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Drug Demand Reduction

Barun Kanjilal

Psychoactive drug (or substance) use is a global phenomenon. It effects almost every country, although its extent and characteristics differ from region to region. The UN estimates that some 180 million people worldwide—4.2 per cent of people aged 15 years and above—were consuming these drugs in the late 1990s, including cannabis (144 million), amphetamine-type stimulants (29 million), cocaine (14 million) and opiates (13.5 million, including 9 million addicted to heroin) (ODCCP 2000). In addition to its known consequences, such as, increased rates of crime and violence, susceptibility to HIV/AIDS and hepatitis, demand for treatment and emergency room visits and a breakdown in social behaviour, the drug problem has even broader implications—the spread of infectious diseases, money laundering, corruption and financing of insurgent or terrorist groups.

At the 1998 UN General Assembly special session on the world's drug problem, member states recognised that reducing the demand for drugs was an essential pillar in the stepped-up global effort to fight drug abuse and trafficking. Demand reduction strategies seek to prevent the onset of drug use, help drug users break the habit, and provide treatment through rehabilitation and social reintegration. The strategy is potentially more effective than the traditional simple 'hunt and kill' of supply sources since demand reduction, through the market mechanism, generates long-term incentives to the producers

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to quit the market. Any control on the supply side on the other hand usually generates incentives for the traders to operate further below ground and earn higher premiums. However, the precondition for achieving success in a demand reduction strategy is adequate flow of information regarding the consumers and their behaviour. In the present context, it implies that the intervention should be designed on the basis of information regarding users of drug in a specific region—what types of drugs are preferred, which groups are more vulnerable, how the preference is revealed in the market, what burden it imposes on the user and his/her family and society, how they cope with these burdens, and so on. Since users behave differently across regions or countries it is important that these information are generated and updated at the regional or country level.

The Drug Demand Reduction Report: South Asia (UNDCP-ROSA 1998) is an attempt to meet this information gap in the context of the South Asian region, especially from the six South Asian countries—Bangladesh, Bhutan, Maldives, Nepal, India and Sri Lanka. Its objective is to provide a sharper focus on several key issues of drug abuse and offer a regional perspective. More specifically, it attempts to present a structured perspective on the prevalence and patterns of drug abuse, its consequences on the individual, family and community, and the responses of governments and communities in these six countries. Thus, it intends to be a comprehensive resource book for a wide audience, including lawmakers, media experts, planners, service providers in diverse settings, academicians and researchers.

The document first reports the magnitude and pattern of the problem related to drug abuse in each of these six countries. The data came primarily from rapid assessment surveys (RAS) conducted in each of these countries. The quantitative information was also supplemented by several case studies (produced as box items) on various types of drug users in these countries. A crude estimate of the actual number of users in selected countries tells us that there are about 2.25 million drug addicts in India, 0.5 to 1.0 million in Bangladesh, 0.014 million to 0.05 million in Nepal and 0.24 million in Sri Lanka. The numbers are insignificant in terms of the percentage of population, but in terms of impact on families and society they are definitely a matter of serious concern.

What are the impacts of drug abuse? It is well documented in the report that drug abuse imposes several tangible and intangible costs

internally on individuals and families, and externally on society. From the viewpoint of an individual abuser of a developing country, the most important impacts are: (*a*) drainage of own and household resources without being supplemented by compensatory economic activity; and (*b*) loss in income due to reduced productivity, disability or incarceration (for drug-related crime). The first consequence, as reported by many studies, could take an alarming shape, especially for the users of expensive drugs, such as heroin. For example, according to one study on opioid/opiate drug users in Kolkata, on an average a non-injector spends about Rs. 100 a day ($2.3) while an injecting drug user spends about Rs. 66 ($1.4) per day (Panda 2000). Assuming that the addiction starts at a very young age, the drain accumulated over the span of addiction may be significantly high. For example, it is estimated that 20 years of opium addiction from the present time is equivalent to a one-time loss of Rs. 40,770 ($850) (UNDCP-ROSA 1998: 83). Given that opium is predominantly used by poorer households, one can hardly exaggerate the magnitude of sacrifice incurred by a typical poor household with one opium user. It is not surprising that the users have to adopt desperate means to mobilise these resources. According to one study of heroin addicts in Mumbai, more than one-third of the addicts had to borrow money, more than one-tenth mortgaged their land, and about 30 per cent sold their land or ornaments to purchase drugs (Sharma et al. 1995).

The individual's potential economic resources are further squeezed by loss in his/her productivity and consequent loss in potential earnings. An individual who starts taking drugs at a very young age loses vital years of skill formation, lags behind others of the same age in terms of quantity and quality of education, and may finally start his/her professional career at an older age with less productive skills. The loss is further aggravated by partial or total disability due to sickness, road accidents, workplace accidents for those who are already employed or even death. Things are worse for some individuals who get involved in crime, are incarcerated and thus kept physically away from the job market.

National-level data on drug-related crimes are sketchy but still useful to get an idea about the extent of loss. The rate of drug-related offences is highest in Sri Lanka, with a rate of 79.89 per 100,000 population, and hovers between one and three per 100,000 population in Bangladesh, India and Nepal (UNDCP-ROSA 1998: 74).

This type of crime includes drug peddling and petty crimes like theft, burglary or pickpocketing. Few micro-level studies also support the national evidence. For example, the study on drug users in Kolkata revealed that the proportion of jail inmates with narcotic drug and psychotropic substances (NDPS) cases to the total number steadily increased from 1.45 per cent in 1995 to 2.29 per cent in 1999 (Panda 2000: 42). The same study reported that 85 per cent of drug users had at least once been in police lock-up.

