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Country Profile - Pakistan

by

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PREVENTION AND TREATMENT OF DRUG DEPENDENCE IN PAKISTAN

OVER VIEW, POLICY AND PROGRAMME.

Pakistan's population is nearing 80 million mark, and area is about 310,000 sq: miles.

Health Care System consists of two components, public and private. In public sector, there are many categories of institutions and hospitals (1) attached to the Medical Colleges called teaching hospitals - where almost all specialities are represented, (2) District Headquarter Hospitals - where facilities for major specialities are provided, (3) Tehsil Headquarter Hospitals, - where medical graduates, usually one male and female, are posted, and (4) Rural Dispensaries - where either medical graduate or more often para-medical personnel offer primary health care. But resource distribution is uneven between the 4 province and within urban and rural areas. The preventive work goes on separately at district level but is integrated at provincial level. Some vertical programme like Family Planning, Malaria Eradication etc: are also in operation and are integrated at provincial and federal levels.

contd page ..2..

Psychiatric services enjoy a very low priority. There are four mental hospitals in the whole country. Total number of beds does not exceed 2000.

Recently all the Medical Colleges have created posts for Psychiatrists and some psychiatric beds have been provided in the teaching hospitals.

Specialised service for the Drug Dependence persons did not exist at all a couple of years ago. Small beginings are being made here and there, particularly at Hyderabad Mental Hospital, Lyari Centre Karachi, C.G. Hospital, Rawalpindi, and more recently in Psychiatric Ward of Khyber Hospital, Peshawar.

Most Psychiatrists have not much experience of treatment of drug dependence especially outside the mental hospitals.

Almost all psychiatric units are grossly under-staffed. There are no formally trained Psychiatric Nurses in Pakistan. Similarly the concept of Community Health and outreach services has not taken root as yet.

Major policy decisions about the health are made by the Federal Government but the implementation and day-to-day administration is the responsibility of the provincial governments.

The private sector consists of general practitioners and vast majority of them offer only out-patient service. But some small indoor units are springing up in major cities like Karachi, Lahore and Rawalpindi.

contd page ...3

a) INDIGENOUS MEDICINE:

Side by side with the existing and developing public health system there is also a system of indigenous medicine of early socio-cultural origins. Its dominating feature is the Unani medicine as practised by hakims. Over the time, especially after the advent of antibiotics, the so-called Unani medicine has incorporated certain allopathic elements. This system has recently met with official approval by the government and in some rural areas constitutes the only available health service. It is estimated that there are some 30 thousand Hakeems as against 12 thousand doctors. In Unani medicine opium plays an important part as a remedy for numerous physical and mental ailments. Hakeems also claim that they can treat drug addiction but this claim needs to be verified and evaluated.

b) AVAILABILITY OF DRUGS.

Traditionally two drugs, opium and cannabis have been used for centuries in Pakistan. At present, in addition to the medicinal opium sold by chemists, opium is sold through some 330 licensed vends through out Pakistan. The total annual quota is currently about six thousand Kgms. Any one can buy up to 23 gms/ per of opium per day and no registration is required. As regards Cannabis, its possession and smoking is strictly prohabited under the law but in actual practice is available easily anywhere in the country. The main reasons for its easy availability is that it grows wild in large tracts of mountains regions and to a lesser extent also in the plains. Psychotropic drugs are also easily

contd page..4

available from chemist shops, though recently control has been tightened on the sale of hard drugs like morphine and pethidine. About two years ago codeine was excluded from the official Pharmacopia and its availability has become difficult.

c) ASSESSMENT OF THE PROBLEM.

Only a couple of years ago, there were no statistics whatsoever regarding the drug problem. Even now the extent and pattern of drug abuse is little known in Pakistan with the exception of Buner area, Peshawar district , Rawalpindi and possibly Karachi, where a few surveys have been carried out. So quantity and qualitywise there is not much epidemelogical data upon which to base drug abuse programmes.

d) IMPACT OF USE HEALTH, SOCIAL AND ECONOMIC.

Again very little is knew about the impact of drug abuse on the health of general population. Most opium users,particularly smokers, shew marked physical impoverishment.

Their families suffer economically but quite a few users maintain marginal economic and social adjustments.

Social stigma is severe in case of opium smokers, opium eaters are relatively better tolerated by the society because smoking is a group activity and has no moral justification whereas most opium eaters develop the habit for health reasons.

A psychiatrist witness the most distressing scenes whem the parents of a young man, usually a student at the university

contd page ..5

level, bring their son who has taken the drugs. He is brought for consultation or the problem is discussed in his absence.

