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United Nations Office on Drugs and Crime

Ministry of Narcotics Control  
Pakistan Bureau of Statistics  
Government of Pakistan



# Drug Use in Pakistan 2013 Technical Summary Report



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## 1. Introduction

This technical summary report on drug use in Pakistan provides baseline information on the prevalence and patterns of drug use. Although several assessments of drug use have been carried out since 1982 in Pakistan, a more comprehensive study was required to understand the extent of drug use and substance<sup>1</sup> misuse. In 2010, the Government of Pakistan Departmental Development Working Party (DDWP) approved a contribution from the national development budget to support more complete research on the drug use situation.

The information generated is intended to inform Federal and provincial governments, civil society, and private-sector organizations when designing and implementing effective drug demand reduction interventions including prevention, treatment, and care services that are targeted, responsive, and needs-led.

Highly-stigmatized and illegal behaviours, such as drug use, can be extremely challenging to survey. Since any single direct or indirect method has inherent limitations in reliably estimating drug use prevalence, a multi-faceted approach was adopted where several methods were combined. National implementing partners conducted a total of four studies in 2012 covering all four provinces of Pakistan as well as Pakistan-administered Kashmir.

A National Health Behaviour Survey (NHBS) based on a household survey approach was conducted by the Pakistan Bureau of Statistics (n = 51,453). Three further studies were conducted by the Centre for Global Public Health Pakistan, University of Manitoba: an assessment of problem drug users (n = 3,330); an assessment of key informants (n = 1,196) and an assessment of selected drug treatment centres.

The estimates generated refer to the annual prevalence of drug use or substance misuse. That is, the proportion or percentage of the population aged 15 to 64<sup>2</sup> who used any illicit substance in the past 12 months. Estimates for drug use prevalence were calculated independently for each drug type and a combination of two or more direct and indirect methods were used, including self-reported direct estimations, the multiplier-benchmark method, and the network-scale up method. After independent calculations were generated for each drug or substance, these were summed together with the overall figure adjusted to take into account poly-drug use.

This report is a technical summary of findings detailing the extent of the drug use problem in Pakistan and the consequences of drug use. In consideration of the key findings, this report also details several steps which can be taken to reduce drug use and associated problems. A full report is currently under development and is due for release in the second quarter of 2013.

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<sup>1</sup>In recognition of the problems that may be caused by the inappropriate use of prescription drugs, their use has been regulated by three major drug control treaties: *The Single Convention on Narcotic Drugs* of 1961 as amended by the 1972 Protocol, the *Convention on Psychotropic Substances* of 1971, the United Nations *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, adopted in 1988.

<sup>2</sup>Based on a national population estimate of 111,323,400 persons aged 15 to 64 according to 2012 UNFPA / NIPS data, thus direct application of this report's estimates to alternative population figures may be invalid.

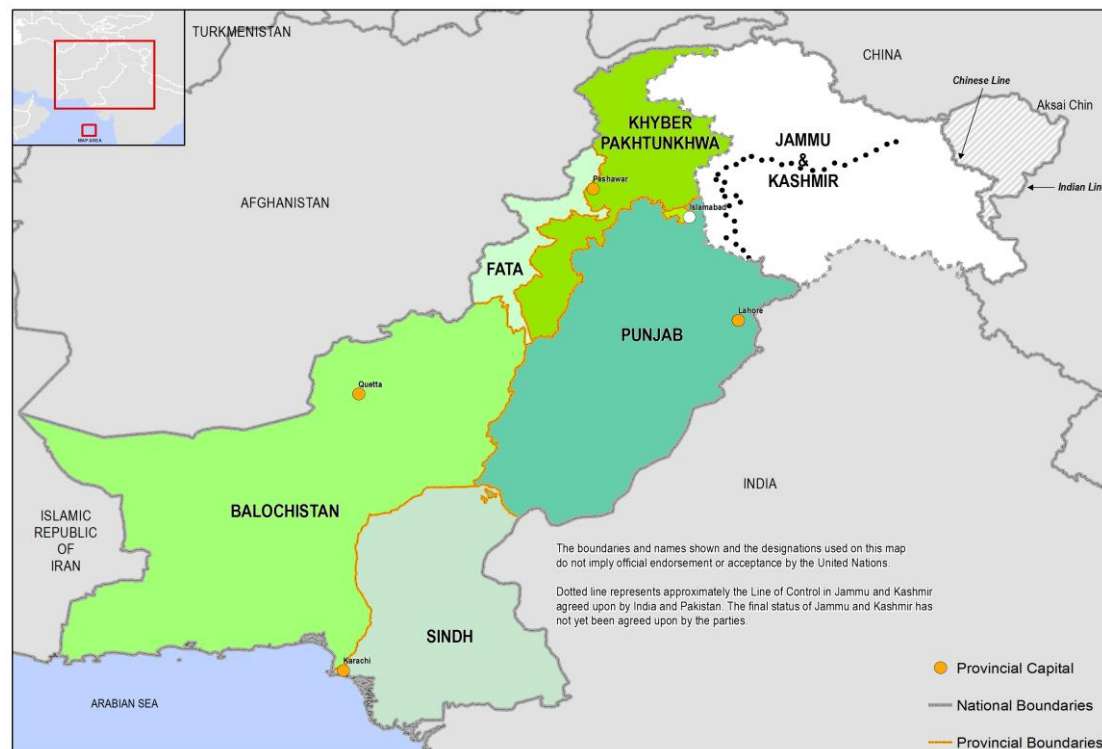




## 2. Background

With around 180 million people<sup>3</sup>, Pakistan is the sixth most populous country in the world. The country continues to thrive as a key actor in South Asia, both politically and economically, despite facing domestic social, economic, and political issues that hinder development. Under the 2011 United Nations Human Development Index, Pakistan is ranked 145 out of 187 countries.

Map 1: General map of Pakistan.<sup>4</sup>



According to the same report, almost a quarter of people in Pakistan are estimated to be living on less than USD 1.25 a day. Stark differences can be seen in literacy rates across gender, as well as urban and rural, sub-divides and between provinces. Despite an overall literacy rate of 58 per cent, only 46 per cent of women are reported as literate. Pakistan's average duration of schooling in a formal education setting lasts 4.9 years<sup>5</sup>.

Pakistan faces extensive domestic challenges with some of the most serious upheavals occurring over the last decade, affecting the lives of millions of people countrywide. The country's vulnerability to natural hazards including floods and earthquakes has impacted large areas of the country, damaging homes, schools, hospitals, law enforcement institutions, farmland, and communications infrastructure. Such circumstances are likely to contribute to a higher demand for illicit drugs due to the losses, hardship, and poverty experienced by millions of Pakistanis.

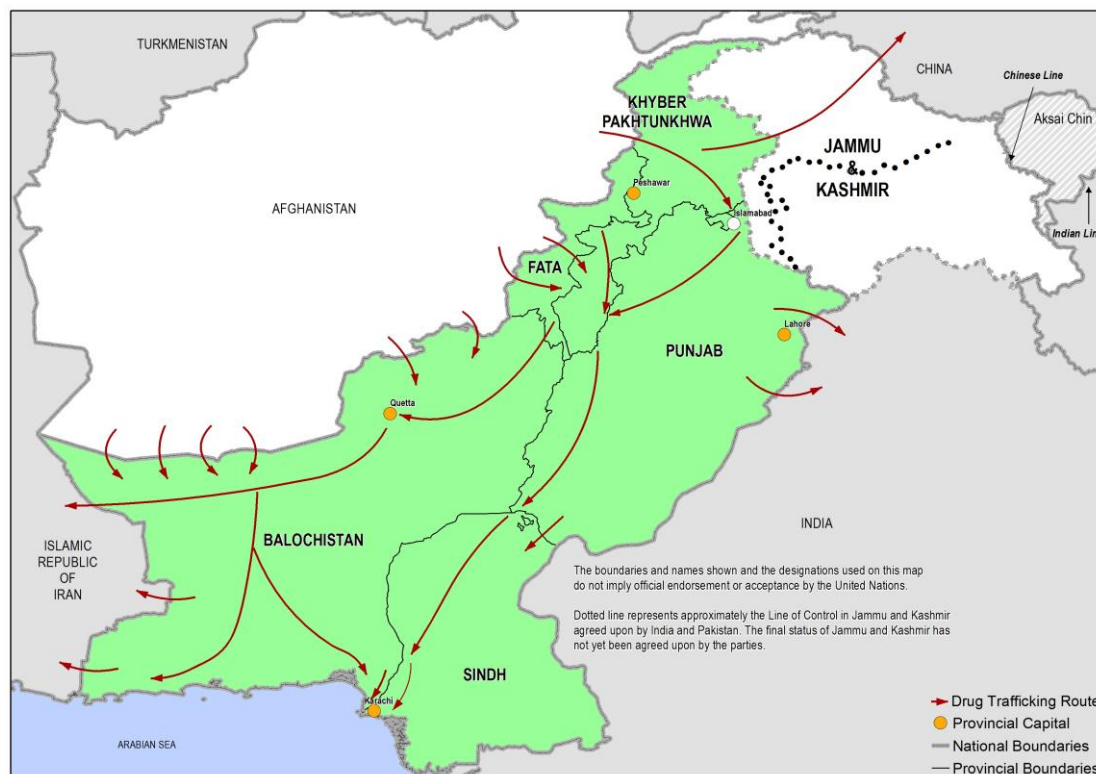
<sup>3</sup> Ministry of Finance, GoP (2012) *Economic Survey of Pakistan (ESP) 2011-12*.

