

Drug Use and HIV Vulnerability

Policy Research Study in Asia

Task Force on Drug Use and HIV Vulnerability



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FORWORD

Message of the Executive Director of UNAIDS

Some 34.3 million men, women and children worldwide face currently a future dominated by a disease unknown just a few decades ago. In 1999, there were 2.8 million deaths from HIV/AIDS - a higher global total than in any year since the beginning of the epidemic. With the HIV- positive population still expanding, adding 5.4 million new infections in 1999 alone, the annual number of AIDS deaths can be expected to increase for a number years before leveling off.

The overwhelming majority of people living with HIV, some 95 per cent of the global total, live in the developing world. That proportion is expected to grow even further as infection rates continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus. In Asia and the Pacific alone, there are already over 6 million persons living with HIV/AIDS.

Effective prevention programmes have reduced HIV risk and lowered or stabilised HIV transmission rates in some countries of Asia. At the same time, however, warning flags have been raised after information from new data collection efforts have revealed that injecting drug use is spreading and that condom use is uncommon, including among clients of sex workers and men who have sex with men. In many places prevention efforts are hampered by the shame and stigma attached to AIDS.

Drug use and HIV vulnerability remain issues of great concern for many countries in Asia and the Pacific because surveys indicate that in some geographical areas more than sixty per cent of all injecting drug users are HIV- positive. In several Asian countries, injecting drug users represent the largest group of those who are HIV-positive.

In 1997, in response to this situation, the UNAIDS Asia-Pacific Intercountry Team established a Task Force, comprised of a team of

experts in drug control and public health. The Task Force designed and commissioned the present study on national drug control and public health policies that could facilitate or impede the implementation of interventions to reduce the risk of HIV transmission among drug users. Study-countries included China, India, Malaysia, Myanmar, Nepal, Thailand and Viet Nam. Data collection for the survey was completed in May 1999 and the report was distributed to governments and concerned agencies for their review and comments.

The results of the study, which are documented in this monograph, indicate that in many countries serious legal and political barriers exist, which impede the implementation of effective preventive interventions for the spread of HIV infection among injecting drug users. Such interventions include needle and syringe exchange or distribution and drug treatment as part of comprehensive package of interventions.

High-risk behaviour is commonplace among drug users in all the study countries and there is an observable trend of multiple drug use. Measures to prevent the spread of HIV among drug users are often localised, short-term, under-funded and insufficient in scope. Adherence to traditional values is strong, making the debate on HIV/AIDS prevention and sexual behaviour sensitive. With the exception of law enforcement, drug problems are not generally accorded high funding priority. There is inadequate dialogue between drug control and HIV/AIDS prevention agencies. Consequently there are only a few programmes in the region, which directly address problems presented by the interface between drug use and vulnerability to HIV infection. In general, drug policies in the study-countries do not support effective prevention of HIV transmission among drug users.

On the positive side, however, results of the survey indicate that governments are, under certain circumstances, ready to review their policies concerning interventions to reduce the risk of HIV transmission among injecting drug users. In many countries only minor modifications to the drug control legislation are necessary in order to implement more effective HIV/AIDS prevention among drug users. In all the study-countries there were many opportunities for the development of interven-

tions to enhance the efficacy of HIV/AIDS prevention among drug users. Change will inevitably have to be incremental, building on, modifying and expanding interventions that are already in place. The researchers strongly recommended improving the collaboration of drug control and public health sectors in developing and implementing policies and programmes targeting drug users.

This monograph is intended to serve as a practical source for professionals working in the fields of policy and programme development, both in the drug control and the public health sectors. Whether government officials or staff of non-governmental organizations, they are the ones who face the challenge of developing new or modifying existing policies and programmes to reduce the risk of HIV transmission among injecting drug users, a task which requires a high degree of courage, patience and stamina. It is hoped that the information provided in this monograph will contribute to the success of their endeavours at this critical stage of the epidemic in Asia and the Pacific.

Peter Piot

Executive Director

Joint United Nations Programme on HIV/AIDS

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CHAPTER 1
MAIN REPORT

CHAPTER 1

MAIN REPORT

I. SUMMARY OF FINDINGS

In many of the study-countries minor modifications to the drug control legislation are necessary in order to implement more effective HIV/AIDS prevention among drug users.

High-risk behaviours are commonplace among drug users in all the study-countries and there is an observable trend of multiple drug use.

In general, drug policies in the study-countries are not supportive of effective HIV prevention among drug users. With the exception of law enforcement, drug problems are not generally accorded high funding priority.

There is inadequate dialogue between drug control and HIV/AIDS control agencies in the seven study-countries. Consequently there are few programmes in the region, which directly address problems presented by the interface between drug use and HIV/AIDS.

Measures to prevent the spread of HIV among drug users and their sexual partners are often localised, short-term, under-funded and insufficient in scope.

Adherence to traditional values is strong in many of the study-countries making debate on HIV/AIDS prevention and sexual behaviour sensitive.

Drug treatment almost invariably focuses on detoxification treatment. Drug users are afforded little choice of treatment, which is mostly compulsory, residential and long-term.

Drug treatment personnel are often non-specialists in the drug field, and derived from the labour, public security or non-governmental sectors. The need for training was observed in all the study-countries. Most treatments on offer include a strong penal element.

Sensitivities of countries to implied criticism from abroad has to be noted. Change will have to be incremental, building, modifying and expanding on interventions that are already in place.

In all the study-countries there were many opportunities for the development of interventions to enhance the efficacy of HIV/AIDS prevention. This assertion is based on the following observations:

- (a) The need for adequate responses to the HIV/AIDS epidemic is acknowledged and understood in all the study-countries;
- (b) The legal impediments enshrined in the drug control legislation were often not serious and may require minor modification to regulations;
- (c) UNAIDS Theme Groups on HIV/AIDS in some of the study-countries are in a position to coordinate and facilitate consensus building and collaboration between stake holders.

Drug and HIV policies and the process of policy review and development in the study-countries were difficult to determine and had to be deduced from multiple sources including verbal briefing by numerous key informants and accompanying documentation

II. RECOMMENDATIONS

It is recommended that countries examine their drug and HIV policies and attempt to achieve greater congruence and compatibility between the two, ensuring that there are no legislative impediments that constrain the implementation of necessary measures to prevent HIV transmission among drug users and their sexual partners.

It is recommended that stake holders, including the national drug and HIV/AIDS control agencies, international and local non-governmental organisations as well as drug users, ex-users and people with HIV/AIDS develop consensus on the best way forward and develop mutually endorsed and acceptable preventive policies.

It is recommended that countries give consideration to instituting regular policy review procedures, and consider adopting more evidence-based policies. These reviews might also include a cost analysis of different treatment options so as to meet the challenge of judicious allocation of scarce resources.

It is recommended that countries adopt a comprehensive approach to treatment and prevention of drug use and HIV transmission. A wide range of services are needed to meet the multiple needs of drug users. The scale of these interventions should be increased and sustainability assured.

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It is recommended that information, education and communication strategies and materials be reviewed, to ensure the accuracy and veracity of drug and HIV/AIDS preventive messages. It is further recommended that countries ascertain that those vulnerable to drug use and those already using drugs be provided with accurate information about the potential health risks that arise from their behaviour and ways of reducing the risk.

It is recommended that measures paying special attention to the prevention of harmful drug use among drug users be undertaken, for example focusing on preventing, wherever possible, the switching from smoking or inhaling to injecting drugs.

It is recommended that policy makers be urged to consider employing prevention and treatment approaches that are in alignment with the principles of 'public health' and 'health promotion' in preference to law enforcement approaches that emphasizes punishment as the principal means of promoting behaviour change.

It is recommended that countries place more emphasis on increasing the availability of voluntary treatments for drug use, most specially treatments that are 'user friendly', 'low threshold' and that employ flexible treatment policies. Attention should also be given to catering for those drug users who have special needs.

It is recommended that countries adopt inter-sectoral training programmes to broaden the knowledge, understanding and skills of drug and HIV/AIDS workers, opinion leaders and decision-makers working in key areas impacting on drug use and HIV vulnerability. Such persons include, for example,

- (a) Various ministry personnel who are engaged in policy making or funding or operating services (e.g. Health, Home, Social Justice and Empowerment, Labour, Social Affairs, Public Security, Finance);
- (b) Other public sector workers who might come across drug users in the course of their work (e.g. police, teachers and educators, doctors, nurses, drug workers, pharmacists, social workers, psychologists, outreach workers, peer educators, religious leaders and others);
- (c) Researchers, social and political scientists who may be interested in studying the drug problem, the interface between drug use and HIV/AIDS to upgrade the data gathering capacities in the countries.

It is recommended that special attention be paid to enhancing the quality of training for direct service providers in the drug field. Countries should consider adopting a strategic approach to training, identifying who needs what training and for what specific purposes, and focusing as much as possible on a training

of trainers so as to maximize the reach and sustainability of these strategies.

It is recommended that countries consider broadening the goals and methods of drug treatment from an abstinence-only goal to encompass treatment and prevention strategies that are more accepting of interim goals.

It is recommended that in countries where injecting is a feature of drug use, explore and consider the use of a range of opioid substitution pharmacotherapies and the distribution or exchange of needles and syringes, and of sterilizing materials.

It is recommended that programmes targeting the prevention of HIV/AIDS among drug users include information about safe sex, focusing on both users and their sexual partners.

It is recommended that countries consider promoting and facilitating the establishment of self help organizations for drug users that could initiate advocacy and enable users and ex-users to create mutually supportive environments.

It is recommended that countries give special attention to the provision of drugs and HIV/AIDS preventive services among drug users presently incarcerated in prisons and other long term labour rehabilitation facilities.

III. INTRODUCTION

Drug use in Asian countries continues to increase and new and ever more hazardous and harmful drug use patterns are continuing to emerge. Many use multiple substances, inject in preference to smoking, 'chasing' or snorting, share needles, syringes, drug paraphernalia and drug solutions and preparations indiscriminately, and use alcohol and other psychoactive drugs excessively. These drug use behaviours occur in the context of countries in Asia, which are highly affected by HIV/AIDS. The present study was commissioned by the UNAIDS Asia Pacific Inter-country Team, Bangkok, to follow upon the report 'Situation Assessment of Injecting Drug use in South East and East Asia in the context of HIV' which was conducted by the Asian Harm Reduction Network (AHRN) in 1997¹. The situation assessment indicated that urgent action is needed to reduce the transmission of HIV/AIDS among drug users and their sexual partners.

1. Asian Harm Reduction Network (AHRN) 1999, *The Hidden Epidemic: A situation Assessment of Drug Use in South East and East Asia in the Context of HIV vulnerability*. Dr. Nick Crofts is the principal author of the work.

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The main purpose of the present study was to establish a basis for effective assistance to governments in the development and implementation of policies and programmes for the prevention of the transmission of HIV among drug users. The study set out to examine drug and HIV laws, policies and strategies focusing on seven countries: China, India, Malaysia, Myanmar, Nepal, Thailand and Viet Nam. The study was not designed to compare the situation across countries nor to critique national laws and policies but rather, as an exploration of factors nationally and regionally which are serving to either facilitate or hinder efforts aimed at reducing HIV/AIDS vulnerability among drug users and their sexual partners.

The study took place between March and May 1999. Each of the seven study-countries was visited by a researcher for 5 working days (with the exception of India, which was visited for 9 working days). The researchers interviewed key informants (often selected by government officials), undertook field-visits, and studied available published literature and other documentation. These included the national drug control plans, the national HIV/AIDS prevention plans, data from HIV sentinel surveillance, reports of national and local studies, project documents and evaluations of ongoing interventions, drug laws and other legislation relevant to HIV/AIDS.

The major issues examined in this study were

- (a) The scope and scale of the HIV epidemic in each country in general and among injecting drug users in particular;
- (b) The publicly stated policies in each country in respect to HIV and drug use;
- (c) The positive and negative impacts of public policy on HIV vulnerability in relation to the use of drugs;
- (d) What is currently being done at the policy level and at a practical level to help prevent HIV transmission amongst drug users and their sexual partners;
- (e) Specific factors that inhibit the ability of governments and non-government agencies to reduce HIV/AIDS vulnerability among drug users and their sexual partners;
- (f) Opportunities for policy reform and the development of interventions that could prevent HIV/AIDS transmission among drug users and their sexual partners;
- (g) Whether and how UNAIDS and its co-sponsors could support countries in their efforts to reduce HIV vulnerability among people who use drugs and their sexual partners.

IV. FINDINGS

A. Drug use and HIV/AIDS in the study-countries

The seven study-countries presented very different drug and HIV situations. It is apparent from Table 1.1 below that HIV infects many drug users in the study-countries. Indeed, the East and South Asian countries contain some of the highest recorded rates of HIV infection among injecting drug users: a mean of 62 per cent of injecting drug users in Myanmar, between 30 to 40 per cent in Thailand and 45 per cent in Nepal are HIV positive. Furthermore, drug users in the region contribute disproportionately to the national epidemics in these countries. Approximately 77 per cent of all known HIV infections in Malaysia are among drug users, as are 69.4 per cent of identified cases in China and 65.5 per cent of identified HIV/AIDS cases in Viet Nam.

Drug use and HIV are not equally distributed geographically. Some cities or provinces in the study-countries have an over-representation of drug problems and have become the epicentres of the HIV/AIDS epidemic in the region. The reasons for this are many. Significant drug problems exist in the large urban conurbation of Ho Chi Minh City and Bangkok, along drug trafficking routes as for instance in Yinning City in the Autonomous Region of Xingjiang in China, or in Quang Ninh province and Lang Son provinces in the north of Viet Nam, Manipur in India and in Dehong Prefecture in Yunnan Province which share a border with Myanmar. Some areas, that attract large numbers of seasonal or migrant workers, may also have significant problems. Phar Kant Jade mining area in Myanmar is one such location.

Table 1.1 provides information on drug use and HIV/AIDS in the seven study-countries. It indicates the extent to which injecting drug users contribute to the epidemic in each country. The table should be read as merely indicative of the situation in each country.

The rapid spread of HIV infection among drug users in many countries of the Southeast and South Asian region has been associated with high-risk injecting practices. These include the use of self-made injection equipment, a high level of needle and syringe sharing, little or no effective cleaning procedures, the presence of 'professional' injectors who use the same needle and syringe to inject many customers, sometimes also dipping the equipment into pots of opium that are contaminated with blood from previously injected users, and the distribution and administration of drugs through common containers or contaminated syringes.

Table 1.1 Drug use and HIV/AIDS among injecting drug users (1999)

Estimated number of drug users	% injectors opiate users	% injectors	HIV infections estimated	HIV infections confirmed	AIDS confirmed	% IDU among HIV+	% HIV+ among IDUs
China							
540,000 ²	Majority	66 ³	400,000	12,580 ⁴	417	69.4 ⁵	No data
India							
2.25 million	500,000	25-30 ⁶ 59 ⁷ 80-90 ⁸	3-5 million ⁹	75,000	5,204	7.3 ¹⁰	60-80
Malaysia							
300,000	200,000	50	49,494	23,571 ¹¹	2,354	77	10-27
Myanmar							
67,489 ¹² 300,000 ¹³	Majority	30	440,000 ¹⁴	21,535	2854	20-30;	62 ¹⁵
Nepal							
40-50,000	Majority	75-96 ¹⁶	27,000	1,262	213 ¹⁷	13	45
Thailand							
1,270,000 ¹⁸	219,391 ¹⁹	60 ²⁰	850,000		5,836	5.25	30-40
Viet Nam							
90,000 ²¹ 185,000 ²²	Majority	No data	75,000- 80,000 ²³	12,410 ²⁴	2404	65.5	17

- 2 Registered drug users; source: China's Battle against Narcotics
- 3 Source: NNCC briefing
- 4 National Programme for the Prevention and Control of AIDS 1998
- 5 Sentinel surveillance, Ministry of Disease Control, Ministry of Health, China
- 6 Total
- 7 Delhi
- 8 Manipur
- 9 Source National AIDS Control Organisation (NACO) 1997-8
- 10 Source National AIDS Control Organisation (NACO) 1997-8
- 11 November 1997
- 12 Registered, Source CCDAC
- 13 Unofficial estimate
- 14 Estimated by UNDP/UNAIDS
- 15 Sentinel Surveillance data September 1998
- 16 Treatment seekers
- 17 March 1999
- 18 32% inhalants, 26% marijuana, 20% amphetamines; Thai Development and Research Institute (TDRI) 1995, data of 1993
- 19 TDRI study of 1995, data of 1993
- 20 Of drug users in treatment; AHRN, "The hidden epidemic"
- 21 Registered, Information from the Viet Nam Drug Control Committee (VNDCC)
- 22 Estimated by the Ministry of Labour, Invalids and Social Affairs, Viet Nam
- 23 National AIDS programme, Viet Nam
- 24 Sentinel Surveillance data 1999

B. The drug laws in the study- countries

Drug laws and regulations were examined in each of the study-countries with the exception of Viet Nam (its drug laws await formal ratification by the National Assembly).

