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Afghanistan's Hidden Drug Problem: The Misuse of Psychotropics

Contents

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Overview

Commonly misused psychotropics

Over the past decade, Afghanistan has gained notoriety as the world's leading producer of opium and heroin. What is less well known is that, according to available evidence, the country itself also has an increasing number of problem drug users.[1] Apart from dependency, addiction and other health-related problems, problem drug use can lead to a wide range of social, economic and legal problems that affect individuals, families and communities. It is not only the use of illicit substances that leads to problem drug use. It also results from the use of psychotropics — pharmaceutical drugs like painkillers and tranquillisers that have a psychoactive effect — in ways not recommended by a qualified doctor or the manufacturer.

While popular perceptions of drug misuse and dependency in Afghanistan tend to focus on illicit drugs like opium or heroin and to a lesser extent cannabis, evidence suggests that many people also misuse psychotropics. A national survey conducted in 2005 by the United Nations Office on Drugs and Crime (UNODC) and the Ministry of Counter Narcotics looked at the incidence of the non-medical use of controlled substances, including use without a doctor's prescription, for an excessive or unjustified period of time. While the estimated numbers of opium users and heroin users were 150,000 and 50,000 respectively, the number of problem pharmaceutical

[1] The information in this paper comes from interviews with pharmacists, government officials, drug treatment workers, doctors and drug users, as well as from other research reports and anecdotal accounts. All numerical estimates of drug supply and use in Afghanistan should be treated with caution: while they indicate general trends and patterns and may inform policymaking, they are estimates only and cannot be considered as confirmed numbers. Estimates of drug use and misuse are notoriously difficult to calculate, and globally there is a dearth of reliable information about the magnitude and nature of drug problems. David Macdonald, *Drugs in Afghanistan: Opium, Outlaws and Scorpion Tales* (London: Pluto Press, 2007), 16-36.

Acronyms

AIDS	acquired immunodeficiency syndrome
EC	European Commission
HIV	human immunodeficiency virus
IDU	injecting drug user
INCB	International Narcotics Control Board
LSD	lysergic acid diethylamide
NGO	non-governmental organisation
SSRIs	selective serotonin reuptake inhibitors
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
UNDCP	United Nations International Drug Control Programme
WHO	World Health Organization

Psychotropic drugs are pharmaceutical drugs such as painkillers and tranquillisers that have a psychoactive effect. They make up part of the category of psychoactive drugs, which are mind-altering substances affecting the central nervous system that can lead to a variety of changes in behaviour, mood and perception.

The UK's Advisory Council on the Misuse of Drugs defines a problem drug user of either licit or illicit substances as:

> *any person who experiences social, psychological, physical or legal problems related to intoxication and/or the regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances.*

Advisory Council on the Misuse of Drugs, "Treatment and Rehabilitation" (London: HMSO, 1982)

drug users was estimated to be 180,000.[2] In 2003, an assessment of problem drug use in Kabul city found 14,298 users of pharmaceutical drugs compared to 10,774 opium users and 7,008 heroin users.[3]

There is a range of types of psychotropic drug misuse in Afghanistan. One problem in particular is the long-term self-medication without a doctor's prescription using powerful painkillers and tranquillisers such as diazepam (brand name Valium), which is cheap and widely available from pharmacies and other retail outlets.

While there may be many reasons for such misuse, conflict-related poverty, social displacement and mental health problems (including chronic anxiety, depression and post-traumatic stress disorder) are known to have been central drivers of this problem.

Psychotropics are known to be increasingly taken in combination with illicit drugs such as opium and heroin, either through smoking or injection. Overprescribing of psychotropics by doctors and the lack of reliable information about the associated risks and dangers — including possible side effects, intoxication and dependency — also contribute to misuse. For example, it has been reported that very young children are given inappropriate drugs such as psychotropic-based cough syrups or powerful painkillers.

However, the misuse of psychotropics is not a problem limited to Afghanistan. Other developing countries, and indeed several developed ones, also experience similar difficulties in controlling and regulating the supply (by prescription and sale from a registered qualified pharmacist) and use (under the supervision of a doctor) of psychotropics for medical reasons.

In Afghanistan it is estimated that up to 80 percent of the psychotropics available have been smuggled into the country without a licence and without testing to determine whether they contain additives or are counterfeit or out of date. While border controls are weak, so are the control and regulation of psychotropics within the country itself. The Ministry of Public Health recently established a legal department in its Directorate of

[2] UNODC and Ministry of Counter Narcotics, *Afghanistan: Drug Use Survey 2005* (Kabul: UNODC Country Office for Afghanistan, 2005).

[3] UNODC, *Community Drug Profile No. 5: An Assessment of Problem Drug Use in Kabul City* (Kabul: UNODC Afghanistan Programme, 2003).

Pharmacy to control and monitor pharmacies and medical institutions and to check whether out-of-date, expired or low-quality medicines are being sold. But with over 9,000 registered pharmacies that need constant checking by low-paid, under-resourced government officials susceptible to bribes and other forms of corruption, this represents a challenge. There is a clear need for stricter regulation of the sale and distribution of psychotropics from other retail outlets, such as shops and handcarts in marketplaces, as well as of their "prescription" and purchase from people with no medical qualifications or expertise.

The supply of and demand for psychotropics are inextricably linked to the trade in illicit drugs like opium, heroin and cannabis. Any steep rise in the cost of psychotropics coupled with a decrease in their availability and ease of access may lead problem users to substitute pharmaceutical psychotropics with drugs like opium and hashish — both of which have a long history of social and medical use in Afghanistan. Current heroin users are increasingly combining heroin with psychotropic drugs, and any reduction in the availability or increase in the price of heroin is likely to lead to increased use of a range of psychotropics as substitute drugs, potentially encouraging a burgeoning illicit street market in these substances.

The problems facing Afghanistan in relation to the misuse of both licit and illicit drugs, including psychotropics, cannot be solved overnight. They require a long-term strategy and commitment by the government and the international community to tackle them. Even if opium was eradicated, the country would still have a demand-driven drug problem — with psychotropics at its core. While strengthening government institutions to be able to control and regulate the supply and distribution of psychotropics is necessary, the following are also essential: better resourced treatment, rehabilitation and harm reduction services for problem drug users; training for doctors and pharmacists on the risks and dangers of psychotropic drug misuse; and provision of reliable and context-sensitive information for the Afghan public about the costs and benefits of psychotropic drugs.

I. Background

The global policy framework

In 1961, the United Nations Single Convention on Narcotic Drugs was developed to prohibit the production and supply of narcotic drugs and drugs with similar effects, specifically cannabis, coca and opium and their derivatives such as hashish, cocaine, morphine and heroin — except for the purposes of medical treatment and research. While the medical use of narcotic drugs such as diacetylmorphine (heroin) was recognised as indispensable for the relief of pain and suffering, the treaty also stated that:

> *addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind.*

This fundamental duality in the nature of drugs, illicit or otherwise, continues to trouble politicians, policymakers and healthcare practitioners, as it highlights a fundamental dilemma: any drug can have both positive and negative effects, costs and benefits, depending on how, where, when and why it is used.

By 1971, it was recognised that many psychoactive drugs had not been included in the 1961 Convention, leading to the drafting of the UN Convention on Psychotropic Substances.[4] The 1971 Convention was primarily concerned with the scheduling and control of a wide range of drugs classified as psychotropics from pharmaceutical drugs like amphetamine-type stimulants, barbiturates and benzodiazepine tranquillisers to other psychoactive drugs such as the hallucinogen LSD.

The 1961 Convention had a negative economic impact on several developing countries that produced plant-derived drugs like cannabis, coca and opium — all used for centuries in many cultures as traditional medicines and for recreational and social purposes. Despite these countries seeking similar tough regulations on psychotropics, both the pharmaceutical industry and the states that produced synthetic drugs formed a powerful lobby that ensured international regulations in the 1971

[4] Although "psychoactive" and "psychotropic" are sometimes used interchangeably, in this paper "psychotropic" is used to describe prescription-only, psychoactive pharmaceutical drugs, including narcotic analgesics such as morphine and pentazocine sold as medicines.

