Relapse and Risk Behavior among Drug Addicts in Peshawar

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Abstract

Drug addiction is a big problem in Pakistan with no or little attention being paid to its solution on the state level. This is a cross-sectional descriptive study to find out the prevalence of communicable diseases among injecting drug-users in Peshawar. The working population and youth in particular are victims of this disease with no solution in sight in the near future. The victims are mostly illiterate, employed abusers with heroin as their choice drug. Cannabis smoking has proved to be the gateway to heroin addiction. Injecting the drug through the intravenous route is on the rise with dire consequences of HCV, HBS and HIV transmission. The number of addicts and the available detoxification facilities are not commensurate and all the efforts seem to be wasteful of national resources. Hence discernable efforts are needed to tackle the problem.

Keywords

Drug addiction, Heroin addiction, Injecting drug users, detoxification and relapse, HIV, HCV and HBS infection, needle sharing.

Introduction

Pakistan has witnessed a continuous change in its drug abuse patterns since its independence. Initially, during 1947-1960s opium and its derivatives were used as social drugs followed by chars/cannabis during 1960s and 1970s due to the influence of western “Hippies Culture” of 'Turn on and Tune in'. By 1970s, in Pakistan synthetic drugs were abused by the youth. By early eighties, “Heroinization” in Pakistan started as result of the Afghan-Soviet war and still persists, challenging the very fabric of Pakistani society. In 1980-81, according to official statistics there were about 5,000 heroin addicts, rising exponentially to 20,000 in 1981, and by 1987, there were 657,000 heroin addicts in the country (GOP, 1986: 318). The million thresholds was crossed in 1988 and by 1993, the number of heroin addicts had swelled to 1,524,000(GOP 1993: 24). According to a 1996 report of the UN Drug Control Programme (UNDP) out of 3.1 million people in Pakistan addicted to various drugs, 51% were addicted to heroin. By that time it was estimated that heroin addiction was increasing at an alarming speed of 7% annually,

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with heroin addicts numbering two million by 1998. Since then there is a complete blackout about any official statistics on addiction and particularly heroin addiction. Any policy or welfare programme for addicts in the country in lieu of any valid and reliable statistics would mean nothing more than an eye wash and ignoring the problem would probably mean putting oil on a smoldering fire.

Method and Material

This is a cross-sectional descriptive study. The results of this study are based on the record of indoor drug addicts obtained from two detoxification centers in Peshawar; one in the private sector known as Dost Welfare Foundation (DWF) and the other in the public sector situated at Khyber Teaching Hospital (KTH) Peshawar. The records contained information of patients/ addicts admitted during January 1, 2009- June 30, 2009. A total of 504 cases were analyzed. Out of this no. 108 addicts were admitted for detoxification to KTH and 396 at DWF during the said period.

Results

Table I: Age of Addicts

Age of the respondents	15 - 25 yrs	26 - 35 yrs	26 - 35 yrs	>46 yrs	Total
Frequency	155 (30.7%)	165 (32.8%)	125 24.8%)	59 11.7%)	504

Table I shows that well over 30% of the addicts were in the young and workable age group of 15-25 years. 32.8% were in the age group of 26-35 years and 24.8% were in the age group of 36-45 years. Only 11.7% were 46 years and above.

Table II: Marital Status

Marital Status	Unmarried	Married	Widow	Divorced	Total
Frequency	233 (46.2%)	266 (52.8%)	2 (0.4%)	3 (0.6%)	504

Table II shows that the majority of addicts (52.8%) were married followed by 46.2% who were unmarried. The married addicts had an average No. of 2.2 children.