The drug laws follow the guidelines of the three UN Drug Control Conventions.²⁵ The Conventions guide drug control legislation and provide states with a broad framework for drug control legislation as agreed upon by the international community. With few exceptions the study-countries were signatories to all the UN Conventions²⁶ and their national laws have been framed to conform to these conventions. The specifics of national legislation are the province of each sovereign state and national drug laws have developed in the context of each country's historical, social and economic circumstances, and are further influenced by the patterns and extent of drug use. Considerable attention is given in each of the study-countries to the establishment of regulatory mechanisms, to supply reduction activities and to law enforcement. Two of the three UN Conventions and national drug legislation pre-dates the HIV/AIDS epidemic, so that little if any attention is paid to the intersection between drug use and HIV/AIDS.

In this study attention focused on those aspects of policy and legislation that impact on drug use and HIV/AIDS vulnerability. This included an examination of legislation and policy which influences the kinds of HIV prevention and drug treatment services that are available and accessible to drug users. It is evident that national drug laws provide the framework within which lie the opportunities as well as the impediments to the implementation of effective HIV/AIDS preventive strategies. In some countries the law prescribes severe punishments for all drug-related offences, including those relating to drug use, the possession of drugs and the possession of drug use paraphernalia including needles and syringes. The exact meaning of the law in respect to the possession of paraphernalia is unclear in a number of the study-countries. In some countries where the law remains silent on the issue, many people who inject drugs are said to believe that if caught in possession of a needle and syringe, they can be arrested and convicted. In practice the possession of a needle and syringe alone is rarely used anywhere in the study-countries to convict a person of a drug offence. However,

25 Single Convention on Narcotic Drugs 1961, the Convention on Psychotropic Substances, 1971 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic substances, 1988 and their amendments.

26 All seven study-countries are signatory to the Single Convention, all but Nepal are signatory to the 1971 Convention on Psychotropic substances and all but Thailand are signatory to the convention against Illicit Traffic in Narcotic Drugs and Psychotirouc Substances of 1988.

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the possession of a needle and syringe may be used along with other incriminating evidence of drug use (e.g. needle tracks) in support of specific drug related charges.

These findings are best illustrated by reference to specific examples: The first two, Malaysia and Myanmar have legislated for severe penalties for drug use that include custodial prison sentences.

In Malaysia the Drug law (Section 10 of the Dangerous Drugs Act, 1952) states that

If a person has in his possession ...any utensil used in the preparation of opium for smoking or consumption ...or smokes or otherwise consumes prepared opium or frequents any place or places used for the purpose of smoking or otherwise consuming prepared opium he shall be guilty of an offence

The penalties on conviction consist of a fine not exceeding 5,000 Ringgit (\$US 1,300) or to imprisonment for a term not exceeding two years or to both.

In Myanmar the penalties for drug use are severe. Under Section 15 of the Narcotics Drugs and Psychotropic Substance Law (1993) the following regulations apply to drug users:

A drug user who fails to register by the Government for this purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment shall be punished with imprisonment for a term which may extend from a minimum of 3 years to a maximum of 5 years.

This means that drug users in Myanmar who do not voluntarily come for detoxification treatment, readily find themselves in prison. However, Myanmar is preparing to open a new secure treatment and rehabilitation facility designed to divert drug users away from the criminal justice system.

The next two examples taken from Nepal and Thailand indicate that although the use and possession of scheduled dangerous drugs are illegal in line with the international conventions, the penalties are of a relatively light nature.

In the Nepalese Drug Law (The Narcotic Drugs Control Act, 2033 -1976) there are provisions for a user to enter a bond instead of going to prison for certain drug offences. Thus, if a person is found to have purchased or is in possession of cannabis or medicinal opium, without commercial motive and in a small quantity, or to have consumed only a small dose, and if it is a first offence, then the Narcotics Drug Control Officer may make him sign a bond undertaking not to commit such offence again and release him. The drug user is required to give an undertaking to enter and remain in treatment for three months and the drug treatment agency is required to submit fortnightly reports on the individuals concerned. The Law also contains a provision for withholding or remitting punishment for minor and first offences.

In Thailand, one of the major objectives of drug policy as articulated in the 5th Narcotics Control Plan (1997-2001) is to develop 'complete treatment and rehabilitation programmes for drug addicts with emphasis on quality service and participation from families and communities'. Apprehending drug users and punishing them is not an objective of Thailand's policy. The National Addict Rehabilitation Act of 1991 makes provision for drug treatment. Most treatment offered in the country is voluntary (provided by 247 treatment centres) and much of it is ambulatory. Correctional treatment (compulsory) is planned but has not been enforced.

In conclusion it may be seen that although drug use is illegal in all the study-countries the penalties for drug use and possession vary across countries. The implications for HIV preventive efforts must therefore be considered on a case by case basis. As already indicated above the level of penalties and the stringency with which they are applied locally impacts upon the feasibility of reaching-out to drug users, and of providing them with information and wherewithal to protect themselves against HIV infection while they are still out of treatment.

C. Drug and HIV policies

The most striking finding was that with some notable exceptions drug policies in the study-countries pay scant attention to HIV prevention. For example, in the Thai Narcotic Control Plan (1997-2001) no mention is made of HIV prevention. Likewise, in an official report from China '*China's Battle against Narcotics*' no mention is made of HIV/AIDS among injecting drug users. The same observations can be made of drug control plans in India, Nepal and Malaysia. In the Drug Control Master Plans that have been developed in Viet Nam, India and Nepal (with the assistance of UNDCP) only the Viet Nam plan makes reference to HIV prevention. Despite Viet Nam's commitment to the eradication of social evils²⁷ (prostitution and drug use) the drug control plan contains the following objective:

To measurably reduce drug abuse and to promote harm-reducing and preventive drug abuse/HIV programmes, to develop a national plan for prevention of drug abuse and related harms, and for the plan to be closely correlated and where appropriate integrated with the National Plan for HIV/AIDS prevention (Viet Nam Drug Control Master Plan, 1995).

In general when the risks of drug-related HIV transmission are acknowledged at country level, the favoured response is to increase efforts to prevent drug use through drug education and life skills development and to detoxify those who use drugs.

27 Viet Nam government No 53/CP 1994 re drug use and prostitution

There was a greater likelihood that HIV prevention among people who use drugs are mentioned in the National HIV/AIDS Plans than in the National Drug Control plans, but most often drug users were not accorded a high priority in national HIV prevention plans. In China, the draft HIV/AIDS plan aims to contain the spread of HIV among drug users to less than 15 percent and is to be achieved through universal dissemination of knowledge. The plan acknowledges, however, that it is unlikely that drug abuse and prostitution will be eradicated within a short period of time (draft plan for 1998-2010). In India, the importance of harm reduction is noted for the first time in a draft National AIDS Prevention and Control Policy that will soon go before cabinet for its consideration. The proposed policy endorses needle and syringe exchange as a key strategy for preventing the transmission of HIV/AIDS through drug injection. In Thailand's HIV/AIDS plan (1997-2001), no mention is made of drug users.

D. Risk reduction strategies: Experience in the study-countries

Despite the difficulties outlined, some interventions aimed at addressing hazardous and illicit drug use in the context of the HIV/AIDS epidemic are being implemented in the study-countries. World Health Organisation (1998) suggests that strategies to reduce the potential harm to injecting drug users should include a number of key components. These should include strategies to reach out and inform injecting drug users about the practical ways in which they can reduce their risks of HIV infection, providing them with the practical means to apply these (i.e. access to sterile injecting equipment, disinfectant materials and easy access to substitution treatment). There are examples of all of these in the seven study-countries.

Outreach

Although in several of the study-countries (e.g., India, Malaysia, Myanmar, Nepal and Viet Nam) outreach approaches and peer-education have been recognised as important, this approach has not become an integral part of the drug/HIV policy in any of the study-countries. In some countries, while peer education is tolerated in a limited sense it is neither endorsed in policy nor funded (e.g. Malaysia), and is often provided in the context of promoting abstinence rather than focusing on HIV prevention. In other countries (e.g. Thailand) this approach, though popular in the HIV/AIDS field where peer led approaches turned into very active self-advocacy organisations, outreach approaches have not been employed in the drug field.

In practice, outreach and peer education has most often been provided by local

and international non-governmental organisations. This has meant that these activities are invariably localised, of limited reach and not fully sustainable. In some of the study-countries, outreach was firmly directed at educating young people (and their families) not to use drugs at all and to enter treatment as soon as they begin using any drugs. In other countries, outreach workers educate drug users about safer drug use. Despite numerous pilot projects there has been little systematic review or evaluation of these projects and most have not been extended beyond the local pilots. The informal distribution of condoms and of injecting equipment through peer education and outreach programmes is however, taking place in the context of some of these projects.

By way of example:

In Nepal: The Strategic Plan for HIV and AIDS for 1997-2001 places emphasis on peer education approaches as a means of reducing HIV transmission among drug users. Work in the community is carried out by local non-governmental organisations.

The Life-saving and Life-giving Society (LALS) in Kathmandu has worked with injecting drug users since 1991, exchanging sterile injecting equipment in return for contaminated equipment. LALS conducts outreach work, distributes bleach and condoms, provides education, counselling and drug treatment referral services as well as primary health care for its clients. Three years into the programme there were indications that unsafe injecting practices have been reduced among those who are in contact with LALS and that knowledge of HIV has risen among its client population. However, the Ministry of Home, which carries most political weight in terms of drug policy and legislation, points out that syringe exchange programmes are not legal and legitimate, and remains to be convinced that these activities are helpful. Police in Kathmandu have remained reluctant to acknowledge and support the work of LALS and have sometimes obstructed HIV prevention activities. On the other hand, police in Dharan in eastern Nepal have provided support to local HIV transmission prevention activities among drug users.

In Myanmar the most active outreach programmes are provided by a local non-governmental organisation, the Myanmar Anti-Narcotic Association (MANA). This organisation provides preventive education to young people. Community outreach workers trained by MANA focus on abstinence and on education about the dangers of drug taking. Several international non-governmental organisations (World Concern and Medicine du Monde) have commenced a pilot project targeting injecting drug users in the community including 'shooting galleries' in Kachin State where there is an extremely high rate of HIV infection among injecting drug users. .

In Viet Nam outreach and peer education approaches are actively promoted under a UNDCP/UNAIDS funded project '*Strengthening the National Capacity for Prevention of Drug Abuse and HIV/AIDS among High-Risk Target groups*' which began in 1998. Additional outreach projects are currently being developed for implementation in Viet Nam's

northern provinces.

However, numerous concerns about the usefulness, efficacy and feasibility of outreach and peer led approaches were expressed in the study-countries. These centred on

- (a) Fears that these interventions might be perceived as normalising and even encouraging drug use or at least, failing to discourage and prevent it;
- (b) Concerns about the lack of assured funding;
- (c) Concerns about the lack of adequate training and supervision for out-reach workers and peer educators;
- (d) Concerns about the resources to deal with the problems encountered by outreach workers as a result of policing activities;
- (e) Concerns about the feasibility and reliability of employing drug users or ex-users as educators;
- (f) Concerns about the lack of clarity that governs the work of outreach workers (e.g. Should they be expected to advise people about safe injecting? Should they also distribute needles syringes or sterilising materials, should they distribute condoms?).

However, as an overall strategy reaching out to injecting drug users is everywhere acceptable though, as noted above, with varying degrees of policy and resource commitment.

Sterile injection equipment and disinfectant materials

Legal access to sterile injecting equipment has to date been limited to informal or pilot projects in three of the study-countries (India, Nepal and Viet Nam). Very small-scale distribution of sterile injecting equipment has taken place in Malaysia. Nowhere is it public policy to provide cleaning supplies (e.g. bleach) or to supply or exchange injecting equipment. However, if the draft National AIDS Prevention and Control Policy is ratified by the cabinet in India, needle and syringe exchange will be supported in policy in that country. Once again, a number of concerns are commonly expressed. First and foremost is the notion that the provision of needles and syringes will actually encourage drug use, and that the provision of injecting equipment runs contrary to the major objective of all drug policies in all seven countries, which is to attain a drug-free society. There are concerns that in a policy environment where access to sterile injection equipment is sanctioned, drug users will no longer be deterred from experimenting with drugs, safe in the knowledge that not much harm can come to them. This is seen as 'sending the wrong message' and as accepting drug use as a 'social

norm’.

Of equal concern is the observation that in a number of the study-countries, there is a shortage of sterile needle and syringes for use in health care facilities. In these circumstances decision-makers may feel that it is inappropriate to provide free needles and syringes to people who use illicit drugs. Concern is also expressed about the validity and ethics of investing significant resources into assisting drug users when so many other basic health and infrastructure-related needs remain unmet

Other reasons include

- (a) Needles and syringes are inexpensive and can easily be purchased;
- (b) If drug users can afford to buy drugs they could also afford to buy needles and syringes;
- (c) Drug users are knowledgeable about the dangers of sharing needle -- if they share they make an informed choice and must accept the consequences.

However, although it is commonly asserted by professional observers that sterile needles and syringes are easily accessible and affordable, in practice this was not always so in the study-countries. Users were often reluctant to purchase and carry needles and syringes for fear of apprehension by police.

Treatment including substitution therapy

Drug treatment services are available in all seven study-countries. With few exceptions these treatment services are aimed at achieving total abstinence through supported withdrawal (detoxification) from drugs. With few exceptions treatment is residential, lengthy and involuntary. Without exception high relapse rates are reported in all countries, regardless of the methods used for detoxification, rehabilitation and aftercare.

Nowhere in the study-countries are substitution treatments an integral part of drug policy and practice. In some countries methadone is used for short-term detoxification alongside many other (often-traditional) medicines.

- (a) Buprenorphine maintenance is available on a limited basis in India, however, this is not supported in policy.
- (b) Longer term methadone treatment has been available at Bangkok Metropolitan Administration (BMA) clinics since 1988 even though official policy dictated that it should be used for withdrawal purposes only. Methadone has in practice been used as a maintenance treatment in certain circumstances.
- (c) Nepal has one government operated methadone maintenance treatment

programme and the government is planning to undertake an independent review of this programme before considering internal recommendations that methadone maintenance treatment slots be increased in Kathmandu and established in other parts of the country.

However, from the point of view of many in the study-countries, the more widespread, long-term provision of substitution treatments is not seen as appropriate, at least not in the foreseeable future. Furthermore where substitution treatments are considered there is insufficient information about the relative merits of different substitution treatments upon which to make informed choices (i.e., methadone or buprenorphine).

The arguments against substitution treatments in the study-countries include the following:

- (a) The cost of substitution drugs is high. Providing drugs to drug users is not an appropriate use of scarce public resources;
- (b) The use of opioid substitution pharmacotherapy in treatment contravenes the spirit if not the intent of the UN conventions on drugs;
- (c) Methadone is an opioid and as such, its use in treatment is in contravention of the law;
- (d) Prescribing an opioid sends the wrong message both to the drug users and to the community at large. Replacing one drug of addiction with another only adds to the problem and undermine any opportunity that the patient may have to recover from their drug addiction;
- (e) Using traditional medicines to treat drug users is more consistent with cultural tradition and more appropriate;
- (f) Countries do not have the capacity to control the importation, distribution and supply of methadone, buprenorphine and other opioids;
- (g) Methadone or other substitution drugs may be diverted to the illicit drug market;
- (h) Substitution treatments have limited applicability. Most drug users do not need or will not benefit from substitution pharmacotherapies;
- (i) Substitution treatments present too many logistic difficulties for treatment providers;
- (j) The effectiveness of substitution treatments for the prevention of HIV among drug users has not been proven - at least not in Asian countries.

Summing up it can be observed that there is no consensus in the seven study-

countries on the best ‘mix’ of drug and HIV prevention approaches nor on how to conduct these interventions. Many important services are at present provided by non-governmental organisations or international organisations and most are offered in the form of pilot projects.

