop in Centre
Chitral	12%	32%	2%	0
Peshawar	69%	82%	62%	81%
Bannu	0	85%	71%	0
Kohat	18%	0	0	0
Haripur	66%	9%	69%	3%
Attock	3%	39%	44%	0
Rawalpindi	2%	2%	4%	0
Lahore	35%	42%	43%	11%
Sargodha	75%	79%	66%	43%
Faisalabad	57%	22%	48%	5%
Sialkot	8%	22%	12%	14%
Okara	0	0%	100%	0
Multan	12%	18%	36%	6%
DG Khan	10%	12%	4%	0%
Larkana	61%	0	3%	33%
Hyderabad	10%	10%	8%	8%
Karachi	20%	28%	22%	15%
Quetta	44%	15%	51%	5%
Pishin	12%	4%	4%	4
Qilla Abdullah	0%	0	68%	6%
Loralai	0	89%	0	0

Table 17: Perceived availability of drug treatment services

In NWFP, Peshawar and Haripur are the two districts where most of the key informants considered that there were sufficient services within the Government and private sector for drug treatment. In Bannu it was considered that there were drug treatment services available only through private or NGO run facilities. For most of the districts in central Punjab such as Lahore, Sargodha and Faisalabad many key informants considered that

[46] Indicates percentage of the Key Informants who said a certain service was available locally

there were services provided by Government, NGOs and the private sector, but did not consider them sufficient to meet the treatment needs of drug dependent persons. In Sind, only the key informants in Larkana district considered appropriate services in the Government centre/s for drug treatment, while in the remaining districts the key informants were not aware of or did not consider services provided by Government, NGOs and the private sector adequate in their districts. Finally in Baluchistan, the key informants in Quetta considered that there were drug treatment services available within Government and private run facilities, while in Loralai, only NGO run and in Qilla Abdulla only private run facilities were considered as providing these services.

Extent of services available

In order to assess the range of services available through drug treatment centres in the public, NGO and private sector, the key informants were asked if in their opinion services such as outreach interventions, including motivational counselling, counselling and psychotherapy, relapse prevention training, social and vocational rehabilitation, follow up and after care services such as 12 step programmes, and religious guidance were available in the various centres. It must be noted that the key informants' responses on the level or range of services offered through government, NGO and privately run drug treatment centres were subjective and based in part on their own knowledge of drug treatment services. Therefore their responses may have a degree of bias in them. It should also be noted that up to one third of the key informants could not answer these questions on available services in the various drug treatment centres.

With regard to services offered through government treatment centres, apart from detoxification, more key informants considered that to some extent counselling, relapse prevention and religious guidance was provided in these centres. However fewer key informants considered that outreach interventions, social and vocational rehabilitation and aftercare services were available through the Government treatment facilities.

More key informants thought that the level and range of services offered through the NGO and private drug treatment facilities were considerably better than in Government centres. However, the key informants did not consider interventions, such as counselling and psychotherapy, relapse prevention and aftercare, to be developed or available to the extent needed. Within the provinces, more key informants in Punjab and Sind thought that the range and level of interventions provided in the various drug treatment facilities were not optimal.

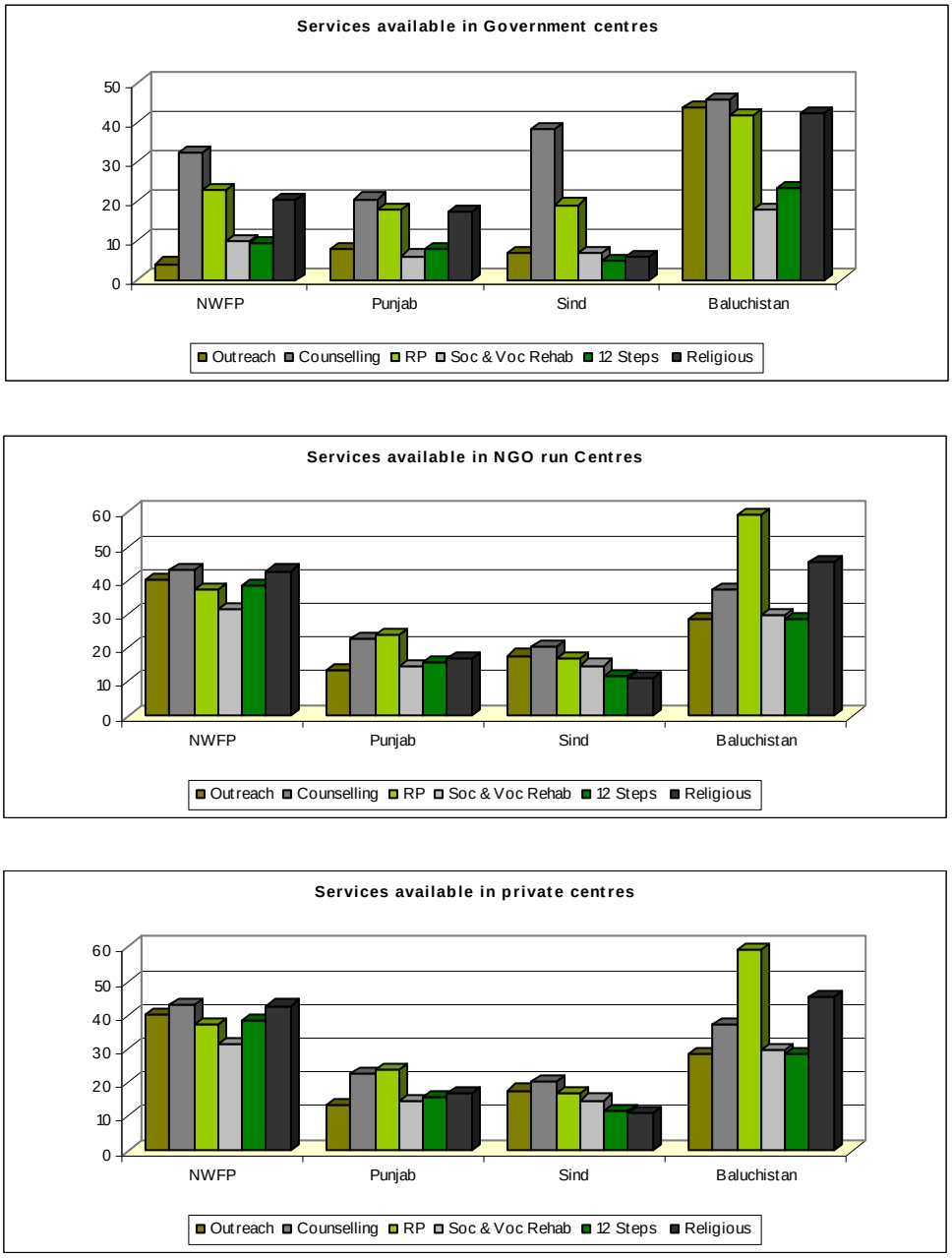


Figure 14: Key Informants' responses on available drug treatment services

Preferred services for drug dependence treatment

In order to assess the kind of service delivery outlets that were perceived to be utilised more often for treatment, of drug dependence, key informants were asked to comment on which of the three services, i.e., Government, NGO or privately operated, were mostly preferred by drug users. With the exception of key informants in NWFP who rated NGO facilities as the most preferred services, the others considered Government run facilities

as the most preferred outlets for treatment of drug dependence. With minor differences across the other provinces, NGO run facilities were preferred second to the Government facilities.

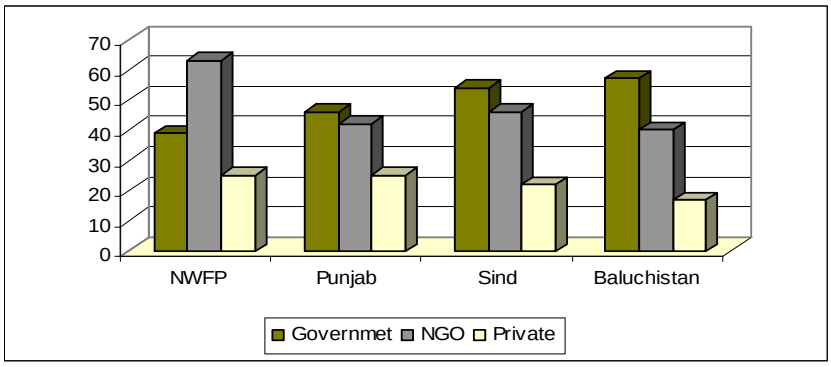


Figure 15: Preferred services for drug dependence treatment

Perceived effectiveness of drug treatment services

In a further effort to assess the key informants' perceptions of the effectiveness of different drug treatment services available, i.e., Government, NGO or privately run, they were asked a series of questions on effectiveness of these services. Perceived effectiveness is often subjective and depends on a number of factors including an individual's personal experiences as well as his or her knowledge and awareness of the treatment process. For the purpose of this study effectiveness was categorised in terms of a) accessibility of the treatment services; b) availability of different approaches and modalities for drug treatment within a service; c) client satisfaction; and d) improving quality of life of drug dependent persons. The key informants were asked for their opinions on how effective they considered the various drug treatment services to be on the given criteria. The response categories or rating scales used included "*least effective*", "*somewhat effective*", "*very effective*" or to a fourth active scale of "*don't know*". It is important to point out that more than half of the key informants interviewed responded as "*don't know*" to the set of questions on effectiveness. Therefore, the measures presented in the next sections are by no means definitive and should be treated merely as an indication of the effectiveness of different treatment services as perceived by the key informants using the above criteria. All the same, this information can serve as a basis for further research on the effectiveness and efficacy of drug dependence treatment services in Pakistan. This information can also serve as a starting

point for deliberations to improve the service delivery of current facilities as well as for future planning of services.