Table III: Education Level

Level of Education	No Education	Primary	Middle	Matric	Inter	BA / BSc	MA / MSc	Professional	Total
Frequency	255 (50.6%)	79 (15.7%)	107 (21.2%)	33 (6.6%)	20 (4.0%)	8 (1.6%)	1 (0.2%)	1 (0.2%)	504

Table III shows that 50.6% of addicts had no education at all and 15.7% addicts were educated up to the primary level. Keeping in view the quality of education in the public sector schools in Pakistan, this group is also considered as illiterate as primary level educated children cannot even write a single paragraph or sentence in any of the languages like Urdu and the provincial language like Pushto in NWFP, Punjabi in Punjab, etc. Again, this level of education does not qualify one for a white collar job in the public sector. Thus the total strength of illiterate addicts in the two groups comes to be 66%. Middle level educated addicts constituted 21% of the respondents. 6.5% were educated up to matric level, 4% up to intermediate level. Graduates and Post graduates were 1.8%. Referring to the professional career only one person was a lawyer by profession.

Table IV: Ethnicity

Ethnicity	Pakistani	Afghani	Total
Frequency	454 (90%)	50 (10%)	504

Table IV shows that 90% of respondents were Pakistanis while 10% were Afghan refugees/nationals who came for treatment. It is worth to note that majority of Afghan nationals, who were admitted for detoxification, were heroin factory workers.

Table V: Employment / Job Status:

Job Status	Employed	Unemployed	Total
Frequency	275 (54.6%)	229 (45.4%)	504

Table V shows that 54.6% of addicts were employed at the time of initiation of the drugs. A report of the government of Pakistan presented in a conference of

SAARC countries in 1996 at Islamabad said that in Pakistan 60% of addicts were employed at the time of initiating the drug abuse (SAARC 1996: 1). After 15 years the pattern remained nearly the same.

Table VI: Initial Drug of Abuse

Initial Drug Abused	Cannabis	Heroin	Opium	Alcohol	Sniffing Glue	Cannabis / Tranqs.	Tranqui-lizers	Total
Frequency	417 (82.7%)	46 (9.1%)	15 (3%)	10 (1.9%)	3 (0.5%)	3 (0.5%)	10 (1.9%)	504

Table VI shows that 82.7% (417/504) of addicts started with cannabis/chars and cannabis proved to be a gateway to heroin addiction. When tolerance increases, the next drug to satisfy the craving is obviously heroin (9.1%). Opium abuse (3%), alcohol and synthetic drugs like tranquilizers/sleeping pills like Sosegone, Temgesic etc (1.9% each), glue and other synthetic sniffing liquids accounted for very small percentages of initial drugs of abuse.

Table VII: Current Drug of Abuse

Current Drug Abuse	Cannabis	Heroin	Opium	Alcohol	Poly Drug Abusers	Tranquilizers
Frequency	15 (3.0 %)	399 (79.2%)	8 (1.6%)	1 (0.2%)	3 (7.5%)	43 (8.5%)

Table VII shows that the most common current drug of abuse was heroin (79.2 %). Only 3% were abusing cannabis, 1.6% raw opium, 0.2% alcohol, and the number of poly-drug abusers was 7.5%. They abused a variety of drugs like cannabis, tranquilizers in injection form, alcohol etc. Tranquilizers were abused by 8.5% addicts.

Table VIII: Mode of Administration

Model of Intake	Injecting	Eating	Chasing the Dragon	Smoke in Cig.	Sniffing / Inhaling	Multiple Modes	Total
Frequency	43 (8.5 %)	9 (1.8%)	369 (73.2%)	30 (6.0%)	19 (3.8%)	34 (6.7%)	504

Table VIII shows that 8.5% of abusers used hypodermic syringes for injecting the drugs into their bodies. These included not only heroin injection but all tranquilizers like Valium and Sosegon. 1.8% of drug abusers who were addicted to raw opium and/or tranquilizer tablets/sleeping pills used their drug orally/eating. 73.2 % of addicts smoked heroin through the 'chasing the Dragon" method, while a small number (6%) of abusers smoked heroin in cigarettes. 6.7% of addicts who were poly drug abusers used different methods of drug intakes at a time depending upon the drug like smoking heroin, eating opium and tranquilizers, injecting drugs like Sosegon and Valium etc.