Table 1.2 Summary of selected key factors that impact on HIV/AIDS vulnerability among injecting drug users in the study- countries

	China	India	Malaysia	Myanmar	Nepal	Thailand	Viet Nam
	Legal aspects						
Drug control policy lead agency	NNCC ²⁸	MoR, MoSJE ²⁹	MoHA/ NNC ³⁰	CCDAC ³¹	MoHA	ONCB ³²	VNDCC ³³
Specific legal constraints to reducing the harm from injecting drug use	Narcotics Drug Control Act specifies: methadone only for medical purposes	MMT not lawful; Gov. outsourcing to NGOs;	MMT & NSEP not lawful; Gov. Outsourcing to NGOs; IDUs treated as criminals	Users who do not register sent to prison; Burma Excise Act prohibits carrying needles	Gov. outsourcing to NGOs, IDUs treated as criminals	MMT not legitimised in law ³⁴	None evident.
Use of drugs an offense in itself	yes	yes	yes	yes	yes	yes	yes
Possession of needle and syringes unlawful	no	no	no	yes	no	no	unclear
Police often arrest people for possession	no	yes	yes	yes	yes	no	no

28 National Narcotics Control Commission

29 Ministry of Revenue, Ministry of Social Justice and Empowerment,

30 Ministry of Home Affairs, National Narcotics Agency

31 Central Committee for Drug Abuse Control

32 Office of Narcotics Control Board

33 Viet Nam National Drug Control Committee

34 Draft bill will legitimise MMT in Thailand, if accepted by parliament

Table 1.2 Summary of selected key factors that impact on HIV/AIDS vulnerability among injecting drug users in the study- countries (cont.)

	China	India	Malaysia	Myanmar	Nepal	Thailand	Viet Nam
Drug treatment							
voluntary	yes	yes	yes	nominally	yes	yes	yes
compulsory	yes	no	yes	yes	yes	yes ³⁵	yes
both	yes	no	yes	yes	yes	yes	yes
drug-free only	yes	no	yes	yes	no	no	yes
methadone for detoxification	yes	rarely	rarely	no	no	yes	no
Lead agency	Ministry of Public Security	MSJE	MoHA	Ministry of Health	Ministry of Health	Ministry of Health	Ministry of Labour, Invalids and Social Affairs
Prevention of HIV transmission among drug users							
Substitution therapy	no (Hong Kong: yes)	limited ³⁶	no	no	limited ³⁷	yes	pilot only
NSEP ³⁸	no (Hong Kong: accessible)	limited ³⁹	no	no	limited ⁴⁰	no ⁴¹	yes
IDU peer led approaches	limited to some provinces	limited	limited ⁴²	limited	limited	no	yes
Opposed to substitution therapy	yes	yes	yes	yes	no ⁴³	no	no
Willing to consider	no support	yes ⁴⁴ , buprenorphine methadone no	yes, perhaps	no support	yes ⁴⁵	ongoing	yes
Opposed to NSEP	yes	no	yes	no	limited support ⁴⁰	unclear	no
Willing to consider	no support	draft policy support	no	no support	National HIV Prevention Plan supports	no support	ongoing

35 Provided for in law but not yet implemented

36 Limited buprenorphine withdrawal and de facto maintenance programmes in operation in several cities

37 One programme in Kathmandu only

38 Needle and syringe exchange or distribution

39 There are NSEPs in Manipur and Calcutta and non-sustained pilot programme in Chennai. However, draft national AIDS Prevention and Control Plan includes NSEP as a strategy to be implemented

40 Except small programmes in Kathmandu and Pokhara

41 Small programme serving Akha Hilltribe people north of Mai Chan

42 Generally focus on abstinence-only messages rather than harm reduction/ HIV prevention

43 But reluctant to scale up until independent evaluation of current programme is undertaken

44 Draft national AIDS Prevention and Control Plan includes NSEP as a strategy to be implemented

45 But have turned a blind eye to two small programmes

Table 1.2 Summary of selected key factors that impact on HIV/AIDS vulnerability among injecting drug users in the study- countries (cont.)

	China	India	Malaysia	Myanmar	Nepal	Thailand	Viet Nam
Opposed to peer education	no, ongoing	no, but no clear support	not signalled yet	no	unclear	unclear	no
willing to consider	n/a	n/a	not signalled yet	n/a	undertaken by NGOs only	no	yes
Policy and programme issues							
Drug use addressed in last HIV/AIDS national plan	yes	yes (inadequate)	yes (inadequate)	yes (inadequate)	yes (inadequate)	no	yes
HIV/AIDS addressed in last national drug plan	no	no	no	no	no	no	yes

Table 1.2 summarises a number of key legal and policy factors as they apply to drug-related HIV/AIDS vulnerability in each of the study-countries.

The table 1.2 also provides information on:

- (a) The lead agency that deals with drug control in each study-country
- (b) The legislation that governs drug control and
- (c) The kinds of drug treatments and other interventions that are available

E. Reducing the harms: constraining and facilitating factors

While there were distinct between-country differences, information and documentation collected from country visits suggests that a number of common ways of conceptualizing drug problems, their determinants and their solutions have guided approaches to drug treatment and HIV prevention. Most of the study-countries have emphasized one or a combination of education and life skills development, institutional drug treatment and rehabilitation of an involuntary nature and punishment for the purposes of deterrence, as lead strategies in their efforts to prevent and eliminate drug use.

A number of factors constraining the application of policies supportive of HIV prevention among IDUs have been identified in all countries. So too have a number of enabling factors, albeit smaller in number. These are described in detail in each of the country reports. Below is an overview of the some constraining and some enabling factors that have been observed. Examples from the study-countries will be used to illustrate these - but are not designed to

be comprehensive or definitive or to provide comparisons between the study-countries.

Constraining factors

A perspective that dictates that a drug-free society is the only acceptable objective for drug policy can impede strategies that are more accepting of short and intermediate treatment goals. So too, historical, social, religious, cultural and economic factors have a critical influence on drug control and HIV prevention policies. Strongly held beliefs about drugs and their adverse effects on the fabric of society, adverse national experiences about drug use in the past, as well as the extent and seriousness of past and present drug problems can militate against the adoption of more tolerant attitudes towards drug use.

For example:

In China the government having successfully eradicated opium addiction after 1949 among an estimated 25 million addicts, now adopts 'a clear-cut stand' against drugs and is determined to eradicate drug use. The State Council has issued emergency notices on cracking down on drug abuse and calling on the whole people to fight against drugs.⁴⁶

In Malaysia, the view that drug use is incompatible with the core values of Islam is expressed through the National Narcotic Drugs and Psychotropic Substances Act (1976) which prescribes severe punishment for drug-related offences.

In all the study-countries there are *many competing health and welfare priorities* and insufficient financial and human resources to meet all needs. Some governments have been slow to recognise the potential seriousness of the HIV/AIDS problem, for example in Myanmar where very few resources are allocated to HIV/AIDS prevention and where media campaigns to prevent HIV are limited by religious and cultural sensitivities. Overall, the control of the distribution and sale of some psychoactive drugs through unauthorised pharmacies is inadequate.

Drug users are rarely accorded high priority where services are concerned, are frequently at the margins of society and form minority or mobile populations. In a number of the study-countries, there is a serious shortage of sterile needle and syringes for use in health care facilities and in these circumstances decision-makers feel that it is inappropriate to provide free needles and syringes to people who use illicit drugs. Methadone for use as a substitution treatment is considered expensive in most of the study-countries and is available for longer-term treatment only in Thailand and in one programme in Nepal. Ambulatory

46 China's Battle against Narcotics 1998

approaches to drug treatments that are more economical than lengthy residential treatments do not appear to have been given serious consideration as an alternative to residential treatment. Where drug use is a major problem in the rural areas (e.g. China, Myanmar, Viet Nam) ambulatory treatment may indeed be unsuitable at present because of the absence of adequate transport and communication facilities and the scarcity of suitably skilled primary health care staff.

The understanding about the determinants and consequences of drug use and drug dependence is limited: Many decision-makers, most of whom are not specialist in the drug and HIV field may have inadequate access to knowledge and understanding about drug use. In most of the study-countries no differentiation is made between dependent or non-dependent users, and even- occasional drug users may find themselves in long-term residential treatment facilities. A significant penal element is present in most of the treatment services in the seven study-countries. Most of the explanations put forward about the reasons for drug taking centre upon the notion that drug users fall prey to the bad influence of their peers. Stopping drug use is regarded as a simple matter of correct information, better life-skills, will power and a commitment to changing 'wrong thinking'. It is assumed that addicts will respond positively to coercion (by the police, family, community etc.) and to detoxification treatment. If that fails longer treatment or a gaol sentence will surely 'convince' people to stop using drugs.

Despite evidence of increasing drug problems in the seven study-countries, little expertise has been developed in identifying and targeting high risk and vulnerable groups. Furthermore, although relapse rates after treatment in the study-countries is uniformly high, there is an unwillingness at present to re-examine treatment approaches.

Drug treatments is often provided by non-specialists with limited knowledge about drug treatment: In some of the study-countries treatment services are provided by people who possess no specialised knowledge and skills in the area of drug dependence.

For example

In China the Ministry of Public Security is responsible for the majority of treatment centres

In Viet Nam the Ministry of Labour, Invalids and Social Affairs is responsible for treatment and rehabilitation services.

In India and Nepal non-governmental organisations provide the majority treatment services.

In Malaysia the Ministry of Home Affairs and the Prisons Department

are responsible for drug treatment programmes.

It is only in Thailand and Myanmar that the bulk of treatment and rehabilitation effort is provided by the health authorities. In some countries treatment services contain a strong penal element.

Insufficient access to scientific and research evidence and a paucity of local research and reliable follow-up data make it difficult for policy makers and treatment personnel to develop ‘evidence based’ approaches. There is little systematic information about the life-experiences of drug users: the extent, frequency and patterns of drug use, needle and syringe sharing practices, experiences with law enforcement, perceptions of the available treatment and rehabilitation facilities and on sexual practices.

The drug treatment systems employ limited approaches and methodologies and although considerable resources are often expended on drug treatment, outcomes are often disappointing. The following salient features of treatment in the study-countries have been noted:

In most study-countries treatment is predominantly residential and compulsory. Because most treatment facilities offer similar treatment programmes, drug users have little or no choice in the selection of treatment goals or treatment modalities and there are few ambulatory, low threshold and ‘user friendly’ treatments.

When voluntary treatment is an option it is expensive.

Treatment is most often focused on detoxification, achieved by a range of approaches. Some detoxification treatments are provided without pharmacological support or with the help of tranquillisers or analgesics. Sometimes traditional methods such as herbal medicines, acupuncture are used. Some countries use opium tincture for detoxification (e.g. Myanmar) and others use methadone (e.g. some treatment centres in China, Thailand). Some countries place emphasis on strict military type discipline, work and recreational therapy (e.g., China, Malaysia, Nepal and Viet Nam). Ancillary services such as counselling and other psychosocial or family focused interventions are rarely provided.

There are no treatment facilities in any of the seven study-countries, which target those with special needs (e.g. internal or cross-border mobile populations, homeless people, street children, sex workers, and women with children).

There are only few examples in the study countries where active measures are undertaken to prevent relapse.

Treatment centres have little experience in dealing with drug users positive for HIV. Some discharge or segregate them. None offer sustained long-term help.

Professional training in drug and HIV prevention interventions are

inadequate in all study-countries and access to scientific journals, books and other information is limited.

Government contracting-out (outsourcing) of prevention and treatment services to non-governmental organisations can hinder effective drug use and HIV prevention. It sometime reflects 'abdication' by governments of their responsibilities for the adequate provision of services to drug users and for monitoring and evaluating and ensuring standards development. For example:

In Nepal the bulk of treatment and rehabilitation services are provided by non-government agencies. The government contributes little to the cost.

In India, drug treatment services are 'contracted out' to the non-government sector, though 90-95 per cent funding is provided.

It is important to point out, however, that encouraging non-governmental organisations to participate and take a lead role in service provision for drug users, is useful as an effective and low-cost method for increasing access to help and increasing the range of services.

There are insufficient efforts to create partnerships between drug and HIV/AIDS control agencies, to harmonise policies and to achieve compatibility and congruence between the two. Few of the National AIDS Plans in the region pay sufficient specific attention to the needs of drug users. Few current National Drug Control plans make mention of HIV/AIDS prevention.

Insufficient attention is paid to bringing the drug treatment and HIV prevention sectors and drug law enforcement sectors into closer alignment. Any strategy that aims to maximise treatment seeking, treatment retention and the improvement of treatment outcomes for drug users requires close co-operation with the law enforcement sector. Where drug users are subjected to severe legal sanctions, and where the local police are unsympathetic to the prevention and treatment objectives, drug users are unlikely to avail themselves of treatment services.

In some of the study-countries law enforcement and supply reduction may be associated with shifts in the types and methods of drug use from those that posed less public health hazards to those posing greater health risks. For example:

In India the introduction of the Narcotic Drugs and Psychotropic substances Act of 1985, which prohibited the use of opium may have contributed to an increase in heroin use in the country.

Thailand's successful eradication of opium cultivation in the Northern Highlands may have inadvertently contributed to the emergence of injecting drug use among the hill people and to the rapid spread of HIV/AIDS among them.

The policy making process in all study-countries is difficult to determine. It is

very difficult to determine how decisions about drug and HIV/AIDS policies are made at national and provincial level, and the extent to which scientific or other evidence is taken into consideration or the fidelity of policy implementation and its impacts and outcomes. Although in most of the study- countries, drug and HIV/AIDS policies are reviewed from time to time, if only to determine priorities and budgets, it is unclear whether during the process account is taken of local and international evidence on what ‘works’.

Determining the policy process is an especially complex matter in countries that have limited democratic institutions but it is by no means limited to such political circumstances.

Governments anxious to adhere to the terms of the UN conventions on drugs sometimes misinterpret the meaning and intent of the conventions. For example, some countries fail to exercise the autonomy afforded by the conventions to implement drug laws that are most appropriate to their own circumstances. Three issues were identified as impeding effective policies and strategies to prevent HIV among injecting drug users.

The first is the ‘*criminalisation*’ and the punishment of drug use itself⁴⁷.

The second concerns the possession of needles and syringes and other drug use paraphernalia and the extent to which these may be used as evidence in convicting drug users for possession and use.

The third concerns the legitimacy of prescribing of opioid agonist pharmacotherapy as a maintenance substitution treatment.

While the UN conventions on drugs are themselves designed and motivated by a wish for a ‘drug-free world’, they make provision for more realistic and achievable outcomes. For example, *the Single Convention on Narcotic Drugs, 1961* was amended by the *1972 Protocol* highlighting the need to provide treatment and rehabilitation to drug users, stressing that this should be considered an alternative or in addition to imprisonment. The amendment to the 1988 Convention against Traffic in Narcotic Drugs and Psychotropic Substances, although confirming that drug use should be regarded as a criminal offence offers a wide range of options for punishment - ranging from prison to a fine to compulsory treatment.

Lack of unanimity on the best approaches to HIV/AIDS prevention among UN agencies and other international organisations confuses local policy makers. Although there is some agreement on many issues pertaining to the prevention of HIV/AIDS among drug users, certain disagreements remain and these impede policy development. For example, the use of terminology has

47 This matter is discussed in some details elsewhere in the document

posed some real difficulties. The terms ‘harm reduction’ or ‘risk reduction’, which are sometimes used as a shorthand way of describing a range of practical approaches to preventing HIV transmission, have become associated with ‘legalisation of drugs’ and with the negation of the ‘drug free’ objective and consequently regarded as politically unacceptable. In fact the strategies that are commonly subsumed under the ‘harm reduction’ term are ‘public health’ approaches to prevention of ‘harms’ that are recommended by the WHO and others.

It is evident that drug policies are highly politicised and matters other than evidence or common sense are often decisive when policies are developed. The activities of UN and other international agencies working at country level themselves reflect the lack of clarity on this matter and are therefore seen as giving mixed signals to local decision-makers.

Facilitating factors

This research identified many opportunities for change in the study-countries and a general willingness to consider alternative approaches to drug control and HIV prevention. Although all countries espoused the ‘drug-free’ principle it was noticeable that in some countries drug policy objectives are being revised to incorporate at least some HIV prevention activities. Some policy makers expressed the view, that a more realistic approach to the drug issue ought to be adopted, may be to ensure there is no ‘increase’ in drug use rather than the somewhat utopian objective of a ‘drug-free’ world.