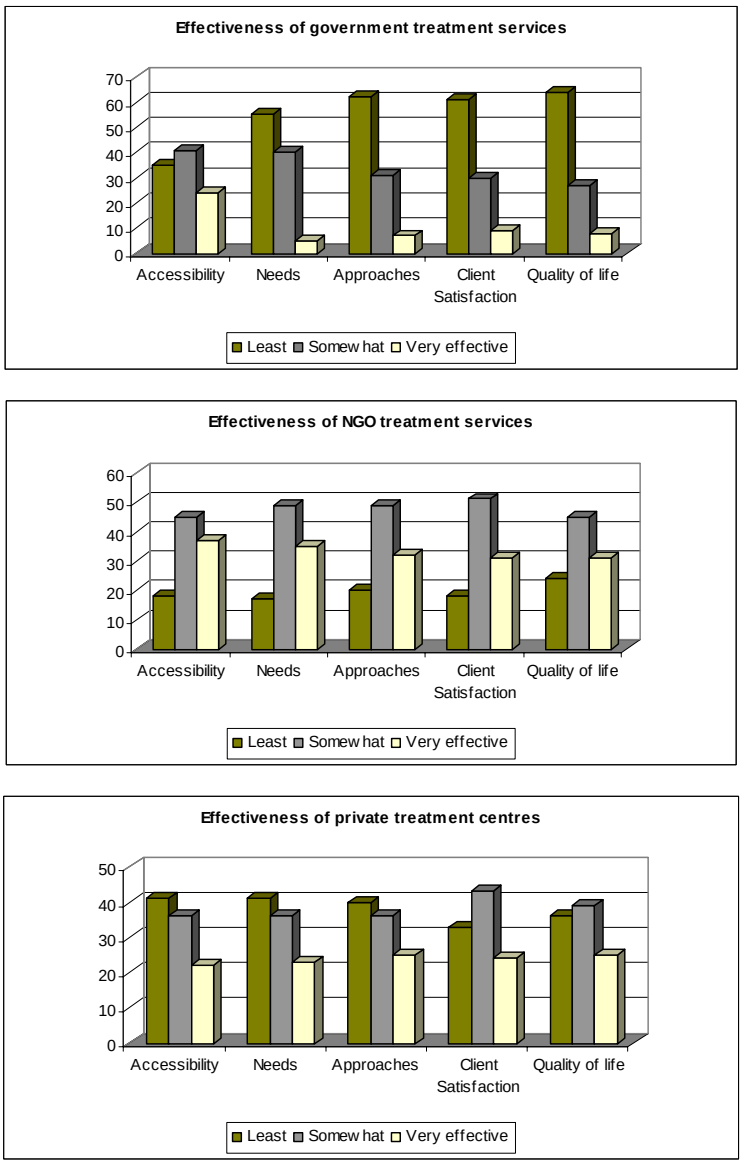


Figure 16: Perceived effectiveness of drug treatment services

The majority of key informants considered that the NGO operated drug treatment facilities were relatively more accessible than the Government facilities. The private treatment facilities understandably were not considered as easily accessible. For the remaining categories, i.e., meeting clients' diverse needs, the approaches and modalities offered for drug treatment, client satisfaction and improving the quality of life of their clients, the Government run treatment facilities were considered as the least effective. Compared to this, the overall level of perceived effectiveness of NGO operated drug treatment services was higher – mostly as *somewhat effective* and to lesser extent as

effective. However, up to a quarter of key informants also considered the NGO treatment facilities as *not effective*. Finally, private treatment centres, although rated at a lesser scale than the NGO facilities, were nevertheless considered as *somewhat effective* in providing services to drug dependent persons, whereas more than a third of key informants also considered private treatment centres as *not very effective*.

Furthermore, regarding the ease or difficulty of accessing drug treatment services by women and adolescents, the large majority of key informants were of the opinion that by and large drug treatment services were less accessible for women and even less accessible for adolescents.

The impression that emerges from the key informants' responses on drug treatment services is that generally they do not perceive treatment services to be very effective in providing assistance to drug dependent persons. A similar impression is apparent while reviewing the responses by drug users on their treatment history, the various treatment services they had utilised and the number of treatment attempts they had in their lifetime. Based on these responses, it is impossible not to conclude that there is a pressing need for more accessible, effective and improved drug treatment services in different parts of the country.

HIV prevention services for injecting drug users

The following paragraphs present information on the awareness among drug users and key informants of the local services for prevention of HIV infection among injecting drug users and care of those living with HIV. These paragraphs also present information on the range of interventions provided and their utilisation by injecting drug users in the districts where such services are available.

Outreach services

Considering that outreach services are not available in most parts of the country, up to 18 percent of drug users nationally, a higher proportion in NWFP and Sind (23 percent), said that outreach workers were available or functioning in their localities. However, this response varies substantially by each district. Out of the 20 districts, in 5 districts - two from NWFP, two from Punjab and one in Sind, a high proportion of drug users, i.e. up to half, were aware of local outreach workers. In 9 districts, up to 21 percent of the drug

users were aware of local outreach workers. In the remaining 6 districts either the drug users were not aware of, or apparently there were no outreach or similar interventions available.

High		Medium		Low	
Peshawar	49%	Lahore	21%	Chitral	0
Bannu	47%	Sialkot	21%	Haripur	0
Larkana	45%	Quetta	20%	Okara	0
Faisalabad	36%	Kohat	17%	Multan	0
Sargodha	32%	Hyderabad	13%	D G Khan	0
		Karachi	12%	Pishin	0
		Rawalpindi	11%		

Table 18: Availability of local outreach interventions

In the districts where outreach services were available, up to one third of drug users, significantly more in NWFP and Sind, had contact 2 to 3 times a week in the past six months. In Punjab only, most of the drug users reported daily contact with outreach workers in the past 6 months.

	Once a month or less	2 - 3 times a week	4 - 6 days a week	Everyday	Don't remember
NWFP	23%	54%	3%	7%	13%
Punjab	13%	21%	21%	40%	7%
Sind	38%	40%	10%	2%	11%
Baluchistan	20%	0%	0%	0%	80%

Table 19: Frequency of contact with outreach workers - 6 months

Range of outreach services

As for the extent of services received during the past six months, out of the drug users[47] who had been in contact with outreach workers, most had received counselling for HIV prevention, i.e., on reducing their risk behaviours and prevention of overdose. Smaller proportion of drug users also reported receiving other assistance such as syringe exchange, provision of condoms and cleaning equipment for syringes, etc. Only in Punjab was the range of services that injecting drug users received, broad enough to

[47] Of these 149 were in NWFP, 177 in Punjab, 92 in Sind and 6 in Baluchistan

cover the essential services that need to be provided to injecting drug users. In the other districts and provinces it appears that the range of services provided by outreach workers needs to be assessed and upgraded in terms of improving the quality and effectiveness of interventions for HIV prevention.

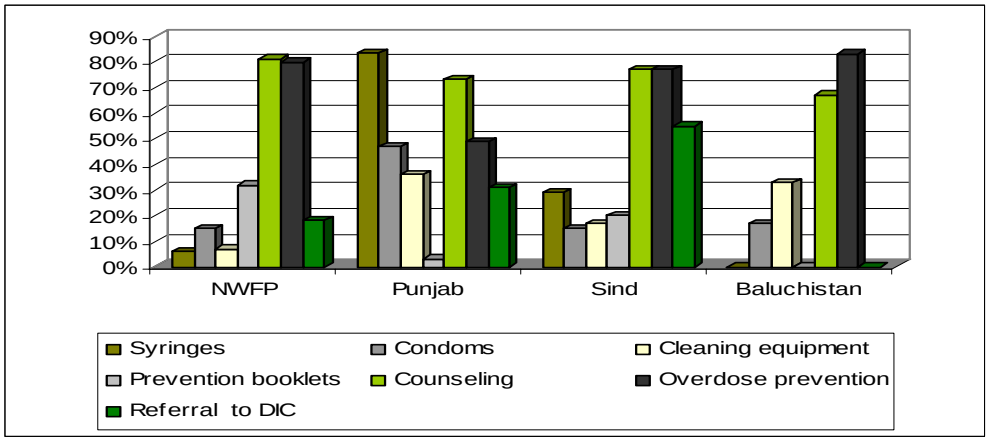


Figure 17: Range of services provided by outreach workers - 6 months

Drop in Centres

Nationally up to 14 percent of drug users, a significantly higher proportion in Sind (25 percent) were aware of local services, such as a Drop in Centre (DIC). Drop in Centres are considered as open access or low threshold service delivery outlets that provide services for the prevention of adverse consequences of drug use primarily to injecting drug users. These services include education and counselling about HIV/AIDS and other infections, provision of clean injecting equipment, counselling for prevention of overdose and behaviour change and other health services. On the district level, only in Peshawar, Larkana and Lahore were a large number of drug users aware of these local HIV/AIDS prevention services.

High		Medium		Low	
Peshawar	46%	Quetta	20%	Multan	4%
Larkana	45%	Sialkot	19%	Bannu	2%
Lahore	37%	Sargodha	17%	Haripur	1%
		Hyderabad	17%	Okara	0
		Karachi	16%	Chitral	0
		Rawalpindi	15%	D G Khan	0
		Faisalabad	8%	Pishin	0
				Kohat	0%

Table 20: Awareness of local HIV prevention services

Next to these, in nine districts between 20 percent of drug users in Quetta and 8 percent in Faisalabad were aware of such services. In the remaining eight districts, most of them in NWFP and some districts in Punjab, the drug users were not aware of local services for HIV prevention. Similarly, most of the key informants in Peshawar, Sargodha and Larkana reported existence of these services locally. Compared to this a lesser proportion of key informants in Sialkot, Lahore, Karachi and Hyderabad were aware of drop in centres functioning in their areas. However it should be noted that this level of awareness among drug users and the key informants could also be related to the existence and coverage of services for prevention of HIV among drug users in these districts.