Afghanistan is a signatory to all of the following conventions (although it has not ratified the 1972 Protocol that amended the 1961 Single Convention):

1961	UN Single Convention on Narcotic Drugs
1971	UN Convention on Psychotropic Substances
1988	UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

Convention were considerably weaker than those in the Single Convention.[5] In essence the UN conventions limited the acceptable use of narcotic and psychotropic substances to medical or research purposes only, and they called on member states to otherwise prohibit the production, distribution and use of psychoactive drugs.[6]

In 2000, the International Narcotics Control Board (INCB), established by the 1961 Convention as a quasi-judicial control body responsible for monitoring the implementation of the conventions, expressed concern about the wide availability and inappropriate or non-medical use of controlled drugs, particularly psychotropics. It was reported that unregulated, excessive drug supply and consumption trends in several countries was tending to escalate, and new problems were emerging.[7] The increase in supply of psychotropics, while relieving the suffering of many, led to concern about their excessive use through overprescription and self-medication, resulting in overconsumption, serious side effects, dependence and addiction.[8]

Diversion of psychotropics onto the illicit market

Several attempted major diversions of psychotropics at the transnational level were reported to the INCB in 2007, including 3 tonnes of phenobarbital (a substance listed in Schedule IV of the 1971 Convention) intercepted between China and Afghanistan and 250,000 ampoules of pentazocine (an opioid analgesic listed in Schedule III of the 1971 Convention) between India and Nigeria.[9] Pentazocine has reportedly been used in Afghanistan by both injecting drug users (IDUs) and non-IDUs.[10] In 2002 the INCB, following a request from the Chinese authorities, asked the Afghan government to verify the authenticity of an import order for 5 tonnes (5,000 kg) of diazepam (Valium) from China to Afghanistan. The order, far in excess of the 76.6 kg annual requirement of diazepam for medical and scientific purposes already established by the Afghan authorities, was found to be fraudulent and it was subsequently rejected.[11]

These known attempts to fraudulently import 3 tonnes of phenobarbital and 5 tonnes of diazepam into Afghanistan suggest that the illicit trade in psychotropics in the country is big business — albeit criminal. What would have happened to such large quantities of these drugs if they had entered the country is unknown. There are, however, two demand-driven possibilities: they may have been sold over the counter without a medical prescription to war-shattered and impoverished Afghans seeking alleviation from their daily psychological and physical suffering; or they would have ended up as additives to street heroin, used by increasing numbers of Afghans. As street heroin is not regularly or accurately tested, there is no way of knowing its level of purity. In many cases, it may not technically be heroin at all, but a chemical cocktail containing a greater proportion of psychotropic substances (like phenobarbital or diazepam) than heroin.

The diversion of psychotropics from domestic licit distribution channels to the illicit drug market is also problematic, with benzodiazepine tranquillisers one of the most abused groups of these drugs. In developed countries like the United States, Canada and some European countries, such diverted drugs are typically bought from illicit

[5] A further convention, the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, regulated the precursor chemicals used in the manufacture of psychoactive drugs and strengthened provisions against money-laundering and other drug-related crimes.

[6] Marcus Roberts, Axel Klein and Mike Trace, *Towards a Review of Global Policies on Illegal Drugs* (London: Drugscope, 2004), 2.

[7] INCB, *Report of the International Narcotics Control Board for 2000* (New York: United Nations, 2001).

[8] Hamid Ghodse, "Pain, Anxiety and Insomnia — A Global Perspective on the Relief of Suffering: Comparative Review," *British Journal of Psychiatry*, 183 (2003), 15-21.

[9] INCB, *Report of the International Narcotics Control Board for 2007* (New York: United Nations, 2008), 22.

[10] UNODC, *Community Drug Profile No. 5*.

[11] Macdonald, *Drugs in Afghanistan*, 213.

street dealers or over the internet, however in many developing countries, including Afghanistan, they can easily be bought over the counter directly from pharmacists or other retailers — even though they are prescription-only drugs. Many developing countries do not have the resources to effectively control and regulate the distribution and sale of psychotropics — drugs that now also constitute a profitable business on the illicit market.

A related problem is the smuggling and misuse of counterfeit pharmaceutical drugs, including psychotropics. A 1999 report claimed that many pharmaceutical drugs available in Afghanistan and in Afghan refugee communities in Pakistan were:

> *adulterated, spurious, outdated, unregistered and illicitly manufactured in Pakistan and India and then illegally imported into Afghanistan.*[12]

In 2003, the World Health Organization estimated that up to 35 percent of all counterfeit pharmaceuticals worldwide were manufactured in India and that 11 percent of all exported pharmaceuticals from India were counterfeit. This represents a large profit for the criminal groups concerned, potentially equivalent to 17 percent of the pharmaceutical industry's annual turnover.[13] The World Health Organization estimates that 10 percent of pharmaceuticals on the global market are fake and that 25 percent of those in developing countries are counterfeit or substandard.[14] More generally, the international pharmaceutical trade has been plagued by well-documented cases of criminal corporate behaviour, including price fixing, unsafe manufacturing practices, negligence and fraud in safety-testing practices, unethical marketing, and the dumping of expired or banned drugs in the developing world.[15]

Overprescription and overconsumption

In addition to the diversion of psychotropics onto the illicit drug market, inappropriate prescribing practices of controlled psychoactive medicines by the medical profession can also lead to excessive availability and overconsumption. These practices include:

> *uninformed prescribing; inconsistent or lax prescribing; wilful and consistent mis-prescribing for misuse; self-prescribing and self-administration [by health professionals]. The principal underlying causes of such behaviour appear to be inadequate training; shortage of information; lenient or lax attitudes; lack of a sense of professional responsibility; unethical behaviour; personal drug addiction; criminal behaviour or direct financial interest.*[16]

The INCB has expressed concern about developing countries lacking the resources and expertise to accurately assess the medical and research needs for psychotropics while also addressing the shortage in supply of licit drugs to meet patients' needs — which is itself related to a chronic shortage of medical staff along with inadequate training and information. It also noted that the availability of psychotropics in developed countries tends to exceed requirements and that there is excessive and possibly medically unjustified psychotropic drug prescription and consumption in the treatment of psychological and social problems.

The medicalisation of social problems is also commonly found in developing countries: some non-medical problems are at risk of becoming defined and treated solely in terms of their symptomatic expression as illnesses and disorders. Physical and psychological symptoms of the individual brought on by social conditions such as homelessness, unemployment, instability and lack of security become decontextualised, and attention is diverted away from their broader socioeconomic and political roots. There is no doubt, however, that both physical and mental health problems cause great pain and distress to many Afghans.

Mental health concerns

While there is a range of cultural interpretations and definitions of what constitutes a mental disorder, globally an estimated 450 million people suffer from some form of mental or brain disorder (including those related to alcohol and substance misuse); of these, 121 million suffer from depression. This means that roughly one in four families has at least one family member who is affected by a mental or brain disorder.[17] In countries that have

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12 UNDCP, *Community Drug Profile No. 1: Problem Drug Use in Afghan Communities — An Initial Assessment* (Islamabad: UNDCP Afghanistan Programme, 1999), 9.

13 *Indian Express*, 14 August 2003

14 WHO, *Counterfeit Medicines: Some Frequently Asked Questions — May 2005* (http://www.wpro.who.int/media_centre/fact_sheets/fs_20050506.htm).

15 John Braithwaite, *Corporate Crime in the Pharmaceutical Industry* (London: Routledge & Kegan Paul, 1984).

16 WHO, *Counterfeit Medicines*, 20.

17 WHO, *World Health Report 2001: Mental Health — New Understanding, New Hope* (Geneva: WHO, 2001).

experienced the horror and trauma of war, violent conflict and social dislocation — like Afghanistan — that figure is likely to be much higher. The World Health Organization recognises that in such contexts, coupled with urbanisation, poverty and associated conditions like high unemployment and homelessness, there is limited capacity to address mental health problems.[18]

The most common chronic mental health conditions are anxiety, depression, sleep disorders and post-traumatic stress disorder — the symptoms of which may include anger, intrusive memories, irritability and the inability to concentrate. In rural areas, factors like isolation and limited educational and economic opportunities can exacerbate mental and behavioural disorders. In treating mental health disorders, there are:

> *five principal symptoms for which psychoactive drugs are commonly prescribed — inability to cope, depression, anxiety, sleeplessness and pain — and they have a number of features in common: they are all symptoms that everyone has experienced at some time or other...*[19]

In April 2008, the Afghan government's Deputy Minister for Technical Affairs in the Ministry of Public Health was quoted as saying that 66 percent of Afghans suffered from depression or some form of mental disorder, with mental illness and drug abuse the most urgent health problems facing the country.[20] Six years earlier, a 2002 national mental health survey of adult household members aged 15 years or older concluded that 78 percent of respondents displayed symptoms of anxiety, nearly 70 percent displayed symptoms of depression and 42 percent displayed symptoms of post-traumatic stress disorder.[21] The survey also showed that in the last ten years, 62 percent had experienced at least four traumatic events. Despite the difficulties of establishing and tracking accurate national data on mental disorders in the Afghan context, given the continuing insecurity, violence, social displacement and impoverishment it is clear that substantially reducing the incidence of such endemic chronic mental health problems in the near future will be difficult.

18 WHO, *World Health Report 2001*.

19 Hamid Ghodse, "Pain, Anxiety and Insomnia," 15.

20 "Scarred and depressed, more Afghans turn to drugs," Reuters, 20 April 2008.