The general impression of both the general public and the professional is that many if not most automobile accidents on reads are directly or indirectly related to drug abuse. This is an interesting area for further investigation and exploration and the drivers should be made a target group of treatment. I think the Drug Abuse Control Programme will find wide-spread public support if some tangible improvement is achieved in this field.

e) MAJOR POLICY APPROARHES.

The Federal government created a central organization, the Pakistan Narcotic Control Board (P.N.C.B) with far-reach -ing mandates. The Board has regional and local offices and there is close liaison with the provincial governments. All programmes and projects relating to drug abuse control are to planned, supervised and monitored by the P.N.C.B. and the provincial departments of health and social welfare are being associated in planning and implementation of programme within the health sector. The speed with which the programme are implemented is different in different provinces. While in Hyderabad, Karachi, it has been easy to strengthen the already existing drug treatment centre (Hyderabad) and initiate a new unit(Karachi), it has not been so easy elsewhere. For example

contd page..6

in N.W.F.P. it was decided to start two treatment centres, one at Peshawar and other at Buner. It has been difficult to find beds in Peshawar, though some work has started on out-patient basis and some indoor work in the psychiatry unit of Khyber Hospital. For Buner- it was the other way round. While accommodation was available but a doctor was difficult to get. About six months ago one medical officer was selected and given training for about two months. But the actual work has not yet started at the time of writing of this paper because of different official bottlenecks and redtapism.

In 1976, a tripartite agreement was signed between UNFDAC, Federal Government, and the Provincial Government. It is planned a 3-years instalments against the long-term objective of reduction of prevalence and incidence of dysfunctional opium, and other types of drug abuse, gradual elimination of non-medical use of opium and gradual replacement of the licensed opium vend system by a net work of treatment and rehabilitation centres in the four provinces. The treatment programme as outlined below is to be seen as a first step towards these over-all goals.

The main short term objectives for the three years period are to collect enough information and data so as to provide sufficient knowledge of the extent and pattern of drug dependence upon which to base long term comprehensive plannings. Further, to establish centres for research and treatment in some of the main cities of Pakistan in which there are recognised drugs abuse

contd page..7

problems, and where some resources in the form of trained personnel and special facilities exist, and where some treatment activities are already going on. Such centres are being established at Buner and Peshawar, Karachi, Hyderabad and Rawalpindi. One future centre is planned at Lahore, and one Information/Research centre in Quetta. These centres are arranged as basis for research, training, method developing, and treatment evaluation. They will have the character of pilot projects and are eventually to serve as model for future centres elsewhere in the provinces.

f) ROLE OF VOLUNTARY ORGANIZATION.

very few voluntary organizations exist who take interest in this programme. Those which do exist do so on paper and always look for support from the government rather than generate their own resources and momentum.

g) INTEGRATION OF TREATMENT FACILITIES INTO H E A L TH S E R V I C E S.

According to the policy of the government, it is intended to integrate treatment facilities for drug abuse into general health services. We have resisted temptation to have a vertical programme like Malaria Control and Family Planning because all such programme tend to become white elephants and these white elephants are difficult to sustain by peer country like ours.

contd page..8

h) TRAINING ACTIVITIES.

As already stated, there is not much experience of treatment of drug dependence in our country. This is an area where international help and guidance of other countries, having more experience but similar patterns of drug abuse, will be welcomed.

A few workers in the field could be periodically trained by holding meetings and visits to treatment centres. These specialists in turn can train other doctors and paramedical personnel.

i) RESEARCH ACTIVITIES.

Since the setting up of the Board, some surveys have been carried out which provides us with estimates of prevalence and pattern of use and characteristics of users. Some treatment evaluation work has also started but it is in preliminary stage. At Peshawar Centre it is proposed to start comparative study of the efficacy of indoor versus outdoor treatment of opium dependent persons. At Rawalpindi Centre, a study is being carried out to study the psychopathology of opium users and a comparison will be made between opium - vend customers and other drug-dependents seeking treatment.

j) FUNDING POLICY.

At present the drug abuse control programme is being funded by three parties, i.e. UNFDEC, Federal Government through P.N.C.B. and by the provincial government. It is proposed that at the end of Pilot Project periods which may be extended from 3 to 5 years, the whole responsibility will be of the provincial governments.

contd page ..9.

k) CRIMINAL JUSTIC SYSTEM VIS-A-VIS DRUG DEPENDENCE.

As already stated it is permissible to pu chase a certain quantity of opium from vend shops. Recently total prohibition has been enforced in the country relating to the use of alcohal. A new law is on the anvil regarding the sale and purchase of psychotropic drugs. Cannabis smoking is totally banned, but in actual practice its use is quite prevalent. While some arrests are being made for the violation of prohibition law, some is not the case about the cannibes abuse. But police and other law enforcing agencies are showing great activity against smuggling and trafficking of drugs.