The need for effective prevention is universally recognised in the study-countries: Prominent is the realisation that HIV/AIDS is a major public health problem which requires serious attention and some politically and culturally awkward approaches (e.g., targeting brothel owners, sex workers, their clients, drug injectors and even ‘professional’ injectors). Many acknowledge, albeit grudgingly, that even though drug users are not in themselves a high priority target group for health and social intervention, that if they are not assisted to protect themselves from HIV infection they may act as an efficient vector for the further spread of the disease.

There was general commitment in all the study-countries to information, education and communication approaches, which though not sufficient in themselves provide a basis upon which more effective and targeted interventions can be built. Although there was unanimity in concluding that detoxification treatment and other abstinence oriented treatment continue to yield disappointing results, nevertheless many decision-makers appear to cling to the hope that if current approaches can only be implemented with more resources and more commitment, these approaches will succeed. The HIV prevention

interventions that are most acceptable in most study-countries are outreach and peer-education and this was actively promoted in some of the study-countries (notably Myanmar and Nepal). In some countries peer-educators were tolerated if not actively encouraged (e.g. Malaysia). In Viet Nam and in certain cities in India outreach workers are able, under certain circumstances, to provide small quantities of injecting and cleaning materials as well as condoms to injecting drug users. However, these are token in nature and not of a scale that would have a population level effect.

Legal impediments to the development of new prevention strategies were not necessarily serious. It is not always easy to determine whether it was the law itself that impeded the development of approaches to allow interim prevention goals for drug users or whether it is the local interpretation of the law. A close examination of the legislation in the study-countries, revealed that quite minor amendments to regulations were needed to facilitate or legitimate new approaches. For example:

In Thailand, although substitution treatments (methadone) have been available in Bangkok for 10 years, it is only now that the Ministry of Public Health is putting forward the appropriate legal amendment to officially enable clinics to provide this treatment.

In some countries where certain regulations do indeed present real difficulties (e.g. Section 15 of the 1993 Narcotics Drugs and Psychotropic substances in Myanmar⁴⁸) there is an ongoing debate and discussion in country about the advisability of retaining the regulation.

Opportunities for prevention activities exist in all countries. Even though certain interventions have proven useful in Europe, Australia or the USA policy makers in the study-countries do not necessarily favour them. Nevertheless, there seemed to be ample opportunities for national and local actions. It is also evident that in many of the study-countries provincial and district authorities enjoy considerable autonomy to interpret national policies in accordance with their local circumstances (e.g., in China)⁴⁹. In some countries non-governmental organisations are able, for example, to legally distribute needles and syringes to users, even though it is not official government policy (e.g., in India and Nepal). This distancing from the national level policy directives has provided some opportunities, albeit limited, to develop projects where they are needed.

It is important to note that even in the absence of formal policy support for certain preventive approaches, pilot projects are often acceptable and can therefore be put to better use. Pilot programmes should be adequately monitored

48 see Myanmar country report for a further discussion of this law.

49 See China country report

and evaluated and could also be used to explore ways of adapting proven and successful preventive approaches from outside the region to satisfy Asian values and traditions.

UNDCP's membership of UNAIDS as a co-sponsor offers opportunities to harmonise the policy frameworks and goals of HIV prevention and drug control and may move some way towards bringing HIV/AIDS and drugs policies closer together. The need for multi-sectoral and comprehensive responses and the absence of consensus between and within international agencies has already been noted. While agencies' different mandates and responsibilities may present barriers to the development of comprehensive interventions, nevertheless UNDCP's recent co-sponsoring of UNAIDS signals its commitment to HIV prevention among drug users.

V. DISCUSSION

The role of United Nations guidelines in drugs and HIV/AIDS prevention

Below is a brief review of the guidelines and advice provided by key UN agencies i.e. the World Bank, UNDCP, WHO and UNAIDS on drug use and HIV vulnerability and the extent to which these were applied in the study-countries.

The *World Bank* in a Policy Research Report on AIDS (1997) notes that there is considerable evidence that HIV transmission can be slowed down dramatically by effecting changes in the behaviours of drug users (especially if they reduce the number of sexual and drug injecting partners and use condoms and sterile injecting equipment).

The *UNDCP* whose role is to provide support and advice to states on drug prevention, treatment and rehabilitation - or demand reduction promotes a 'balanced approach' to drug control. Supply reduction such as policing or alternative development to drug cultivation should be counter balanced by demand reduction. The concept is explained thus:

"The distinction between demand reduction and supply reduction is that demand reduction activities are concerned with the drug abusers or potential abusers, while the latter concentrates on stopping illicit production and trafficking. The interrelationship between the two can be seen when producers begin to consume part of their own illicit production, when traffickers pay for co-operation with illicit drugs along the supply route, and when the end user, the drug abuser sell illicit drugs to pay for

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and obtain their own supply thus supply may help create and augment demand and demand sucks in supply of illegal drugs”⁵⁰

Further guidelines to states on demand reduction was included in the Declaration on the Guiding Principles of Demand Reduction which UNDCP proposed to the General Assembly of the United Nation in June 1998. Although HIV/AIDS is not mentioned as a specific consequence of drug use the declaration proposed that demand reduction should cover all areas of prevention from discouraging initial use to *reducing the negative health and social consequences of drug abuse*. Furthermore, it notes that drug demand reduction should be integrated into broader social welfare programmes, included in health promotion and preventive education programmes so as to ensure an environment in which healthy choices become attractive and accessible. Importantly, the declaration suggests that demand reduction policies should be based on evidence and knowledge acquired from research and from lessons learnt from past programmes. Systematic and periodic assessments of drug problems are to be encouraged, as are careful evaluation of ongoing policies and programmes.

In the study-countries a ‘balanced approach’ is accepted but not necessarily practised. Law enforcement expenditure and resources invariably exceed all demand reductions resources and efforts. The proposal that countries should reduce the negative health and social consequences of drug abuse are only partially heeded if HIV/AIDS, which constitutes the most serious potential harm, is not adequately dealt with. Moreover the suggestions that demand reduction policies should be based on evidence and knowledge from research and other programmes is likewise rarely considered.

The *WHO* articulated the principle of ‘Health For All’ in a number of declarations.⁵¹ The need to ensure that drug use and HIV prevention should be dealt with in the context of public health is made clear. Drug use should be addressed through public health interventions as one of the many ‘harms’ in the population.

In the study-countries the public health approach is not generally extended to drug users. It is evident that the ‘harms’ associated with drug use are not generally addressed because such an approach is seen to conflict with drug control policies. In addition, a much quoted findings from experience worldwide by WHO recommends that activities to prevent the spread of HIV among IDUs should begin early (before the prevalence reaches 5%). This advice is all too often ignored.

51 The Declaration of Alma-Ata on Primary Health Care (WHO 1978), Global Strategy for Health for All by the Year 2000 (WHO 1981) and the Ottawa Charter on Health Promotion (WHO 1986)

UNAIDS whose co-sponsors include WHO, UNDCP and the World Bank, presented the United Nations General Assembly at the Special Session on Drugs (March 1999) with a statement advocating the following key measures for strengthening effective HIV prevention programmes:

Early interventions while the HIV prevalence is still low

Providing a comprehensive package of measures to include sterile injecting equipment, raising awareness among and educating injectors and their sexual partners, and

Making available drug treatment programmes, providing access to counselling and to care and support for HIV infected injectors and providing condoms.

UNAIDS singles out outreach and peer-education programmes as effective ways of reaching drug users who constitute a 'hard to reach' population. Beyond specific prevention approaches UNAIDS highlights the need to ensure a supportive environment within which these programmes can be implemented.

The report indicates that in order to create such environment it may be necessary to challenge and change the ways in which the community regards drug users (e.g., as a criminal, the perpetrator of social evil, a deviant, a subversive), and the ways in which drug users are managed (e.g., involuntary or compulsory treatment, imprisonment).

It is evident that there are many opportunities in the study counties for improving policy and interventions on preventing HIV/AIDS among drug use in ways that will be fully supported by the international community.

The impact of UN Conventions on national drug control legislation

It is important to dispel the notion that the UN Conventions on illicit drugs recommend heavy penalties for drug possession or for personal consumption. Nor do the conventions rule out the use of agonist pharmacotherapies such as methadone maintenance or buprenorphine treatment or prescribe that national laws should prohibit the implementation of programmes that facilitate access to sterile drug injection equipment.

In fact, the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances is the only one that addresses the issues of punishment for drug use per se stating that:

'...each party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intention-

52 Commentary on the United Nations Convention Against Traffic in Narcotic drugs and Psychotropic Substances 1988 (December 1988)

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ally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption’.

However, it is made clear in the Commentaries to the Convention that governments can choose between wide ranges of judicial responses. The offence of ‘possession of drugs for personal consumption’ may for example be punished by a fine or by simple censure and not necessarily by a prison sentence.⁵² This confirms what has already been discussed namely that national laws can legitimately facilitate strategies designed to help prevent drug users from becoming infected with the HIV.

Summary

It is clear from the findings reported above that injecting drug use is a major vector for HIV transmission in all the countries examined in this study. Of all the different ways that the AIDS virus can be transmitted, directly injecting a substance contaminated with HIV into the blood stream is by far the most efficient. It is also evident that injecting drug use contributes disproportionately to the scale of the epidemic in the region.

However, despite widespread high risk behaviours among drug users none of the study-countries (with the exception of Viet Nam) include in their stated public policies the kind of measures to prevent HIV/AIDS among drug users and their sexual partners advocated by scientific community and UN agencies. To-date, there are relatively few programmes in the region, which directly address problems presented by the interface between drug use and HIV/AIDS.

As indicated in this report, there is little dialogue between drug prevention and treatment, law enforcement and HIV/AIDS prevention authorities and while a number of the study-countries have nominally established multi-sectoral responses these are yet to be rendered effective in most cases.

Drug treatment generally focuses on detoxification treatment only, and in all seven study-countries, drug users are afforded limited access to voluntary treatment. In the main, drug treatment is of a compulsory nature and includes a strong penal element. In general, drug policies are not supportive of effective HIV prevention strategies among drug users. Measures are often localised, short-term, under-funded, and insufficient in scope. Even where policies targeting vulnerable groups are favoured by policy makers they are not necessarily translated into practice, because of insufficient resources and inadequate training.

The challenge remains to identify factors that might facilitate change, and to identify useful opportunities and levers that might lead to policy changes in the direction of a more benign and effective policy improving the efficacy of HIV/AIDS prevention. Such opportunities exist in all study-countries. Many policy makers are beginning to accept that although the goal of a drug-free society is preferable, it might be difficult to achieve in the short term and that the threat³¹ of the HIV epidemic necessitate some interim measures to keep the epidemic

CHAPTER 2
PEOPLE'S REPUBLIC OF CHINA

CHAPTER 2

CHINA

I. SUMMARY OF FINDINGS

China's experience with large scale opium addiction prior to the establishment of the People's Republic in 1949 has resulted in its determination to be a drug free society.

Few activities other than a small number of 'pilot projects' are at present specifically targeted at reducing the risks of HIV/AIDS among injecting drug users.

Very few such approaches designed specifically to reduce the harm from injecting drug use are favoured in China at present.

The responsibility for drug treatment is shared between the Ministry of Public Security and the Ministry of Public Health. Each brings a different perspective to the problems of drug treatment but neither is supportive of strategies targeted specifically at reducing the risk of HIV infection among injecting drug users.

Methadone can legally be used only for medical purposes. Some treatment facilities run by the Ministry of Public Health use methadone for detoxification. Extending its use is generally regarded as inappropriate and expensive.

Needle and syringe exchange or distribution is generally seen as redundant.

Although the government ministries in Beijing provide guidelines and assistance in strategic planning, budgets and activities are determined on the provincial, district and commune level and can thus be responsive to local need. This provides the opportunity of matching interventions to local needs.

Pilot projects are generally welcomed in China and can be used to demonstrate usefulness and efficacy if properly monitored and evaluated. So far they are rarely if ever expended or sustained after the end of the pilot.

Out-reach and peer led activities are acceptable and could be extended if funding and training are made available.

II. RECOMMENDATIONS

UNAIDS can play a role in consensus building by resolving some of the conflicting aims and priorities within key agencies (e.g. the Ministry of Health, the Ministry of Public Security, the National AIDS Programme, UNAIDS, UNDCP etc.).

UNDCP's co-sponsoring of UNAIDS provides the opportunity for joint programming where HIV infection among injecting drug users is occurring.

Chinese scientists could be encouraged to develop culturally acceptable approaches to reduce the risks of HIV infection among injecting drug users.

Community based approaches that include community mobilisation and community support for relapse prevention are acceptable and should be developed. Special attention should be given to making these approaches relevant to the HIV/AIDS epidemic.

Out-reach and peer education activities should be developed to include information on needle sharing and sexual transmission.

Consideration should be given to needle and syringe distribution (or exchange) and condom distribution.

Chinese authorities should give urgent attention to developing programmes in provinces where HIV prevalence among injecting drug users is still low.

Much could be done to improve the existing treatment and rehabilitation services for drug users in China. Shorter, non-institutional treatments should be considered along with more effective relapse prevention and rehabilitation.

Training in the fundamental concepts of addiction would be useful to the treatment community. Often casual and occasional users are confused with drug dependent individuals.

China should also give consideration to developing further its alcohol policies to include education on safe drinking limits and the effects of uncontrolled drinking. Heavy drinking is a feature of many social gathering in China and can thus prove to be a serious risk factor for unsafe sex and the transmission of HIV.

III. INTRODUCTION

When the People's Republic of China was established in 1949 there were some 20 million opium users in China. At the beginning of 1950, the Government Administration Council issued the order prohibiting the taking of opium. This

led to a nation-wide drug prohibition campaign. Opium and other dangerous drugs were confiscated, the growing of opium was prohibited, opium dens were closed, drug users were rehabilitated and people growing opium or trafficking in drugs were severely punished. Over 369,700 people who were involved in drug production or trafficking were rounded up and punished and thousands of drug users were treated of their addiction. China was able to maintain a drug free status for the next 30 years (Zhang Chongde and Chen Yuan, 1998).

Drugs began to re-emerge as a problem in the early 1980s but China adopted a vigorous and resolute policy to fight drug use a policy which, is profoundly determined by China's previous experience of large-scale opium addiction.

The HIV/AIDS epidemic in China that emerged in the 1990s is closely linked to injecting drug use. As in other countries in the East Asia region (notably Thailand and Myanmar) the epidemic seems to have been 'jump-started' by drug users and although the epidemic is spreading to other groups they still represent the largest numbers of infected individuals in China. It is critical therefore to examine strategies in China that straddle these two overlapping issues.

IV. FINDINGS

A. Epidemiology of Drug Use

Drug trafficking and drug use began to re-emerge in the early 1980s and there has been a steady increase in the numbers of illicit drug users ever since. At first identified drug use was localized in border areas with Myanmar particularly in Yunnan province and was practised mostly among minority groups. From the mid 1980s the numbers of drug users began to spread inland. Drug use has since spread to as many as 1924 counties in China. The emergent drug use patterns vary from region to region but general trends suggest a move from opium smoking to heroin that is either smoked or increasingly used by injecting. Official information provided by the National Narcotics Control Commission (NNCC) is described in Table 2.1.

However, the true extent of illicit drug use is difficult to determine. Drug use is severely punished and is likely therefore to be kept secret and furtive as much as possible. Moreover the system used to collect official data which result in registration does not adequately reflect the real situation. (See note on data gathering in later section).

Nevertheless there is evidence that the majority of registered drug users (about 80%) are young and male and that an estimated 2/3 of them inject drugs (Source:

Table 2.1 Number of registered drug users in China

Year	Number of registered drug users
1990	70,000
1991	148,000
1992	250,000
1994	380,000
1997	540,000

Source: China's Battle against Narcotics

NNC Bureau briefing). It is noteworthy, however, that in a report comparing the drug use situation between 1993 and 1997 in Wuhan, the ratio of female drug users had increased from 18.5% to 35.8%. Research evidence about injection use is somewhat more equivocal and reflects some regional and temporal differences but suggests that the transition from smoking to injecting is rising in most sites. The sharing of needle and syringes has been reported to be commonplace in various parts of China and re-usable glass syringes are most frequently used with varying attention to sterilization. In many parts of China disposable needles and syringes can be obtained easily and cheaply (1 Yuan). However, in some regions particularly in remote areas needle and syringes are not easily obtained and drug users have been known to use home made paraphernalia.