21 Barbara Lopes Cardozo, Oleg O. Bilukha, Carol A. Gotway Crawford, Irshad Shaikh, Mitchell I. Wolfe, Michael L. Gerber and Mark Anderson, "Mental Health, Social Functioning and Disability in Postwar Afghanistan", *Journal of the American Medical Association*, 292(5) (2004), 575-84.

II. The Regulatory Environment and Supply of Psychotropics

Current controls and regulations

According to Afghan government officials, the importation, sale and domestic manufacture of pharmaceutical drugs was more strictly controlled and regulated through the Ministry of Health before the Soviet invasion in 1979 than it is today. Psychotropics were officially only available by prescription from a registered pharmacy, although there were some "quack" doctors who would provide a prescription for a price. Even the location of pharmacies was regulated by the Ministry of Health, which ensured that all pharmacists were suitably trained and qualified and that doctors were issued with official, government-printed prescription pads. A prescription cost 20 Afs[22], of which 19 Afs was kept by the pharmacist and 1 Af was paid to the Ministry of Health. While any Afghan citizen with sufficient capital could open a pharmacy, a registered pharmacist had to be employed there, and government restrictions meant that pharmacies had to be a certain distance from each other. This is in stark contrast with the situation in Kabul in 2008: many pharmacies now operate without a trained or qualified pharmacist on the premises. One street in the city has over 40 pharmacies on it, many of which are located next door to each other.

Since 1979 the illicit as well as the licit import, wholesale and retail sale of psychotropics has

22 Currently the Afghan currency, the Afghani (Afs), is traded at approximately 50 Afs to the US dollar. The exchange rate before 1980 is unknown.

increasingly become a profitable enterprise, in part due to the lack of effective institutional controls. Until 1992, significant production capacity existed within the country due to a factory that was originally opened in 1968 by the German Hoechst Corporation. Most pharmaceuticals imported legally came through the Ministry of Health by way of the state-owned enterprise Avicenna Pharmaceutical Institute.[23] But in any war economy there are very limited, if any, regulatory bodies able to prevent smuggled, out-of-date, counterfeit or adulterated drugs from reaching the consumer. Despite recent attempts by under-resourced Ministry of Public Health[24] authorities to control the illicit trade in psychotropics, prescription-only drugs are still available and frequently sold over the counter without a medical prescription from pharmacies, other retailers in the marketplace and even handcarts. Over the last few decades reports suggest that psychotropic drugs have flooded into Afghanistan from neighbouring and regional countries including Iran, Pakistan, China and India without any effective controls or regulatory mechanisms in place to prevent their misuse.

> *We estimate that up to 80 percent of the psychotropic drugs brought into Afghanistan are illegally smuggled in without an official government import licence.*
>
> Government official, Kabul, April 2008

In 2003 the Ministry of Public Health released a National Medicine Policy to ensure that all medical drugs were effective, safe, of good quality and fairly priced, and that they were prescribed, dispensed and used in a proper manner appropriate to the needs of the patient. The policy emphasised that the availability of drugs such as psychotropics with risks or specialised modes of use, including injection, should be subject to particular restrictions.[25]

Proposed amendments to the Afghan Law of Medicine are currently under review by the Commission of Health and Public Welfare of the Upper House (*Meshrano Jirga*) of Parliament. These amendments are designed to facilitate the control and regulation of the production, importation, storage, supply, sale and use of pharmaceutical drugs, and they will, on paper at least, work towards addressing some of the issues and complexities identified in this paper.

Since 2007, under Article 5 of the National Drug Law, the Drug Regulation Committee in the Ministry of Counter Narcotics has been responsible for controlling psychotropics (and narcotics) as well as the chemical precursors that are imported into Afghanistan and used in the manufacture of heroin. These drugs are on the Controlled Substances List that is included in the government's National Licensed Drug List. They require a special import licence, and they are stored and tracked differently compared to other medicines.

The Drug Regulation Committee consists of five members appointed for a four-year period: two experts from the Ministry of Counter Narcotics; one medical and one pharmaceutical expert from the Ministry of Public Health; and one customs expert from the Ministry of Finance. Anyone intending to import psychotropics must first apply to the Directorate of Pharmacy in the Ministry of Public Health and obtain a certificate from the National Board for Psychotropics along with a licence from the Drug Regulation Committee. During 2007, 40 such licences were approved for the legal importation of psychotropics from countries as diverse as Denmark, Egypt, France, Iran, Switzerland and the Netherlands.[26]

Once an import licence has been granted, psychotropics — like other pharmaceutical drugs imported legally into the country — are kept at customs for testing by the Directorate of Pharmacy in Kabul before being released to the importer. NGOs do not pay any tax on these drugs if they are imported for humanitarian reasons, but private sector importers pay a tax of four percent plus a two percent value-added tax. Importers frequently complain that the drugs are kept too long at customs, sometimes in inappropriate conditions, before being tested and released. It has also been claimed that the process of importing psychotropics

[23] Anna Paterson and Asif Karimi, *Understanding Markets in Afghanistan: A Study of the Market for Pharmaceuticals* (Kabul: AREU, 2005).

[24] In 2003 the Ministry of Health was renamed the Ministry of Public Health.

[25] Ministry of Health, *National Medicine Policy* (Kabul: Transitional Islamic State of Afghanistan, 2003).

[26] Ministry of Counter Narcotics, "List of Legally Imported Narcotic and Psychotropic Drugs for 2007" and "List of Legally Imported Narcotic and Psychotropic Drugs for 2008."

is very time-consuming, and the need for several official signatures along the way increases the risk of corruption in efforts to hasten the process.

The supply chain

Distribution and sale

While there are no reliable statistics available, it has been estimated by government officials that up to 80 percent of psychotropics entering Afghanistan are smuggled over the border with no licence or proper testing. A study conducted in 2005 estimated that the percentage of private sector pharmaceutical imports smuggled into the country was between 60 and 80 percent.[27] Ministry of Public Health officials have also made the reasonable claim that many smuggled drugs are sold in towns closer to the borders, with fewer now reaching Kabul where there are tighter restrictions in place.

Research suggests that factories in neighbouring Pakistan have consistently produced cheap substandard or counterfeit pharmaceutical drugs specifically for the Afghan market, where there has been less official oversight than in Pakistan itself.[28] Many of the 37 factories located in the North West Frontier Province were established during the Soviet era at a time when there was little quality control in that area of Pakistan and no licensing requirements for producing drugs that were not even approved for consumption in Afghanistan. According to one trader, during that period:

> *Local manufacturers and traders sent their agents to find what was in demand in Afghanistan. Then they would produce whatever was in demand and put the required label on it. Poor quality raw materials were used to manufacture these products.*[29]

In 2005 it was reported that, due to increased government controls, Pakistani drug manufacturers were shifting their operations from Peshawar to Khyber Agency in the Federally Administered Tribal Areas.[30] The pharmaceutical trade in Pakistan is also reportedly rife with corruption, from the bribing of government officials to disregard quality control requirements and provision of inducements and incentives to doctors and pharmacists to prescribe specific medicines.[31] A Pakistani psychiatrist claimed that the annual US$47 million trade in psychotropic drugs in 2003-04 was characterised by poor regulation of prescription and dispensing, noting that:

> *In Pakistan, most medicines, including psychotropics, are available over the counter. Pharmacies are not staffed by trained or qualified personnel and are not regulated by any professional body. These "chemists" are also important in influencing psychotropic sales (hypnotics and tranquillisers), as many patients present to them with their complaints.*[32]

Situated in Kabul's central Polyclinic, the Legal Department of the Directorate of Pharmacy has, since 2005, been responsible for quality control and monitoring the distribution and sale of all pharmaceutical drugs. It is the first government body since the 22-year period of Soviet invasion, civil war and Taliban rule to take practical steps to control pharmaceutical medicines imported and sold in Afghanistan. With few government regulations and functioning control mechanisms in force, several banned drugs such as methaqualone and metamizole were, until recently, easily available in Kabul and other parts of the country. Now, in theory at least, any pharmacy found to be selling these banned drugs is liable to face sanctions.

Currently the Legal Department has a staff of 80 technical inspectors divided among four zones of the city of Kabul, along with another eight members of a "swift response group" equipped with motorcycles. Their job is to control and monitor all pharmacies, clinics and hospitals to ensure that the medical equipment used is of an appropriate standard and that expired, out-of-date and low-quality medicines are not being sold. If a person is found to be selling these types of drugs, their premises can be temporarily closed and they are brought to the Department to account for themselves. If it is a serious offence, they may be sent to court; if it is a lesser offence, they can be fined or have their premises closed for a week or longer. The Department also investigates complaints from the public about overcharging or unqualified people supplying prescriptions. In 2007, inspectors claimed to have collected and destroyed 200 tonnes of smuggled, banned, counterfeit or expired drugs from around the country.