Utilisation of services

Out of the drug users who were aware of drop in centres, up to half of them nationally - with lesser proportions in NWFP and Baluchistan - had also used the local services for prevention of HIV/AIDS in the past 12 months.

At a district level, however, there is a higher degree of disparity among the drug users who had utilised the services of a DIC or other similar HIV prevention service in their area. In Karachi and Sialkot the large majority, i.e. 80 percent or more had utilized local HIV prevention services. Compared to these, in the central districts of Punjab i.e., Lahore, Sargodha, Faisalabad and in Larkana[48], up to half of the drug users had utilized local services for HIV prevention. In the remaining districts such as Hyderabad and Peshawar, even fewer drug users, i.e., 14 and 13 percent respectively had utilised these services in the past 12 months.

Frequency of contacts

Nationally a small number of drug users[49] had utilised the services of a DIC in the past six months; the highest frequency of use of these services was in Sialkot, Larkana, Karachi and Lahore. In Sialkot for instance the drug users on average had used the

[48] In Lahore 45 percent, Sargodha 57 percent, Faisalabad 44 percent and in Larkana 42 percent had utilised the services of DIC or other similar service in the past 12 months.
[49] Of the 202 or so drug users who had utilised services of DIC in past 6 months, 32 were in NWFP, 95 in Punjab, 75 in Sind and none in Baluchistan.

services at a DIC around 57 times in 6 months or about twice a week, whereas in other places such as Sargodha the drug users had utilised services around once a week.

District	Mean # of contacts	District	Mean # of contacts
Sialkot	57	Peshawar	10
Larkana	46	Faisalabad	3
Karachi	37	Kohat	1
Lahore	33	Rawalpindi	1
Hyderabad	27	Quetta	1
Sargodha	22		

Table 21: Frequency of use of DIC services - 6 months

Range of services provided

Along with the frequency of contacts that the drug users had with the “drop in centres” it is equally important to consider the range or type of interventions the drug users might have received through these services. On the whole, the drug users in Sind reportedly received a much broader range of services than those in Punjab or in NWFP.

	NWFP	Punjab	Sind	Baluchistan
Syringes	8%	93%	66%	0
Condoms	19%	31%	42%	17%
Prevention booklets	24%	9%	17%	0
Overdose prevention counseling	89%	83%	77%	0
Pre and post test counseling	34%	20%	54%	0
Counseling	79%	79%	69%	0
Referral for HIV testing	6%	5%	36%	0
Referral for HCV testing	6%	5%	36%	0
STD diagnosis	3%	2%	8%	0
Referral for drug treatment	29%	3%	9%	0

Table 22: Type of services received at DIC - 6 months

Comparing the type of services provided to the drug users listed in the above table, essentially most of the drug users in Punjab received new syringes and counselling especially for overdose prevention. Fewer drug users reportedly received pre and post test counselling and referrals for HIV or HCV testing. In Sind more drug users were provided with pre and post test counselling, referral for HIV and HCV testing, along with provision of syringes, condoms, counselling for overdose prevention, etc. Only in NWFP

were a substantial proportion of drug users referred to drug dependence treatment along with the other services listed in Table 22.

From the preceding paragraphs it can be surmised that the services for HIV prevention among injecting drug users are more organised in Lahore, Sargodha, Faisalabad and Sialkot in Punjab. In Sind such services are more organised in Karachi and to lesser extent in Larkana and Hyderabad. In NWFP and Baluchistan such services are apparently better organized in Peshawar and Quetta respectively, but not at the same level as they are in the other two provinces.

Reasons for not using HIV prevention services

Along with the range and quality of services provided for prevention of HIV among injecting drug users, there are other important factors that determine the effectiveness of services such as organizing the services in a manner that would make them more client oriented and accessible that would therefore affect utilisation of services by the clients. Among the drug users who had not utilised the services of local DIC or similar services in the past 6 months, two major reasons cited, were "*difficulty in reaching the DIC*", especially in Sind, followed by perceived "*complicated rules"*, more so in Sind and NWFP. Fear of "*being caught"* by the police and fear of "*being registered"* – implying that their personal details would be given to the authorities and might subject them to harassment– were additional reasons why many drug users did not utilise the services of DIC. Another important reason cited mostly in NWFP was the perception by the drug users that *staff* at the DIC was "*not very cooperative or helpful"*. These are all important issues that need to be addressed in order to improve the effectiveness of HIV prevention and care services in Pakistan.

	Difficult to reach	Complicated rules and procedures	Afraid of being registered	Afraid of being caught by police	Staff not cooperative	Don't want other people to see
NWFP	21%	44%	31%	24%	51%	8%
Punjab	26%	19%	25%	18%	12%	16%
Sind	49%	30%	13%	32%	17%	9%
Baluchistan	0	0	0	90%	0	0

Table 23: Reasons for not using DIC services - 6 months

Summary of main findings

- More drug users in NWPF and Sind had received treatment for their drug problems
- Most of the drug users had been treated for heroin dependence followed by opium, cannabis, other opiates and benzodiazepines.
- 17 percent of the drug users had been treated for opioid use in the past 12 months
- The mean age at first ever treatment for drug dependence was 30.15 years implying that the drug users regularly used heroin for 7 years, opium for 9 years, other opiates for 12 years, and had been injecting for 4 years before they sought assistance for their drug dependence.
- The quality of services provided for drug dependence needs to be assessed for effectiveness and efficacy in providing the continuum of care and meeting the diverse needs of the clients.
- Up to 70 percent of the drug users expressed an unmet need for treatment of their drug dependence in the course of their drug using career.
- Most of the drug users considered it difficult to access services and receive treatment for their drug dependence
- Up to 18 percent of drug users were aware of local outreach workers in their area
- Of these 70 percent had contact with an outreach worker. In NWFP and Sind most of the drug users had contact between 2 to 3 times in a week, while in Punjab most reported daily contact with outreach workers in past 6 months.
- Most of the drug users received new syringes, condoms, cleaning equipment and counselling especially for overdose prevention through outreach workers.
- In Punjab the outreach services are more organised whereas in Sind the stationary services or drop in centres for prevention of HIV are better organised.
- In the districts of Sialkot, Larkana, Karachi, Lahore and Hyderabad the drug users had a high frequency of contacts with DIC.
- Many drug users had not utilised the stationary services for prevention of HIV as they were considered as difficult to reach, had complicated rules or procedures or the drug users were afraid of being registered or being caught and harassed by the local authorities.

6

Drug abuse problems

Drug users in the course of their drug using career also develop serious health and social problems. Moreover, illicit drug use, delinquency and crime are often observed as closely interrelated behaviours. Drug users' involvement in criminal activities, whether in petty or organised crimes result in major social costs to the society. In this section, data are presented on the health and social consequences of drug use as experienced by the problem drug users interviewed as well as perceptions of the key informants on the extent of the social, legal and health problems caused by drug use.

Criminality

Nationally up to 38 percent of the drug users interviewed had been arrested at least once in their lifetime on drug related charges – this proportion was significantly higher in NWFP (46 percent) and lower in Baluchistan (22 percent). The mean age at first arrest for a drug related offence was 26 years nationally, while it was significantly higher in Baluchistan (34 years). These drug users had been arrested on an average 4 times for a drug related offence in their lifetime and had spent up to 2 years in jail.

The chart below presents the progression of drug users from the age of their first drug use to heroin use, opiate use, initiating injecting drug use, being arrested for a drug related offence and seeking treatment for their drug problems.

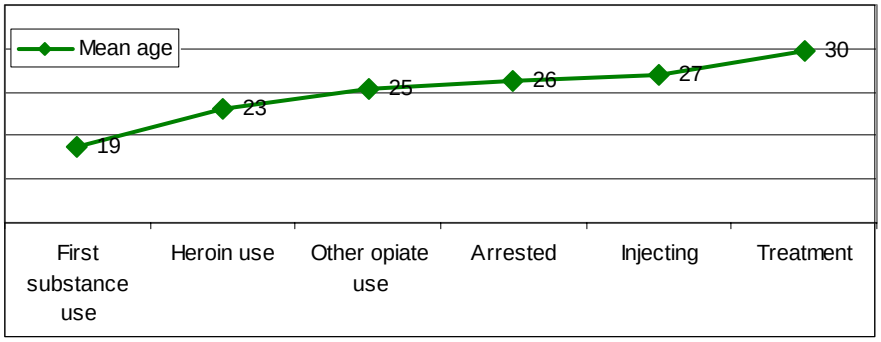


Figure 18: Progression in drug careers

On average the problem drug users were arrested for the first time on a drug related offence 7 years after initiating any substance use and after 3 years of regular heroin use. At the other end of the spectrum, the drug users were seeking assistance for their drug problems after 7 years of regular heroin use and then relapsing back to drug use. This is important information that can be taken into account while designing interventions for problems drug users.

Offences committed

An overview of the different offences for which opioid users had been arrested in the course of their drug using careers indicates the extent of their involvement in criminal activities as well as the social costs of drug use. The majority of drug users had been arrested for charges related to their use or possession of drugs (65 and 38 percent respectively). Additionally, many of the drug users had also been arrested for selling or trafficking of drugs – probably their dependence and the effort to continue financing their drug use make them more vulnerable for recruitment by local drug dealers. Along with the drug related charges, a substantial proportion of drug users were also arrested on charges related to theft and smaller numbers for burglary and shoplifting.