<sup>4</sup> All maps in this summary report are preliminary.

<sup>5</sup> Pakistan Bureau of Statistics, GoP (2011) *Pakistan Social and Living Standards Measurement Survey 2010-11*.

Further, it is probable that drug trafficking from Afghanistan, to and through Pakistan, leads to increased levels of opium and heroin use in Pakistan even if most drugs are intended for higher value markets in other countries.

Map 2: Opiates trafficked through Pakistan, 2009

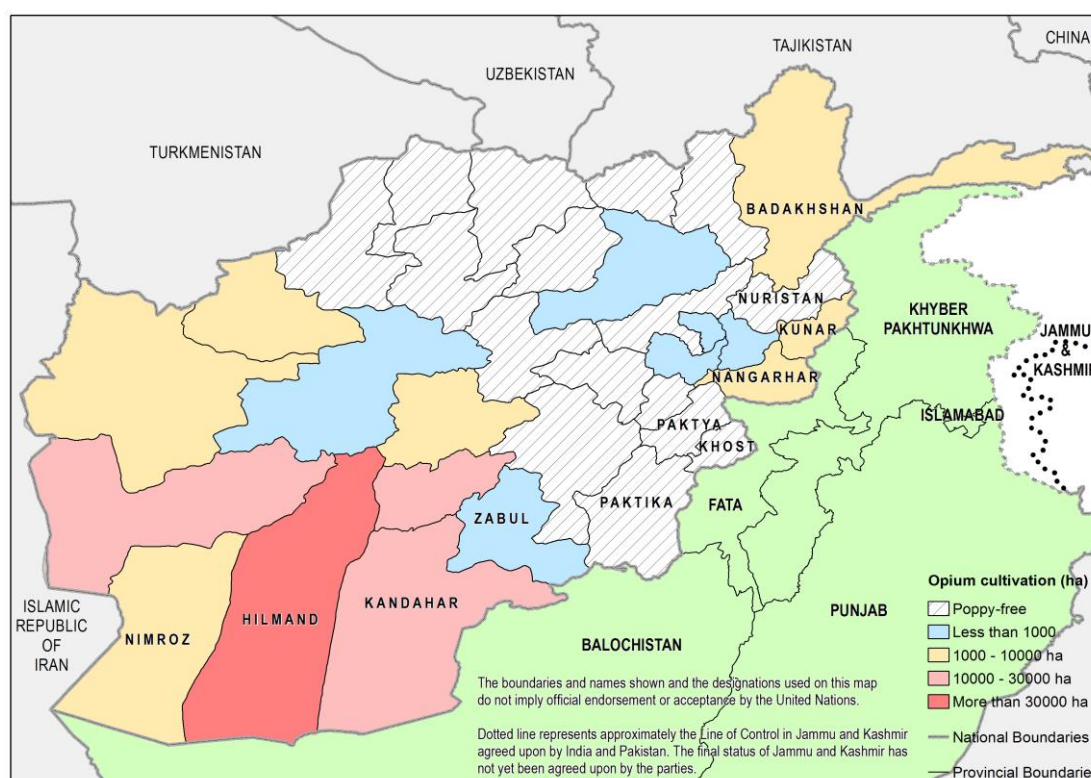


Afghanistan produces an estimated 60 to 70 per cent of the world's supply of illicit opiates.<sup>6</sup> More than 45 per cent of illicit opiates from Afghanistan cross into Pakistan, *en route* to destination markets in Europe, Asia, and to a lesser extent, Africa and North America. Global trafficking routes and seizure data in Pakistan indicate that trafficking routes within Pakistan run from Afghanistan, through the western provinces of Khyber Pakhtunkhwa and Balochistan, to Iran in the west and Pakistan's coastline in the south, including the sea ports of Karachi and Port Qasim, as seen in Map 2. Of the 11 Afghan provinces bordering Pakistan, only four were declared poppy-free or estimated to have cultivated less than 100 hectares of poppy<sup>7</sup> in 2012.

<sup>6</sup>UNODC (2012) *World Drug Report*.

<sup>7</sup>UNODC (2012) *Afghanistan Opium Survey – Summary Findings 2012*.

Map 3: Opium cultivation in Afghanistan, 2012, at provincial level



Research has also pointed to Afghanistan gaining importance as a principal cannabis resin or hashish supplier.<sup>8</sup> UNODC estimates that in 2011, farmers in Afghanistan planted 12,000 hectares of cannabis resulting in the illicit production of 1,300 tons. Like poppy cultivation, large-scale cannabis cultivation takes place in the southern and less secure provinces of Afghanistan, with many of the same farmers involved. This is, in part, because the same organised criminal groups traffic opium and cannabis.<sup>9</sup> As a result, cannabis resin originating in Afghanistan is trafficked through Pakistan along the same routes as opium and heroin. Seizure data from Pakistan corroborates this. In 2010, 212 tons of cannabis was seized, almost twice the level of 2007. Pakistan assessed that all of the cannabis resin seized on its territory in 2010 originated in Afghanistan.<sup>10</sup>

Available data also points to a prevalence in the supply of amphetamine-type stimulants (ATS) and cocaine, in addition to plant-based drugs derived from cannabis and opium poppy. Law enforcement authorities in Pakistan have made seizures of methamphetamine in the last few years, as well as identifying irregularities around the import of related precursor chemicals such as ephedrine. Smaller seizures of ephedrine and amphetamine, mainly in the air and seaports of Karachi, have been made over the past three years. The most significant seizure of cocaine took place in Karachi in 2010 when 226 kg were seized from a container originating from Africa.

The availability of controlled medication without a proper prescription is also very high in Pakistan. According to a World Health Organization-supported publication, the

<sup>8</sup>UNODC (2012) *World Drug Report*.

<sup>9</sup>UNODC (2011) *Survey of Commercial Cannabis Cultivation and Production*.

<sup>10</sup>UNODC (2012) *World Drug Report*.

Pharmaceutical Country Profile,<sup>11</sup> a legal framework has been put in place to control and regulate prescribing practices. However, enforcement of the legal provisions during the dispensing process remains a challenge. Pharmacies are often the first point of contact for patients seeking health care, also doubling as general convenience stores, with long opening hours and a limited presence of qualified pharmacists. Business practices often reflect commercial rather than health care motivations, complicating medical regulations<sup>12</sup>

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<sup>11</sup> Ministry of Health, GoP (2010) *Pharmaceutical Profile for Pakistan*.

<sup>12</sup>International Journal for Quality in Health Care(2005); Volume 17, Number 4; *Quality of pharmacies in Pakistan: a cross-sectional survey*.

### 3. Key findings

#### 3.1. National drug use: estimation of drug use prevalence and patterns

An estimated 5.8 per cent, or 6.45 million, of the population in Pakistan aged between 15 and 64 used drugs in the last 12 months.

Table 1: Annual prevalence of drug use in Pakistan, 2012.