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27 Paterson and Karimi, *Understanding Markets in Afghanistan*.

28 J. Khan, *Pakistan-Afghanistan Pharmaceutical Market*, unpublished report (Kabul: AREU).

29 J. Khan, *Pakistan-Afghanistan Pharmaceutical Market*, 2.

30 J. Khan, *Pakistan-Afghanistan Pharmaceutical Market*, 2.

31 J.Khan, *Pakistan-Afghanistan Pharmaceutical Market*.

32 Murad Moosa Khan, "Murky Waters: The Pharmaceutical Industry and Psychiatrists in Developing Societies," *Psychiatric Bulletin*, 30 (2006), 85.

According to Legal Department staff, a further objective of their work is to attend to the problem of prescription-only drugs, particularly psychotropics, being sold over the counter, especially by unqualified or untrained pharmacy staff. To open a pharmacy, an application has to be forwarded to the Minister of Public Health and a licence granted by the Legal Department through the Directorate of Pharmacy. A licence is then issued and the Department checks to ensure that there is a qualified professional pharmacist on the premises. There are now approximately 2,000 registered pharmacies in Kabul and a total of around 9,800 across the country.[33] Many of these pharmacies provide medical information and healthcare advice, and they commonly sell medicines to customers without a qualified pharmacist on the premises. While officially every registered pharmacy needs a licensed pharmacist to operate, there are simply not enough qualified pharmacists in the country to meet the demand, and anecdotal reports from some pharmacists suggest that pharmacists can simply "sell" their licence to several different shops for a monthly fee to "legitimise" their business.

In all provinces where the security situation permits it, Ministry of Public Health control mechanisms now exist. However, as in other areas of government, low-paid officials are susceptible to the temptations of corruption, such as being offered a bribe to ignore the sale of expired or poor-quality medicines. Generally in developing countries, as is the case in Afghanistan, official corruption is most prevalent when salaries are low, opportunities great and policing weak.[34]

The psychotropic drug market

Apart from illegal sources or importing directly themselves, pharmacies can purchase their supplies of psychotropics from drug wholesalers. In Kabul, the main wholesale market for pharmaceutical drugs and small-scale medical equipment is in the Taimani district of the city, where there are over 130 shops involved in the trade. This signifies the sheer scale of the market, and such a large number of traders has led to a very competitive market — wholesalers complain that smuggled, tax-free drugs increase supply, push prices down and reduce their profit margin.

A spokesperson from the newly formed Drug Sellers Association, representing the interests of drug wholesalers (as opposed to importers or retailers), reported that the Association wants smuggling curtailed. Apart from reducing profits, it recognises that many of the medicines smuggled into the country are of poor quality and often out of date — posing health risks to consumers. If pharmaceutical drugs were produced in Afghanistan, and the police and other officials were less susceptible to bribes from smugglers, the association claims the incidence of smuggling would decrease. There are a number of companies which have recently been licensed to produce pharmaceutical drugs in Afghanistan, although it is likely to be considerable time before they are able to meet the country's needs.

A primary aim of the Drug Sellers Association is to ensure that only quality pharmaceuticals that are legally imported and tested by the Ministry of Public Health are sold in Afghanistan. While drugs are imported from many countries — Germany, Turkey, Russia, China and India, among others — those manufactured in Pakistan under licence from multinational companies are more popular because they are easier and cheaper to import. Iran also exports drugs to Afghanistan, often at substantially cheaper prices than other countries; however, those from Pakistan are generally preferred as they are perceived to be of international quality (few international pharmaceutical companies operate in Iran). It has been reported by drug treatment service providers that returned refugees from Iran prefer Iranian drugs since they are more familiar with them, while returnees from Pakistan naturally prefer those from Pakistan.

The Drug Sellers Association acknowledged that there are not enough trained pharmacists to provide a rational and professional system for dispensing pharmaceuticals in Afghanistan. As there are limited numbers of doctors, and many Afghans cannot afford to go to a doctor even if one is available, pharmacists often sell drugs without a prescription — whether or not they are trained or qualified. Ideally only a qualified doctor should determine the choice of a patient's drug and its dosage, duration and termination, but in Afghanistan this is currently not always feasible.

It is important to note that many of these factors relating to the importation, supply, distribution and prescription of psychotropic drugs are also likely to apply to non-psychotropics, such as antibiotics and anti-inflammatory drugs.

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[33] A 2005 study reported that there were "around 13,000 licensed private pharmacies in the country" (Paterson and Karimi, *Understanding Markets in Afghanistan*, 14).

[34] L. Palmier, "Bureaucratic Corruption and its Remedies," in M. Clarke (ed), *Corruption: Causes, Consequences and Control* (London: Frances Pinter, 1983).

III. The Misuse of Psychotropics in Afghanistan

If used correctly with a prescription and under medical supervision, psychotropic drugs can be of great benefit to consumers. Their misuse is particularly problematic, however, as it can lead to serious health-related, social and financial problems for the user, their family and the community. Compounding this fact is that, in the Afghan context, these substances may be perceived and treated as medicines (*dawa*) and not as drugs or intoxicants (*nashaimawad* or *mukhadir*) — which are *haram* (forbidden) in Islam. This may exacerbate their potential for misuse as the risks and dangers may not be understood or addressed and the misuse of psychotropics rationalised as simply "taking medicine."

A drug wholesaler's shop

While many psychotropics are cheap (for example, a one-month supply of standard-dose diazepam costs less than US$1), the cumulative costs and related healthcare costs can have a negative impact on families' household expenditure. In 2004, research into rural livelihoods found that health costs constituted the second-largest expenditure in the majority of households and that ill-health, both physical and mental, had an enormous impact on livelihoods.[35] It was also found that expenditure on healthcare was a key factor in creating indebtedness; scarce family assets were often sold to pay for treatments — including the purchase of drugs that anecdotal evidence suggested were ineffective, resulting in people repeatedly spending their resources on useless medication or having to seek other forms of treatment. In Laghman and Herat provinces, for example, households spent between nine and 26 percent of their total income on family healthcare needs.

Paradoxically, in many areas of Afghanistan illicit psychoactive drugs like opium are used medicinally for a range of diseases, while a drug like Valium can be misused, leading to dependency and other problems usually associated with illicit drugs. This creates the potential for confusion and misunderstanding about what constitutes a "dangerous drug," and has distinct policy implications.

Many Afghans are illiterate and unable to read or understand instructions to safely use psychotropics. Indeed such instructions may be written in a foreign language, rendering them unintelligible to most. Afghans are therefore unlikely to have access to accurate and reliable information about the possible side effects and risks of intoxication, dependency and addiction to psychotropics. It has been found that often they do not know the name or type of drug they are taking, even when prescribed by a doctor; when asked the name of the drug being taken, they frequently reply using descriptive terms such as "a white sleeping pill," "a yellow tablet" or "a painkiller."[36]

The available evidence suggests that the most commonly misused psychotropic drugs found in Afghanistan are: analgesics (painkillers) like morphine-based cough syrups, tramadol and pentazocine (Sosegon); hypnosedatives like barbiturates, particularly phenobarbitol; and benzodiazepine tranquillisers like diazepam (Valium) and lorazepam (Ativan). There are a number of distinct forms of misuse of these psychotropics, and these can overlap. The main problems related to the misuse of psychotropics based on the available evidence are: long-term self-medication; polydrug use and illicit injection; and overprescription and iatrogenic illness.

Long-term self-medication

Hypnosedatives or benzodiazepine tranquillisers like diazepam are often legitimately prescribed for short-term use by medical practitioners for a range of chronic mental health problems such as anxiety, depression and sleep disorders — all endemic in

[35] Jo Grace and Adam Pain, *Rethinking Rural Livelihoods in Afghanistan* (Kabul: AREU, 2004), 51-52.

[36] UNDCP, *Community Drug Profile No. 2: Opium and Other Problem Drug Use in a Group of Afghan Refugee Women* (Islamabad: UNDCP Afghanistan Programme, 1999).

the Afghan population. However, in Afghanistan — as in many other countries in the developing world — when the prescription is finished, the drug can easily be bought over the counter and its use continued without further medical advice. This is most likely to happen if the drug has a desirable effect, but poverty also appears to play a key role. A doctor's appointment can cost up to 200 Afs; so, after a prescription for psychotropics is finished, it is cheaper to simply go to the market and buy more of the drug rather than return to the doctor who will charge for a repeat prescription.

Anecdotal evidence from drug treatment centres that operate in Afghan communities suggests that nearly every family with easy access to supply has a family member self-medicating with tranquillisers. Older people who have been using such drugs for a long period of time are reputed to keep their own stock; when another family member, even a child, has a problem they simply "prescribe" the drug for them. In rural areas, especially those engaging in opium cultivation and production, it may be more likely that opium is used rather than a tranquilliser since supply can be easier to access. Both men and women may pass on information to each other about the use and perceived benefits of tranquillisers, perpetuating non-medically prescribed consumption.