	Use of drugs	Possession of drugs	Selling drugs	Thefts	Trafficking of drugs	Burglary	Shop lifting
NWFP	75%	50%	26%	12%	16%	7%	1%
Punjab	74%	41%	15%	31%	7%	1%	9%
Sind	43%	22%	8%	6%	5%	0.3%	2%
Baluchistan	41%	14%	19%	16%	30%	3%	22%
Nationally	65%	38%	17%	16%	11%	3%	8%

Table 24: Drug related & other offences committed

Detention and incarceration

Apart from being arrested for drug related charges, up to half of the drug users interviewed had also spent time in jail or had been detained in a police station for a considerable time. The drug users who had been detained had spent on average around 12 days in detention. Those who had spent time in jail had served between 5 months to 5 years in jail for criminal offences.

It is also noteworthy that up to 6 percent of the drug users, who had spent time in jails or detention centres, injected drugs while being incarcerated. Most of these drug users reportedly were able to acquire syringes to inject drugs. Similarly up to 4 percent of these drug users also had sex while incarcerated. Hardly anyone reported use of condoms while having sex in jail or a detention centre.

Health and other social consequences

It is widely known that different patterns and levels of drug abuse impact differently on society, therefore the key informants and drug users were also asked questions on drug related problems. They key informants were asked to comment on their perceptions of a) the problems caused to individuals as a result of their drug use; and b) the impact or problems faced by society because of drug use. It is important to point out that the key informants' perceptions of drug problems could be based on some objective quantification, e.g., number of drug users known to have experienced a certain problem along with the context and the respondents' subjective assessment or perception of the severity of problems caused by different drug use.

In order to quantify the responses, the key informants were asked firstly, to assess the problems each index drug was causing. A standard question format was used in which, for each drug type, the respondents reported if its use caused "*major problems*", "*some problems*" or "*no problems*" in their area. As in other sections, two active categories of "*drug not used*" and "*don't know*" were also included to ensure that key informants did not answer arbitrarily. The mean rating of the perceived problems associated with major drugs of abuse is presented in the chart below.

The key informants considered heroin as the drug that was causing major problems in society at large. Second to heroin, the other drugs were considered with similar ratings as causing problems in the communities. Therefore from key informants' perception, with minor differences in their rating, use of cannabis, inhalants, sedatives and tranquilisers, other opiates and opium was considered to have caused substantial problems in their communities.

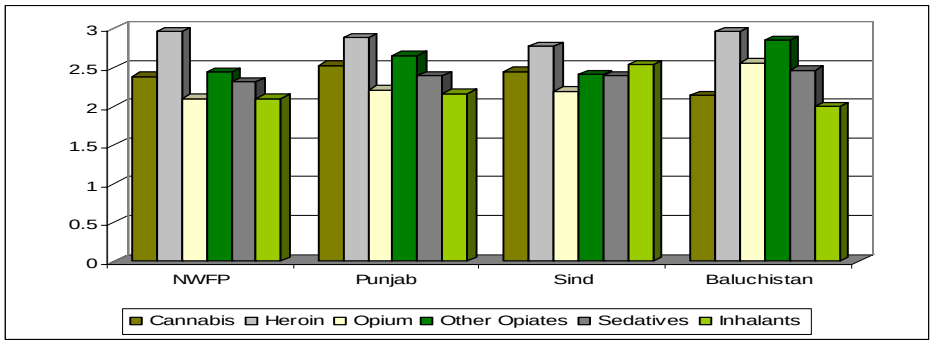


Figure 19: Key Informants' mean rating of perceptions of drugs causing problems

Similarly when the drug users were asked use of which drug had caused most problems in terms of health and social consequences to them, almost all mentioned heroin, opium or other opiates as the drugs that had caused them more problems.

Health consequences

Around 90 percent of the opioid users in Sind and NWFP and more than two thirds in Punjab and Baluchistan reported having faced serious health problems due to their drug use. The health problems drug users had experienced could be summarised as overall malaise and general weaknesses of the body, aches, inability to work, sexual dysfunction, coughs and respiratory problems, infections such as Tuberculosis, Hepatitis C and HIV – the latter reported by small numbers of drug users. It is important to restate here that while citing the reasons why some of the respondents who had earlier injected and currently not injecting, up to 22 percent, - significantly more in Sind (53 percent) - had said that they had not been injecting as they themselves were either infected with Hepatitis C or HIV.

Concerning self reported infections among the drug users[50], up to 27 percent reported being infected with Hepatitis B. Similarly 18 percent reported having Tuberculosis, while up to 11 percent - significantly more in Punjab and Sind - reported being infected with Hepatitis C. Finally confirming various recent reports of a concentrated epidemic of HIV infections, the self reported HIV prevalence was 8 percent among drug users. It is important to note that these are self reported status and were not confirmed by on the spot or laboratory testing. Nevertheless the prevalence of such infections presents a serious public health problem rendering treatment and care of problem drug users increasingly challenging.

	HBV	TB	HCV	HIV
NWFP	18%	14%	1%	3%
Punjab	29%	15%	17%	1%
Sind	23%	18%	11%	23%
Baluchistan	35%	29%	7%	1%
Nationally	27%	18%	11%	8%

Figure 20: Self reported infections

[50] The number of respondents who answered questions on Hepatitis B was 411, Hepatitis C 552, HIV status 355 and Tuberculosis 397. The proportions presented here are of those, who out of these numbers mentioned having the infections.

Similarly when key informants were asked to describe the impact of drug use on individuals and the society, most of them also mentioned infections such as HIV, TB, Hepatitis C, etc., as the major health consequences of drug use that had increased the burden of disease and of caring for drug dependent persons.

Social consequences

Around 60 percent of the drug users mentioned having faced problems in their relations with their spouses, parents and other family members. These problems included separations, drug users facing anger and resentment from their spouses or families, other family disputes and fights and the fact that some of the drug users had been expelled from their homes. More than half of the drug users also reported having work related problems as they could not meet the requirements of their jobs – tardiness, absenteeism, neglect of work and other responsibilities and finally being fired from the job. More than a third of drug users additionally reported having problems with their non drug using friends as those friends did not wish to associate with them. The key informants also described an increase in the disruption of family and social life of drug users, work related problems such as loss of productivity, and legal problems, especially an increase in petty crimes, as the impact of drug use on society.

Selling or donating blood

Many drug users in the course of their drug using careers also resort to selling blood to finance their drug use – a practice that can have deleterious public health consequences, especially in situations where the donor is infected with HIV or HCV, and the control for screening of blood donors and the blood products may not be very strict. The problem drug users who were interviewed in the study were asked if they had ever sold or donated their blood. Selling blood appears to be a common practice among drug users in Baluchistan where more than a third of drug users reported doing so. In Punjab and Sind, this was not as common - up 14 percent of drug users in Punjab and 18 percent in Sind reported ever selling their blood. In NWFP this was an even less common practice as only 7 percent of the drug users reported selling their blood. Apparently selling blood does not seem to be a recent practice as on average the last time drug users had sold their blood was 9 years ago.

Severity of Dependence

While no clinical measures or diagnostic criteria for dependence were applied to the respondents, at the end of the interview each opioid user was administered the Severity of Dependence Scale (SDS)[51]. SDS is a 5 items questionnaire that provides a score indicating the severity of dependence on opioids. Each of the five items is scored on a 4 point scale from 0 to 3. Ascending SDS scores indicate higher levels of dependence[52]. In the current sample of drug users the mean score was reported as 8.3 compared to the mean score of 8.4 in the 2000 assessment study. Within the provinces drug users in NWFP had a significantly higher score of 9.2. Researches on application of SDS and its interpretation suggest cut-off scores of 5 or more for opioid dependence that would be comparable with assessment of population requiring treatment for opioid dependence. If, for instance the cut off point of 6 is taken, it would suggest that up to two thirds of opioid dependent persons in Pakistan are in urgent need of treatment and care.

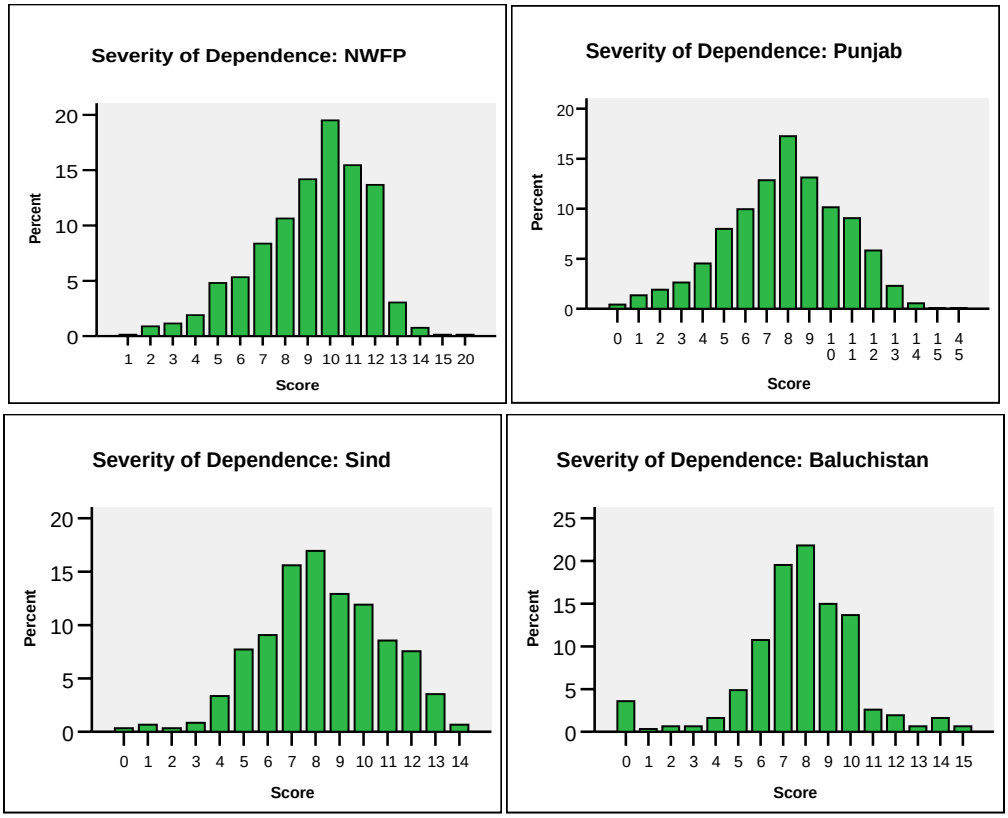


Figure 21: Severity of Dependence Scale

[51] Gossop M., Darke S., Griffiths P., Hando J., Powis B., Hall W., Strang J (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heron, cocaine, and amphetamine users. Addiction, 90(5):607-14
[52] WHO: Management of Substance Abuse