In Yunnan, Xinjiang, and Guangxi there are high numbers of heroin users while in Neimenggu (Inner Mongolia), Ninxia autonomous Region, Qinghai and Hebei there is a greater proportion of opium smokers.¹

B. Mechanisms for Drug Control

China's legal framework for drug control was formulated in 1979 and was part of the Criminal Law. It imposed severe punishments for the manufacture, trafficking and supply of illicit drugs. Ten years later, the State Council of the People's Republic of China promulgated the Procedures for Narcotic Drugs Control (in 1987) and the Procedures for Psychotropic Substances Control (1988). The Decision of the Standing Committee of the National People's congress on the Prohibition Against Narcotic Drugs, which was adopted at the 17th meeting of the Standing Committee of the 7th National People's Congress in December, 1990 set out the regulations and penalties for drug trafficking, possession and use. It specifies the following in Section 8.

1 China responds to AIDS: HIV/ AIDs situation and Needs Assessment Report. Ministry of Health with UN Theme group on HIV/AIDS in China Nov. 1997

Whosoever ingests or injects narcotic drugs shall be punished by the public security organ with detention of not more than fifteen days, and may simply or concurrently be punished with a fine of not more than 2,000 yuan, and the narcotic drugs and the instruments used for drug ingestion or injection shall concurrently be confiscated.

Whosoever addicted to drug ingestion or injection shall, in addition to being punished as provided in the preceding paragraph, be forced to quit the addiction and be subjected to treatment and education. Persons who ingest or inject narcotic drugs again after being forced to quit may be subjected to rehabilitation through labour and shall be forced to quit during the period.

The National Narcotics Control Commission (NNCC) was established in 1990 by the State Council and consists of personnel from 23 governmental and mass organizations. Its role is to provide a unified leadership for narcotic control, to coordinate the efforts to solve major problems and to formulate principles and policies. Executive organs for narcotic control were also established in all provinces, municipalities and autonomous regions in China directly under the central government.

In 1998 after the First Session of the 9th National People's Congress, the Ministry of Public Security was empowered to assume overall leadership for China's narcotics control under the direct leadership of the State Council.

The essence of China's drug policy is as follows:

'Prohibiting trading in drugs, taking narcotic and planing poppies simultaneously, eradicating sources of drugs and obstructing channels of trafficking, enforcing the law strictly and solving the problem by examining both the root causes and its symptoms' (NNCC)

Possession of drugs is severely punished e.g. the possession of 50 grams of heroin or 1000 grams of opium can result in imprisonment of not less than seven years or life imprisonment. Those who smuggle, traffics in, transports or manufactures narcotic drugs incurs heavy penalties and may under certain conditions be sentenced to death (Decision of the Standing Committee of the National People's Congress, 1990).

In January of 1995 the State Council promulgated the *Procedures for Compulsory Drug Addiction Rehabilitation*. According to the regulations, drug users are made to receive medical and psychological treatment as well as education in China's legal system and public ethics until their addiction is cured. China has clearly articulated policies on drug use. These can be summarized as follows:

"To check the increase of drug addiction, effectively and thereby eradicate drug-related crimes, the Chinese government will improve and strictly implement various measures in accordance with the regulations of the *Procedures for Compulsory Drug Addiction Rehabilitation* formulated by the State Council; all addicts will be **forced** to undergo

treatment. Those who relapse will be sentenced to re-education through labour. For those who have given up drug addiction, the work to keep them healthy both physically and mentally must be done well”.

From: China's Battle Against Narcotics (1998)

The government's policy is to actively rehabilitate drug users. It is the duty of the local government to organize Public Security, Judicial, Civil and Public Health Departments to carry out the work of compulsory rehabilitation. The process of compulsion varies and depends on the local authorities and the public security personnel. Those detained by officers of the Ministry of Public Security on suspicion of drug use are first persuaded to come off drugs in their own homes under supervision by the police. Alternatively they are encouraged to enter voluntary treatment in one of the facilities run by the Ministry of Health. But, when this persuasion and voluntary measures fails, drug users are invariably sent to compulsory centres. The judicial treatment centres are used for those who have committed offences (in addition to using drugs).

C. Drug Treatment

By the end of 1997, 695 compulsory treatment centres had been established consisting of 77,000 beds at which 183,000 drug users had been treated. In addition there are 86 treatment and rehabilitation centres through labour to which so far 210,000 drug users had been admitted (NNCC briefing). Altogether China has quadrupled its capacity to treat drug users in the last 5 years. At compulsory treatment facilities symptomatic treatment is provided for detoxification using both western and traditional Chinese medicines. The compulsory treatment generally lasts between 3-6 months but may be as long as one year.

The role of Health Services

Following the restructuring of government departments the responsibility for this matter has been given to a newly established department the State Drug Administration (SDA) which has been likened in China to the US Federal Drug Administration. This is an independent department, established in October 1998, which works in collaboration with the Ministry of Health but is not part of it. Not all its functions have as yet been determined. That means that they have wide ranging responsibilities for food safety and for the approval of drugs for use in China including the treatment of illicit drug users. The Ministry of Health is only involved to the extent that some of the treatment centres are situated within hospitals run by the Ministry.

There are over one hundred treatment facilities managed by the SDA treating

some 10,000 patients every year. These are closed units located within Psychiatric Hospitals, which means that although entry to treatment is voluntary the treatment itself is compulsory; once a drug user enters the treatment unit she/he signs an agreement that she/he will not leave until treatment is completed. Thus the voluntary treatment centres collaborate closely with the public security departments. Treatment in voluntary establishment has to be paid for by the patients and the cost varies from about 2000-5000 Yuan per treatment and is a considerable sum relative to average income. A variety of drugs are used in the voluntary treatment centres, many of which are Chinese herbal medicines. There is a great deal of work in the scientific research community to develop better drugs for detoxification using local herbs and traditional methods (including acupuncture). Research is also focused on drugs that may be used to prevent relapse and to deal with the longer-term consequences of detoxification such as chronic insomnia. It is noteworthy that some of the more promising herbal medicines have been found to be too expensive for general use.

Methadone

Some voluntary treatment centres use methadone for detoxification but its use is strictly regulated. Methadone treatment was the responsibility of the Ministry of Health and now of the SDA and it is for them to determine its use. However, because the Ministry of Public Security has been given a lead role in drug control, any change in use has to be discussed and approved for by the Ministry of Public Security and its drug control organ the NNCC. At present the medical use of methadone is regulated by the Narcotics Drug Control Act, which stipulates that:

“The use of narcotic drugs is restricted to medical treatment, education and scientific research. Medical units equipped with beds, capable of performing operation or those considered to be qualified may apply for a ‘Narcotic Drug Purchasing Card’”

Article 31 of the Narcotics Drug Control Act

In practice this means that methadone can only be used in approved medical in-patient facilities and restricted to medical treatment. It is the understanding of medical authorities that maintenance (longer-term treatment which does not treat the symptoms of detoxification) is thereby prohibited.

Treatment in voluntary facilities managed by the health authorities lasts no less than one month and up to three months and in general some drugs will be

prescribed to assist patients to detoxify for the first 21 days. Patients have to pay for treatment, which is expensive, and the health authorities lack the financial and human resources to extend the service (e.g. to replace or augment the compulsory treatment centres). The doses of drugs prescribed to assist detoxification vary and depend on the needs of the patient. The SDA is exploring the possibilities of prescribing some Chinese medicines after discharge to help prevent relapse.

Treatment Outcomes

There is no systematic follow up data available for either the compulsory or the voluntary treatment system, but by all accounts (Ministry of Health, NNCC) relapse rates are very high and are estimated to range from 60-90%.

China cites one example of a successful programme to create a drug-free city. The account of the successful eradication of drug use in Baotou is illustrative of the Chinese vision of what should be done in the country to deal with drug use.

Baotou- Inner Mongolia Autonomous Region

It is a city of some 2 millions which had a very serious drug problem before 1949. Drug problems re-emerged in the 1980s and 90s. In 1990 there were just 69 drug users in Baotou but a year later the numbers of users increased to 1894 and by May 1999 - 3730 drug users had been registered in the town. When users are first identified they are immediately sent to the city's compulsory treatment centre and if they relapsed are sent to a Labour Correction camp. So far 1023 have been treated in the compulsory treatment centre, which opened in 1997, and a further 2221 have undergone Labour Correction treatment. Altogether after treatment 740 have remained drug free for 3+ years and 751 have been off drugs for 1-3 years and 609 for less than one year. In June 1999, 1115 were in the process of being treated in one of the two facilities in the city. The city has already achieved drug - free community status in 76% of the city.

The reasons for this success are said to be the multi-sectoral approach, which is led by public security with the participation of community organizations (Street Committees, Watchdog Committees, the police, Care - Young people's Association, the Women's Federation and the Youth League). Recovering drug users are placed in a social assistance programme that ensures that the above organizations provide ongoing support and supervision to ex-users. Furthermore, the city has set up a system of rewards and punishments for the police to encourage them to apprehend all drug users. Members of the community are also encouraged to inform on suspected traffickers and drug users.

This experiment is considered to be a model for the whole nation and leaves little doubt that interventions other than those with an abstinence goal will have scant appeal in China at the moment.

Relatively little progress has been made in China in efforts to rehabilitate drug users following detoxification. One exception may be the therapeutic community (Daytop) which has been established in Yunnan Province.

D. HIV/AIDS

General information

China is undergoing major social and economic changes and has been increasingly open to trade and economic ties with countries in Asia and elsewhere. This opening up has facilitated the gradual spread of HIV/AIDS among the general population. The HIV/AIDS epidemic in China can be seen to have gone through three distinct phases. During phase one (1985-1988) just 7 provinces reported HIV/AIDS infections and all cases were among foreigners or overseas Chinese. During the second phase of the epidemic (1989-1993) HIV/AIDS spread to 21 provinces and most cases reported from the provinces were along the coast and from big cities. HIV was also identified among drug users in Yunnan province limited geographically to the southern areas of Yunnan Province bordering Myanmar. The period between 1994-1998 saw a rapid expansion of the epidemic spreading to 31 provinces, municipalities and autonomous regions in China and to have spread from a concentration among the minorities to the majority Han population and to be increasingly transmitted sexually.

The true extent of the epidemic in China is difficult to determine because of insufficient information. Although the numbers of infections appear to be rather small for a country the size of China, the National Programme for the Prevention and Control of AIDS estimated in December 1998 that there may be more than 400,000 HIV infected people in China². Sentinel surveillance began in 1995 when 42 HIV sentinel sites were selected throughout China and the number of sentinel sites rose to 60 in 1997. The population groups that were defined as targets at the sentinel sites include: drug users, commercial sex workers (CSW), long distance truck drivers, ante-natal clinics, blood donors and male patients in clinics for sexually transmitted diseases (STDs). Not all groups are represented at each site. IDUs are tested in 19 sentinel sites in 16 provinces. Thus, although the surveillance reflects trends in HIV infection it does not adequately inform about the size of the problem. The available data on HIV is

2 UNAIDS country profile - March 1999

currently derived from all sources including the sentinel survey (Table 2.2) and information about HIV cases identified in medical establishments³. HIV is a notifiable disease and the records are kept in the health sector and are anonymous.

Little voluntary testing takes place and pre- and post counselling is in short supply. There is a general reluctance to test drug users in either treatment or rehabilitation centres (except for the anonymous unlinked testing of the sentinel surveillance). This is because those found to be HIV positive are immediately discharged in accordance with a regulation jointly issued by the Ministry of Public Security, Ministry of Justice and the Supreme Court. There is also a reluctance to inform people of their status because of the fear that patients will commit suicide.

Yunnan remains the province with the highest number of infections and accounts for 51% of all infections in China (September 1998). As can be seen on Table 2.3, the modes of HIV/AIDS transmission in China are sharing of needles among IDUs, unsafe sexual practices, unsafe blood transfusions and unsafe homosexual activities in some cities. Thus the populations most vulner-

Table 2.2 Reported HIV/AIDS cases from 1985-1998

Year	Total	HIV	AIDS
1985	5	4	1
1986	1	1	0
1987	9	7	2
1988	7	7	0
1989	171	171	0
1990	299	297	2
1991	216	213	3
1992	261	256	5
1993	274	251	23
1994	531	502	29
1995	1567	1515	52
1996	2649	2611	38
1997	3343	3217	126
1998	3906	3170	136
Total	12639	12222	417

Source: Sentinel surveillance, Division of Disease Control, Ministry of Health

3 Reported cumulative AIDS cases - 439 (31st December 1998) of whom 224 have already died. Reported cumulative HIV+ cases - 12,580 (31st December 1998) UNAIDS country profile - March 1999

Table 2.3 HIV/AIDS transmission categories 1985-1998

Transmission risk factor	Total	%	HIV	AIDS
Homosexual	18	0.13	10	8
IDUs	8776	69.4	8575	201
Heterosexual	816	6.5	711	105
Blood products	35	0.3	30	5
Mother to child	9	0.07	7	2
Other	2985	23.6	2889	96
Total	12639	100	12222	417

Source: *Sentinel surveillance, Division of Disease Control, Ministry of Health*

able to HIV infection are drug users, STD patients, migrants, ethnic minorities and commercial sex workers. By 1998, 69.4% of all detected HIV cases were as a result of drug injection.

The majority of those infected by HIV are male (81.9%). It is worth noting incidentally, that STDs have increased considerably in China in the last few years and now rank as 3rd among all infectious diseases in China (after dysentery and hepatitis).

HIV among injecting drug users

Drug users engage in high-risk behaviours and were the first to be infected with the HIV in China and most new cases (70%) are related to sharing needles among injecting drug users. To-date they represent the largest category of infected people. In 16 provinces HIV was identified among drug users. However, in a recent study conducted by the Ministry of Health (Department of Disease Control) jointly with the Ministry of Public Security among drug users in 9 provinces; 6000 drug users were tested for HIV (800 in each province 50% of the total were IDUs). The results indicated that there were very low rates of HIV infections (about 1%) in 8 of the provinces and no HIV infections in one of the 9 provinces.

Yunnan Province

HIV infections were first identified in Yunnan in 1989. A survey conducted between 1992-4 in Dehong prefecture in Yunnan on the border with Myanmar revealed that more than 30% of drug users were injecting and that between 70-80% of them were sharing injecting equipment.

Altogether 5678 infections have been reported in Yunnan province and 89% of these are among injecting drug users. The highest prevalence of HIV is among young people aged between 15-30 and as many as 14% are amongst women. In the last few years there has also been a notable shift from infections among the minority population to the Han population and from the rural into the urban areas. Prospective data from Yunnan province indicates that infection rates of spouses of IDUs was increasing and rose from 3% in 1990 to 12% in 1996.

There are also well documented epidemics among IDUs in the provinces of Xinjiang, Sichuan and Guangxi.

Xinjiang Autonomous Region

In Xinjiang drug use has markedly increased in 1996 with 50-80% of drug users injecting by December 1997 of whom 17% were infected with HIV. HIV rates had doubled in a six-month period.

In Ili prefecture, HIV among tested injecting drug users increased from 9% in January 1996 to 76% in August of the same year.

In Yiling city the rates of reported HIV among drug users rose from 26% in 1995 to 49% in 1996 and rose to 70% in 1997 (Zunyon Wu and Zhang Jiapeng 1998). It should be noted that the rate of condom use among IDUs in Yiling city among IDUs is less than 1% (Ref: China Responds to HIV/AIDS).

Altogether 1615 cases of infection have been reported, estimates of HIV infected IDUs are considerably higher.

Sichuan Province

An HIV epidemic has been identified among the Yi minority (figures not available) especially in the Liangshan prefecture, on the Kunming-Chengdu main road which is also the main trafficking route from Myanmar through China. A study conducted in 1995 among drug users showed that 35% of those tested were HIV positive.

Guangxi Autonomous Region

About 90% of drug users inject drugs. Reported cases of HIV infection from Baishi City rose from 0.43 in 1996 to 77.2% a year later. (Zunyon Wu and Zhang Jiapeng 1998)

Hepatitis C infections among opioid users are believed to be as high as 80% among certain populations.

E. Prevention and Control of HIV/AIDS

The control of HIV/AIDS

Since the establishment of the People's Republic of China in 1949 China has successfully controlled a number of communicable diseases such as smallpox, diphtheria, typhus, cholera and plague with highly effective public health measures. However, HIV/AIDS is the kind of infection that does not easily lend itself to conventional public health measures such as testing, reporting or isolation. This is because HIV is often spread amongst marginalized or stigmatized groups through behaviours that are essentially private. (Ren-Zong Qui 1996). China's efforts to control the spread of HIV/AIDS began formally only one year after the first case of HIV was identified in 1985. Thus the National AIDS committee was established in 1986 and the Programme for AIDS Prevention and Control was established in 1987.