The 2005 National Drug Use Survey estimated that more men than women use psychotropics on a daily basis, with some using for consecutive periods stretching to well over ten years. Of the estimated 180,000 psychotropic drug users cited in the survey, 50 percent were men, 30 percent women and the rest children.[37] It should be noted that because of their social position, women may have been more difficult to access by surveyors and therefore possibly constitute a larger, if hidden, population of psychotropic drug users than men. Women may also be more likely than men to talk about healthcare issues with each other and, in doing so, share information about access to and use of psychotropics.

According to an NGO responsible for coordinating drug treatment services in Gardez (Paktia province), 70 percent of female clients attending community-based drug treatment services take psychotropics, while only 15 percent take opium and 13 percent take hashish. In another outreach treatment service in Kandahar, 40 percent of female clients take psychotropics, while 50 percent take opium, 4 percent take hashish and 4 percent take heroin. By contrast, only 20 percent of women attending a Helmand treatment service take psychotropics, while 65 percent take opium and 10 percent smoke heroin.

In areas where opium is cultivated and produced, it appears to have become the preferred drug since it is easily available and relatively cheap. The further from opium production an area is, the more likely it is that psychotropics are used there. However, according to one drug treatment coordinator interviewed for this research, both women and men who use illicit drugs may also move to using psychotropics for financial reasons:

> *if there is no money for the drug of choice like opium, heroin or hashish, these users become compelled to use psychotropics, which are much cheaper because they are mostly smuggled, tax-free and counterfeit. Also there is less blame or stigma attached to taking psychotropics, so this can be used as an excuse to take these drugs as they are considered medicine not an intoxicant.*

An outreach programme for female problem drug users in Kabul estimated that 30 percent of its clients used only psychotropics, while a number of the 70 percent of clients that used opium also used psychotropics. At another outreach programme in the city, 50 percent of female clients used psychotropics, including the benzodiazepine tranquillisers diazepam, chlordiazepoxide, lorazepam and oxazepam.

In 2003, a study of 200 drug users in Kabul revealed that 40 percent had taken psychotropics — 52 men and 28 women. The most common drug cited was diazepam (Valium), which was used by almost three quarters (59 respondents) of the psychotropic users. Other drugs cited included methaqualone, pentazocine and lorazepam, along with non-prescription analgesics like ibuprofen and paracetamol.[38]

It is not only in urban areas that there are problems related to the self-medication of psychotropics. In February 2001 a study reported that nearly ten percent of households in four rural districts in eastern Afghanistan (Khak-e Jabar in Kabul, Hesarak in Nangarhar, Azro in Logar and Sayed Karam in Paktia) had someone misusing psychotropics, with three to seven percent of the adult population estimated to be misusing psychotropics on a regular basis. The main drugs cited in the study were diazepam, lorazepam, methaqualone and

[37] UNODC and Ministry of Counter Narcotics, *Afghanistan: Drug Use Survey 2005*.

[38] UNODC, *Community Drug Profile No. 5*, 21.

pentazocine.[39] An earlier study in 1999 of 50 Afghan refugee women in New Akora refugee camp outside Peshawar in North West Frontier Province, Pakistan, revealed that more than half were using psychotropics; a third of this group stated they were using diazepam while nearly two-thirds stated they were using painkillers.[40]

In all of these studies, the primary reason for taking psychotropics was claimed to be as medicine to help cope with the problems of daily life — both physical and psychological — and to alleviate the symptoms of chronic mental health problems. In particular, diazepam was seen as a panacea for a wide range of ills, including physical pain, anxiety, depression, stress and sleep disorders attributed mainly to war and conflict-related social upheaval and disruption. Long-term self-medication of painkillers is also prevalent among those suffering chronic pain from physical injuries sustained during the many years of fighting in Afghanistan.

While properly prescribed psychotropics may provide relief in the short term, they tend to result in a range of problems if used over a long period.[41] In one study, 96 percent of respondents reported at least one problem associated with their use of psychotropics, and 85 percent reported multiple problems — particularly related to their health and financial situation.[42] However, as psychotropic drug users may also be using illicit drugs such as alcohol, hashish, heroin or opium, it can be difficult to establish which drug is responsible for which problem.

Polydrug use and injection of psychotropics

Polydrug use refers to the taking of two or more drugs either together or in quick succession. A psychotropic drug may be used as a psychoactive additive to illicit drugs like heroin before use or it may be taken separately alongside an illicit drug.

While street heroin in Afghanistan is rarely tested, law enforcement informants suggest that a number of psychotropics, including diazepam, metamizole and phenobarbital, have been added to heroin — by heroin producers, street dealers and users themselves. It has been reported in several areas of the country that there is growing use of a diazepam-opium smoking mixture; diazepam apparently enhances the effect of opium and helps the user sleep. Drug treatment workers say that various psychotropics are added to opium sold in Kabul because users do not trust the purity of the opium and want a stronger effect from the drug. It was also claimed that street dealers may encourage polydrug use and are always eager to advise which drugs to mix in order to make the effect stronger.

Doctors currently engaged in research with street drug users in Kabul report that many street IDUs and non-IDUs are polydrug users who often mix heroin with diazepam or phenobarbital. This latter combination is sold on the street as a mix called *gulbutton* and is seen to have a stronger effect than heroin by itself. The antihistamine and sedative drug Avil is also commonly mixed with heroin before injecting and is preferred to lemon juice as a mixing agent. In this case, an ampoule of Avil is added to the heroin to dissolve it without the need for "cooking," sometimes with an ampoule of Valium also added. No distilled water or cooking is needed to dilute the heroin powder, suggesting that it is relatively pure. Research conducted between June 2005 and June 2006 on 463 IDUs in Kabul found that 56 percent mixed Avil with heroin before injecting it.[43] It has been suggested that adding these drugs to heroin hastens its absorption into the body.

As in other countries, some heroin smokers may switch to injecting the drug because the effect is quicker and more pronounced, and it is more cost effective.[44] In Kabul, some heroin users claim that injecting the drug is easier to hide from police than smoking it.[45] When IDUs cannot access or afford

[39] UNDCP, *Community Drug Profile No. 4: An Assessment of Problem Drug Use in Rural Afghanistan — The GAI Target Districts* (Kabul: UNDCP Afghanistan Programme, 2001).

[40] UNDCP, *Community Drug Profile No. 2*.

[41] The Glossary section of this paper provides information on types of problems related to specific psychotropics.

[42] UNODC and Ministry of Counter Narcotics, *Afghanistan: Drug Use Survey 2005*.

[43] Catherine S. Todd, "HIV, Hepatitis C, and Hepatitis B Infections and Associated Risk Behavior in Injection Drug Users, Kabul, Afghanistan," *Emerging Infectious Diseases*, 13(9) (2007).

[44] In Burma and Laos, as is likely to happen in Afghanistan, a decline in opium production led to a shortage of heroin and a shift in consumer behaviour — not only from smoking to injecting heroin but also replacing heroin with psychotropics as well as methamphetamine (Transnational Institute, *Withdrawal Symptoms: Changes in the Southeast Asian Drugs Market*, Drug and Conflict Debate Papers No. 16, August 2008).

[45] In this instance "smoking" refers to the method of use known as "chasing the dragon," in which the drug is usually placed on tin foil and heated underneath, and the resulting fumes are inhaled through a tube.

heroin, they may buy pentazocine (Sosegon) or tramadol to mitigate their withdrawal symptoms. This represents a significant potential problem in Afghanistan: if law enforcement interventions are successful and heroin availability decreases and its price increases, current heroin users — both smokers and injectors — may shift to using substitute drugs, particularly psychotropic analgesics such as Sosegon and tramadol.

Researchers in Kabul report that 85 percent of 273 IDUs they interviewed use Valium or another benzodiazepine tranquilliser — either orally or mixed with heroin and injected — to help them sleep.[46] It was informally estimated that 50 percent also use tramadol tablets, which cost 40 Afs for a blister strip of ten tablets, although these are becoming more difficult for drug misusers to buy from pharmacies. Less than 5 percent of the sample reported that they used phenobarbital tablets. IDUs claimed that heroin is now more difficult to buy because of police intervention, so psychotropics are increasingly added to or substituted for heroin. IDUs returning from Iran claimed they had used Sosegon as refugees there, but pointed out that it is difficult to buy Sosegon without a prescription at pharmacies in Kabul now — although a prescription can be bought from some doctors for up to 200 Afs.