Summary of main findings

- Up to 38 percent of drug users had been arrested at least once in their lifetime on drug related charges
- On an average problem drug users were arrested after 7 years of initiating drug use, and 3 yeas of regular heroin use
- On average the drug users had been arrested around 4 times for a drug related offence and spent up to 2 years in jail
- Up to half of drug users had been arrested for other criminal offences
- Many drug users reported facing serious health and social problems
- 8 percent of drug-users self-reported being HIV positive, 11 percent reported being infected with HCV and 18 percent reported being infected with Tuberculosis
- The mean score on severity of dependence scale is 8.3 indicating a population with needs for treatment, care and other interventions to address their drug dependence and other related problems
- Up to two third of the estimated opioid dependent persons in Pakistan are in urgent need of treatment and care

7

Drug abuse trends

In this section data is presented on the patterns and trends of drug abuse as reported by the key informants interviewed in the various districts of the country. The selection of key informants was on the basis that either in their professional capacity or through their position in the community, these individuals would have knowledge about the local drug abuse patterns and trends. The main professional categories of more than 1,000 key informants that were interviewed included: social workers (18 percent), local councillors (17 percent), teachers (17 percent), recovering addicts (8 percent), police officials (7 percent), general practitioners (7 percent), health workers (5 percent), drug treatment professionals (5 percent), psychiatrists (3 percent) and outreach workers (2 percent). Overall, up to 90 percent of the key informants interviewed were males.

In order for the key informants to comment accurately on local patterns and trends of drug abuse, it was essential that they had come in contact with drug users in their area. The key informants were asked about the number of drug users they had personal contact with in the preceding 12 months. On average the respondents reported to have had personal contact with 30 drug users in this period. Based on the information provided by the key informants a more comprehensive national picture of commonly used substances, the age groups, and socio economic status of the persons using these substances was developed and is presented in this section.

Commonly used substances

From a list of illicit and licit substances that are known to be used in Pakistan, the key informants were asked to comment if these substances were "*commonly used*", "*used somewhat*", "*rarely used*", "*not used*" or if they "*did not know*". The last two categories were included as active categories so that the respondents would not give arbitrary answers to the other response categories. Based on the key informants' responses the precedence of commonly used substances was prepared and is presented in the chart below. Nationally the key informants listed cannabis products such as hashish as the most commonly used substance in their areas. Second to this sedatives and

tranquilisers, such as benzodiazepines, were listed as commonly used substances. These were followed by heroin, opium and other opiates. The category of "*other drugs*" also appears prominently in the list of substances whose use was reported as "*common*". Among these substances, alcohol[53] was reported as a commonly used substance along with pharmaceutical preparations such as antihistamines. The key informants' rating of commonly used substances also corresponds with the drugs reportedly being used by the opioid users interviewed. Up to half of the key informants considered that injecting drug use was becoming a common phenomenon among drug users in general.

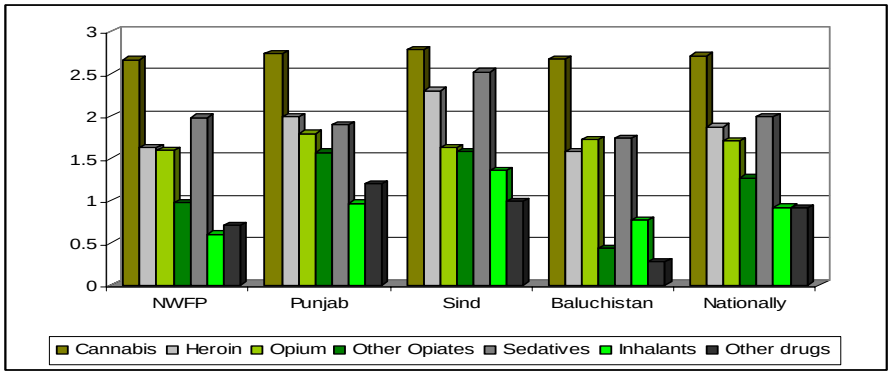


Figure 22: Commonly used substances - mean rating

Gender, age and socio economic status of users

The key informants were further asked to list the commonly used substances among men, women, young people[54] and adolescents and their corresponding socio economic status. Corresponding to the listing of commonly used substances, the key informants considered cannabis, heroin, sedatives and tranquilisers and other prescription drugs as the most common substances used primarily by the low income groups, followed by the middle income groups and to lesser extent by the upper income groups. Additionally, sedatives and tranquilisers and other opiates were perceived to be more commonly used by women and inhalants by adolescents in almost all parts of the country. Concerning the typical age at which people initiated use of different substances, inhalants and cannabis (hashish) were the two substances whose use reportedly initiated at early ages i.e., on average 15 and 17 years respectively. This information from key informants on

[53] Alcohol was part of the list of substances as it is not included under the INCB's list of substances under international control and therefore out of the scope of current study

[54] Young people for the purpose of study were defined as those between 16 to 25, while adolescents were defined as under 15 years of age

initiation of substance abuse more or less corresponds with the information provided by drug users.

Substance	Mean age
Cannabis	17
Heroin	22
Opium	29
Other Opiates	23
Barbiturates	23
Benzodiazepines	25
Inhalants	15

Table 25: Typical age at first substance use

Perceived changes in drug abuse trends

In order to document the perceived changes in the use of various substances over the 5 years, since 2001[55] as well as the last 12 months, key informants were asked whether the use of each index drug had "*decreased a lot*", "*decreased a little*", "*not changed*", "*increased a little*", and "*increased a lot*"[56]. Each response was quantified and the mean values for each drug were calculated and are graphically presented in the figures below.

It is important to note that the key informants' qualification of change in ordinal categories from "*decreased a lot*" to "*increase a lot*" was based not only on some objective quantitative figure but also on the local context and their own perceptions of changes in their localities and districts.

For both the time periods, the key informants considered that nationally there has been a substantial increase (*increased a lot*) in the use of cannabis and sedatives and tranquilisers, while there has been *some increase* in the use of barbiturates. The key informants in NWFP, however, considered that there has been some decrease in the use of heroin, opium and other opiates in their province. In the other provinces the key informants considered that there was still some increase in the use of heroin, opium and other opiates in both periods. Inhalants are another class of substances whose use was reported as increasing among adolescents.

[55] The National Assessment on Drug Abuse was conducted in Pakistan in 20000
[56] These are the same categories which are used for summary expert opinions in the ARQ Part II: Extent, patterns and trends of drug abuse, filled in by each member state and submitted to CND

With regard to the reasons for the perceived changes in drug use, the key informants considered that since more people were aware of the harmful consequences of heroin use, its use has decreased (as in NWFP) or not increased to a great extent. Furthermore, many key informants also considered that as there was less availability of heroin in some areas or it was more expensive than the other drugs such as other opiates, sedatives, or tranquilisers and barbiturates, more people were using the latter substances. To explain the increase in the use of cannabis, most of the key informants suggested that cannabis or hashish was widely available in the country and there was, to a certain extent, social acceptability of hashish use.

It is an important point for the consideration of policy makers and planners that in the absence of effective evidence based prevention and treatment programmes any net decrease in the use of a substance is often offset by an increase in the use of another substance, which then compounds the drug related problems to be addressed.