	Annual prevalence (%)			Number		
	Estimate	Low estimate	High estimate	Estimate	Low estimate	High estimate
<b>Cannabis</b> <sup>A,B</sup>	<b>3.6%</b>	2.9%	4.3%	<b>4,030,000</b>	3,232,000	4,828,000
<b>Opiates</b> <sup>D</sup>	<b>0.9%</b>	0.6%	1.2%	<b>1,024,000</b>	660,000	1,389,000
<b>Heroin</b>	<b>0.7%</b>	0.4%	1.0%	<b>813,000</b>	488,000	1,137,000
<b>Opium</b>	<b>0.3%</b>	0.1%	0.5%	<b>345,000</b>	134,000	556,000
<b>Cocaine</b> <sup>B</sup>	<b>0.01%</b>	0.00%	0.04%	<b>8,000</b>	1,000	39,000
<b>All opioids</b>	<b>2.4%</b>	2.0%	2.9%	<b>2,716,000</b>	2,232,000	3,200,000
<b>ATS</b>	<b>0.1%</b>	0.1%	0.2%	<b>134,000</b>	81,000	218,000
<b>Amphetamines</b>	<b>0.1%</b>	0.1%	0.1%	<b>111,000</b>	81,000	142,000
<b>Methamphetamine</b> <sup>B</sup>	<b>0.02%</b>	0.00%	0.1%	<b>22,000</b>	300	76,000
<b>Injecting drug use</b> <sup>E</sup>	<b>0.4%</b>	0.2%	0.6%	<b>423,000</b>	190,000	657,000
<b>Tranquilizers/sedatives</b> <sup>C</sup>	<b>1.4%</b>	1.1%	1.8%	<b>1,592,000</b>	1,173,000	2,011,000
<b>Painkillers</b> <sup>C</sup>	<b>1.5%</b>	1.4%	1.6%	<b>1,692,000</b>	1,573,000	1,812,000
<b>Solvents/inhalants</b> <sup>B,C</sup>	<b>0.03%</b>	0.00%	0.09%	<b>33,000</b>	300	99,000
<b>Any illicit drug use</b> <sup>F</sup>	<b>5.8%</b>	4.6%	7.1%	<b>6,450,000</b>	5,090,000	7,870,000

Cannabis is the most commonly used drug used by 3.6 per cent of the population between the ages 15 and 64, or approximately four million people. Findings from a study of key informants<sup>13</sup> support these findings with respondents perceiving cannabis as the most commonly used drug. The studies also reveal marked problem cannabis use, indicating that a high percentage of cannabis users are becoming dependent. Approximately 68 per cent of last-year users from the household survey qualify for dependence, based on IDC-10 drug dependence criteria. According to the problem drug user survey, one in four problem drug users are dependent on cannabis with no use of opiates in the past year.

Compared to other national estimates, opiate use is very high, with one per cent of the population, or one million people, using heroin or opium. The prevalence of opioid-based painkiller misuse is also high with 1.5 per cent of the population, or nearly 1.7 million people, having used this prescription drug for non-medical purposes over the last year.

<sup>13</sup> See Annex for the methodology.

New patterns of drug consumption are emerging across Pakistan. Levels of amphetamine-type stimulant (ATS) and cocaine use, while at 0.1 per cent and 0.01 per cent respectively, indicate increasing use of these substances. A detectable emergence of methamphetamine use has been found in certain areas of the country. Around 22,000 people are estimated to have taken methamphetamine in the last 12 months, equivalent to a prevalence estimate of 0.02 per cent. This finding is noteworthy because it is the first time a study has generated data relating to the use of amphetamine-type stimulants (ATS) in Pakistan. Previous reports from data collected by law enforcement authorities had pointed to increased activity around the production and distribution of ATS in the country. Until now, however, there has been uncertainty on whether this increase was due to local demand or whether ATS were intended for users in other countries.

Solvents, inhalants, alcohol, sheesha, and tincture of opium, have also been reported by key informants as emerging drug consumption substances.

Of the household population<sup>14</sup> surveyed, the most commonly reported substances misused are opioid-based painkillers followed by tranquilizers and sedatives. Women are more likely to consume amphetamines and painkillers, with tranquilizer and sedative misuse nearly equal for men and women. Cannabis, heroin, and opium are consumed almost exclusively by men.

Findings from the household survey reveal high levels of non-medical use of prescription drugs among men and women who had been hospitalized in the past year for mental health issues. In particular, non-medical use was high among those hospitalized for anxiety, depression, and stress, after adjusting for age, sex, urban or rural area, and literacy level. The findings reveal a 13-fold increased risk of tranquilizer or sedative misuse among this cohort which may point to self-medication following discharge from inpatient facilities. Moreover, men and women suffering from chronic illnesses and past-year hospitalization are found to be at high risk of misusing opioid-based painkillers without necessary medical supervision. These findings can be supported by wider global-level epidemiology, which finds that 'nonmedical use of prescription drugs is typically greater among patients than in the general population and the gap widens further for those patients who are mentally ill'<sup>15</sup>.

The studies also reveal that there are around 420,000 people who inject drugs (PWIDs) in Pakistan, which represents 0.4 per cent of the population<sup>16</sup> - a higher number than previously reported. The use of contaminated injecting equipment among PWIDs is one of the major routes of HIV transmission and research from the problem drug use study revealed almost three-quarters of opiate-using PWIDs share injecting equipment. HIV prevention and care services remain in short supply throughout Pakistan and, as such, many PWIDs and their sexual partners are at serious risk of transmitting HIV and other communicable diseases.

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<sup>14</sup> See Annex for the methodology.

<sup>15</sup> UNODC (2011) *The non-medical use of prescription drugs: policy direction issues, discussion paper*.

<sup>16</sup> Since this study only sampled individuals aged between 15 and 64, the term 'population' throughout this report only refers to this age group.

### 3.2. Drug-use patterns by age and gender

Table 2: Annual prevalence of drug use in Pakistan in 2012, by gender

	Men				Women			
	Estimate	Number	Low estimate	High estimate	Estimate	Number	Low estimate	High estimate
<b>Cannabis</b>	6.8%	3,940,000	6.5%	7.2%	0.2%	95,000	0.1%	0.2%
<b>Opiates</b>	1.7%	970,000	1.2%	2.1%	0.1%	50,000	0.0%	1.0%
<b>Cocaine</b>	0.01%	7,700	0.00%	0.02%	0.0001%	80	0.000%	0.001%
<b>All opioids</b>	3.3%	1,900,000	3.1%	3.5%	1.5%	810,000	1.4%	1.7%
<b>ATS</b>	0.1%	60,000	0.1%	0.1%	0.1%	73,000	0.1%	0.2%
<b>Amphetamines</b>	0.1%	39,000	0.04%	0.1%	0.1%	72,000	0.1%	0.2%
<b>Methamphetamine</b>	0.04%	21,000	0.01%	0.1%	0.002%	1,000	0.000%	0.01%
<b>Injecting drug use</b>	0.8%	440,000	0.7%	0.9%	0.1%	7,000	0.000%	0.1%
<b>Tranquilizers/sedatives</b>	1.3%	750,000	1.2%	1.4%	1.6%	840,000	1.4%	1.7%
<b>Painkillers</b>	1.6%	930,000	1.5%	1.8%	1.4%	760,000	1.3%	1.6%
<b>Solvents/inhalants</b>	0.1%	33,000	0.03%	0.1%	0.001%	400	0.000%	0.004%
<b>Any illicit drug use</b>	8.5%	4,900,000	8.1%	8.9%	2.9%	1,600,000	2.7%	3.1%