Even in much more remote, rural areas of the country, it appears that benzodiazepine tranquillisers have been taken by polydrug users. A study conducted in Badakhshan in 2005 reported that 22 percent of opium users also used tranquillisers — sometimes to mitigate opium withdrawal symptoms. These drugs were easily purchased without a prescription from local markets in Ishkashim and other locations.[47] In the same year in the district of Shughnan, it was reported that heroin users were mixing heroin with psychotropics such as chlorpromazine, diazepam and diclofenac before smoking it.[48]

Out of a group of 50 male drug users at a drop-in centre in Kabul in April 2008, most were heroin smokers. Only five were IDUs, and four of these were also using pentazocine. One IDU claimed to take three blister strips of Valium per day — that is, 30 tablets —which is far beyond any permitted maximum dose, suggesting that either he had developed a high degree of tolerance to the drug or, just as likely, that the drug was substandard. Most of the men present also admitted to using Valium, which costs 13 Afs for one ampoule or 10 Afs for one strip of 10 mg tablets. It was claimed by staff at the drop-in centre that some users also buy Mandrax (methaqualone) from pharmacies, although this drug seems to be less commonly used than it has been in the past. One staff member said that Mandrax, along with hashish and alcohol, was one of the main drugs available in Kabul roughly 20 years ago but that its availability had decreased significantly since then.

While many of the men attending the drop-in centre were homeless and unemployed, a small number had their own businesses and were relatively wealthy. This means that they should, in theory, be able to buy better quality drugs. While securing livelihoods and greater incomes for drug users does not guarantee that they will become drug free, providing income-generation activities and vocational training opportunities must be seen as an integral part of any treatment and rehabilitation programme in an impoverished country like Afghanistan. Without an income to support their family and without access to employment, it is even more likely that drug users undergoing a treatment programme will relapse.

While psychotropic drugs are often mixed with heroin before injecting, they can also be injected on their own. During 2007 a drug treatment outreach team in the Shor bazaar area of Kabul worked with 283 female clients, most of whom were polydrug users. The drugs reported as having been used included cannabis, heroin, Largactyl, Librium, opium and Valium. Twelve of the women were IDUs who had returned from Iran and experienced some difficulty in accessing heroin and opium when they arrived in Kabul, leading to some of them injecting Sosegon. One woman claimed that she injected over 20 ampoules of Sosegon a day.

While most of the examples in this section were taken from Kabul-based studies, injecting drug use has also been reported by treatment services in several other areas of Afghanistan, including in and around towns and cities such as Ishkashim, Gardez, Herat, Mazar-i-Sharif and Kandahar. While the drug use patterns of IDUs in these areas are largely unknown, they are likely to follow those of IDUs in Kabul with respect to their substitution and addition of psychotropics.

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46 Dr M. Helmand and Dr M. Raza, pers. comm.

47 Marc Theuss, G.E. Poole and Falak Madhani, *Addiction in the Border Regions of Badakhshan, Afghanistan: Range, Trajectory and Impacts*, unpublished report (Kabul: Aga Khan Development Network).

48 Marc Theuss, *Drug Use and Abuse in Afghan Shughnan* (Berlin: Institute for East-European Studies, 2005) (http://www.oei.fu-berlin.de/cscca).

Overprescription and iatrogenic illness

In 1979 in the United Kingdom, when prescriptions for benzodiazepines peaked at 30 million per year, there was substantial evidence to suggest that dependence on such drugs used for sleep disorders was largely an iatrogenic disease — that is, "a condition created and maintained by doctors."[49] In the case of Afghanistan, "iatrogenic" refers to those adverse effects or complications relating to the use of psychotropic drugs that are caused by or result from medical treatment or advice from a doctor, a pharmacist or an unqualified person dispensing medicine in a pharmacy.

In Afghanistan, there is a tendency to overprescribe pharmaceutical drugs, particularly antibiotics, and combinations of medicines are prescribed without proper consideration of their possible side effects. In 1999 in Nawsad district, Helmand Province, it was reported that there was a particular problem with the misuse of pharmaceutical drugs:

> *the use of strong prescription medicines for minor ailments is frightening. Shopkeepers of medical stores, rarely qualified pharmacists, recommend a range of medicines, often the most expensive, to make their business profitable and to ensure cure.*[50]

In Afghanistan, iatrogenic disease is one also borne of omission; few doctors who prescribe psychotropics, or pharmacies that sell them, provide adequate information about their risks and dangers to patients as well as the attendant risks of self-medication. A compounding problem is diagnosis and drug prescription by unqualified people working as doctors or pharmacists, risking incorrect diagnoses and potentially prescribing the wrong drugs.[51] Along with the high proportion of low-quality and counterfeit drugs, this can spell serious problems for consumers, especially those who cannot afford the fees of better qualified and informed doctors.

There are many anecdotal reports of unqualified drug prescribing, with semiliterate, inexperienced and unqualified people setting themselves up as "doctor-pharmacists" in rural villages where there is no easy access to a health clinic. They import their own pharmaceuticals and then "prescribe" these drugs without knowing enough about their effects, correct dosage and possible side effects. It has been claimed that in some villages in Shinwar district of Nangarhar province over 50 percent of villagers go to such "quacks."

Claims have been made by a number of NGO treatment centres and by other sources in Kabul that private residential drug treatment providers in the city are now providing heroin addicts with a pain-free detoxification regime of benzodiazepines and painkillers, administered both intravenously and orally. They charge $200 for a 15-day residential detoxification and "treatment" programme where drug withdrawals are totally pain-free, rather than providing clients with symptomatic treatment only. On being discharged, the client is given tranquillisers for up to 6 months; drug users report that only the blister strips are provided, with no information about possible side effects or the potential for dependency. When this prescription is finished they suffer withdrawal symptoms, as this is the first time they have been drug-free since starting the detoxification and treatment programme. At this point, they are at significant risk of relapse and starting to use heroin again. Drug users have reported to NGO drug treatment providers that when they return to the clinic they are held responsible for their own relapse and then have to pay $200 for further detoxification, in all likelihood leading to a continuation of this cycle of addiction.

Other problems related to psychotropics

The most serious problems relating to psychotropics appear to be: long-term self-medication; overprescription; lack of provision of information about their risks and dangers by both qualified and unqualified doctors and pharmacy employees; and the addition of psychotropics to illicit drugs. As is the case in South Asia more generally,

> *the dynamics of the licit and illicit markets are connected to some extent ... on the streets the distinction between the two apparently distinct markets fades easily.*[52]

However, there are some other significant potential problems and issues in relation to the misuse of psychotropics. One is the possible use of steroids or other potentially harmful psychotropics by *hakims*

[49] Charles Medawar and Anita Hardon, *Medicines out of Control? Antidepressants and the Conspiracy of Goodwill* (Netherlands: Aksant Academic Publishers, 2004), 35.

[50] Anna M. Pont, *Blind Chickens and Social Animals: Creating Spaces for Afghan Women's Narratives Under the Taliban* (Portland, Oregon: Mercy Corps, 2001) 67.

[51] Anna Paterson and Asif Karimi, *Understanding Markets in Afghanistan*.

[52] Martin Jelsma, "Learning Lessons from the Taliban Opium Ban," *International Journal of Drug Policy*, 16(2) (2005), 99.

(herbal medicine practitioners) as additives to herbal medical preparations. A media report from neighbouring Pakistan claimed that some *hakims* there have used steroids and veterinary drugs in their preparations but that people still seek their services because they charge much lower fees than doctors.[53] Traditionally many *hakims* have used natural psychoactive substances such as hashish and opium in some of their preparations; while there is always a risk that some less scrupulous *hakims* will use easily available psychotropics as additives to these preparations, this risk could increase substantially if the availability of opium and hashish decreases. With the proliferation of bodybuilding clubs in Kabul, there have been anecdotal reports of the misuse of steroids by bodybuilders, including by injection.

A significant problem also exists with children and adults taking morphine or other psychotropic-based cough syrups, which are easily available over the counter. While they may initially be taken for genuine medical reasons, if use continues after the initial symptoms have stopped, there is a risk of dependency and other problems developing. Drug treatment workers report that infants or very young children taken to a pharmacist because they will not stop crying, or because the family cannot afford a doctor, are likely to be given syrups containing Avil, phenobarbital or Phenergan. Drugs like these should never be given to children under the age of two years unless in exceptional circumstances and under strict medical supervision.

Currently the opioid analgesics buprenorphine and methadone are on Afghanistan's Essential Drug List for use only in drug-substitution therapy programmes as a means of preventing the spread of HIV and other blood-borne diseases among IDUs and drug users at risk of injecting. To date no agency implementing drug substitution programmes has been granted an import licence for these drugs, yet researchers working with street drug users in Kabul in 2008 report that buprenorphine is already being sold illicitly in Kabul and used by some IDUs. While the introduction of these drugs is necessary as part of the harm-reduction strategy aimed at the prevention of HIV/AIDS among IDUs, their strict control to avoid diversion to the illicit market is of paramount importance.

[53] *News on Sunday*, 25 August 2002.