L) RESPONSE TO INTERNATIONAL TREATMENT.

Pakistan is already a sigmtory to 1961. Single Convention and alse of 1971 Convention on psychotropic drugs and hazards.

m) PREVENTION ACTIVITIES.

No organised prevention activities have been started yet on a large scale. A few pamphlets were prepared by P.N.C.B. and were sent on a limited scale to very selected groups. Similarly, mass media has been used a few times emphasising the menace of drug abuse. It is still being debated and discussed which would be the best strategy to prevent the spread of drug abuse. The drug abuse is looked down upon by vast majority of

contd page ..10

the people. Even the (rebellions youth) do not like to be called a 'Charsi' (Cannabis smoker) and Afeemi (opium eater). Our religion also unreservably condemns non-medical use of every intoxicant. But ordinary priest usually singles out alcohal as the mother of all evils does not emphasize the harm which other intoxicants could do. While this discremin-ation can be understood as far as opium is concerned because of its immense therapeutic potential one cannot understand the attitude towards cannabis. Similarly hazards to health could be exploited to start a campaign of prevention. Some people are of the opinion that softer policies should not be adopted and we must crush the drug abuse with a heavey hand. Very few people take exception to this line of thinking as far as traffickers, pushers and padellers are concerned but as regards the drug dependent persons , most people will agree that they must be treated as patients. And before new law is enforced the facilities for treatment should be considerably increased. Side by side other activities like reducing the cultivation of opium and substituting it by other creps may be stepped up.

DRUG ABUSE TREATMENT AND PREVENTION.

Technical aspects of treatment.

a) TREATMENT FACILITIES.

Until the signing of the tripartite agreement no institution in Pakistan offered special service for treatment of drug dependent persons. It was carried out in the old mental hospitals of the country or in the psychiatric units attached to different teaching hospitals alongwith other psychiatric patients. Since then preparation are under way to set up special treatment centres at Peshawar, Buner, Karachi and Hyderabad. RAWALPINDI Citywise the position is as described below:

1. P E S H A W A R.

At present a psychiatric out-patient, a 10 bed ward exists at Khyber Hospital. There are two trained and qualified Psychiatrists working at this hospital. This hospital is one of the two teaching hospitals of the Khyber Medical College.

Drug dependent patients were till recently treated only on out-patient basis but more recently a minumum of three beds have been reserved in this psychiatric ward for drug dependent patients.

Besides a separate 10 bed centre is planned, which will provide treatment exclusively for drug dependents. The scheme has been approved in principle but actual implementation is held up due to non-availability of beds. General laboratory facilities are available. Drug testing equipment has already

contd page..2..

arrived. Recruitment of personeel will commence immediately after the beds are available.

Similarly a small research study comparing out-patients versus indoor patients is also planned at Peshawar. Research instruments are awaited and work on this research programme will start immediately.

2. B U N E R.

In August, 1978, 8 beds were ear-marked at Civil Hospital Chamla in Buner area, for drug dependent persons.

A general duty doctor has already received training for two months and will get periodic training in the coming year. The approval for initiating the actual work is in the final stages and it is hoped that it will start functioning within a month or so.

3. K A R A C H I (SIND).

At the Civil Hospital, Karachi a 26 bedded psychiatric unit with out-patient service is in operation. This hospital is teaching hospital for Dow Medical College. It is headed by the Assistant Professor of Psychiatry at Dow Medical College. This hospital has closed liaison with psychiatric unit of the Jinnah Post Graduate Medical Centre, and the research and teaching potentiality is very good.

Preparation are under way to have a 10 bed unit for rehabilitation in the Lyari area of Karachi under the supervision of Civil Hospital, Karachi. Laboratory equipment has also arrived and a treatment evaluation programme in collaboration with the W.H.O. is also planned.

contd page ...3.

4) H Y D E R A B A D

At Hyderabad mental hospital, there is a 35 bed unit for drug dependent persons already functioning under the supervision of the Medical Superintendent of the hospital. This mental hospital serves as a teaching facility for the Liaqat Medical College, Hyderabad.

5) R A W A L P I N D I

The Central Government Hospital in Rawalpindi has a 16 bed psychiatric unit with a separate out-patient facility. It is headed by an experienced psychiatrist. It is a federal teaching hospital. There is good liaison with the Central Government Polyclinics on the one hand and the provincial Social Welfare Centre in the rural Lunda bazar, community near Islamabad. Eight beds have been reserved for drug dependent persons and there is a programme to study psychopathology of the opium users.

There are other research oriented activities going on from time to time. Laboratory facilities are good in National Health Laboratory including drug detection in body fluids.