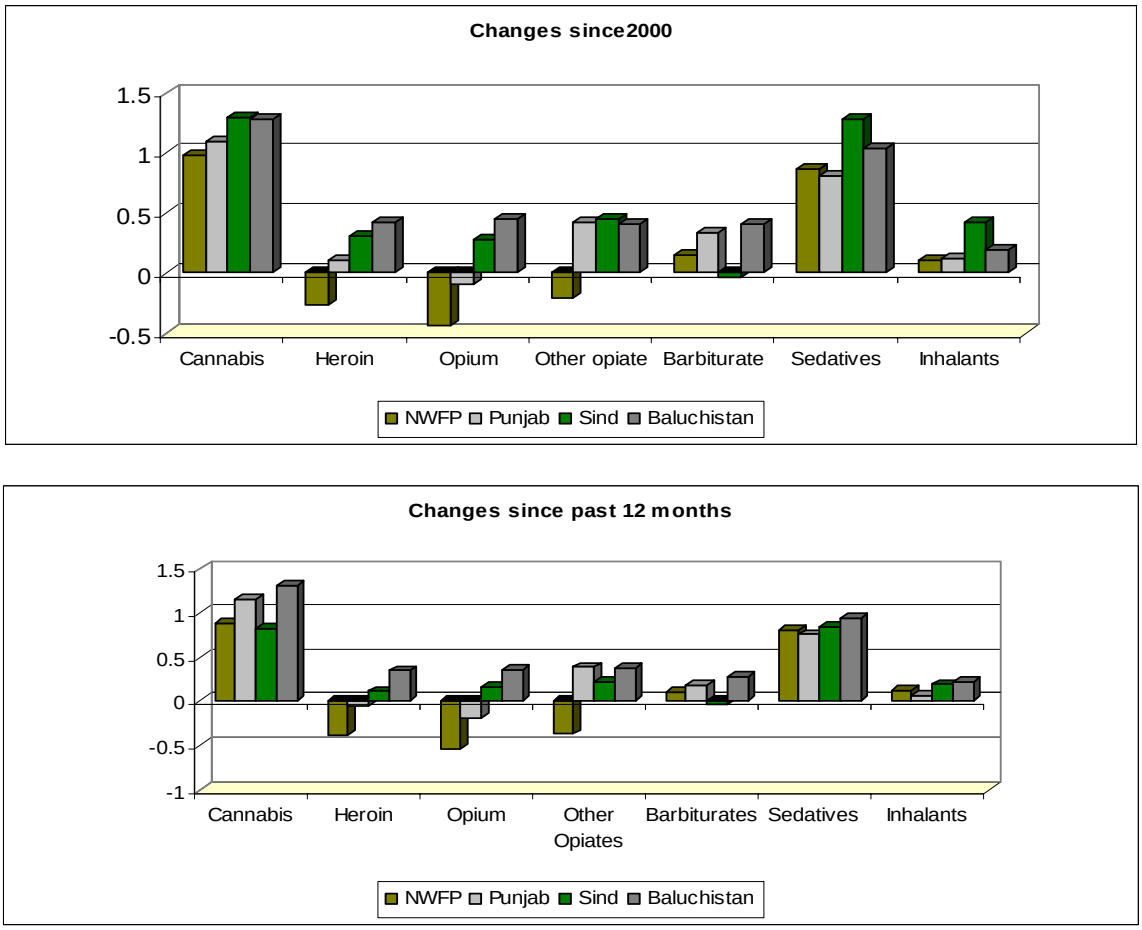


Figure 23: Ratings of perceived changes in drug use

Emerging drugs – Ecstasy use

Another component of the national assessment attempted to look at newer trends of drug use such as that of Ecstasy through focus group discussions with young people in some urban centres in Pakistan. This was especially important, since Ecstasy users would not be reported in the treatment settings and many of the key informants at this stage might not have had sufficient information or knowledge about Ecstasy use. The focus group discussions were held in Islamabad, Lahore, and Karachi, with middle to upper middle class youth aged 18 to 25. The main objective of the focus groups was to learn the participants' perceptions and experiences of the use of drugs such as Ecstasy in the *recreational gatherings* organised by urban upper middle class youth. It must be noted that since only 28 young men and women participated in the 3 focus groups, the findings can not be considered as valid for generalization for the entire country. However this is important information that can alert the policy makers about emerging drug use, and can also form a basis for further qualitative research on recreational drug use among youth in urban centres of Pakistan.

Awareness of drugs used at parties

The participants in the focus groups thought that drug use among young people at parties had increased in the past few years. The main drugs that were reportedly used at the parties include hashish, alcohol, ecstasy and to some extent cocaine. The participants considered that hashish being easily available and cheap was more commonly used. They were also of the opinion that Ecstasy use had increased, since young people wanted to try something *new*, which they considered as *not harmful,* and which would give them *a kick* for 4 to 5 hours. The participants also gave an extensive list of brand names and slang used for Ecstasy in their circles. Most of these brand names are used internationally and indicate the awareness of this group of respondents of the "*international culture*" of drugs used in parties and raves. The main names cited are given in the box below:

Ecstasy brand names and slang
Diamond, Blue Marlboro, Love Dove, Ferrari, Double Cherry, Armani, Mitsubishi, Anchor, Role, Pink, Butterfly, goli tapna

The participants were of the view that Ecstasy was being used in parties organised and attended mainly by young men and women aged between 16 and 25 years, who mainly belonged to upper or upper middle class families. House based parties, organised by a few individuals or a group of friends were the main settings in which Ecstasy was being used. Some participants mentioned that young people driving fast motor bikes, or involved in car racing used Ecstasy to enhance their risk taking behaviour.

Perceived benefits and problems due to Ecstasy use

Referring to the perceived benefits of using Ecstasy at parties and social gatherings, the youth were of the opinion that it was *convenient*[57] to use Ecstasy since it could keep a person *normal* and *functional* and that there was *no stigma* associated with its use. They felt that Ecstasy made them *social*, *confident* and able to make *new contacts*. The young people thought Ecstasy users had more *fun* at their parties and could dance for hours without getting tired or exhausted. Some participants also mentioned that Ecstasy was also used for enhancement of sexual pleasure.

As for the problems that may arise out of Ecstasy use, some participants mentioned that at times young people became violent which could lead to fights and disruption at the parties. Some people had reportedly *misbehaved* or *sexually harassed* other people. Only a few participants were aware of any health consequences of using Ecstasy and mentioned that Ecstasy users could become dehydrated and collapse. Others mentioned cases of *severe depression* experienced by some of their friends due to Ecstasy use.

Perceived availability

Participants in the focus groups reiterated that use of drugs such as Ecstasy has increased among young people over the past few years, but then also said that these drugs were not easily available. The participants mentioned that in order to have access to a dealer one needed references from another person who was known to the dealer or was an established customer. At some occasions the organisers of the parties or events arranged to get Ecstasy on their own. With regard to its price most of the participants mentioned that the Ecstasy tablets allegedly brought from UK cost 25 to 50[58] US dollars per tablet. The focus group participants considered that bringing Ecstasy from UK was

[57] The words in italics in these paragraphs are verbatim expressions of the participants and may not necessarily be factual.
[58] 1USD equivalent to approximately PKR 60

relatively easy because it did not have any smell; the pills were small and could easily be brought in large quantities. Furthermore, they thought that since Custom officials in Pakistan were not *really aware* of Ecstasy, a person could easily bring these in his or her baggage without much risk. Some of the focus group participants said that prices of Ecstasy would go down as it was now being brought from China, India and even produced locally. The locally produced Ecstasy was not considered of good quality but would cost between 10 to 13 US dollars.

Conclusions

Given that there are signs of Ecstasy and probably other amphetamine-type substances (ATS) emerging on the local drug scene, there is a need to a) train local law enforcement officials to recognise these substances for seizure purposes; b) increase public awareness, especially targeting urban youth through educational programmes on the health and social consequences of using substances such as Ecstasy; c) instil an early warning system to continue monitoring the trends in drug use, identify emerging drugs, undertake follow up in-depth studies and inform national policy makers on appropriate actions and steps. Furthermore, there is an evident need for focus assessment studies on the extent and pattern of drug use among youth in urban centres and educational institutions in the country.

Summary of main findings

- The key informants considered cannabis as the most commonly used substance, followed by sedatives and tranquilisers, heroin, opium and other opiates in the order of occurrence. Injecting drug use was also considered as a common phenomenon among drug users.
- Furthermore, most key informants considered a substantial increase in the use of cannabis and sedatives and tranquilisers in the past years. While key informants in NWFP considered that there was some decrease in the use of heroin, opium and other opiates in their province, key informants in the other provinces considered there was still some increase in the use of these substances.
- Compared to common use of substances, opioids and especially heroin was considered as the drug causing more harm in the society and to the individuals. However use of cannabis and other substances was also considered to be causing substantial harm.
- Ecstasy is considered as an emerging drug especially among youth belonging to the higher socio-economic groups in some urban centres in Pakistan.

8

Conclusions and implications

The first part of this section describes prevalence of opioid use in Pakistan while the second part discusses implications of the findings and suggests some priority areas that need to be addressed for prevention, treatment and rehabilitation of drug abuse in Pakistan.

Prevalence of opioid use in Pakistan

Based on the information collected during the assessment, the annual prevalence of opioid use in Pakistan is estimated around 0.7 percent of the adult population (95% CI 0.4 - 1), with a corresponding estimate of 640,000[59] opioid users. Out of these around 77 percent are estimated to be heroin users. Similarly, the prevalence of injecting drug use is estimated around 0.14 percent of the adult population or around 130,000 injecting drug users. It is important to note that the absolute number of injecting drug users in Pakistan has almost doubled since 2000 – an alarming trend that needs to be addressed as a priority.

By provinces, Baluchistan has the highest opioid use prevalence of 1 percent followed by 0.7 percent in NWFP. Punjab and Sind provinces have an estimated prevalence of 0.4 percent each. In terms of absolute numbers, the highest number of opioid users and injecting drug users are in Punjab followed by Sind. By districts, Pishin, Karachi central and Chitral are the three districts with a high prevalence of 1 percent of opioid use among the adult population.

National	Opioid Prevalence	95% CI	IDU Prevalence
NWFP	0.7	0.5 – 0.9	0.06
Punjab	0.4	0.2 – 0.6	0.2
Sind	0.4	0.2 – 0.6	0.2
Baluchistan	1	0.8 – 1.2	0.1
Overall Pakistan	0.7	0.4 – 1	0.14

Table 26: Prevalence of opioid use in Pakistan

[59] Based on 91 million adult population (15 -64 years): Source: UN Population Division Data

North West Frontier Province

The estimated prevalence of opioid use in NWFP is 0.7 percent of the adult population (95% CI 0.5 – 0.9) or around 90,000 opioid users, while the prevalence of injecting drug use is 0.06 percent. Within the province, Chitral district where most of the opioid users were dependent on opium has the highest prevalence. Kohat district has the next highest prevalence of opioid and injecting drug users, i.e., 0.8 and 0.1 percent respectively. Peshawar district ranks third in the overall prevalence of opioid use, but in terms of absolute numbers has the highest number of both opioid users and injectors in NWFP.

