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Country Profile - Bangladesh

Problem of Drug Dependence in Bangladesh

by

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Bangladesh is a deltaic country with only 56 000 square miles and 80 million inhabitants. The average population density is almost 1 500/square mile. Illeteracy rate is 85% and 80% live in rural areas. Population is predominantly muslim, with strong religious faith. The economy is basically agricultural, and family life is still very cohesive. There is continuous migration to urban areas in search of jobs, which have recently increased due to various socio-economic factors. Increased mobility is substantial since the social upheavals during the liberation struggle, when large number of people, especially youths, migrated to neighbouring countries. During the post-liberation period, evidence of youth unrest, decline of earlier social values and loss of the sense of belonging are becoming increasingly apparent, especially in urban areas. Rapid change in the socio-economic milieu has imposed further strain on the adjustment capability of an individual resulting in increased frustration level among the youths of the country.

Health system

The health system of the country is still basically urban-oriented. However the Government is presently engaged in establishing a health complex in each thana, which is the administrative unit with subsidiary centres located at the village level to cater to the needs of the rural population. To meet the shortage of qualified doctors mid-level medical assistants and village doctors on the line of "Chinese Barefoot doctors" are being trained in huge numbers to tackle common medical problems of the villages and to improve the immunization programme, family planning and health education. Besides the expected improvement of medical care in the rural areas with the introduction of this system, there may be increased risk of drug dependence also in the village where this problem is almost non-existent at present.

Magnitude of the problem

There has been no survey in Bangladesh to assess the problem of drug dependence, so the magnitude of the problem is almost unknown. As drug dependence is still considered as a moral problem, very few people come for medical help, so hospital and

out-patient statistics are of no benefit for its assessment. However, some cases with pethidin, barbiturate and tranquiliser abuse, including Mandrax, seek treatment either voluntarily or brought by relations Being a predominantly muslim country, there is strong stigma against alcoholism, and this is mostly limited to urban and slum areas. Besides religious restrictions, alcohol is prohibited for muslims by law and cannot be served to them in public The extent of alcoholism is still insignificant though there are signs of gradual increase Dependence is mostly confined to opiates — crude opium, morphine and pethidine, barbiturates, cannabis, indica and occasionally mandrax Recently, Diazepan, Meprobumate and other related drugs are being increasingly abused Dependence on hard drugs like cocaine and heroine is not yet in evidence just because these are not available There are sixteen thousand officially registered crude opium addicts approximately in the country at present who purchase drugs from the Government-approved shops There is no record of cannabis indica or any other drug purchasers as there is no system of registration. Figure for opium dependence is undoubtedly low as there are many more who might be procuring from illecit sources. Cannabis indica smoking is the most popular form of dependence which is mainly practised by the people of industrial areas, students and working people with long hours of duty, like truck drivers, etc. Cannabis indica in the form of "ganja" is available from licensed Government shops and also from illicit channels. The availability of Ganja, however, appears to be plenty from illicit sources.

Availability of drugs

Except for cannabis indica and a small quantity of alcohol, all the drugs are imported. There is strict restriction on the import of these drugs. Import figure of 1977 is given below.

a.	Secobarbital	4 88 kgm	g.	Codein	402.14 kgm
b.	Meprobamate	25.56 kgm	h.	Pholcodein	16.66 kgm
c.	Phenobarbitate	310.7 kgm	i.	Ethyl Morphine	2.91 kgm
d.	Thiopentone	10 0 kgm	j.	Medicinal opium	4 62 kgm
e.	Pethidine	55 31 kgm	k.	Opium (non-medical)	200.00 kgm
f.	Morphine	5 04 kgm			

No other drugs including amphetamine have been imported and are mostly not available. There are 268 opium shops which sell small quantities of crude opium to persons with permits Many of these shops do not have enough opium to sell due to the short supply, as there is a policy of gradual reduction in import but may be continuously compensated from illicit sources. It is estimated that there are 10 cases of undetected smuggling of opium per one case of detection by the customs Cannabis indica is being cultivated in a compact area under supervision of excise people to meet the annual consumption which is about 30 000 kgm. The area under cultivation is roughly 700 acres which is subject to variation. Cannabis indica is sold through 600 Government-approved shops in small quantity to each person However, the availability of cannabis indica appears to be plentiful even from illicit sources. Though other drugs like barbiturate pethidine, morphine and psychotropic drugs are only available in chemists' shops and expected to be sold on prescription, there is no system of registration of sales and psychotropic drugs are frequently available without prescription. No organizations, individuals or private enterprises have exclusive right to import or export of psycho-active drugs. However, wholesale trade of cannabis is controlled by a Government agency Prescriptions are required for barbiturates but not for meprobamate.

Legal situation

Bangladesh is a party to single convention on Narcotic drugs in 1961 and amended protocol of 1972. But this country is not a signatory to the convention on psychotropic substances, 1971, or to any bilateral or multi-lateral treaty concerning narcotic and psychotropic drugs. Psycho-active drugs are controlled by Drug Act 1940 and Dangerous Drug 1930, and rules framed under these acts in 1967 to conform with the single convention. Different acts to conform different international convention such as a) opium acts, 1857 b) opium acts 1878, c) excise act 1909, d) opium smoking act 1932 and d) dangerous drug act 1930, were enacted at different times. A comprehensive act is in advance stage of implementation, which will include all previous acts under the title of "Narcotic Drug Ordinance". This will provide provisions for banning of opium in 1979 and cannabis indica in a future date.

Enhancing of the punishment, recording systems for morphine and pethidine for doctors, provisions of a narcotics control board and introduction of treatment and rehabilitation of addicts, are being incorporated in this Act. At present it is not a crime to consume opium or cannabis indica or drugs which fall under dangerous drugs, etc , but illegal possession of these in larger quantitites is punishable

Treatment facilities

There is no treatment facility in the country at present The establishment of separate treatment centres at this stage is neither feasible nor necessary, due to the shortage of manpower and financial difficulties It is essential to have treatment centres with appropriate staff at least in big cities Integration of general health care system with additional treatment facilities will be the most suitable approach to start something in the absence of proper assessment. Psychiatric clinics attached to medical colleges may serve as Pilot Centres for this purpose. Experience thus gained may be extended later according to the necessity.

Manpower

There is extreme shortage of trained manpower in the country. There are only nine working psychiatrists, no psychiatric social worker and psychologist who is actively engaged in mental health work. But a large number of general social workers and psychologists pass out from the universities and may be potentially utilized for the purpose of dependence, treatment and rehabilitation centres after due training under the supervision of trained psychiatrists

Conclusion

Drug dependence in Bangladesh has not yet become a big problem But the stage is set for increase in the dependence rate in future due to the rapid socio-economic changes, decline of social values, industrialization and increase of stress. Immediate measures must be taken to prevent the spread of this problem.

Assessment of the problem through an appropriate survey of at least target groups like studens and industrial workers is immediately needed and should be taken as top priority. The utilisation of social workers and psychologists for the prevention, treatment and rehabilitation work will fulfil the present deficiency in manpower Socio-economic factors which are conducive to drug dependence need to be tackled as preventive measures. Increased health education programme, strict restriction on drugs and provision of treatment are needed to reinforce other preventive measures