Table IX: Present Living Status (living with)

Living Status	Alone	Drug users	Family	Friend	Inn	Others	Relatives
Frequency	3 (0.6 %)	1 (1.2%)	1 (0.2%)	483 (95.8%)	2 (0.4%)	1 (0.2%)	3 (0.6%)

Table IX shows that 95.8% of addicts were living within their families. It is good omen that people have learnt to live with drug addicts, as previously addiction was a stigma and in many instances the parents/families had deserted/disowned the addicts and left them to live on the streets. Less than 1% lives on streets with other addicts. A small number are supported by relatives.

Table X: Needle Sharing Habit

Needle Ever Shared	Shared	Did Not Share	Total
Frequency	95 (18.8%)	409 (81.2%)	504

Table X shows that 95/504 (19%) of addicts reported that they shared needles for administration of the drug. A few of them were found to be sex-workers as well. Many cases of HCV/HIV and HBS have been detected among drug addicts and the rate of these infections was the highest among those who shared needles. This aim of this study was also to study the prevalence of this infection among those who shared needles.

Table XI: Risk Behaviour

Risk	No of Respondent	Test Result			Total
		Positive	Negative	Never Tested	
HBS	504	10 (2%)	161 (32%)	333 (66%)	504
HCV	504	42 (8.3%)	127 (25.2%)	335 (66.5%)	504
HIV	504	6 (1.1%)	165 (32.7%)	333 (66%)	504

Table XI shows that 66% of addicts were never tested for any contagious diseases like HCV, HBS and HIV before admission to the DATC. Overall, 2% of addicts were found HBS positive, 8.3% were found HCV positive and only 1.1% of addicts were HIV positive at the time of their admission for detoxification. National figures of prevalence of HBS are 3% while for HCV is 4-5%. The existence of HCV is higher (8.3%) among drug addicts and those who share needles.

As mentioned above only 95/504 respondents had shared needles and had unsafe sex before admission to DATC. It is difficult to establish that whether they were HCV and HBS positive before needle sharing/having unsafe sex, could be a cause for infection. This needs further research.

If we assume that all the infected addicts were from the 95 needles sharers and sex workers, the rate of infection shows that 10/95 (10.5%) were HBS positive, 42/95 were HCV positive (44.2%) and 6/95 (6.3%) were HIV positive. The situation is alarming and needs immediate steps to do something to contain the disaster.

Table XII: Any Previous Treatment / Relapse

Any Previous Treatment	Yes	No	Total
Frequency	226 (45%)	278 (55%)	504

As shown in Table XII, 55% of addicts had joined the detoxification programme for the first time, whereas 45% of addicts had relapsed and previous detoxification had not been successful.

Discussion: HCV, HBS and HIV Risks Among Addicts

Since the discovery of HCV in 1989, the virus has become a major health hazard worldwide (Sajjad et al. 2006: 4). According to a WHO report of 2002, about 3% of the world population is infected with HCV and 3-4 million people are diagnosed as HCV positive every year pointing to the graveness of the situation causing about 0.25 million deaths a year. In an interview with the News on Sunday Islamabad, the president of the Pakistan Society of Hepatology, Dr. M. Umar of the Holy Family Hospital Rawalpendi, on the occasion of World Hepatitis Day, 2010, said that approximately 500 million people are living with either hepatitis B or C, the world over (Qasim 2010). The same news item said that in Pakistan 1.2 million people are vulnerable to hepatitis B or C and the prevalence of the two killer diseases is about 3% and 4-5% respectively since its first description in Pakistan in 1992 (Sajjd et al. 2006*)*.

Experts have identified many causative factors of HCV transmission including blood transfusion, re-use of syringes by medical practitioners in poor countries which can be contaminated, shaving at the community barber shops, tattooing and ear and nose piercing, un-sterilized surgical equipment and unsafe sex. The use of discarded syringes and unsafe sex are the most common causes of the spread of the virus among the addicts, as mostly, they pick these syringes from the garbage dumps of the hospitals and share them for injecting drugs. Consequently, they have the highest prevalence rate of the infection standing at 10.9% for HBS, 45.6% for HCV, and 6.5% for HIV against the over all prevalence rate of 2% HBS positive, 8.3% HCV and 1.1% addict as HIV positive. With respect to Peshawar, there is a stronger perception than reality among the experts that syringe use was introduced in Peshawar and elsewhere in Pakistan by some NGOs so that the problem be spread and they will attract foreign donations and funds in the name of the HIV/HCV spread.