	Prevalence	Numbers	IDU Prevalence	IDU numbers
Chitral	1	2,000	0.05	100
Peshawar	0.6	8,000	0.07	900
Bannu	0.5	2,000	0.02	100
Kohat	0.8	3,000	0.1	400
Haripur	0.5	2,000	0.04	200
NWFP	0.7	90,000	0.06	8000

Table 27: Prevalence of opioid use in NWFP

Punjab

In Punjab, the opioid use prevalence is estimated as 0.4 percent (95% CI 0.2 – 06) or around 200,000 opioid users. The prevalence of injecting drug use in Punjab is estimated around 0.2 percent with corresponding estimates of around 100,000 injecting drug users. Within the province, there is a higher prevalence of opioid use in the districts of Okara and Sialkot where the prevalence is estimated at 0.8 and 0.7 percent respectively. In terms of absolute numbers, the district of Lahore followed by Sialkot and Okara has the higher number of problem drug users. While Okara district has the highest prevalence of injecting drug use (0.3 percent) Lahore district has the highest number of injecting drug users, i.e., 11,000 compared to 5,000 in Okara.

	Prevalence	Numbers	IDU Prevalence	IDU numbers
Rawalpindi	0.3	7,500	0.05	1300
Lahore	0.3	16,000	0.2	11,000
Sargodha	0.4	7,000	0.2	3000
Faisalabad	0.2	7,000	0.1	5,000
Sialkot	0.7	13,000	0.3	6,000
Okara	0.8	12,000	0.3	5,000
Multan	0.1	1,500	0.03	600
DG Khan	0.2	1,400	0.03	200
Punjab	0.4	200,000	0.2	100,000

Table 28: Prevalence of opioid use in Punjab

Sind

The prevalence of opioid use in Sind is estimated as 0.4 percent of the adult population (95% CI 0.2 – 0.6) or 87,000 opioid users, whereas the prevalence of injecting drug use is estimated around 0.2 percent or 44,000 injecting drug users. Within the province, the highest prevalence of 1 percent of opioid use is in the central district of Karachi whereas the overall prevalence in the four districts of Karachi is estimated around 0.6 percent. The absolute number of opioid users in Karachi's four districts is around 41,000 while the number of injecting drug users is estimated around 20,000. The other two districts in Sind where the assessment was conducted were Larkana and Hyderabad. In these districts the estimated prevalence is 0.3 and 0.2 percent respectively or about 4,000 opioid users in each district.

	Prevalence	Numbers	IDU Prevalence	IDU numbers
Larkana	0.3	4,000	0.1	1,300
Hyderabad	0.2	4,000	0.05	1,000
Karachi South	0.7	9,000	0.4	6,000
Karachi East	0.5	11,000	0.2	4,100
Karachi Central	1	12,000	0.2	3,000
Karachi overall	0.6	41,000	0.3	20,000
Sind	0.4	87,0000	0.2	44,000

Table 29: Prevalence of opioid use in Sind

Baluchistan

Finally Baluchistan with 1 percent prevalence (95% CI 0.8 – 1.2) has the highest rate of opioid use in the country, while Pishin district (1.1 percent), has the highest prevalence among all the districts in Pakistan. The absolute number of opioid users in Baluchistan is estimated around 45,000. In Quetta and Pishin districts the estimated prevalence is 0.9 and 1.1 percent respectively. In terms of numbers these are estimated around 5,200 opioid users in Quetta and 2,500 in Pishin. The prevalence of injecting drug use in Baluchistan is estimated as 0.1 percent. In Quetta and Pishin the number of injecting drug users is estimated as 400 and 300 respectively.

	Prevalence	Numbers	IDU Prevalence	IDU numbers
Quetta	0.9	5,200	0.1	400
Pishin	1.1	2,500	0.1	300
Baluchistan	1	45,000	0.1	4500

Table 30: Prevalence of opioid use in Baluchistan

The estimated numbers of opioid users and injecting drug users for the provinces are indicative. These, if at all, should be used and interpreted with caution. Also, the overall prevalence estimate for Baluchistan should be interpreted with caution as only two districts that are geographically close were covered in the assessment, and may have given a biased picture of the province.

Priority areas to be addressed

A comprehensive strategy for drug abuse prevention, treatment and rehabilitation in Pakistan should address all the main areas of interventions: developing an environment that is conducive to prevention and treatment efforts; policy measures to address the control of both licit and illicit substances; prevention of drug use; reduction of the social and health consequences of drug abuse; treatment of drug dependence and criminal justice system measures. Nevertheless based on the findings of the national assessment, some important issues that need to be addressed in Pakistan are:

- There is a population of opioid users, mostly in their mid thirties, who have had a history of over 10 years or more of regular opioid use, who are also poly drug users, and have had multiple attempts at treatment for their opioid dependence.
- There is an increasing population of problem drug users who are injecting drugs - a population that has doubled in the last 5 years or so. Coupled with this is an increasing population of problem drug users with psychiatric and other co-morbidities such as HIV, Hepatitis C, and Tuberculosis.
- Moreover, there is also a younger population of opioid and inhalant users whose needs are to be addressed.
- There is an unmet need for treatment of drug dependence among problem drug users. On the other hand the quality and range of services offered through existing treatment services are not adequate in relation to the challenges and the diverse needs of their clients.
- Use of cannabis type substances continues in large segments of the society along with increasing use of inhalants among adolescents who are primarily street based.
- There is an increasing use of other opiates such as morphine, codeine, pentazocine, buprenorphine, etc., as well as tranquilisers and sedatives which are being obtained through a black market as well as from pharmacies without prescriptions. Apparently, the dispensation or sale of these controlled substances through pharmacies is unregulated.

School and community based prevention programmes

There is a need to look at prevention of drug use beyond the customary one-off public awareness events – the myriad of walks, sports and other "*drug free competitions*", or initiatives to provide information on the hazards and consequences of drug use to young people. Prevention programmes need to be planned as concerted efforts that focus on enhancing the protective factors for prevention of drug use as well as to help reduce the risk factors that promote drug use among adolescents and young people in different settings. Primary prevention programmes[60] therefore, need to have three dimensions:

1. Prevention in schools through drug abuse education in the context of health curriculum such as "*personal, social, and health education*", which focuses on health promotion, and is based on developing links between knowledge, values and skills. Such life skills based programmes empower students with appropriate information and skills to take greater control of their lives and improve their own health. School programmes that have corresponding family skills training programmes for parents and families have been found to be more effective than programmes targeting only young people.
2. Community based prevention programmes targeting out of school youth with the objective of preventing use of substances such as inhalants, cannabis and other drugs used by vulnerable young people. These programmes are usually developed in partnership with youth and community leaders and parents. Peer to peer programmes, as an example, involve youth in sports, creative activities, and community service as healthy alternatives as well as help young people develop prevention skills. Peer led programmes can reach out to young people in multiple settings in the community such as youth or sports clubs and associations.
3. Prevention programmes and interventions for most-at-risk adolescents (MARA) such as child labourers and street children. These programmes include interventions that provide a safe and supportive environment for at risk adolescents, improve their access to health and social services in the community, provide assistance and services for prevention and treatment of drug use,

[60] For resources on prevention among youth in different settings and initiatives please see the relevant UNODC publications at www.unodc.org/youthnet

sexually transmitted diseases and other health and social needs[61]. Prevention programmes for most-at-risk adolescents can be implemented in partnership with other similar initiatives such as UNICEF's child protection programmes or International Labour Organization's (ILO) programmes for elimination of child labour.

Improved delivery of treatment services

There are two areas of interventions that need to be considered as part of improved delivery of treatment services. The first concerns accessibility, quality and range of interventions and services provided, especially in light of the key informants' and drug users' perceptions of the effectiveness of these services. Both of these groups have indicated a major gap in the delivery of a continuum of care for drug dependent persons. Improving delivery of services would firstly require the development of standards and protocols of essential services that should be provided through drug treatment facilities[62]. Secondly, drug treatment facilities need to be *certified* for the quality of services provided based on the standards and protocols. Thirdly, training programmes need to be instituted to develop or upgrade the skills of key staff and service providers in these institutions. Finally, there is a need to put in place a system of ongoing monitoring of the delivery, quality and coverage of drug treatment services as well as the evaluation of the various interventions for their effectiveness.

There are many districts in the country, where treatment of drug dependence is not fully developed or available – districts such as Kohat, Okara, Sialkot and even Rawalpindi - where during the assessment key informants indicated few, inadequate or no services available for treatment of drug dependence. One priority area would be development of treatment services in districts where they do not currently exist.