An Institute of Neuro-Psychiatry and Brain Research is being set up in Islamabad which will have facilities for treatment and research facilities in the field of drug dependence.

6) L A H O R E

Drug dependence related activities are carried out in Lahore, Punjab. Some drug dependent persons are treated along with other psychiatric patients at the psychiatric unit (23 beds) of the Mayo Teaching Hospital which serves King Edward Medical College under the supervision of the Psychiatric Department.

contd page ..4.

At Government Mental Hospital, one unit (36 beds) is reserved for treatment of drug addcits which are mainly admitted on a non-voluntary basis. A scientific evaluation of the treatment results of this unit will be of great value for the planning of a future centre at Mayo Hospital. Mental Hospital may be moved to other premises in the near future. It has not been considered advisable to set up a centre there.

Research, planning and coordination of activities in Lahore are deemed highly probable. Such a centre may start functioning in 1979-80. Concomitantly survey research on the extent and pattern of drug abuse and dependence in certain rural areas of the Punjab will be carried out.

7) Q U E T T A.

In Quetta, Baluchistan, a Drug Abuse Advisory Centre is providing treatment facilities to outdoor patients under a competent psychiatrist. The immediate objective of this centre is to conduct survey research, providing information and education concerning drug dependence - related problems. Support for such activities are envisaged in the country-wise programme. This centre could be expanded in the future.

8) G I L G I T.

In the Northern Areas of Pakistan which are sparsely populated, some activity has started. A non-psychiatric physician has started acupuncture and other treatment of drug-dependent persons. But no formal or official programme has yet been approved.

contd page..5.

b) TREATMENT METHODS.

The usual treatment methods practised in Pakistan consists of :-

1. Sudden withdrawal, in case of non-opiate drugs.

2. Gradual reduction, usually with substitution of phenothiazine anxiolytic and/or anti-depressant drugs. Mostly this withdrawal is carried out as in-patient. But attempts are being made to do the same on out-patient basis. In the past because of lack of record keeping and follow up facilities the result of out-patients detoxification could not be evaluated.

3. Acupuncture has been tried to control withdrawal symptoms in Military Hospital in Rawalpindi. Initial results are encouraging. But the sample tried was rather small. More psychiatrists were given brief training under the auspices of U.N. and Pakistan Narcotic Control Board. Acupuncture apparatus has been supplied to Karachi, Peshawar and Hyderabad centres. In near future more trial will be given to this method of treatment.

4. Indigineous method.- Some non-allopathic practitioner called Hakims have started Tark-e-Afyum (Give-up-opium)tablets which are gaining popularly. The exact ingredients are not known and possibly vary from one Hakim to another.

c) INTAKES REFERRAL AND FOLLOW UP OF PATIENTS.

There is no fixed method of intake or refer al of patients in Pakistan. Since there were no specific drug dependent treatment facilities, the patients will go to a general practitioner or psychiatrist depending upon accessibility

contd page..6.

of the type of doctor or educational background of the patient. It is intended that apart from other sources from where patients may be referred opium-vend shops will be tested as referral points for programme in the immediate future.

In Buner which is an opium cultivating area out-reach activities are being planned and help of the local community will be enlised.

d) COMMUNITY LIAISON.

At present there are no out-reach activities. Except in Karachi and Rawalpindi. The social services are non-existent. The other community organizations can only play their role when the treatment centre themselves are in operation.

e) PATIENT'S CHARACTERISTICS.

The characteristics of the patients differ with the type of the drug use and also whether it is the urban or the rural population. For example in Rawalpindi the vend-customer of opium showed a mean age of 46 years, whereas in Kuria village it was 37 years. The mean age of first opium use was 32 in Rawalpindi and 26 in Kuria. The reasons for initiating the opium use were self-treatment of pain, cough, dysentry etc: were 44 per cent in Rawalpindi and 22 per cent in Kuria. The reason as social interaction was 11 per cent in Rawalpindi and 48 per cent in Kuria. Curiosity as a motive to start the drug use was the same in the two population i.e 22 per cent.

contd page...7.

As regards the use of psychotrepic drugs- the following characteristics were noted:-

(1) Drug abuse is more prevalent among the single than married.

(2) About 70 per cent of dependents fell within the income group of Rs.200-400 P.M. i.e. poor people.

(3) 51 per cent of drug users belong to age group of 21-30 years- followed by about 25 per cent in the age group of 31-40 years.

Majority of drug abusers were introduced to drug before they were 30 years old.

61 per cent used it in the company of friends. Most of these drug users were male but because of social barriers investigation about the female population is very difficult, and incomplete.

Opium smoking is more common in N.W.F.P. than in the Punjab, more in the rural than the urban areas.