In March 1990 the Chinese Ministry of Health adopted a medium term plan in line with global policies. This plan was divided into a comprehensive national plan and included in addition 13 plans for selected provinces. In 1995 a new National AIDS Committee was established consisting of 33 ministries, government and non-government agencies and hosted by the State Council and the budget for the National AIDS Programme rose sharply for 1996-7. Indeed in 1996 State Councillor Peng Peiyun declared that:

'The Government has placed AIDS prevention and control among the priorities of the Ninth Five-Year Plan and China's Twenty-First Century Agenda' (October, 1996)

Nevertheless, in its Medium and Long-term programme prepared for the years 1998-2010 by the Ministry of Health, State Development Planning Commission, Ministry of Science and Technology and Ministry of Finance, are highly critical of China's current efforts in HIV/AIDS control. It comments that China's capacity to deal with the problem is inadequate, that a functioning multi-sectoral and co-ordinated approach is yet to be created. It notes incidentally that the understanding of the issues among some leaders is insufficient. The programme further highlights the fact that to-date there is a lack of knowledge, research, medical and health services and surveillance and a weak management of blood safety. However the report expresses the objectives that:

'By the year 2002 relevant laws, legislation and regulations relating to the prevention and control of AIDS and STD are to be formulated and perfected, responsibilities of governmental departments and social sectors concerned in the control of AIDS as well as rights and obligations of AIDS ... to be defined'

(p. 9 of Medium and Long Term Plan)

The operational objectives of the programme include the implementation of education activities on the prevention of AIDS and STD in 100% of the rehabilitation and detention and education centres and in 80% of the prisons and reformatories by the year 2002. Moreover, it is planned to step up 'legal education on the banning of drug abuse and prostitution among high-risk population groups, to urge them to change their wrong behaviours. Use of condoms is to be encouraged, education on the harmful effects of sharing a syringe is to be developed' (Medium and Long Term plan 1998-2010). The overriding objective is to contain the spread of HIV/AIDS among IDUs by the year 2002.

The Department of Disease Control at the Ministry of Health is the focal point of China's AIDS effort and the Ministry is responsible for the development and implementation of the plan.

Risk reduction: acceptable interventions

'What is needed in addition to efforts to reduce both the supply of and the demand for drugs, is a forceful effort at reducing the harmful consequences of drug use, in particular educating injecting drug users about the dangers of sharing needles and of the health risks associated with using unsterilized needles in general'

(China Responds to AIDS. China Ministry of Health and UN Theme Group on HIV/AIDS in China. p. 11)

The importance of reducing the risks for drug injectors of contracting HIV are accepted and understood in China, and have been clearly articulated in the National AIDS Plan as an objective to be reached by the year 2002.

Educating people to say 'No' to drugs is a fundamental part of China's drug policy hence the emphasis placed on education and publicity. China has launched an intensive programme of preventive education, and much work is going into raising awareness about the dangers of drugs. In order to promote drug education among teenagers a book titled 'A textbook of narcotics control education and narcotics prevention education' has been distributed among middle-school students as their extracurricular readings and TV documentaries have been produced to deliver information about the harms of drugs. A major anti-drug exhibition was organized in 1998 in Beijing and one and a half million people including the country's leaders visited it. The exhibition was shown subsequently shown in many other parts of China and altogether an estimated 160 million people saw the exhibition.

Peer education /outreach is the most acceptable form of intervention as is the provision of information about the safe use of needles and syringes - this was emphasised as the major vision for the future. Some pilot projects targeting specific risk behaviours are being implemented or are at the planning stage.

Views on other types of intervention

Many in China do not favour certain interventions that are commonly used elsewhere in the attempt to prevent the spread of HIV/AIDS among drug injectors

Needle distribution of exchange schemes

There appears to be little or no support for this. It was generally asserted that needles are easily and cheaply available. The cost is approximately one Yuan (8 Yuan = \$1)). No one saw much point to delivering free equipment when the health service is starved of clean and sterile equipment. However, there were areas, most especially in border regions where needle and syringes were by no means easily available.

Substitution therapy

The view of many scientists in China is that such treatments should be more easily available. Scientists and the NNCC are aware of the usefulness of methadone in other countries most especially as a measure for HIV/AIDS prevention among IDUs. An Expert Committee chaired by Prof. Cai-Zhi Ji of the National Institute on Drug Dependence at the Beijing Medical University suggested that methadone be used experimentally (in pilot projects) and that the detoxification period should be prolonged. However, few go as far as to recommend maintenance. There is little conviction that where prevention of HIV are said to be successful that it can really be attributed to this one intervention.

Methadone for the purposes of detoxification was generally viewed positively though many felt that Chinese medicines might be more appropriate and perhaps more acceptable. The question of competing priorities and the general problems within the health service was repeatedly brought up.

Giving the wrong message using an opiate to treat opiate addiction was considered by many to be a contradiction in terms. China is firmly wedded to the notion of drug use elimination, and despite the evidence of high relapse and treatment failure rate are not willing to consider anything other than an abstinence goal for drug treatment.

At present the use of methadone is highly regulated (see Narcotic Drug Control Act). Thus the Ministry of Health is constrained by these legal obligations and cannot provide methadone in the context of ambulatory treatment nor in any other than 'medical treatment' of the (physical- medical) symptoms of addiction.

Many drug users in China live in rural areas and have limited access to treatment facilities. It was considered impractical to have large-scale methadone programmes while addicts cannot be expected to attend a clinic daily.

V. DISCUSSION

A. Constraining factors

Administrative changes: China has been undergoing administrative reforms and far reaching changes began to be implemented in October 1998. Ministries at the central level in Beijing have been considerably downsized. (e.g. the Ministry of Health has only approximately 200 staff in Beijing). Very little funding is available from the central government for interventions though some small pilot projects are occasionally funded. Local provincial, prefecture and commune level have to obtain their own revenues and implement their own activities. China is a politically and administratively de-centralized country thus the implementation of laws and directives is largely dependent on the local situation and on local interest and budget.

Policy and strategy: The major responsibilities of ministries on the central level is policy and strategy development and the provision of guidelines for action to provincial and other local bodies. The role of the provincial authorities is tactical and strategic as they translate central government guidelines to local conditions. There is local flexibility in how the general guidelines are operated. It is important to note that local level activities depend largely on availability of resources and on the priorities set by top local officials. For the implementation of drug policy, much depends on the relationships between different sectors in the community e.g. health and the local narcotic control authorities. This de-centralised system provides an opportunity for local community based actions although it is generally understood that once the central government favours a policy, the regions will generally comply.

Whose responsibility is Drug and HIV prevention? The NNCC believe that the responsibility for preventing the risk of HIV/AIDS among drug users is the responsibility of the Ministry of Health and that methadone could be part of detoxification if the Ministry of Health chooses to introduce this into the

voluntary treatment system. However, the relevant department in the Health Ministry (now the State Drug Administration) notes that any change in drug treatment needs to be approved and sanctioned by the NNCC, which has the lead role in China in drug control. Asked whether they would like the sole responsibility for drug treatment the SDA retorted that they had no capacity to undertake such a role. Respondents within the health sector did not feel that the system of treatment as it stands needed immediate or radical change.

Evidence-based drug and HIV prevention policy: China has many research facilities and a long tradition in drug research but the focus of study has been on two major issues: the improvement of detoxification technologies, and on epidemiological surveys (e.g. determining HIV status among users). China has not yet conducted systematic post-treatment or rehabilitation follow-up studies so there is scant information on whether the very extensive rehabilitation efforts are having the desired benefits.

There do not seem to be mechanisms in place, which would facilitate policy, reviews in the drug field and very little inclination, to change course. The conviction that China must strive towards a drug-free society at all cost prevails. Very few are clear about how policy can in fact be changed or reviewed. Most of those working in the drug and HIV field have very little notion about how to bring about change in thinking though there is little doubt that the power to change lies firmly in the hands of senior personnel within the Ministry of Public Security.

B. Estimating the size of the drug problem: data gathering:

It is unclear how drug use/addiction is defined in China. Much of the information about use comes from the families of the users and the local community and passed on to the Ministry of Public Security. There is little doubt that because the penalties for use are severe that users try to hide their use for as long as possible. There are varying estimates about the true extent of drug use and these may be considerably higher than the numbers of registered users.

Information about drug use is collected in a number of different ways. The two major methods are as follows:

- (a) Local police operating on a commune level provides information to the Ministry of Public Security. Police officers visit every household but it is not clear how often as the staffing level of public security on the commune level is rather small. Theoretically the figures are continuously updated. Those currently in treatment or in rehabilitation are also included in the figures (may be double counted because information is also gathered from the treatment centres). Once a drug user is identified the information is

passed on from the commune to the prefecture and provincial authorities. In practice it is not clear how/whether this information is updated or whether anyone ever gets off the record. There is no specific information about the mode of drug administration so it is not clear how many of the known/registered drug users are drug injectors.

- (b) The health sector has its own recording system. The ministry has a computerised database in 16 provinces. All admissions to the voluntary drug-treatment centres run by the Ministry of Health (now the SDA) are recorded. These figures reflect the number of admissions and not the number of patients. However the patients are also counted and registered under the Public Security system.

CHAPTER 3
INDIA

CHAPTER 3

INDIA

I. SUMMARY OF FINDINGS

Injecting drug use is well established in a number of cities in India and it will be difficult to slow or prevent the trend towards injection as an increasingly favoured method of drug administration. Injecting drug use is increasing in many areas of India especially among young males living in socio-economically disadvantaged areas. The number of drug users is sufficiently high as to present a major additional source for fuelling the HIV epidemic in India.

Risk behaviour such as the sharing of drug injection equipment is highly prevalent among people who use drugs, presenting an environment in which an explosive spread of HIV and other blood borne diseases such as hepatitis B and C is inevitable. It is not a question of whether this might occur, rather, how quickly and how extensively this will be.

Knowledge of HIV and ways to reduce risk is inadequate among most drug use sub-populations.

The risk of HIV transmission from injecting drug users to sexual partners is high and behavioural change strategies adopted to date to reduce this risk have been minimal.

Sero-prevalence among injecting drug users in some northeastern states of India is among the highest in the world. Recent evidence suggests escalating rates among slum dwellers in Delhi.

National documents of importance such as the *National AIDS Prevention and Control Policy* and the *NACO Country Scenario Report, 1997-98* reflect less than adequate identification and description of the nature and level of risks and their determinants which drug use and drug injection might pose in fuelling the HIV epidemic in India.

There has been no exploration to date of the influence of drug use networks and their dynamics on the diffusion of at risk injecting behaviour nor on the influence of the socio-political environment. For example, whether legislation, public policy, law enforcement and interdiction activity are supportive of,

facilitate and promote lower risk behaviour or alternatively, whether they hinder and make it less likely, and whether law enforcement and interdiction activity renders drug injection more likely by increasing the price and reducing the average purity of illicit of drugs.

Currently adopted law enforcement and supply reduction strategies may have contributed to the shifts in drug use and methods of administration from those that posed less public health hazard to those posing greater hazard. This may also be serving to exacerbate HIV vulnerability or at least, hindering efforts aimed at reducing such vulnerability.

The introduction of the *Narcotic Drugs and Psychotropic Substances Act (1985)* which, among other things, banned the use of opium appears to have had a substantial influence on a shift to the use of heroin.

Narcotic or psychotropic drug use is itself illegal under Section 27 of the *Narcotic Drugs and Psychotropic Substances Act (1985)*. This also appears to hinder some HIV prevention efforts.

National and state authorities responsible for HIV/AIDS prevention might helpfully pay more attention to addressing the hazards which licit and illicit drug use has potential to play in fuelling the HIV/AIDS epidemic in India.

Manipur State stands out as an example of what can and needs to be done to slow, stop and even reverse a drug-fuelled HIV/AIDS epidemic in India. Its drug and HIV/AIDS prevention policies are progressive and consistent with the international experience and empirical evidence on what works best. The challenge for the Government of India will be to adopt such policies and strategies more broadly while there is still time to limit the extent of a drug-related HIV/AIDS epidemic.

Unlike the situation in the north-eastern states, other state governments (which have responsibility for health policy and intervention) have been slow to recognise the threat which drug use poses and to adopt the necessary legislative and policy reforms which could support broad based efforts aimed at limiting drug-related HIV transmission.

Sterile injection equipment is difficult to access from the perspective of affordability, public policy and health and law enforcement sector practices and is serving to substantially amplify the hazards for HIV transmission.

There is incorrect understanding within government of the principles, methods and outcomes associated with the concept of harm minimisation and its approaches.

Some State AIDS Cells do not appear to understand or support the need for certain HIV/AIDS prevention approaches such as needle and syringe exchange.

The demand for drug treatment is very high but responses are in general inadequate, both in scale, accessibility, policy and practice.

Access to drug treatment is limited, be it abstinence oriented or substitution in nature, particularly among those living in poverty, those living in rural areas and those with special needs (e.g., women, people with children, homeless people, street children, sex workers).

There has been little or no real change in the model of drug de-addiction offered in India since the early 1980s, despite substantial anecdotal and empirically derived evidence that it is associated with poor treatment outcomes. Government has signalled an intention to reform drug treatment with greater emphasis on rehabilitation, however, these changes cannot of themselves prevent a drug-related HIV/AIDS epidemic.

Drug treatment is generally oriented towards abstinence and treatment is associated with limited reach and throughput of those who are in need and who might otherwise benefit from treatment, with high relapse rates and with limited beneficial public health impacts and outcomes over time.

Unhygienic and physiologically hazardous drug injection practices are common place and are associated with substantial health hazard and harm.

Inadequate attention has been paid to HIV vulnerability in prisons, where unsafe sex and unsafe drug injection may represent a major public health hazard.

There is inadequate information and understanding among key policy decision-makers in relation to methadone maintenance treatment.

The draft *National AIDS Prevention and Control Policy* endorses needle and syringe exchange as a legitimate strategy for preventing HIV transmission arising out of injecting drug use.

However, the draft *National AIDS Prevention and Control Policy* defines harm minimisation in a way that precludes optimum use of available HIV prevention strategies among people who use illicit drugs.

Prevention and treatment goals are oriented towards abstinence from drug use and this is serving as a specific barrier to potentially more effective health protection interventions.

The law as it exists at present when taken in conjunction with many policies and practices currently adopted by government and by the non government sector may be serving to hinder effective strategies and actions which could otherwise reduce or contain the risk for HIV transmission.

While the multi-dimensional nature of drug use and its determinants is recognised by National AIDS Control Organization (NACO), it also acknowledges

the need for implementing multi-sectoral responses that have been long identified but not as yet acted upon.

Inadequate attention has been paid to supporting, facilitating and promoting the development of user self-organisations and their intimate involvement in drug and HIV prevention policy, planning and evaluation of strategies and activities for addressing drug use and related harms, including HIV/AIDS.

The government has favoured an outsourcing of services on the basis of a hypothesis that this could foster community development and more effective responses at the ground level. While there are obvious benefits associated with this approach, there are in addition serious risks if it is not accompanied by adequate attention to on-going standards development, service delivery guided by empirical evidence rather than personal opinion or commercial interests and to monitoring and evaluation of the delivery and effectiveness of interventions.

Many non-government organisations are working under extremely difficult circumstances, often left largely to their own devices and without technical and financial support in helping drug users at risk or already infected with HIV.

Regional harm reduction responses are required given the regional nature of the drug use and HIV risk phenomenon that is now prevalent (particularly in Bangladesh, Nepal, Myanmar and Pakistan).

There is a need for agencies of the United Nations system to work together and with the government in a more communicative, integrated and co-ordinated manner in addressing drug use problems as they impact on HIV vulnerability.