The Relapse

Addiction relapse may be defined as the return to destructive or heavier substance use after a period of abstinence. Experts say that there is a high rate of relapse for people with opiate addiction (everydayhealth.com). Heroin, being the choice drug in Pakistan, has the greatest potential for relapse. The abuse of opiates is not a new phenomenon in Pakistan but has been a part of the drug culture since time immemorial; before 1960, opium was the only drug of addiction and by 1980s Pakistani addicts started experiencing more potent opiates in the shape of heroin. This study shows that 45% of addicts had already got treatment for detoxification but relapsed. Experts are of the opinion that one year after stopping opiates, there is

an 85% chance of relapse (Garbut 2010). Medical professionals and social workers are of the opinion that the present trend of injecting drugs among the addicts is due to changes in the quality of street heroin. The street heroin currently available cannot be inhaled as it has dire impacts like lungs fibrosis, and in many cases has caused respiratory distress among the users (Altaf et al. 2007: 4, 7). On the other hand, due to the insufficient and inefficient health delivery system, detoxification is rendered ineffective being for a period of ten days to the maximum (Alam Shah 2010) .

Results

The results are startling: 66% of addicts were not tested for any communicable disease at the time of admission to the DATC. The overall infection rate was 2% for HBS, 8.3% for HCV and 1.1% for HIV. The national prevalence figures are 3% and 4-5% for HBS and HCV. Among the injecting drug users (IDUs) the rate was much higher, i.e. 10.5% HBS, 44.2% HCV and 6.3% HIV positive cases resembling a jungle fire which can engulf the whole society sooner or later. Detoxification is a long and cumbersome process and may last for months. Unfortunately, the present detoxification period of indoor patients at Peshawar is inadequate and lasts for ten days maximum. The number of addicts and the no. of detoxification centers and the number of days of detoxification are not commensurate and seem to be a waste of national and international resources

Recommendations

The world over, there are two strategies of combating the drug menace; the supply reduction strategy and the demand reduction strategy. The supply reduction strategy has failed totally as it is always a trans-border/international phenomenon and related to the production and trafficking of drugs. Internally, Pakistan has controlled the drug production problem to a great extent but neighbouring Afghanistan, with which we share a 1200 miles long porous, unmanned border, is a major producer and exporter of opium and heroin at present. This has minimized the impacts of Pakistan's efforts about drug control and the drugs inflow continues unabated. This is indeed a difficult situation and needs long term strategies.

The other effective strategy is the demand reduction side. This means addicts who depend on drugs are treated and rehabilitated so that the demand for drugs reduces and hence less drugs will be consumed which will diminish the demand for the drug of abuse. This has been a successful strategy in most of the world's countries including may European countries.

The demand side reduction needs proper actions on the part of the states. In many countries like Pakistan, detoxification and rehabilitation is voluntary and the

addicts are free to join or not to join any detoxification programme. This should be changed and detoxification be made compulsory. Communities, non-government organizations and law enforcing agencies should be involved in the identification and referral of an addict to a detoxification center. This will help the government to know the exact or nearly the exact number of addicts and will be on record. Follow-up will be easy and the relapse rate can be minimized. The involvement of communities will discourage the drug peddlers and suppliers and in a short period the spread of addiction can be controlled. This can be the most effective alternative. The government is already spending a lot on the establishment and maintenance of detoxification centers. This will streamline the proper use of national resources on one hand and on the other discourage the corrupt law enforcing officials who patronize the business.

Another strategy is to legalize the drug use, an unthinkable solution in the present international scenario of economic dependency of Pakistan on the western donors who dictate to Pakistan what to do and what not to do in the field of drug abuse. Direct legalization may not work but we can think on the medicalisation of drugs. This aspect has been discussed in details in the first author's book entitled "The Politics and Economics of Drug Production on the Pakistan-Afghanistan Border," published from UK in 2003.

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