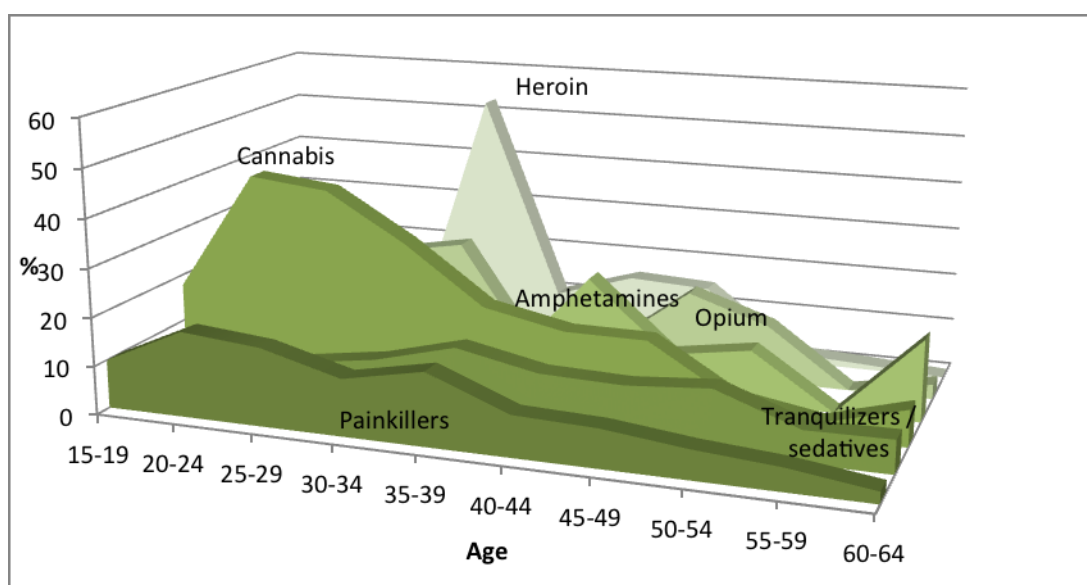
Proportionately, more men have used drugs in Pakistan in the last year compared to women, although prevalence estimates for women are likely underestimated. The proportions are 8.5 per cent and 2.9 per cent respectively. A higher level of tranquilizer and sedative misuse, and comparable level of opioid-based painkiller and ATS use, can be seen among women. Populations that have experienced stress, anxiety, and other difficult life experiences, including post-traumatic stress disorder, may be at higher risk of painkiller, and tranquilizer and sedative misuse. In many countries, ATS is often used among women for weight loss.

The ages of those currently misusing prescription drugs, such as painkillers, and tranquilizers and sedatives, are distributed evenly between 15 and 64 years of age. Regular cannabis users are predominantly young, with more than a third aged between 20 and 29 years of age. Of these, 40 per cent use cannabis charas and 31 per cent use cannabis bhang. Opium use peaks among those aged between 25 and 29 years, at 22.5 per cent, and those aged between 40 and 44 years, at 23 per cent.

Perhaps surprisingly, 17 per cent of opium users are aged between 60 and 64 years. More than half of the current heroin users, or 53 per cent, are aged between 30 and 34 years, while the mean age of opiate users in the problem drug use assessment<sup>17</sup> is 37 years. Among the youngest drug users, aged between 15 and 19 years, the most commonly used drugs are cannabis and amphetamines, at 18 and 15 per cent respectively.

<sup>17</sup> See Annex for the methodology.

Figure 1: Age distribution of 'current users' in the household survey, by six drug types.



#### Drug use among women in Pakistan: low prevalence or a hidden population?

As described in the 2010 UNODC report on female drug users in Pakistan, 'unlike male drug users who congregate and use drugs with other drug users, drug use is a discreet, hidden and more of an individual activity for female drug users'. The exhaustive studies which included more than 50,000 household interviews as well as interviews of more than 3,000 problem drug users, show that women constitute only 25 per cent of the total population of drug users in Pakistan.

The question then is: how accurate is the number or did the study fail to adequately survey women? There is some evidence that drug use among women may have been underestimated. This is likely due to the higher levels of stigma associated with drug use by women. Among the small population of household survey respondents that revealed past-year illicit drug use, approximately 42 per cent were women. Of those who qualified for dependent drug use, according to ICD-10 criteria, approximately 30 per cent were female. Further, among those who injected drugs, 45 per cent were female. These numbers show that the gender ratio among drug users may not be as imbalanced as the estimates of drug use prevalence suggest.

In the general population, 45 per cent of current users are women and the average age of use among men and women is 34 years. Current drug users are those who have used in the past 30 days. Drug use patterns vary considerably between men and women. Women are more likely to consume amphetamines and painkillers, with 92 per cent of female users regularly misusing painkillers, and tranquilizers and sedatives. In comparison, only 48 per cent of male users also misuse these substances. Men are more likely to use cannabis than women, at 44 per cent and less than one per cent respectively.

Revealingly, no women reported opiate use in the household survey compared to five per cent of male respondents. This result, coupled with the low number of women participating in the problem drug use survey, results in a low national-level estimate of opiate use among women. It is also possible that women tend to misuse prescription opioids rather than heroin or opium.



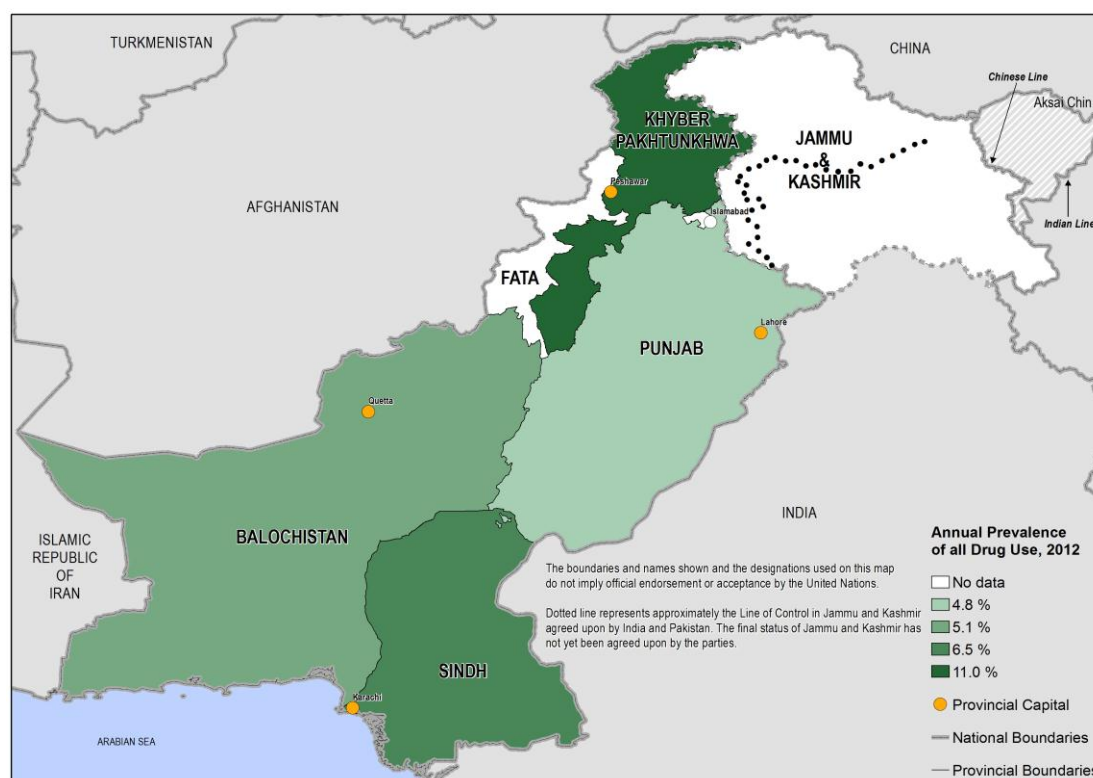
Respondents in the general population survey were asked about the types of drugs they knew. Women were less likely than men to report knowing about illicit drugs, but in some regions the degree to which women denied knowledge of certain substances was surprising. For example, in Khyber Pakhtunkhwa only 82 per cent had heard of heroin and in Balochistan only 68 per cent admitted to having heard of heroin.

The newly-registered use of ATS is still less prevalent than other drugs. However, perhaps surprisingly, ATS use was found to be equal among men and women.

### 3.3. Provincial-level estimates of drug-use prevalence and patterns

The highest prevalence of any drug use is seen in Khyber Pakhtunkhwa where 11 per cent of the population use illicit substances. The provinces of Sindh and Punjab reveal levels of use of 6.5 and 4.8 per cent respectively. Based on the limited data available for Balochistan, the number of drug users is calculated at around 5.1 per cent or 280,000 users, although this figure is likely to be an underestimate across the province, this prevalence rate is sizeable regardless.