It is well known that chronic drug use may lead to serious health-related problems. Most recent evidences point to a clear link between AIDS and injectable drug users (IDUs). The sharing of infected injection equipment and other drug paraphernalia among IDUs is an efficient and rapid means of transmitting the virus. In states like Manipur in India, it is estimated that drug users constitute about 75 per cent of all HIV-positive cases (*Health for the Millions* 1997). This is a serious issue especially in countries of the Golden Triangle (Laos, Myanmar and Thailand), where 90 per cent of heroin users are IDUs. The effects spiral upwards when one considers the accelerating effect of HIV infection on the development of tuberculosis. According to WHO projections, in 2000 approximately 10 per cent of TB in Asia would be attributable to AIDS, and would seriously affect countries like India, Thailand and Nepal.

An analysis of the impacts of drug abuse remains incomplete without proper emphasis on gender. The UNDCP-ROSA report does not approach this perspective in an explicit way although there are few references spread over the document. Assessment of drug abuse by females and males in terms of their relationship to each other and their socially assigned roles dispels the misconception that drug abuse is a man's problem. Whether alcohol and drugs are consumed inside or outside the home, women experience adverse social, health and economic consequences, which can include domestic violence. A woman living with a drug-dependent spouse is often, by necessity, the sole supporter of her family. In addition, these women, including partners of male IDUs, are at risk of sexually-transmitted diseases, including HIV, since most of them are unable to negotiate for safer sex. The problem becomes more acute when women themselves use drugs. Treatment of such cases are more difficult since many women either delay treatment or choose not to seek it because of social disapproval of drug-using women, and the need to care for children and support a household.

Where is the solution? The report reviews the national drug demand reduction programmes of the six SE Asian countries and finds that even in the absence of precise information on the extent of the problem, most countries in this region have initiated several steps to control drug abuse despite low priority accorded to drug control programmes. These programmes are still biased to supply control, and even where the importance of demand reduction is being realised, these two activities are often seen as separate and distinct.

Yet it is encouraging to note that four of the six countries (Bangladesh, India, Nepal and Sri Lanka) covered by this report have prepared and adopted a National Master Plan to develop anti-drug strategies. In Nepal and Sri Lanka national policies on drug abuse control have also been drawn up. The emphasis on demand reduction strategies is quite evident. For example, in the national policy of Sri Lanka, educational programmes using mass media to impart relevant knowledge and improve coping skills, particularly directed towards the youth, have been proposed. It was also proposed that preventive education should be attempted through both formal and non-formal means. The National Master Plan in Nepal was implemented in 1995. As a part of the plan, the Ministry of Education is expected to develop curriculum for schools, and audio-visual aids as preventive packages. Training programmes for parents, teachers, community leaders, police officials and other key functionaries were also proposed.

Prevention and treatment interventions seem to have contributed to the progress made in developed countries. The 40 per cent decline in overall drug consumption and the 70 per cent decline in cocaine consumption in the United States between 1985 and 1999, for instance, went parallel to an increase in demand reduction expenditure (research, prevention and treatment) from $0.9 billion in 1985 to $5.6 billion in 1999 ($20 per inhabitant)—a more than four-fold increase after adjusting for inflation. Large-scale prevention campaigns in the US reversed the upward trend of drug abuse among eighth graders as well.

Follow-up studies in the United Kingdom found that two years after the end of treatment, regular heroin use as well as acquisitive crimes were halved. Similar studies in the United States also showed that involvement in illegal activities could be halved, and weekly heroin and cocaine use were down by as much as two-thirds one year after the end of treatment (ODCCP 2000). The same story

could also be repeated in South Asia if strong political will is exerted and adequate resources are committed.

The problem with the demand reduction strategy is that its output is less visible than that of a supply reduction strategy. Also, the multifaceted and multidimensional nature of demand generation requires it to be tackled in the social context (Sain 1992). This implies a solid integration of social sectors, which is conspicuously weak in developing countries. Given the limited capability of government apparatus for such an intervention, it is imperative that non-government organisations are involved in this process. It is encouraging to note that South Asian countries have taken positive steps in this direction. The first sign of such an initiative manifested in inauguration of South Asian Federation of NGOs (SAFNGO) of SAARC countries in April 1995. The main objectives of SAFNGO are to develop interaction among NGOs regionally and internationally, to establish a database of information and resources available in the SAARC region, and to organise regional conferences and seminars to further understand and resolve problems. Since 1995 several workshops have been conducted, but the database is yet to be established. The present report is expected to be a good starting point in that direction.

References

Health for the Millions, May–June 1997.

Panda, S. (2000). *Rapid situation assessment: Opioid/opiate drug use in Calcutta*. Kolkata: Society for Applied Studies.

Sain, B. (1992). *Drug abuse: A global tragedy*. New Delhi: H.K. Publications.

Sharma, U., M. Elinary and **C.M. Bhatt** (1995). Drug abuse: Consequences and responses. India Country Report, Ministry of Welfare, Government of India.

UNDCP, Regional Office for South Asia (UNDCP-ROSA) (1998). *Drug demand reduction report: South Asia*. New Delhi: UNDCP-ROSA.

United Nations Office for Drug Control and Crime Prevention (ODCCP) (2000). *World Drug Report*. Vienna: ODCCP.

Barun Kanjilal is at the Indian Institute of Health Management Research, 1 Prabhu Dayal Marg, Sanganer, Jaipur 302 011. E-mail: barun@ühmr.org.