II. RECOMMENDATIONS

It is recommended that consideration be given to:

- (a) Broadening the definition of harm minimisation contained within the draft National AIDS Prevention and Control Policy in alignment with international understanding, deleting any reference to “minimising harm by reducing or minimising drug use leading eventually to elimination of drug use” and replacing this phraseology with a broadened perspective that can provide an effective pathway forward in reducing drug related harm;
- (b) Ensuring there is congruence in policy, planning and activity regarding harm minimisation within other government ministries involved in drug policy and intervention (Ministry of Social Justice and Empowerment, Ministry of Finance, Ministry of Home, Ministry of Health and Family Welfare);

- (c) Ensuring that all State AIDS Cells are brought up to date on the evidence in support of harm minimisation policies and strategies and that NACO promotes their early adoption through policy and funding mechanisms, so these cells may exert their maximum benefit in preventing or minimising the extent of a drug use fuelled HIV/AIDS epidemic;
- (d) Establishing firm policy commitment by government at federal and state levels in support of needle and syringe exchange and availability programmes, peer education and outreach, drug substitution maintenance treatment, bleach cleaning programmes, safer drug use and safer sex information and education programmes;
- (e) Advocating for harm minimisation policies, strategies and activities among all sectors including the health, law enforcement, education, administration, community and religious sectors;
- (f) Adopting a pro-active approach in explaining to the public, advocating and supporting harm minimisation approaches as a fundamental basis for responses to drug-related harm while at the same time pursuing novel research-based approaches aimed at finding more effective ways of preventing or reducing drug use;
- (g) Broadening the goals and methods of drug treatment from an abstinence-only goal to encompass other treatment and prevention goals, while retaining more ambitious treatment goals for those who are personally equipped, environmentally supported and motivated to pursue these outcomes;
- (h) Exploring the use of a range of opioid substitution pharmacotherapies as a cost-effective approach to reducing drug-related harm among those who do not wish or who are unable to respond to drug-free treatment;
- (i) Implementing needle and syringe exchange programmes where injecting drug use is prevalent;
- (j) Adopting drug and HIV/AIDS prevention policy review and reform, strategic and service planning, monitoring and evaluation that actively engage current and recovered drug users;
- (k) Supporting, facilitating and promoting the establishment and operation of drug user self-organisations through policy, funding and other practical assistance;
- (l) Reviewing current legislation and policy with a view to adopting reforms that are necessary to remove any impediments to scaling up, sustaining and optimising key HIV/AIDS prevention strategies;

- (m) Paying more attention to the risk of HIV transmission among the sexual partners of injecting drug users through intensified interventions targeting this group and their sexual partners;
- (n) Ensuring that the government retains a role in standards development, drug and HIV/AIDS prevention service delivery guided by empirical evidence rather than personal opinion or commercial interests and to monitoring and evaluation of the delivery and effectiveness of interventions.

III. INTRODUCTION

According to the last national census in 1991, India has a population of 846.3 million. 25.7 per cent of its people lived in urban settings. Life expectancy at birth is 62.8 years for males and 64.2 years for females. India ranks 138 on the Human Development Index of UNDP. Its health and education expenditure is both approximately 2 per cent of the total public expenditure. Per capita annual expenditure on health is US\$ 0.43. The national AIDS budget is about US\$ 25 million. The budget has increased in recent years. The per capita gross national product is approximately US\$ 190.00.

IV. FINDINGS

A. Patterns of Drug Use

Opiate drug use in India followed two distinct courses since the early 1980s. The major metropolitan cities of India (e.g. Calcutta, Mumbai, Chennai, and Delhi) had witnessed massive spread of heroin smoking in the early 1980s.

The type of heroin available was of impure and crude variety known as “brown sugar” or “smack”. The heroin problem in these cities initially started among students and the educated youths but soon spread to the poorer sections of the population of daily wage earners and people living in the slums. The major modes of intake of heroin in all these cities were smoking or “chasing” (smoking the fumes coming out of heroin heated over an aluminium foil).

The predominant pattern of heroin use in the northeastern states of the country (Manipur, Mizoram and Nagaland), in contrast, was injecting from the beginning. The type of heroin that was available in the Northeast was of a much purer variety and was known as “white sugar” or “number four”. A high prevalence of injecting and high levels of HIV risk behaviour among the injecting drug

users in the Northeast had also facilitated the spread of HIV among them in all these three states.

The prevalence of opioid use in Calcutta among the general population is 0.3 to 0.5 per cent. The estimate is higher if considered among the male population (0.5-0.7 per cent) since the problem is largely a male problem (98 per cent of opioid drug users are male in detoxification programmes as well as in street based surveys). Half of the opioid drug users in Calcutta inject, based on street based surveys (ICMR, 1996).

Recently, since the early 1990s the pattern of drug use has changed. There have been reports of increasing buprenorphine injecting in the cities and rising dextropropoxyphene injecting in the Northeast. The change in trends and patterns of drug use and rising HIV among the injecting drug users have already been well documented in several research publications, research reports and programme reports of non-governmental organisations. This has also, for the first time, been mentioned in the draft National AIDS policy document.

The extent to which ethnic clashes and political unrest increases HIV vulnerability among people who use drugs is largely unexplored in India, but may play a role (Panda, UNDCP/ROSA, 1998).

Cannabis and opium have been used traditionally for centuries. Use of these traditional drugs is reported to be more prevalent in low socio-economic groups (S. Kumar, 1999). In many rural areas, the use of opium and cannabis continues and is tolerated as a part of local cultural tradition. The use of alcohol and tobacco is widespread in India and is responsible for substantial health and social harms. Synthetic and semi-synthetic opioids such as buprenorphine, morphine and heroin have emerged as major drugs of dependence during the past decade or more, particularly in urban settings. So, too, has the use of a range of psychotropic drugs developed for use in clinical medicine. Multiple drug use has become highly prevalent and is associated with substantial morbidity and mortality.

A rapid assessment undertaken recently by *Sharan* in five cities of India found that drugs commonly injected included: diazepam, pheniramine (Avil), promethazine (Phenargan), Fortwin and grade 3 heroin ("smack"). During a shortage of buprenorphine (Tidigesic) in 1995, alternative forms of buprenorphine (e.g. Binorphan made in Chandigarh) became available. Non injected drugs included heroin, nitrazepam, diazepam (Calmpose), codeine phosphate (e.g. Phensedyl), dextropropoxyphene (e.g. Proxyvon, Spasmo-proxyvon), cannabis preparations (e.g. charas, ganja), opium and opium straw (dodha). Injectable drug use included a cocktail of many of the above mentioned pharmaceuticals. Multiple drug use in general has been described by some as a new 'trend', but

it is now well established (Dorabjee et al, 1999).

Users from higher income groups reportedly prefer smoking or chasing brown sugar heroin while among students, benzodiazepine and cough mixtures that contain codeine (Phensedyl) are popular. Among those who inject, it is generally brown sugar that is used while a small number reportedly inject white heroin (no. 4). White heroin lends itself better to injecting because it is more soluble (Dorabjee et al., 1999).

People from lower income groups usually “chase” (fume inhale) heroin but many have now switched to injecting a cocktail of different pharmaceuticals. The cocktail commonly consists of buprenorphine, pheniramine or promethazine and diazepam.

Some cases of dextropropoxyphene (Proxycodon and Spasmo-proxycodon) injecting are reported to occur among people described as coming from the lower middle class (Dorabjee et al, 1999).

In any circumstances, the use of oral dextro-propoxyphene preparations by injection is likely to be associated with substantial soft tissue damage including venous sclerosis, abscesses, ulcers, venous occlusion and peripheral oedema. So too is the injection of diazepam undiluted in normal saline or water. The progressive loss of peripheral veins is inevitably associated with injection into high risk larger veins such as the femoral or jugular veins and injectors often miss the vein and hit a major artery or nerve, leading in some cases to acute circulatory compromise, gangrene, loss of limbs and associated severe pain. Some injectors switch to intra-muscular injection when they lose all of their peripheral veins (Panda, UNDCP/ROSA, 1998).

Dorabjee et al (1999) note that a small number of injectors have learned to convert smokable heroin or “smack” into injectable preparations using citric acid, celine tablets or lemon juice. They also note that some of the older users began to use heroin after opium and cannabis became difficult to obtain.

An article in the Delhi magazine, *India Today* (5 April 1999) highlighted the recent introduction of cocaine, methylenedioxymethamphetamine (MDMA or ‘ecstasy’) and other amphetamine-type stimulants in India. The use of these psycho-stimulants appears isolated to the more well to do but may not remain that way indefinitely if international trends provide any useful guidance.

While most drug users prefer heroin when it is affordable, of good quality and easily accessible, there has been a move towards the increased use of pharmaceuticals due to their easy accessibility and low prices.

The cost of the dose of a cocktail of pharmaceutical drugs is about Rs. 20. Heroin

costs Rs. 50 for about 100 mg while larger quantities are available at Rs. 200-300 per gram.

B. Epidemiology of Drug Use

In 1989, the Ministry of Welfare undertook a study in 33 cities to ascertain the nature and extent of illicit drug use. The samples were drawn from official records of police, jails and welfare agencies and from police officers, lawyers, chemists, teachers, journalists and community leaders. Among the study findings it was reported that

- (a) Drug use was prevalent among all castes and religious groups;
- (b) Many were from lower social strata;
- (c) Drug users were mostly male, literate and from the 16-35 year group;
- (d) Most drug users were fully aware of the risks of drug use;
- (e) Cannabis and heroin were the main drugs used (pre-dating the shift to buprenorphine);

Based on these reports, the Ministry projected the number of drug users to be 2.25 million nation-wide. A study by Mohan and Desai (1993) concluded that there were about 0.5 million opiate users living in urban India and about 0.3 million cannabis users. Some senior government officials suggest that outside of the Northeast, injecting drug use is “insignificant”.

Drug use among females appears uncommon in India at present and there is no clear evidence that it is increasing among them. One estimate is that between 1 and 2 per cent of admissions to drug treatment centres are women while 5 per cent of drug users in Manipur and 10 per cent of drug users in Misoram are women (ICMR, 1995). However, drug treatment data are likely to underestimate the prevalence of problems among women if social customs are associated with particularly harsh attitudes towards women who have problems associated with the use of drugs.

According to a study in 33 cities and neighbouring areas in India, males (96.5 per cent) were “more given to drug abuse than females” (3.5 per cent) (Ministry of Welfare, 1992). Studies in West Bengal, Calcutta, Rajasthan, northeastern states and other regions reported that females represented 1 to 4 per cent of the drug users.

According to data available from a major study based on wide coverage and conducted in 1992, most of the users are 16 to 35 years of age, although drug use is more prominent among the 18-25 years group. In another study it was reported that the mean age for taking first heroin was 14 years. Reports of initiation of

drug use as early as 10 years are also available. On the basis of various surveys on an average 75 per cent of the drug abusers will fall in the age group 16 to 35 years (S. Kumar, 1999).

A study undertaken by SHARAN¹ found that injecting drug use is particularly prominent in Imphal, Calcutta, Delhi, Chennai and Mumbai.

One estimate is that about 25 to 30 per cent of all opioid drug users inject (Dorabjee et al, 1999). However, in Delhi it was found that about 59 per cent were injecting at the time of interview. In Manipur it is estimated that 80 to 90 per cent of drug users inject.

It is reported that opioids and other injectable drugs are now widely used in Delhi, particularly in the slum areas of East, West and South Delhi. A shift to drug administration by injection is visible in almost all slum areas (Dorabjee et al, 1999).

Injecting commonly occurs in public places such as in toilets, under bridges, alongside canals, in parks and in homes. Shooting galleries can also be readily found. High-risk practices such as front loading occur (Dorabjee et al, 1999).

In most cases, needles and syringes are not cleaned at all between use. They may be wiped with a dirty cloth or the syringe may be flushed with water if it is available, regardless of its source. Sputum, cotton, pieces of paper and shirt or cloth ends may be used to clean needles and syringes. While injecting near drains or nullahs, sewage water is often used to rinse syringes out. Some drug users rinse their injecting equipment with tap water, if available. Those who inject in public toilets commonly use the water from storage drums or directly from the tap. Some injectors try to clean out blocked needles with thin pieces of wire from electrical cables. The use of dirty and blunt needles is naturally associated with abscesses in many users.

Dorabjee et al (1999) found that opioid users have switched over to injecting primarily for the following reasons:

- (a) Heroin became expensive. Average daily use costs Rs. 100-250 per day while the use of pharmaceuticals costs far less, perhaps Rs. 20-50;
- (b) It became difficult to procure good quality heroin;
- (c) Police acted on dealers and drug users in known dealing locations;
- (d) Injectable drug preparations such as injectable buprenorphine and pethidine were easily accessed;
- (e) Injectables were found to be effective in rapidly alleviating drug with-

1 UNAIDS/NACO funded the dissemination workshops in 5 cities.

drawal among those unable to procure their previous opioid of choice or who wished to attempt stopping drug use;

(f) Injectables were found to provide a rapid onset drug effect or “high”.

The switch to injecting was particularly evident during the period 1990-96. A few injecting drug users reportedly “... learned how effective an injection of buprenorphine (Tidigestic) can be when administered in detoxification centres”.

Other drugs that are used to manage withdrawal include clonidine (an alpha-2 agonist) and diphenoxylate. Even though there are very limited treatment slots, bed occupancy may not be as high as one might otherwise expect, suggesting that treatment may not necessarily be liked or perceived as helpful or user friendly by many. Other factors including capacity to pay or capacity to support the family while not working may also be serving to reduce access.

Consumption of alcohol is common and increasing in India. Poly drug use is believed to be associated with an increase in drug overdose related deaths, although there are no studies which can conform this perception among some of the key informants interviewed. One would fully expect this to be the case given the high-risk drug use environment and given the general lack of information among injecting drug users and limited access to the practical means to protect themselves.

Professional injectors or “street doctors” who inject other people can be found. This is maybe an important factor serving to increase HIV vulnerability among people who inject drugs.

A study undertaken in Chennai found that sexual behaviour was not given much attention or importance by drug users. Users reported often indulging in unsafe sexual practices when under the influence of drugs, particularly alcohol and cannabis (Kumar et al, 1995).

It is not clear whether users under the influence of buprenorphine are less likely to engage in high-risk sexual practices compared with those under the influence of heroin, although there are some anecdotal reports suggesting this might be the case. Users reported being less “knocked off” when using buprenorphine, but cross-sectional sero-prevalence data does not reveal any significant differences (Kumar et al, 1997).

There is a great deal of drug use in prisons, but no documented evidence that HIV is spreading among inmates as a consequence. Prison populations are not routinely tested for HIV. Mandatory HIV testing is not undertaken within the criminal justice system more broadly. HIV infected prisoners used to be segregated from other prisoners but this is no longer the case. There are no policies and programmes concerning the prevention of HIV transmission in

prisons. It did not prove possible to confirm anecdotal reports that condoms were recently introduced into one or several prisons. General precautions² are reportedly not used to prevent disease transmission following blood spills in prison settings.

Kumar (1999) reports that in order to reduce the substantial increase of drug abuse in correctional settings the Centre for Drug Abuse Prevention in collaboration with the Drug Advisory Programme, Colombo Plan Bureau, has organised a training course on management of treatment and rehabilitation of drug users in prisons settings. HIV prevention in prisons utilising the principles of harm reduction does not appear to be an issue for serious consideration at present.

To date, only a minor proportion of the HIV/AIDS epidemic in India is attributable to drug use, although in some parts of the country, notably, the Northeast, this is not the case. The *NACO Country Scenario Report, 1997-98* pays almost no attention to injecting drug use and to drug use more generally as a risk factor for HIV transmission in India. The issue of drug use is discussed very briefly within a chapter on *targeted intervention*, where there is mention of “outreach programming to prevent HIV transmission through injecting drug use”. There is also no exploration of the influence of drug use networks and their dynamics with respect to sharing behaviour nor to the socio-political environment as it impacts on drug use patterns and trends.

The report also notes that a Community Health Action Network of non-governmental organisations in Mizoram has commenced an intervention project among injecting drug users in the capital city of Aizwal and in adjoining areas. It is mentioned elsewhere in a chapter on information, education and communication that “certain high risk groups are visible and easily accessible, where other groups like men who have sex with men and injecting drug users are very difficult to locate and interaction with these groups is also not easy.”

There are a number of explanations. One is that current mechanisms for assessing drug-related risk are inadequate in concept or application. Another is that people with experience and skills working in the drug field have not been engaged in data collection, analysis and intervention planning. There may also be some sense of uncertainty and perhaps discomfort within the specialised HIV sector about ways of working effectively with people who use drugs.

In discussions with senior government officers, it became evident that the importance of drug use as a factor in fuelling the HIV epidemic in India remains to be fully acknowledged by the government in India. One can only guess at the

2 Otherwise known as ‘universal precautions’

reasons but it may in part be that many people working in the HIV/AIDS area have little or no experience working directly with people who use drugs and as such, do not have an affiliation with the matter or alternatively, may not feel all that comfortable working with people with drug problems.