IV. Policy Implications

With up to 80 percent of psychotropics brought illegally into the country, it will remain difficult for authorities to prevent smuggling and fraudulent practices in relation to these drugs. In the same way that Afghanistan's infamously porous borders facilitate the smuggling of illicit drugs like opium and heroin out of the country, they also facilitate the smuggling of psychotropics into the country. Endemic corruption among government officials and other players in the supply chain means that bribes and kickbacks are an integral part of the trade in both opiate and psychotropic drugs.

The supply and demand sides of the trade in both illicit and licit drugs are inextricably interwoven. It is not only policy concerns about opium poppy eradication and its effects on poor rural households, likely to result in "economic crisis, compounded insecurity and increased political tensions," that warrant thorough consideration.[54] Another possible unintended consequence of the current policy to eliminate poppy is that as it becomes more successful, supply decreases, price increases and users of opium and heroin will look for substitute drugs — and there is no shortage of psychotropics to fill the gap. Many of these drugs are likely to be counterfeit, out of date or contain dangerous additives, and their effects may be just as harmful as those arising from the misuse of opium or heroin. Under these circumstances, current heroin smokers are likely to move toward injection of heroin that will increasingly contain psychotropic additives; some heroin injectors will move to injecting psychotropics instead as they will be cheaper and easier to obtain, although they carry their own very serious risks and dangers. Any shift to injecting drug use, whether of heroin or psychotropics, or a combination of both, will increase the possibility of sharing injecting equipment and risk the transmission of HIV/AIDS and other blood-borne diseases. In Afghanistan injecting drug use has already been recognised as one of the main drivers of the spread of HIV/AIDS in the country.

[54] David Mansfield and Adam Pain, *Evidence from the Field: Understanding Changing Levels of Opium Poppy Cultivation in Afghanistan* (Kabul: AREU, 2007).

Despite recent attempts by the under-resourced Ministry of Public Health to control the trade in psychotropic drugs, their popularity and easy availability due to lack of effective regulation and control mechanisms mean that many Afghans still have access to these drugs through a wide range of outlets and are able to self-medicate. Conversely, there is a risk that if regulations regarding the trade and sale of psychotropics are more rigorously enforced and availability is substantially reduced, a proportion of the users of these drugs will substitute illicit drugs such as opium, heroin, cannabis or alcohol to cope with their problems. Furthermore, polydrug users taking both heroin and other illegal drugs as well as psychotropics are likely to increase their consumption of illicit drugs if psychotropics increase in price or become more difficult to obtain. The structural factors that engender chronic mental health problems and the need for self-medication with psychotropics are unlikely to improve substantially in the near future. The country also has little capacity for providing sufficient counselling, support and other therapeutic interventions for sufferers.

On the whole, the wide availability of psychotropic drugs heightens the risk of new drug mixtures emerging which will carry potential risks and dangers currently unknown to drug treatment service providers. For example, a new and particularly harmful form of crystalline heroin, simply called "crystal," has recently emerged in Herat, Kabul and other locations, although it is unknown whether this drug contains any psychotropic substance.

Any quick reduction in availability due to stricter controls or substantial price increases in psychotropics should be avoided. Such proposals should be treated with caution; reducing availability or increasing prices should be graduated. For long-term self-medicators of tranquillisers who can no longer find or purchase them, suddenly stopping their use is likely to cause severe withdrawal symptoms; they will need to be provided with the opportunity to detox under proper medical supervision using a gradual reduction programme.

Significant increases in the control and regulation of psychotropics may contribute to the development of an illicit street market for these drugs, further increasing the risk of poor-quality, out-of-date and adulterated drugs being sold to vulnerable groups. There is already anecdotal evidence of some psychotropics being sold by street drug dealers in Kabul. On the other hand, any substantial increase in price or any reduction in the availability of heroin may lead to a growing demand for cheap psychotropics from heroin users, including IDUs.

V. Ways Forward

There are no quick or easy solutions to the complex problems presented by the misuse of psychotropic drugs in Afghanistan, especially given the interaction between the licit and illicit drug markets. There is a lack of understanding of the fact that while the controlled use of psychotropics for medical purposes may be beneficial, it is very easy for this to lapse into misuse and long-term self-medication, resulting in problems related to side effects, intoxication and dependency.

The fact that for centuries both cannabis and opium products have been used in traditional medicine and in many areas, including most of South Asia, for recreational purposes is often overlooked. The paradox is clear: there should be an obvious distinction, but what constitutes a medicine and what constitutes an intoxicating drug is unclear. These "traditional" psychoactive substances are now illegal under statutory law; by definition they have no acceptable use and can only be misused.[55] On the other hand, psychotropic pharmaceuticals are legal if prescribed by a doctor and dispensed by a pharmacist and if their use is medically justified. However, in Afghanistan many psychotropics are not prescribed or dispensed in the proper way, and few consumers have easy access to information about their short-term and long-term side effects and potential for misuse and dependency.

There is a clear need to provide Afghans with reliable, practical information to empower them

[55] Permitting households in Afghanistan to grow sufficient opium for their own medical purposes, particularly those in more remote rural areas far from health clinics or reputable pharmacies, is a debate outside the scope of this paper, but one that deserves closer attention. Most Afghans over the age of 40 will remember being given some type of opium preparation for cold, cough, toothache or other symptoms as a child. For many of their own children, this has now been replaced by unregulated psychotropics, with all their related risks and dangers.

to make rational choices and decisions about the types of psychotropic drugs they consume, although this alone will not necessarily prevent misuse. The information made available should spell out the risks, dangers and possible harmful effects of taking psychotropics without proper medical approval and prescription, including adverse side effects and the potential for overdose and dependency, as well as the risks of polydrug use and self-medication.

However, while providing this information is critical, it should be done in a way that is sensitive to the particular context of licit and illicit drug use in Afghanistan. For example, overly severe warnings about the potential dangers of using psychotropics may inadvertently encourage some to turn to illicit substances like hashish or opium as substitute medicines. Conversely, severe warnings about the dangers of self-prescribing opium as a medicine, especially for children, may lead to the use of psychotropics with little awareness of the potential for their misuse.

There is a need for a balanced approach to drug education, in which the risks and dangers of psychotropics are acknowledged and discussed in tandem with those in relation to illicit substances. Making the public more aware of the potential risks and dangers of psychotropics through media campaigns as well as longer-term educational programmes would also facilitate the work of the Ministry of Public Health in trying to control and regulate their retail trade — efforts which are already hindered by a lack of transparent and accountable governance, the weakness of the state, endemic corruption and insecurity.

In this context, it is a complex problem to develop interventions to control the trade in psychotropics. The most effective interventions are likely to be those that take place at the interface between the prescriber, the retailer and the consumer of psychotropic drugs. The training of doctors, pharmacists and other healthcare workers — particularly community health workers — is of paramount importance. Professional training at college and university level should contain substantial, rather than token, coverage of the effects of psychotropics and illicit drugs, their risks and dangers, the nature of drug dependency and culturally appropriate treatment options for the people of Afghanistan.

While better professional training of pharmacists at university level is necessary, those currently working in pharmacies, whether trained or not, should be encouraged to provide customers with written information in Dari and Pashto on the dangers and risks of the psychotropics they are dispensing. For those customers who are illiterate, pharmacists — in conjunction with community health workers — should explain these risks and dangers, particularly those related to the long-term use of psychotropics.

Stricter regulation of private detoxification and drug treatment clinics is also needed to ensure that no overuse or overprescription of psychotropics occurs as part of the treatment of clients who are drug dependent. At the same time, drug treatment service providers in the government and NGO sectors should be given funding to provide quality treatment, rehabilitation and harm reduction services to misusers of psychotropics.

For Ministry of Public Health and other officials tasked with controlling and regulating the distribution and sale of psychotropics, good supervision, monitoring and support is necessary to encourage high standards of professional practice and to minimise the risk of bribery and other corrupt behaviour. While law enforcement has a role to play, it must be remembered that increased action against the availability and sale of heroin and other illicit drugs may have the unintended consequence of an increase in the use of psychotropics as additives to such drugs or as substitutes for them.

To enable any of these interventions to occur, the international community needs to acknowledge that demand-driven drug problems in Afghanistan require funding to address them just as much as supply-driven problems and the trafficking of opiate drugs out of the country. In the long term, the problems related to the misuse of drugs, including psychotropics, may pose an equally impermeable barrier to human and economic development in Afghanistan as opium cultivation and heroin production.

Glossary of Psychotropics Used in Afghanistan

The accepted classification of medical drugs such as psychotropics usually contains two names for each drug: the generic name (beginning with a lower-case letter), and the brand name (beginning with an upper-case letter), for example, "diazepam (Valium)."