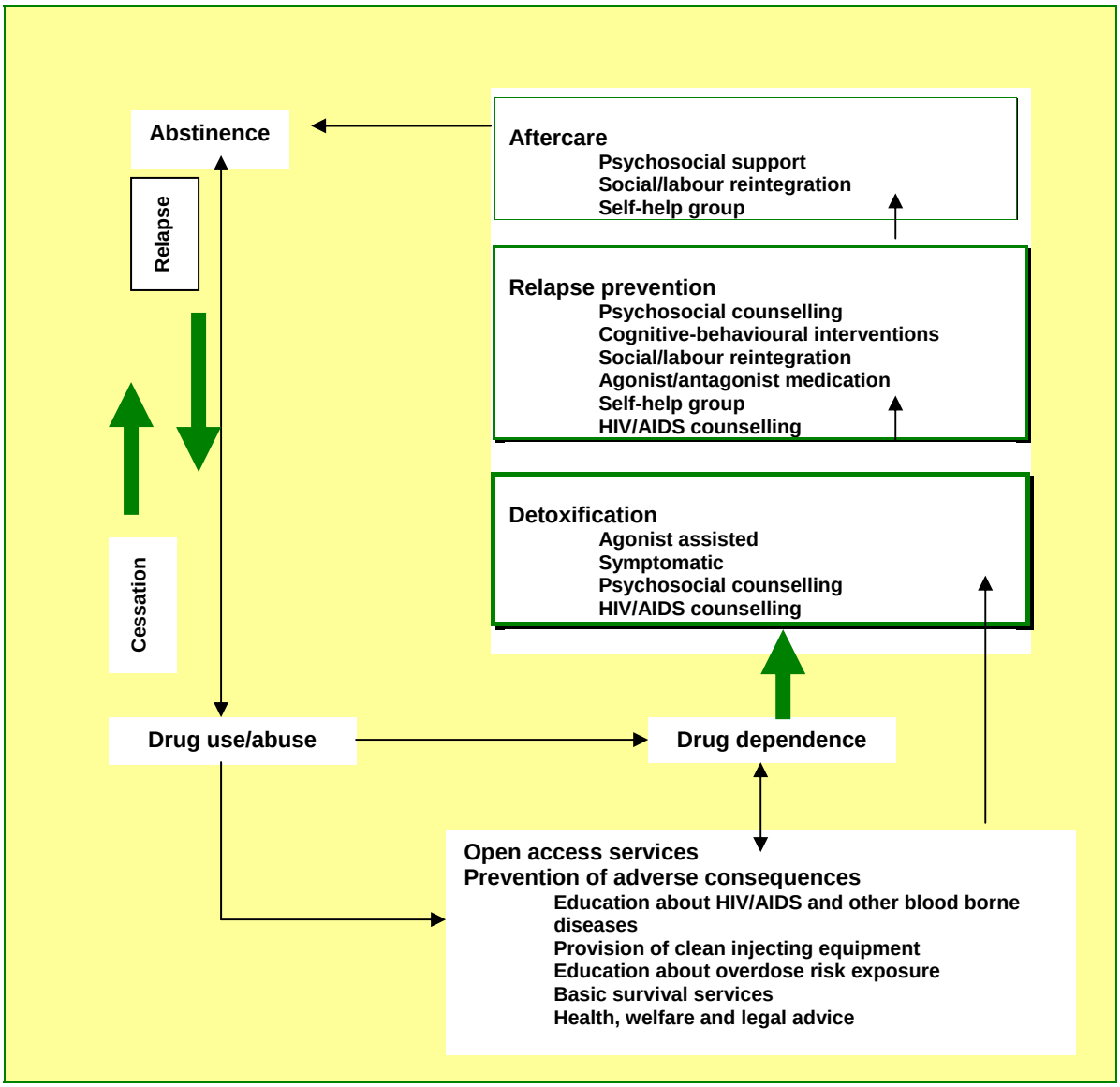
Meeting changing and diverse needs for treatment and care

The evidence suggests that face of the drug abuse situation in Pakistan is changing. Opioid users are mostly poly drug users; many are injecting, and have psychiatric and other co-morbidities such as Hepatitis C, Tuberculosis, and HIV/AIDS. Treatment

[61] WHO Working with street children – training package on Substance use, sexual and reproductive health including HIV/AIDS and STDS www.unodc.org/youthnet
[62] For detailed reading refer to UNODC's Drug Abuse Treatment and Rehabilitation – a practical and planning and implementation guide, and other related WHO and UNODC publications.

programmes or services therefore need to develop capacities to address the increasing challenges of caring for drug dependent persons along with provision of conventional interventions as a continuum of care. Some of the issues that need to be considered are a) How to manage withdrawal on a poly drug user, or a person who has hepatitis C, HIV or Tuberculosis?; b) A referral system within different services for diagnosis, treatment and care of psychiatric and other co-morbidities such as Tuberculosis, Hepatitis C, HIV/AIDS, etc., among drug users; c) Build capacity of key service providers to treat drug users for other than opioid dependence, i.e., for dependence on inhalants or stimulants. d) Addressing the knowledge gap of key service providers in treatment facilities concerning emerging trends and care issues.

Figure 24: Structured treatment and rehabilitation



Drug Abuse treatment and rehabilitation: A practical planning and implementation guide, UNODC

Opioid Substitution Therapy

Substitution maintenance therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing opioid use, associated deaths, HIV risk behaviours such as injecting drugs and criminal activity. Substitution maintenance therapy is now considered as a critical component of community based approaches in the management of opioid dependence and the prevention of HIV infections among injecting drug users[63]. In Pakistan as the assessment results indicate, there is a large proportion of opioid dependent persons with a high SDS score, who have a long history of regular opioid use and have repeatedly undergone abstinence based treatment. It is time that policy makers and service providers consider introduction of "*Opioid Substitution Therapy*" for those drug users who meet certain criteria, such as opioid use for 5 to 7 years, injecting, history of multiple treatment attempts, co-morbidity, age, social support, etc.

Outreach interventions

Community based interventions such as outreach is another area that needs attention. Outreach activities by trained workers motivate and support drug users who are not in treatment to reduce their risk behaviours such as injecting, sharing of injecting equipment, or unprotected sex with multiple partners. Research indicates that outreach activities taking place outside the conventional health and social care environments can reach out to those drug users who are not in treatment, and increase the rate of drug treatment referrals.

In Pakistan outreach interventions are available in some districts, and in some of these districts the drug users indicated an adequate coverage of outreach workers. However, there are other districts that have outreach services that are not fully covering the problem drug users, as well as districts where such services do not exist at all. Some of the districts where there is a priority need to improve the coverage and delivery of outreach interventions for prevention of HIV among injecting drugs users are Lahore, Sialkot, Okara, Kohat, Karachi, and Rawalpindi. Moreover, there is a need to initiate outreach interventions for drug users in as many districts as possible.

[63] WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention, 2004

Control and sale of psychotropic substances

The assessment results indicate an increasing use of psychotropic substances – licit opiates, tranquilisers and sedatives such as benzodiazepines - a trend confirmed by the key informants. This trend further complicates the entire drug control strategy where the main focus of the law enforcing agencies has been on illicit substances such as heroin and hashish. Clearly, these licit substances are being obtained over the counter through pharmacies and other channels. A major priority consideration for Government of Pakistan should therefore be to regulate the import, production, supply and sale of these psychotropic substances. However the most important step would be to regularise the sale of psychotropic substances through a prescriptions system with appropriate checks and safeguards to detect and prevent misuse of the prescriptions.

Fostering research, monitoring and evaluation

Research in various aspects of drug use and associated problems is currently on a low priority in Pakistan. While prevention and treatment programmes have been implemented for over three decades there is no system in place to monitor the quality of interventions or to evaluate the efficacy and effectiveness of these responses to drug abuse. On the other hand there are many research institutions and university departments of social and behavioural sciences where students and faculty regularly conduct research. An effective strategy would be to develop linkages with these university departments at the national and local levels to use their expertise and resources to conduct research on drug abuse and related issues. Similarly, these institutions can be part of a regular monitoring and evaluation mechanism that could monitor the drug abuse situation, and responses for prevention and treatment, as well as evaluate the efficacy and effectiveness of these interventions.

Some suggested areas of future research that can be undertaken by research institutions are:

- Focus assessment studies on the nature, extent and pattern of drug use especially among youth in different settings.
- Evaluation of the effectiveness and efficacy of interventions for prevention and treatment of drug use
- Study of social and economic impact of drug use
- Research on networks and dynamics of injecting drug use

Setting up a drug abuse information system

Since 2002, UNODC has been providing assistance to the Government of Pakistan to implement a "*Drug Abuse Information System*" primarily through monitoring the demand for treatment in 4 pilot locations. In 2007 the scope of treatment reporting has been extended to 8 cities in the country. It would be worthwhile to consider further expansion and instituting the entire "*treatment reporting system*" in partnership with the Ministry of Narcotics Control, the Anti Narcotics Force and a major national university. A national drug abuse information system could also consider including other indicators of drug use that could provide ongoing information on the patterns and emerging trends of drug abuse in the country. One important indicator for consideration could be monitoring the availability, price and purity of heroin and other illicit substances in various locations. Similarly, the information system could also incorporate monitoring of the quality and effectiveness of responses to drug problems at various levels.

Priority areas for prevention, treatment and rehabilitation of drug use

- School based prevention programmes focusing more on "personal social and health education" for in-school adolescents and youth with corresponding family skills training programmes
- Community based prevention and health promotion activities in partnership with local community leaders and parents
- Prevention and intervention programmes for street children and other most-at-risk adolescents (MARA) in partnership with UNICEF, ILO and other international and national stakeholders.
- Improving scope, coverage and delivery of drug treatment services to meet the changing and diverse needs of drug dependent persons, especially those with co-morbidities such as HCV, HIV and TB
- Introduction of opioid substitution therapy (OST)
- Improving the scope, coverage and delivery of outreach interventions for prevention of HIV risk behaviours among drug users
- Control and sale of psychotropic substances, especially through pharmacies
- Developing linkages with universities to foster research in drug abuse, monitor the drug abuse situation and responses, and evaluate the effectiveness of interventions
- Establishment of a national drug abuse information system with multiple indicators and an expanded scope

UNODC,
Country Office for Pakistan
House 50, Street 1, F-6/3
Islamabad

Printed in Pakistan
September 2007 - 500