Map 4: Annual prevalence of all drug use, 2012.



#### *Khyber Pakhtunkhwa*

The province of Khyber Pakhtunkhwa has the highest prevalence of drug use compared with Sindh and Punjab, with 11 per cent of the population using drugs. Cannabis, opioid, and tranquilizer and sedative use were highest in Khyber Pakhtunkhwa with prevalence rates of 5.1 per cent, 5.8 per cent, and 2.4 per cent respectively. Opiates are used by 1.4 per cent of the population. With 30,000 men and women having used ATS in Khyber Pakhtunkhwa, this

province demonstrated the highest prevalence of ATS use. Levels of dependent drug use in Khyber Pakhtunkhwa were found to be higher when compared to dependence levels in other regions.

#### *Balochistan*

Although drug use estimates for Balochistan are conservative due to a lack of data collected beyond the provincial capital of Quetta thus not directly comparable with estimates from other provinces, drug use prevalence estimates for the province are still noteworthy. Balochistan has a high opiate use prevalence, at 1.6 per cent of drug users or 88,000 people. In addition, 0.2 per cent or around 13,000 people took methamphetamine in Balochistan in the last year. Tranquilizer and sedative misuse is also considerable with 1.8 per cent of the population (100,000 people) using these substances illicitly.

#### *Sindh*

With 4.2 per cent of the population using cannabis in the last year, the province of Sindh had the second highest prevalence rates for hashish, bhang, and charas use. An estimated 560,000 people in Sindh used opioids last year. Of these, 66 per cent used opiate-based painkillers and 34 per cent used heroin or opium or both. Almost 100,000 drug users in Sindh are estimated to be injecting drugs. Prevalence estimates for tranquilizer, sedative, and ATS use are not as high as in other provinces.

#### *Punjab*

Punjab is the most populous province in Pakistan. Based on a population estimate of 61.41 million persons aged 15-64, 4.8 per cent of this population, or 2.9 million people, were estimated to be using drugs across the province last year. Punjab alone has 530,000 heroin and opium users, which equates to 0.9 per cent of the provincial population. Of all ATS users in Punjab, the vast majority used amphetamine compared to methamphetamine, at 0.1 and 0.001 per cent respectively. Around a quarter of a million drug users are estimated to be injecting drugs in Punjab.

#### *Pakistan-administered Kashmir*

Overall prevalence rates of drug use in Pakistan-administered Kashmir are relatively low, compared to general rates in Pakistan. An estimated 3.8 per cent of the population in Pakistan-administered Kashmir used drugs in the last year. However, the prevalence of cannabis use is comparable to other provinces, at 3.2 per cent. In contrast, levels of illicit tranquilizer and sedative misuse are lower, at 1.1 per cent. Combined heroin and opium prevalence rates in Pakistan-administered Kashmir are 0.7 per cent, which is similar to elsewhere in Pakistan. Of all ATS users in Pakistan-administered Kashmir, relatively few used amphetamine compared to methamphetamine, at 0.0001 and 0.02 per cent respectively

Table 3: Annual prevalence of drug use in Pakistan, 2012, by province.<sup>18</sup>

	Punjab		Sindh		Balochistan**		KPK	
	Annual prevalence % (95% CI)	Estimated number of users <sup>1</sup>	Annual prevalence % (95% CI)	Estimated number of users <sup>2</sup>	Annual prevalence % (95% CI)	Estimated number of users <sup>3</sup>	Annual prevalence % (95% CI)	Estimated number of users <sup>4</sup>
<b>Cannabis</b>	3.1 (2.9-3.3)	1.9 m	4.2 (3.5-4.9)	1 m	2.8 (2.0-3.6)	156 k	5.1 (4-6.2)	770 k
<b>Opiates</b>	0.9 (0.6-1.2)	530 k	0.7 (0.4-1.0)	190 k	1.6 (1.2-2.0)	88 k	1.4 (1.0-1.8)	215 k
<b>Cocaine</b>	0.007 (0.00-0.04)	4 k	0.03 (0.00-0.1)	8 k	0.003 (0.00-0.02)	170	None sampled	
<b>All opioids</b>	1.7 (1.3-2.2)	1 m	2.2 (1.7-2.7))	560 k	1.7 (1.2-2.3)	97 k	5.8 (4.8-6.8)	870 k
<b>ATS</b>	0.1 (0.06-0.16)	60 k	0.1 (0.03-0.1)	20 k	0.2 (0.1-0.4)	13 k	0.2 (0.07-0.3)	30 k
<b>Amphetamines</b>	0.1 (0.06-0.14)	60 k	0.1 (0.03-0.1)	18 k	0.0 (0.00-0.01)	56	0.2 (0.07-0.3)	30 k
<b>Methamphetamine</b>	0.001 (0.00-0.01)	600	0.02 (0.00-0.04)	5 k	0.2 (0.07-0.4)	13 k	0.001 (0.00-0.01)	150
<b>Injecting drug use</b>	0.4 (0.2-0.6) <sup>***</sup>	250 k	0.4 (0.2-0.6)	95 k	0.3 (0.1-0.5)	19 k	0.3 (0.1-0.5)	48 k
<b>Tranquilizers/ sedatives</b>	1.2 (0.8-1.6)	725 k	1.2 (0.8-1.6)	310 k	1.8 (1.2-2.4)	100 k	2.4 (1.7-3.0)	360 k
<b>Painkillers</b>	0.9 (0.7-1.0)	530 k	1.4 (1.2-1.6)	370 k	0.2 (0.06-0.3)	9 k	4.4 (3.7-5.0)	660 k
<b>Solvents/inhalants</b>	0.01 (0.00-0.04)	6 k	0.06 (0.00-0.1)	16 k	0.1 (0.00-0.2)	6 k	0.05 (0.00-0.1)	8 k
<b>Any illicit drug use</b>	<b>4.8 (3.9-5.7)</b>	<b>2.9 m</b>	<b>6.5 (5.0-8.0)</b>	<b>1.7 m</b>	<b>5.1 (3.4-6.7)</b>	<b>280 k</b>	<b>11.0 (8.6-13.5)</b>	<b>1.7 m</b>

<sup>18</sup>Provincial-level prevalence estimates based on 2012 population data by UNFPA/NIPS; province totals do not sum to the national total as a result of the inclusion of the Federally Administered Tribal Areas and Islamabad in the national population estimate.

### 3.4. Drug-related high-risk behaviours

There are an estimated 420,000 people who inject drugs (PWIDs) in Pakistan. Heroin is most likely to be administered via injection, although users also reported injecting amphetamines, painkillers, and tranquilizers. Men are more likely to inject than women, and the top three drugs injected are heroin, benzodiazepines or tranquilizers, and other opiates. The majority of PWIDs inject two to four times a day and the most common places to inject are in parks, closed streets or abandoned buildings. Of the small number of household survey respondents that revealed past-year illicit drug and injecting drug use, approximately 45 per cent are women.

Among regular opiate users who inject drugs, 73 per cent reported sharing syringes either before or after someone else. When asked why they shared, most reported it was because there was only one needle available. The average age of first injection initiation was 26, approximately 2.5 years after the average age of first heroin use. While 73 per cent of PWIDs reported sharing a syringe, only 2.5 per cent of all PWIDs had accessed needle and syringe supply or exchange services. The average number of times PWID use a syringe is three, which means the average user uses only one new syringe per day and not one syringe per injection episode.

Almost half of all PWIDs reported high-risk injecting behaviours, making them highly vulnerable to blood borne diseases such as HIV and Hepatitis C. Only 11 per cent had accessed a drop-in centre or other form of low-threshold service providing prevention, treatment, care, and support for HIV. Less than two per cent of PWIDs reported having been tested for HIV.

Sexual risk behaviours amongst opiate users are high, particularly among women and within correctional settings. Of the 68 per cent of women who reported having sex in the past six months, 38 per cent reported having sex with other drug users or PWIDs. Around 70 per cent reported having unprotected sex and 36 per cent reported having a steady sex partner who is HIV positive. Among female opiate users, 30 per cent reported receiving money or drugs for sex and 20 to 30 per cent of male opiate users reported giving money or drugs in exchange for sex. Men are more likely to report giving money than drugs in exchange for sex, and both behaviours are particularly high in Balochistan and Sindh when compared to other provinces. Of the 124 opiate users who reported having sex while in prison, only one reported using condoms 'most of the time'. This suggests 99 per cent of men who have sex in correctional settings are not always using protection, placing themselves at high risk of contracting or transmitting HIV and other sexually transmitted diseases.