In Afghanistan, two main categories of psychotropics are misused: analgesics (painkillers) and hypnosedatives. The latter category consists of drugs that have both hypnotic (sleep-inducing) and sedative effects. Among these, there are two types of drugs: the so-called minor tranquillisers, mostly the class of chemicals known as the benzodiazepines; and the major tranquillisers, mostly referring to barbiturate and barbiturate-type drugs. The minor tranquillisers are used for mental health problems that are chronic but not acute, whereas the more powerful major tranquillisers are now mainly used to control severe mental health problems such as schizophrenia and mania.[56] Before the discovery of benzodiazepines, these major tranquillisers were used for a much broader range of mental health conditions.

There is a new class of anti-depressant drugs called selective serotonin reuptake inhibitors (SSRIs), but there is little evidence that these drugs are currently being misused in Afghanistan. Some of the most popular SSRIs are fluoxetine (Prozac), paroxetine (Paxil) and citalopram (Celexa).

Minor tranquillisers

This class of psychoactive drugs has varying properties, including anxiolytic, hypnotic, muscle relaxant and sedative, which are all achieved by slowing down the central nervous system. The benzodiazepines have a number of therapeutic uses for treating symptoms associated with agitation, anxiety, sleep disorders and seizures. If used for a limited period (no longer than three to four weeks) under medical supervision, they are well-tolerated, safe and effective drugs for a wide range of conditions. However, commonly noted side effects associated with benzodiazepine tranquillisers include excessive sleepiness, dizziness, weakness and unsteadiness. Suddenly stopping after only a few months of daily use may bring on feelings of a loss of self-worth, agitation and insomnia. These drugs can also affect memory and concentration.

All benzodiazepine tranquillisers can cause psychological and physical dependence as well as what is known as the "benzodiazepine withdrawal syndrome." People particularly at risk of dependency are those with a history of drug addiction and those suffering from chronic pain, long-term mild depression and chronic sleep disorders.[57] Rapid withdrawal from benzodiazepines that have been taken continuously for more than a few months can lead to symptoms that are similar to those of alcohol and barbiturate withdrawal, including seizures, tremors, muscle cramping, vomiting and sweating.

The higher the dose and the longer the drug has been taken, the greater the risk of withdrawal symptoms becomes. However, withdrawal symptoms can also occur at standard dosages and after only short-term use. Benzodiazepine treatment should always be discontinued as soon as possible via a gradual dose reduction regime, preferably under medical supervision.

Although all benzodiazepines have basically the same effect, different types can be shorter or longer acting. The older benzodiazepines like Valium and Librium are metabolised more slowly, meaning that their effects last for 12 hours or more. If they are taken at night to induce sleep, the user may have problems waking up in the morning and remaining alert. If taken during the day, they can lead to fatigue. Shorter-acting benzodiazepines like Ativan and Temazepam, developed to address this problem, are more likely to lead to dependency. If taken at high dosage over a long period and if the use of these drugs is stopped suddenly, severe withdrawal symptoms including muscle seizures and convulsions are likely to occur.

The first benzodiazepine, chlordiazepoxide, was synthesised in 1955, while diazepam appeared in 1963 and was soon followed by another 12 in the same drug family. The most common ones used and misused in Afghanistan are as follows, with diazepam (Valium) by far the most commonly cited by users:

[56] Andrew Tyler, *Street Drugs* (London: Hodder and Stoughton, 1986).

[57] Alex Baenninger, Jorge Alberto Costa e Silva, Ian Hindmarch, Hans-Juergen Moeller and Karl Rickels, *Good Chemistry: The Life and Legacy of Valium Inventor Leo Sternbach* (New York: McGraw-Hill, 2004).

- alprazolam (Xanax, Anpra)
- chlordiazepoxide (Librium, Librax)
- clonazepam (Rivotril)
- diazepam (Valium)
- lorazepam (Ativan)
- oxazepam (Serax)
- temazepam (Restoril)

Major tranquillisers (hypnosedatives)

This category refers to the barbiturates and barbiturate-type drugs, both of which are more powerful and potentially more dangerous substances than the minor tranquillisers. Although they are powerful hypnosedatives, barbiturates can contribute to increased aggressiveness and violence, and they have very high addiction potential. They can be taken both orally and intravenously, as one report notes:

> *They are practically the most lethal of all injected substances, and one of the most dangerous to withdraw from.*[58]

The major tranquillisers found in Afghanistan are:

- chlorpromazine (Largactil) — a hypnosedative used mainly as an anti-psychotic in medicine. Like phenobarbital, it intensifies the central depressive action of drugs with similar activity to tranquillisers and heroin. It is used in tablet form by street drug users, including IDUs, and it is sometimes mixed with heroin and injected.
- methaqualone (Mandrax) — a drug sold by street drug dealers that is still reportedly found in Afghanistan, although its use has declined over the past few years. This is probably due to the increased availability of heroin and the efforts of the Ministry of Public Health to eradicate methaqualone. First synthesised in 1955 as an anti-malarial drug, its powerful effects and potential for abuse were quickly recognised, and its use has been banned in most western countries.
- phenobarbital — a barbiturate that usually comes as a white powder and is reportedly mixed with heroin, increasing the dealer's profit but also the risks associated with the use of such a drug cocktail.

Analgesics (painkillers)

While diacetylmorphine (heroin) is still the most powerful painkiller known to medical science, there are several other opiates — drugs derived from the opium poppy such as morphine and codeine — and opioids (synthetic painkillers) that are misused in Afghanistan:

- buprenorphine (Temgesic) — discovered in 1968, it is a semi-synthetic long-acting opioid painkiller derived from thebaine, which is a constituent part of the opium poppy. It is generally administered by the sublingual route (under the tongue) or intravenously, not orally.
- diclofenac (Voltarol, Voltaren) — a non-steroidal anti-inflammatory drug taken to reduce inflammation and as a painkiller. Its over-the-counter use has been licensed in some countries, although not in Afghanistan (apart from in cream or gel preparations).
- fentanyl (Duragesic) — a potent opioid painkiller with a high potential for abuse
- metamizole (Dipyrone, Novalgin) — a painkilling and anti-inflammatory drug that was easily available in Afghanistan under the brand names Dipyrone and Novalgin until 2004 when its sale was banned by the Ministry of Public Health. The sale and use of Dipyrone has also been banned in more than 30 other countries, including the United States, where in 1979 it was declared unfit for human consumption because it was found to produce a serious side effect known as agranulocytosis, a dangerous and potentially fatal condition.
- morphine-based cough syrups
- omnidol — mainly containing paracetemol, a non-prescription painkiller, this drug also contains caffeine and diazepam. Its sale was banned in neighbouring Pakistan in 2006 by the Drug Registration Board because of its "irrational" combination of both central nervous system stimulant (caffeine) and central nervous system depressant (diazepam) drugs, and because the co-administration of paracetemol and diazepam is not required in any clinical situation.
- pentazocine (Sosegon) — by far the most commonly reported painkiller misused, often as a heroin substitute. Easily available in both tablet and ampoule form, it can be injected on its own or in combination with other drugs. In some countries the use of pentazocine has been banned, and in the United Kingdom its prescription is discouraged as it places undue strain on the heart and can lead to hallucinations and thought disturbances.

[58] Andrew Tyler, *Street Drugs*, 103.

- tramadol — an opioid drug and synthetic analogue of codeine available in both injectable and tablet form. Tramadol is a controlled substance under Afghanistan's Essential Drug List (a wise decision given its potential for misuse among IDUs in Kabul); however, in other countries it is available with, and in some countries without, a normal prescription. This demonstrates the problem of trying to categorise psychotropics: globally there is often no consensus on the risks and dangers posed by particular drugs.

Other psychotropic drugs

- chlorpheniramine maleate (Avil) — an antihistamine with sedative properties that can be used to dilute heroin before injection. It makes heroin easier to dissolve either directly if in ampoule form or, if used in tablet form, in distilled water. Users have claimed it prevents allergic reactions such as skin rashes.
- dothiepin hydrochloride (Prothiaden) — an anti-depressant with anxiolytic properties and the market leader in the Indian anti-depressant market.
- hyoscine (or scopolamine) — a highly toxic drug that should only be used in very small doses. An overdose can cause delirium, paralysis, stupor and even death. Commonly used in the treatment of nausea, motion sickness and intestinal cramping (as Buscopan), it is also used as a general depressant and an adjunct to narcotic painkillers.
- promethazine (Phenergan) — for allergies and motion sickness (not for children less than two years of age) but with marked sedative/hypnotic effects. It is a prescription-only drug in the United States but is available over the counter in the United Kingdom, Sweden and several other countries.

The Afghanistan Research and Evaluation Unit (AREU) is an independent research organisation headquartered in Kabul. AREU's mission is to conduct high-quality research that informs and influences policy and practice. AREU also actively promotes a culture of research and learning by strengthening analytical capacity in Afghanistan and facilitating reflection and debate. Fundamental to AREU's vision is that its work should improve Afghan lives.

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