

“The War on Drugs”: The Case of Bangladesh

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Despite decades of history of failure of the “war on drugs” (Coyne & Hall, 2017), Bangladesh recently joined this controversial journey, with policies that took at least 130 lives across the country (Gupta & Pokharel, 2018). In addition, it has added another example of a structural failure to realize, examine, foresee, and address the intricate issues surrounding drug abuse, including the principles of self-medication and harm reductions, and the supply-demand-misuse dynamics of the drug market.

At the core of this complex issue is our quest to understand (i) why some people use addictive drugs while others don’t, even within the same social context, and (ii) why all addicts do not use the same drug(s). Then we elaborate on why a crackdown on the drug market successfully fails.

Dozens of factors have been identified to explain why some people go on to (mis)use addictive drugs. These include socioeconomic disparities, physical and mental health, social integration/isolation, and overall quality of life, but about half of someone’s risk of addiction is embedded in their genes (National Institute on Drug Abuse, 2018). A complex interplay of these biological and environmental factors make them suffer from “painful affect states and related psychiatric disorders” (Khantzian, 1987). However, these mental health issues are not as straightforward as many other physical health conditions, since they do not exhibit as a set of well-defined signs and symptoms. Therefore, much like undetected cancer, patients themselves remain unaware of their underlying deteriorating illnesses. Even when they realize an underlying state of painfulness, existing social stigma makes it even more challenging for them to express their painful experiences.

The principle of ‘self-medication’, in simple terms, may be analogous to the use of potent painkillers by potential addicts, similar to a potential non-addict’s use of over-the-counter drugs (such as conventional painkillers) to relieve some muscle aches, or a cup of coffee to keep awake. Further, even though there are multiple painkillers in the market, just as a non-addict may continue to take medication or substances which help relieve pain, it may be extrapolated that a potential addict may also try different drugs and settle for one(s) that they find most useful to relieve their pain (Khantzian, 1987; Tyndall, 2018). An addict may feel the need to be on drugs the way a diabetic patient needs to be on medication. However, the striking difference is that the drugs of abuse have myriad serious adverse effects (including addiction and sudden death), and hence may not be legally prescribed by any physician (except in some extraordinary circumstances under medical supervision).

The issue gets a lot more complex here. Because these are ‘addictive’ drugs, the users experience a strong ‘craving’ (referred to as ‘withdrawal symptoms’) if they stop taking the drug(s). That is why they need to keep taking the drug(s). So, the ‘demand’ for the drug is there, which almost inevitably begets supply (Chasteen, 2016). However, because the drugs are supplied in an illegal and unregulated way, the drug market often involves a host of crimes including trafficking. Therefore, the authorities feel the need to crack down on the drug market with a view to addressing the issue of drug abuse. So why do they fail so successfully (Coyne & Hall, 2017)?

The issues of drug misuse and the drug market phenomenon are intrinsically complex. For example, cracking down on addicts would involve a host of issues including displacement, discrimination (socially, economically, ethnically marginalized are more likely to be affected), deterrence (from healthcare access, for example), and detention among others (Agozino, 2000; Carver & Harrison, 2016; Moore & Elkavich, 2008). These have significant distal yet inevitable tolls on healthcare resource utilization and equity (Janjua et al., 2017; Kerr et al., 2014; Provine, 2008). On the other hand, a crackdown on the drug suppliers/dealers would result in a decrease in the number of people supplying drugs. Because the *demand* would not change overnight (remember the issue of craving?), a decrease in drug *supply* would result in an artificial increase in drug price (Caulkins & Reuter, 2010; Caulkins, Reuter, & Taylor, 2006; Levitt & Dubner, 2006). This

would have a double-edged impact on the drug market. While an increase in drug price may have a monetary toll on drug users, who would likely then compromise food and nutrition to satisfy their drug demands (Burriss et al., 2004), detention of some drug dealers would create vacancies in the drug market for the potential new dealers. These new dealers may now be additionally incentivized by higher revenues thanks to an artificial price hike (Caulkins & Reuter, 2010; Caulkins et al., 2006; Levitt & Dubner, 2006; Wagner & Carbone, 2001).

More to this problem is the notoriety of the drug market. With a view to evading the existing drug policy and/or to take advantage of a potentially unregulated market, the drug market is inherently evolving to introduce new, experimental, and potentially life-threatening, products to the market, ranging from ‘Fentanyl’ in North America to ‘Glue’ in Bangladesh (Galenianos & Gavazza, 2017; Shazzad, Abdal, Majumder, Ali, & Ahmed, 2013; Tyndall, 2018). A crackdown focusing on a particular drug will most likely result in an introduction of other equally or more harmful drugs to the market (for example, illegal crystal meth & MDMA laboratories have only recently been reported for the first time in Bangladesh (The Daily Star, 2019)), unless there is an evidence-based focus on a more comprehensive drug regulatory framework along with expanded access to harm-reduction services (Islam et al., 2017; Tyndall, 2018).

Well, how big is the illegal drug market in Bangladesh? While rigorous data are lacking, available evidence suggests that about 2.5-7.0 million people are addicted to drugs in Bangladesh (Haider, 2018; Shazzad et al., 2013). As a glimpse to the size of the illegal drug market economy, more than 40 million pills of Ya-ba (methamphetamine) have been seized by the regulatory authorities in 2017 alone, according to the Annual Drug Report 2017 published by the Department of Narcotics Control of Bangladesh (Department of Narcotics Control, 2018), with the recent Rohingya emigration crisis allegedly adding more complexities to the existing drug market (Islam, 2018). However, there is only limited access to harm reduction services for only a fraction of people who use drugs (Maehira et al., 2013). In the light of a recent development in which over a hundred drug dealers reportedly surrendered to the regulatory authorities (Khan & Jinnat, 2019), there was no mention of provisions for correctional facilities and/or rehabilitation services for those addicted.

While the solutions must come from evidence derived from local context, global best practices may help address some of these issues. For example, primary prevention focusing on factors which put people at risk of addiction may particularly help keep younger people away from addictive drugs (International Narcotics Control Board, 2018), and secondary prevention approaches focusing on those who are already addicted through the inclusion of a range of harm reduction services (Islam et al., 2017; Tyndall, 2018). Provision of appropriate correctional facilities for those incarcerated for drug dealing and/or drug abuse may include provisions for harm reduction services and treatment of existing health conditions. A framework to generate more research-based evidence to inform future policy formulation might play a pivotal role.

To conclude, a convergence of science and sensibility is required to address the intricate issues of drug market and drug misuse. While the existing approach is a “search for ‘criminals’”, the issue rather mandates a well-concerted “research for scientific evidence”.

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