Table 4: Proportion (%) of people who inject opiates by (a) province or region and (b) frequency of injecting.

Opiate users	Total	Male	Female*	Punjab	Sindh	KPK	Balochistan	PAK <sup>19</sup>
% injected in the past-year	32.4	32.8	11.4	42.5	33.3	15.2	20.6	19.4
% injected in past sixmonths	31.3	31.6	11.4	41.8	31.1	14.7	19.0	12.9
% of PWID who inject daily	80.6	80.5	100.0	77.7	93.8	70.7	89.1	75.0
Frequency of injection (%)								
<b>Once a day</b>	23.1	23.2	0.0	19.9	8.6	46.9	45.5	75.0
<b>2-4 times a day</b>	60.4	60.4	66.7	64.6	66.9	40.7	39.4	25.0
<b>4+ times a day</b>	14.9	14.9	16.7	15.1	23.8	1.2	12.1	0.0
<b>Don't know</b>	1.6	1.5	16.7	0.4	0.7	11.1	3.0	0.0

#### *HIV, Hepatitis B, and Hepatitis C*

Pakistan is in the midst of a concentrated HIV epidemic, notably among injecting drug users, female sex-workers, and men who have sex with men. Among PWIDs, UNAIDS reports the HIV prevalence is 27.2 per cent. They also report that among those who have received an HIV test in the past 12 months only 9.1 per cent know their results<sup>20</sup>.

The overall prevalence of self-reported HIV among problem drug users in this study was 32 per 1,000, and 57 per 1,000 among past-year injectors. The self-reported HIV prevalence among PWIDs in this study was nearly five times lower than the estimated population prevalence. This gap in self-reported status and HIV prevalence estimates could be due to the high levels of stigma associated with HIV. They could also be due to the use of unlinked anonymous testing in seroprevalence studies or low testing among PWIDs. Unlinked anonymous testing is a practice used to estimate population prevalence of HIV without informing the participant of their status, instead referring them to other testing services.<sup>21</sup>

Table 5: Percentage of PWIDs injecting in the past-year (n=1,079) self-reporting infection of Hepatitis B, C, or HIV or AIDS.

'Have you ever been told you have:'	Punjab	Sindh	KPK	Balochistan
Hepatitis B	15.6	15.0	13.8	27.1
Hepatitis C	18.3	40.1	2.1	15.0
HIV or AIDS	6.0	9.6	2.1	0.9

<sup>19</sup>Small sample size may render stratified estimates unstable (females=5, Pakistan-administered Kashmir=6).

<sup>20</sup>[http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce\\_PK\\_Narative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_PK_Narative_Report[1].pdf).

<sup>21</sup> Archibald P et al. (2013) *Geographical and temporal variation of injection drug users in Pakistan, Sex Transm Infect.* (0):1-11.

In the general population only half of those surveyed had ever heard of HIV. Awareness was higher in urban areas, compared with rural areas, and higher among men than women. HIV awareness strongly improved with higher education and literacy levels.

Table 6: Percentage of household survey respondents who had heard of HIV or could name one or more modes of transmission.

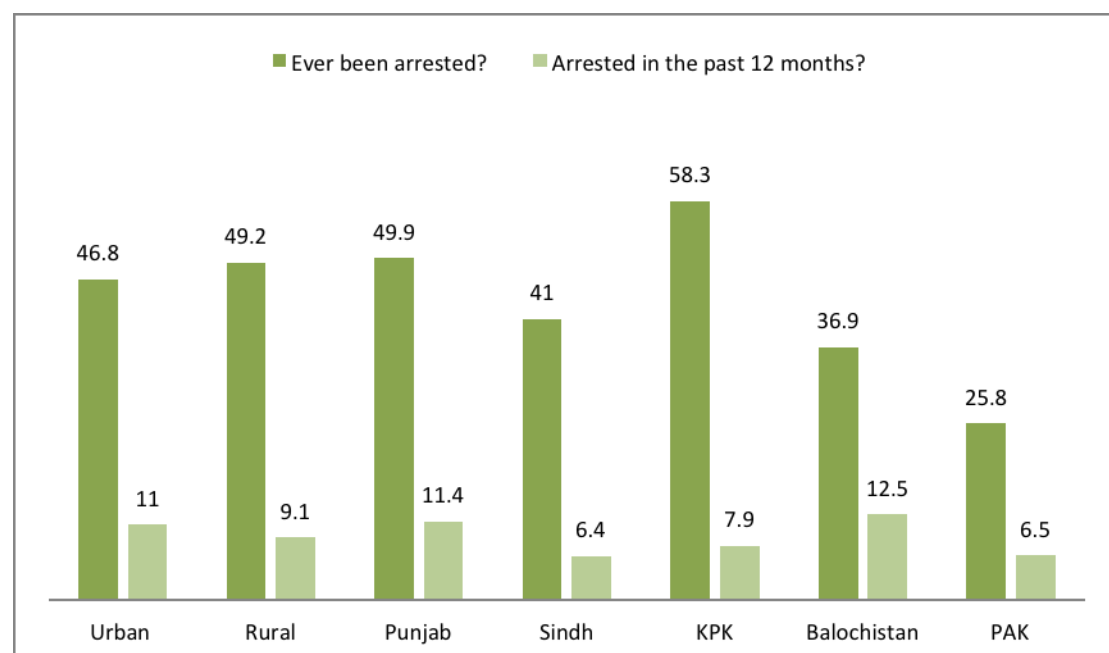
	Overall	Males	Females	Urban	Rural
<b>Awareness of HIV</b>	<b>48.9</b>	60.8	40.2	65.8	39.8
One mode of HIV transmission named	29.2	43.3	21.7	41.6	20.2
Two modes of HIV transmission named	19.7	27.8	13.8	30.9	13.7
Three modes of HIV transmission named	12.2	17.3	8.5	19.7	8.2

Awareness of HIV and transmission behaviours may correspond to safer sexual practices. In this study, those who could name three routes of HIV transmission were 2.7 times more likely to report condom use during sex than those who could not.

### 3.5. Arrest and incarceration

Approximately half of all opiate users self-reported an arrest for a drug-related offence and 10 per cent had been arrested during the past year. Of those ever arrested, more than 70 per cent were arrested for using drugs and around 40 per cent for possession of drugs. The average age of first arrest was 27 years. The frequency of arrest among opiate users in Khyber Pakhtunkhwa was highest with 58 per cent ever arrested, and only 26 per cent of respondents in Pakistan-administered Kashmir arrested for drug-related crimes.

Figure 2: Proportion (%) of opiate users by province or region with (1) a history of arrest, and (2) an arrest during the past year.



Of those respondents ever arrested for drug-related offences, three quarters self-reported arrest for drug use. Significant numbers also reported arrest for possession, dealing, and trafficking, while almost 10 per cent reported arrests for trigger offences such as theft, burglary, and prostitution. Based on self-reported data, no violent or sexual crimes were committed, with only six arrests for domestic violence.

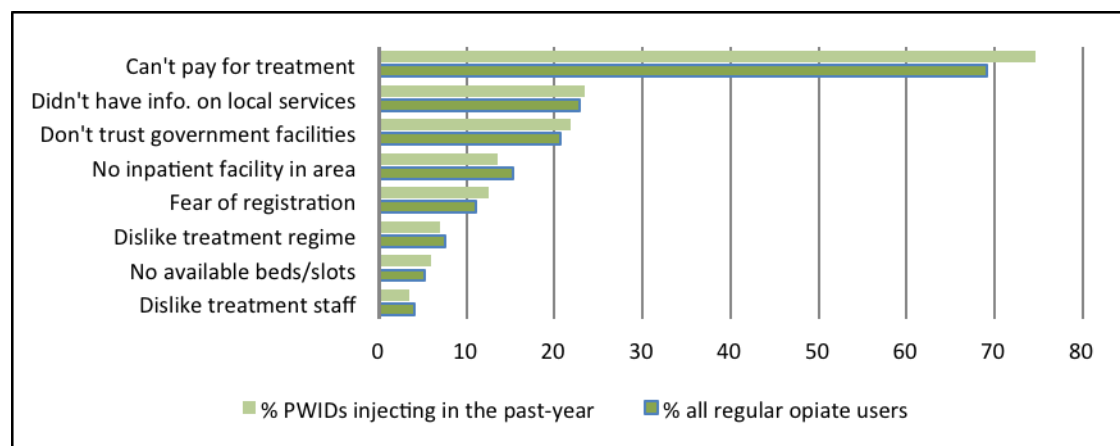
### 3.6. Drug dependency and treatment

Around 4.1 million drug users in Pakistan are thought to be dependent<sup>22</sup> on substances. In other words, 64 per cent of people using a drug or misusing a substance in 2012 qualify as dependent and require specialist interventions.

When key informants were asked whether there were drug treatment services in their locality, around one third of informants in Punjab, Balochistan, and Khyber Pakhtunkhwa reported local drug treatment services. In Sindh, only 17.4 per cent of key informants cited a drop-in centre in their area. No key informants in Pakistan-administered Kashmir were aware of services for drug users in the region. Findings from the problem drug user assessment also revealed insufficient treatment service capacity and coverage, with less than half of all opiate users reporting an operating drug treatment centre in their area. More than three quarters of respondents across all regions of Pakistan identified an 'urgent' need for drug treatment centres.

Of regular opiate users, 41 per cent had been in treatment during their lifetime and 10 per cent in the past year. More than three-quarters of regular opiate users and PWIDs report wanting to get help but being unable to. The majority identified cost as the main barrier to accessing treatment.

Figure 3: Among regular opiate users who want to seek help but are unable to, response to the question 'What prevented you from getting help?'



Only nine per cent of regular opiate users and 16 per cent of PWIDs were in contact with outreach services and drop-in centers (DIC) in the past six months. Only five per cent of

<sup>22</sup> The definition of dependent drug user is defined by the World Health Organization in accordance with the ICD-10 classification of mental and behavioural disorders: WHO (1992b) *Clinical descriptions and diagnostic guidelines*.

regular opiate users and 11 per cent of past-year injectors had accessed a DIC in the past year. Of those, only 1.7 per cent of PWIDs attended a DIC for an HIV test, and 1.1 per cent for a Hepatitis B or C test.

Structured treatment and low-threshold interventions are currently only available to a limited number of drug users. UNODC estimates these services cover, at most, 30,000 drug users each year (Table 5). Of past-year users participating in the household survey that had sought treatment in the past year only 18 per cent were women.

Table 7: Estimated provision<sup>23</sup> of interventions for drug users in Pakistan, 2012-2013, prepared by UNODC

Province or region	Structured drug treatment						Low threshold services for DUs and PWIDs			Total services for drug users	Total capacity for drug users
	Government	NGO	Private	Private, not registered <sup>24</sup>	Sub-total	Annual capacity	DICs	Other	Annual capacity		
Sindh	8	7	8	4	27	334	14	0	7,000	41	7,334
Punjab	7	12	8	4	31	779	24	0	18,050	55	18,829
Khyber Pakhtunkhwa	5	6	1	4	16	552	1 <sup>25</sup>	0	500	17	1,052
Balochistan	4	2	0	4	10	141	2 <sup>26</sup>	0	1,000	12	1,141
Islamabad and Rawalpindi	1	2	5	4	12	184	0	0	0	12	184
Pakistan-administered Kashmir											
FATA											
<b>TOTAL</b>	<b>25</b>	<b>29</b>	<b>22</b>	<b>20</b>	<b>96</b>	<b>1,990</b>	<b>41</b>	<b>0</b>	<b>26,550</b>	<b>137</b>	<b>28,540</b>

According to recent research, drug treatment services are running without a solid evidence-base. Further, information on drug use prevalence, trends, and behaviours is lacking. Current information management systems are poor and there is a scarcity of data on treatment effectiveness. Treatment centre locations do not necessarily correspond to potential demand.<sup>27</sup> The quality of treatment and interventions provided is also low, partly due to reduced human resources capacity and ineffective referral systems. For instance, less than one per cent of opiate-using PWIDs in the problem drug user study had been referred to structured treatment in the past 12 months.

<sup>23</sup>Since many clients in structured treatment require multiple treatment episodes owing to the high probability of relapse, number and capacity presented in the table is the minimum level.

<sup>24</sup>Exact locations unknown although anecdotal information supplied confirms total number distributed evenly across Pakistan.

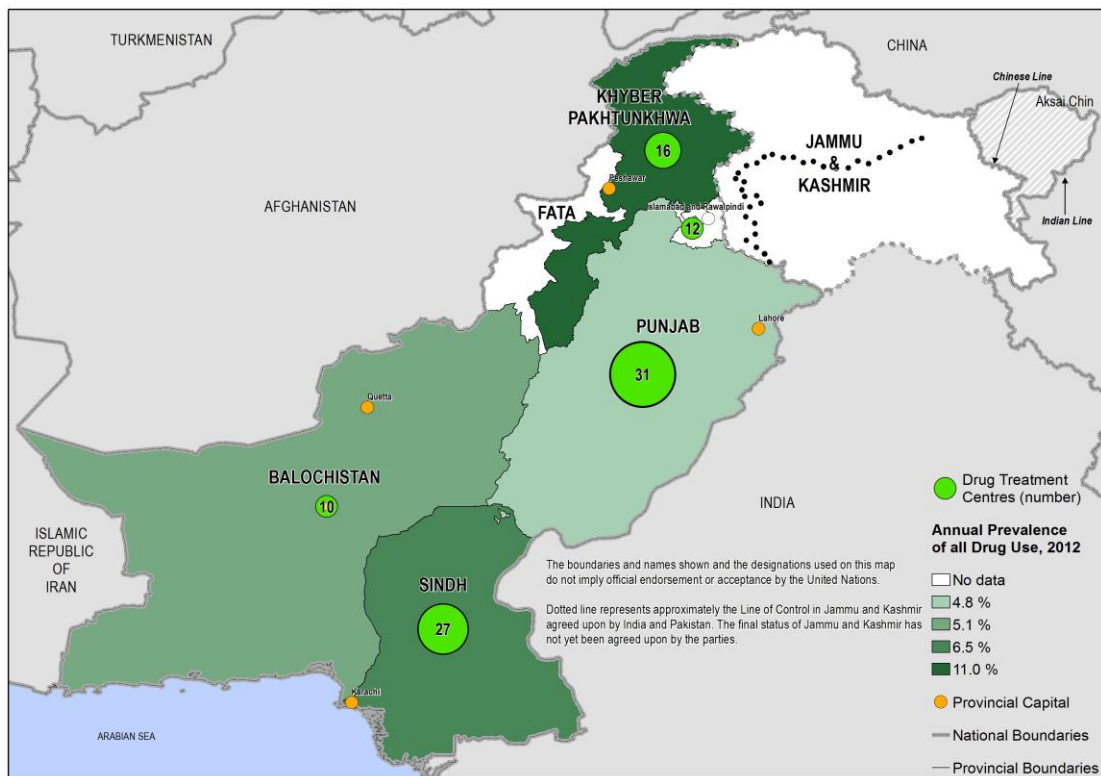
<sup>25</sup>Services due to open by mid-2013.

<sup>26</sup>Services due to open by mid-2013.

<sup>27</sup>UNODC (2012) *Assessment of the National Drug Treatment and Rehabilitation System of Pakistan*.



Map 5: Distribution of drug treatment centres in Pakistan, 2012





#### 4. Findings and way forward

Drug use is a problem in Pakistan. Interplay between the supply of opiates, cannabis, synthetic and over-the-counter prescription drugs, and social and economic factors, make the population vulnerable to drug use and related problems. Reliable data on drug use prevalence have been described in this technical summary report and can be used to improve existing drug control measures in policy development, programme design and service delivery.

##### Findings

An estimated 5.8 per cent, or 6.45 million, of the population in Pakistan aged between 15 and 64 used drugs in the last 12 months

Plant based drugs are the most predominantly used drugs in Pakistan by those between the ages of 15 and 64 with 3.6 per cent or just over four million annual users of cannabis. High levels of opiate use have been found with 0.9 per cent or just more than one million users of which 0.7 per cent use heroin and 0.3 per cent use opium annually. Levels of use for opiates are highest as a proportion of the population in provinces that border cultivation areas in Afghanistan.

Synthetic drugs in the form of amphetamine type stimulants or ATS have emerged as a concern with 0.1 per cent found to use amphetamines and 0.02 per cent using methamphetamine. While the levels of annual use of ATS are low the findings are nonetheless noteworthy because it is the first time a research study has reported related data for Pakistan.

Non-medical use of prescription drugs have been found to be used by a sizeable population of men and women although it is significant that more women use tranquillizers and sedatives than men.

##### Way forward

The Anti-Narcotics Policy of Pakistan (2010) defines the priorities and methods in implementing drug control, including supply reduction, drug demand reduction and international cooperation. The Policy is translated into practical measures in the Government's Drug Control Master Plan 2010-2014 (DCMP), which aims 'to reduce the health, social and economic costs associated with drug trafficking and substance use in Pakistan'. The DCMP envisages a drug-free Pakistan by 2020 and its strategy focuses on supply reduction through invigorated and strengthened law enforcement, demand reduction through accelerated initiatives, and increased international cooperation and support.

In particular, the DCMP places emphasis on sustained, continuous prevention programmes for schools and communities, improved effectiveness of treatment delivery and scaling up of

treatment services. In addition, the DCMP envisages expanding the Government's capacity to collect and maintain data related to drug use.<sup>28</sup>

Supporting the objectives of the DCMP requires a consolidated and coordinated approach from the Federal and provincial governments, civil society and private sector, and is likely to require changes in approach and priority. Such strengthening can only be ensured through sustained and stable commitments. Areas of special focus are recommended in order to strengthen support for the objectives of the DCMP: supply reduction, demand reduction including drug use prevention, treatment, drug related HIV prevention and care, as well as, increased research, monitoring and evaluation, and international cooperation.

### Supply Reduction

Sustained efforts to reduce the supply of narcotics and related precursor chemicals should be made, and supported.

Particular focus should be given to Balochistan and Khyber Pakhtunkhwa where trafficking routes are active and the supply is highest. There is a correlation between areas with high levels of opiate use and close proximity to trafficking routes from the provinces in Afghanistan where opium and cannabis cultivation are highest.

The emergence of synthetic drugs, including amphetamine type substances or ATS, and related precursors, requires attention by law enforcement and regulatory authorities.

### Demand Reduction

#### *Prevention*

Evidence-based interventions for the prevention of drug use,<sup>29</sup> with a focus on families and life-skills education, should be widely implemented. These wrap-around efforts may work particularly well given the strong family networks in Pakistan.

With regard to the non-medical use of prescription drugs, existing recommendations on understanding and reducing misuse have been made<sup>30</sup>. Specifically, a medication management system is required to ensure medication is only available to those who need it. Awareness-raising among policy-makers, clinicians, parents, young people and teachers is also needed. Further, health care professionals need to be trained to prevent, recognise, and manage non-medical prescription drug misuse.

There is a strong need to increase education and prevention efforts in HIV and hepatitis awareness among the general population and high-risk groups. Prevention of the negative social consequences of drug use is critical for both drug users and society at large. Considering that the HIV epidemic in Pakistan is driven by high-risk injecting behaviours among drug users, it is important that service coverage is expanded in consideration of the

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<sup>28</sup> *Drug Abuse Control Master Plan 2010-2014*, Ministry of Narcotics Control, GoP, February 2010

<sup>29</sup> <http://www.unodc.org/unodc/en/drug-prevention-and-treatment/index.html>.

<sup>30</sup> [http://www.unodc.org/docs/youthnet/Final\\_Prescription\\_Drugs\\_Paper.pdf](http://www.unodc.org/docs/youthnet/Final_Prescription_Drugs_Paper.pdf).

comprehensive package model<sup>31</sup>. There is a need for increased engagement with people who inject drugs through the strengthening of community-based outreach services and mainstream health providers.

#### *Treatment and care services*

The scope and coverage of treatment and care services should be expanded nationally, including pharmacologically-assisted psychosocial treatment of opioid dependence and effective aftercare provision for recovering users.

Efforts should focus on treatment service delivery, as a priority, considering prevalence rates of opiate use and severity of dependence. Drug treatment centres in Pakistan should be supported to consistently implement the national 'Treatment Protocols for Drug Use' endorsed by the Ministry of Narcotics Control in 2012.

It is also recommended that health ministries and civil society expand drug prevention and treatment capacity and coverage, both to the general population and to specific sub-groups, including women and offenders.

#### *Monitoring and evaluation of programmes and interventions*

The regular monitoring of drug use in Pakistan would aid policy efforts to address needs and provide data for the evaluation of programmes and interventions. This would help reduce drug use and high-risk behaviours. A national surveillance programme would be highly beneficial, both for understanding trends over time and for measuring improvements in population health that may result from implementation of these recommendations.

#### *International Cooperation*

Both supply and demand reduction efforts will require expanded international engagement and cooperation.

Pakistan needs to be better connected to source and destination countries to counter the trafficking of narcotics and precursor chemicals to and through Pakistan.

Countering drug and precursor trafficking will require Pakistan and partner states to actively share law enforcement information and experiences on modus operandi and methods. In addition, Federal and provincial law enforcement agencies in Pakistan need to be fully aware of international and regional commitments.

The health sector, especially at provincial level, along with civil society need to be supported to formulate and implement prevention and treatment policies and services that are consistent with international best practice. Successful demand reduction methods and experiences from states within the region and beyond can, and should be, considered for adoption or adaptation to Pakistan.

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<sup>31</sup>World Health Organization HIV/AIDS Programme.  
[http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf).



## 5. Annex: Methodology

### **Table 1: Annual prevalence of drug use in Pakistan, 2012.**

<sup>A</sup> Household survey indirect estimate of population proportion using the network scale-up method. Based on the number of drug users known to a respondent, a personal network prevalence was calculated for each respondent, and the average prevalence of those surveyed (N=51,453) was taken as the population prevalence.

<sup>B</sup> Estimated from the proportion of poly drug users (opiate users) who also used other drugs.

<sup>C</sup> Self-reported from household survey (N=51,453), weighted to account for survey methods, adjusted for gender of respondent.

<sup>D</sup> Multiplier-benchmark method of regular opiate users. A benchmark value was developed based on a survey of 62 treatment centres in 19 districts of Pakistan. The multiplier came from a survey of 3,330 problem drug users (last year or last 30 day heroin or opium users) in those same districts.

<sup>E</sup> Estimated from the proportion of problem drug users and household users who report injecting drugs in the past year.

<sup>F</sup> Estimate adjusted for poly-drug use among household and problem drug users.

<sup>†</sup> Based on a national population estimate of 111,323,400 million persons aged 15-64 (2012, UNFPA/NIPS), direct application of these estimates to other population figures may not be valid.

### **Table 3: Annual prevalence of drug use in Pakistan, 2012, by province.**

<sup>1</sup> Based on a population estimate of 61.41 million persons aged 15-64 (2012, UNFPA/NIPS).

<sup>2</sup> Based on a population estimate of 25.95 million persons aged 15-64 (2012, UNFPA/NIPS).

<sup>3</sup> Based on a population estimate of 5.59 million persons aged 15-64 (2012, UNFPA/NIPS).

<sup>4</sup> Based on a population estimate of 15.08 million persons aged 15-64 (2012, UNFPA/NIPS).

\*Province totals do not sum to the national total as a result of the inclusion of the Federally Administered Tribal Areas and Islamabad in the national population estimate.

\*\*Only one city, Quetta, was able to provide adequate data to derive an estimate of problem drug use for the entire province of Balochistan. As a result, the prevalence of problem drug use in Balochistan is likely to be higher than reported here.

\*\*\*This estimate was 0.3 per cent, derived from the problem drug use population, and 0.1 per cent, derived from the household population, summed to estimate the national population prevalence. For programmes and services directed towards the problem drug use population, a population estimate of 0.3 per cent should be used.







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