While those working in the HIV/AIDS field have accepted that application of the principles of social justice alongside of those of empathy, care, respect, preservation of human dignity, non marginalisation and non stigmatisation are of fundamental importance in effectively reaching and addressing sexual practices that pose high HIV risk, many of these human service providers appear not to have accepted that these same principles apply equally to people exposed to HIV risk through drug use.

C. Treatment and Rehabilitation

The government approach

The philosophy of the government is to engage the non-governmental sector in the delivery of drug treatment and rehabilitation services. The approach adopted by the Ministry of Social Justice and Empowerment is to recognise drug abuse as a psycho-socio-medical problem which is best handled by adoption of a community-based approach, assuming that community facilities, mobilisation of resources and skills, manpower and care are available in the community. Such community participation, as distinct from institutional services, is considered less costly and eliminates the need for institutions that tend to deprive drug users of contacts with his family and the community.

Accordingly, the Ministry has adopted a three-pronged strategy consisting of

- (a) Building awareness and educating people about ill-effects of drug abuse;
- (b) Dealing with the addicts through a programme of motivation, counselling, treatment, follow-up and social reintegration of cured drug addicts;
- (c) Imparting drug abuse rehabilitation training to volunteers having in view to build up an educated cadre of drug abuse control operators.

The first seven drug treatment centres were established in Delhi in 1985-86. The counselling centres and de-addiction-cum-rehabilitation centres are run by 331 non-governmental organisations. The number is growing slowly.

There are a total of 19 private and public detoxification and rehabilitation centres in Delhi and 413 de-addiction centres in India (see Table 3.1).

Tbale 3.1 Characteristics of treatment centres in India

Government de-addiction centres	72
Non government counselling centres	218
Non government de-addiction centres	123
Total	413

Each of the major cities have at most 300-450 beds available meaning that access to treatment is in practice severely limited. Some centres are reported to charge high rates for admission while others apply onerous admission criteria, further limiting access. According to statistics provided by the Ministry of Social Justice and Empowerment, about 90,000 people were admitted for detoxification in 1998. The length of admission varies from 7 to 28 days.

All admissions for drug treatment are voluntary, but in practice, many are admitted under coercion from family, police and others. The Ministry of Social Justice and Empowerment has responsibility for the provision of voluntary drug treatment while involuntary drug treatment may occasionally be provided from within the confines of mental health hospitals. The courts may refer to mental hospitals people who come before them with drug problems when no (serious) crime has been committed. Otherwise, the courts will send people to prison where specialised drug treatment is generally unavailable. Prisons are the responsibility of the Ministry of Home.

Clonidine, codeine, dextropropoxyphene and other symptomatic medication are used to manage opioid withdrawal, in both urban and rural settings. The patient must often pay the full cost as the government cannot afford to foot the bill.

If people in treatment relapse (during or after managed withdrawal or rehabilitation programmes), they are not subjected to mandatory discharge from treatment as in some countries. Rather, they are counselled, some of their programme freedom may be reduced and an individualised treatment plan will often be re-negotiated between client and clinician. Notwithstanding, chronically relapsing patients may generally be “treated as failures and discarded”.

If patients admitted to a drug treatment centre relapses, some centres would discharge them immediately, some would reprimand them, some would counsel them, and some would remove privileges such as being able to watch TV, smoke

or have access to the games room.

There have been little or no observable changes in the nature of drug treatment and in the settings in which it is provided, during the last decades. The admission criteria of some treatment centres present barriers to treatment seeking. For example, some centres require that clients return on up to five occasions to “demonstrate their motivation to stop using drugs”. Sometimes, the patient’s wife is required to sleep in the ward to provide practical support. All food and medicine bills have to be paid by the patient, or a bag of rice has to be brought, or the patient’s wife brings food to them twice daily. High levels of regimentation are often imposed within the treatment setting.

HIV prevention in treatment and rehabilitation programmes

There is no signal from government that HIV/AIDS prevention will be established as a central element of all drug treatment programmes. Some senior government officers believe that HIV transmission can be effectively limited if drug treatment and rehabilitation can be enhanced. Limited reach, low retention, high drop-out and high relapse rates when combined with other logistical considerations provide an explanation why this might not be so.

While a lot of effort and resources, from government, non-governmental and bilateral funding agencies, had gone into the injecting epidemic in the North-east, only a low impact in the area was observed with relapse rates among drug users being as high as 90 per cent.

Kumar et al (1997) report that the number of agencies involved in HIV testing and counselling is low and that existing facilities do not attract, access and help drug users. He adds that there are at present no HIV-positive drug user’s support groups in Chennai. Very few agencies dealing with drug use problems pay attention to HIV prevention through harm reduction information and education of drug users. Few treatment centres provide such information and education to clients while they are in treatment. Many drug treatment agencies do not consider HIV intervention as an urgent issue.

Kumar et al (1997) report that a study undertaken in Chennai revealed that the majority of heroin dependent persons undergoing detoxification had relapsed within six months of treatment. No aftercare was provided for these people. They add that the government’s strategy to create detoxification centres at all medical colleges and district hospitals will probably not be sufficient as an HIV/AIDS prevention strategy. For example, in Madras, there are 17 agencies providing drug and alcohol treatment. Only one has an official mandate that commits it to HIV prevention among injecting drug users. Many non-governmental organisations do not understand what harm minimisation is and it is not

being translated into services which reach the wider drug-using population.

D. Mechanisms for Drug Control

Legislation and application of the law

Current drug policy is “to reduce availability of drugs” through the *Narcotic Drugs and Psychotropic Substances Act of 1985* which is aimed at reducing demand through a multidimensional approach i.e. the identification of users, referral to treatment and rehabilitation, education and public awareness. Notwithstanding, key informants advise that a multi-sectoral approach is yet to be applied in practice. Drug addiction is itself defined as an offence, a matter that is of great concern from a drug treatment and prevention perspective.

The Narcotics Drugs and Psychotropic Substances Act of 1985 and its amendment, the Prevention of Illicit Traffic in Narcotics Drugs and Psychotropic Substances Act, 1988, provide guidance to the legal management of illicit drug use. This Act provides for between 10 and 20 years imprisonment for a range of drug-related offences, plus a fine of between Rs. 0.1 to Rs. 0.2 million. The Act was designed to comply with the three international drug conventions and to increase the severity of penalties in the understanding that this was what was expected by the United Nations and in the hope that this would in addition serve as a more effective deterrent to drug use. The amendments of 1988 introduced lighter penalties in certain cases where possession could demonstrated to be for personal use.

For example, Section 27 provides for a lesser punishments in circumstances where the quantity of drugs found in possession are for personal use and are less than 5 grams in the case of heroin, less than 25 grams for hashish, less than for 5 grams of morphine and less than 100 mg for herbal cannabis.

Notwithstanding, it is reported that prosecuting agencies have in the past often charged people under provisions which allow for more severe penalties and have left it to the defendant to establish in court that the drugs found in their possession were for personal use only. This aligns with one of two premises: that moral retribution is argued as a basis for law enforcement or alternatively, that harsher penalties provide for a more effective deterrence effect.

Since higher punishment is aligned with stricter bail provisions, people charged with drug offences invariably remain in prison until their case is heard in court. Given the long delays in coming to trial, this will inevitably mean that many innocent people will spend several years or more in prison without recourse to natural justice (referred to as “under-trial cases”) (UNDCP/ ROSA, 1998).

In this respect, a public interest litigation filed in 1994 on behalf of under-trial

prisoners under the Act lead the Supreme Court to rule that after accused persons have suffered imprisonment which is half the maximum punishment provided for the offence, any further deprivation of liberty would violate their fundamental rights as described by Article 21 of the *Constitution* which promises justice, fairness and reasonableness in procedural matters.

The burden of proof in respect to possession for ones own use lies with the accused, although it is stated that the benefit of lesser punishment (a different matter) is “given to the accused in a liberal manner”.

Section 31 (*Death Penalty for certain offences after a previous conviction*) prescribes the quantities of drugs that shall be punishable with death if a person is convicted of engaging in the production, manufacture, possession, transportation, import into India, export from India or trans-shipment of amount equal to or in excess of these limits:

Table 3.2 Quality of drugs that may warrant death penalty

Opium	10 kg
Morphine	1 kg
Heroin	1 kg
Codeine	1 kg
Thebaine	1 kg
Cocaine	0.5 kg
Hashish	20 kg
Amphetamine	1.5 kg

Section 39 of the Act provides for the release of a person charged with an offence of the consumption or possession of a small quantity of drugs for their own use, on condition they agree to undergo treatment for “de-addiction” at a recognised institution, and that they also enter into a bond to appear and furnish before the court evidence of their medical treatment, within one year. Additional requirements must also be met.

Section 64 A of the Act provides immunity from prosecution on one occasion in a person’s lifetime if charged with an offence relating to the possession of a small quantity of drugs, providing he or she seeks treatment for de-addiction on

a voluntary basis from a recognised institution and satisfies certain other requirements.

Section 71 of the Act provides for the establishment of drug de-addiction centres and prescribed their roles and responsibilities.

An amendment bill is currently before the Upper House of parliament in India. It contains 49 amendments to the *Narcotics Drugs and Psychotropic Substances Act of 1985*. There are concerns within the Ministry of Revenue that this bill will lapse before the parliament is able to debate the provisions. This amendment bill will seek to broaden the coverage of the Act and at the same time, lessen the severity of some of the penalties for drug users given the realisation that harsher penalties for such persons have not been well accepted by the judiciary.

At the same time, the severity of provisions aimed at drug traffickers will be increased under the provisions of the amendment bill, if passed by parliament. It is the intention of those who drafted this amendment bill that current strict bail provisions will only be applied to those offenders who are charged with committing more serious offences. The provisions of the current law have been found seriously wanting and the courts have found themselves repeatedly failing to secure convictions. Only one death sentence has ever been handed down and that decision was ultimately reversed, so this provision is seen as both redundant and unhelpful.

Some of the more salient amendments for the purposes of this research that have been proposed are as follows:

- (a) The Act shall be called the Narcotic Drugs and Psychotropic Substances Act, 1998;
- (b) Section 7A is to be amended to allow the National Fund for Controlling Drug Abuse to be utilised for the purposes of :
 - (i) identifying, treating, rehabilitating drug addicts;
 - (ii) preventing drug abuse;
 - (iii) educating (the) public against drug abuse;
 - (iv) supplying drugs to addicts where such supply is a medical necessity.

There are a number of sections under “Offences and Penalties” that add a provision for more lenient punishment (6 months) where contravention of the Act involves a small quantity of drugs. Previously, the Act provided only for an imprisonment period of 10 to 20 years, depending on the circumstances.

Section 27 makes it illegal to consume any narcotic or psychotropic drug and makes persons liable to imprisonment for a period of up to one year or a fine or

both, if the drug is specified in the official gazette. This is double the existing prescribed penalty. If it is not specified, the person may be liable to imprisonment for up to 6 months, or a fine, or both.

These amendments appear to be founded on two principles: (a) increasing penalties acts as an increased deterrence to drug use, thereby reducing demand, and (b) the imposition of more severe penalties satisfies the principle of *just deserts* as it applies to illicit drug use, which is seen as immoral behaviour.

Several key informants expressed the view that the injecting epidemic that arose in Manipur was substantially influenced by the adoption of harsh anti-drug policies at that time - the so-called “police model”. Kumar (1997) reports that there was a severe crackdown on drug supplies following the assassination of Prime Minister Rajiv Gandhi in 1991. It was established that Sri Lankan “terrorists” were involved in the assassination, resulting in a focus of attention by law enforcement officers on this ethnic group living in Tamil Nadu. This led to an acute shortage of heroin supplies, prompting many heroin users to shift to injectable buprenorphine, which was readily accessible at the time. While some shifted back to heroin when it became available again, others continued to use buprenorphine.

When strict laws came into play in Southeast Asia, Afghanistan or the ‘Golden Crescent’ area emerged as an alternative supplier of heroin. Following this, heroin was readily found in Indian metropolitan cities.

The NDPS Act (1985) that banned opium use in India was strictly enacted at this time. This it believed to have had a noticeable impact at the community level, influencing people to shift from using cannabis and opium to fume inhaling (“chasing”) brown sugar heroin.

As the price of these drugs escalated, people moved towards the use of less expensive substitutes and in particular, towards the use of injectable buprenorphine. This drug was popularised unwittingly by the medical profession when introduced as an injected pharmacotherapy to facilitate opioid withdrawal in detoxification centres and hospital settings. Hitherto, its indications had been largely limited to post-operative analgesia, although the sublingual preparation had, for a number of years previously, been used in other countries as an effective opioid maintenance treatment. The use of buprenorphine subsequently carried across to Bangladesh and Nepal.

The spread of injecting drug use in India highlights the significant impact which regional policies and programmes could have on national drug use and conversely, the influence of events on the region. Regional trends are particularly salient in their influence on drug use patterns at country level.

It is not clear that any meaningful evaluations have been undertaken in relation to law enforcement and interdiction policies, strategies and activities pertaining to drug problems in India. Manipur is an exception to this observation, where the “police model” was implemented and subsequently abandoned when it became clear that it had not stemmed the tide of drug use and when HIV transmission had continued at an alarmingly high rate.

An additional and important consideration in relation to drug policy and measures of their effectiveness is the possibility that they may unwittingly contribute to harm, for example, by shaping market forces in a way that promotes transition from drug use by oral or inhalational routes to drug use by injection.

A National Drug Master Plan for Drug Control was developed by the Ministry of Welfare, Ministry of Health and Family Welfare with the support of UNDCP, in 1991. The Master Plan has not been presented to cabinet and does not have the status of a document for implementation. The Ministry of Social Justice and Empowerment is currently working on a national demand reduction strategy. It appears that the Master Plan has been set aside and will not be implemented.

Defining drug use itself as illegal is highly worrisome from a public health perspective as it can act to deter people from accessing prevention, harm reduction and treatment services since to admit to drug use is to admit to a crime that is punishable by imprisonment, or a fine, or both. Increasing the penalty makes matters worse and from a deterrence perspective, is highly unlikely to make any difference whatsoever. Most importantly, when drug use is itself illegal, explicit HIV prevention information and education targeting people who continue using drugs may also be seen as illegal since advising people how to use illicit drugs more safely would likely amount to aiding and abetting illegal activity. It would be instructive to learn whether there is any claimed empirical evidential basis behind this proposed amendment to increase the penalty.

Drug policy review

The Ministry of Health and Family Welfare adopts a lengthy and extensive process in the development of its annual and Five-Year National Health Plans. The Planning Commission, the highest government body responsible for the disbursement of funds to state governments, which have the overarching responsibility for the delivery of health services, oversees this process according to a funding formula.

The process involves 8 to 10 working groups and 6 to 7 sub-sectoral working groups that examine key areas of health and make recommendations. These groups include representation from the government, non-governmental and

academic sectors. Regional conferences are held in the North, East, West, South and Northeast to examine base papers that emanate out of the deliberations of these working groups. Priorities for action are considered with a view to what might work today and at the same time what might be sustainable over the next 10 to 15 years.

The National government sees its role in balancing the concerns and agendas of the States and of particular bodies such as the Medical, Nursing and Pharmacy Councils, with the view to protecting and promoting the broader interests of the nation. An important guiding principle is that of equity and ensuring that no one is denied access to basic health care, regardless of their ability to pay.

Other government agencies involved in policy development include the Department of Revenue and Excise, Ministry of Finance, which has responsibility for the *Narcotic Drugs and Psychotropic substances Control Act, 1985*, whereas rehabilitation of drug users is under the purview of the Ministry of Social Justice and Empowerment. Demand reduction is also the mandate of the Ministry of Social Justice and Empowerment.

There is little co-ordination and integration of planning and action between these three Ministries. While there are processes whereby current legislation, policy and if necessary, the Constitution of India could be reviewed and amended, this can prove to be a lengthy and difficult process. Few medical and other health practitioners and those involved in drug treatment were engaged meaningfully in discussions that led to the drafting of the *Narcotic Drugs and Psychotropic Substances Act, 1985*. The primary health care sector plays almost no role in drug prevention or treatment intervention.

In response to a question about the capacity of government to respond to international empirical evidence on what works best in preventing HIV transmission through drug use, even when this evidence runs counter to socio-cultural and religious traditions, beliefs, and values, voiced the opinion that empirical evidence is rarely or never important. New evidence is accommodated but the consequences are watered down to accommodate the government's position, for example, the definition of *harm reduction* that is included in the draft National AIDS Prevention and Control Policy. A number of key informants advised that there is no culture of doing so in government at present and that the alcohol and other drugs field is no different in this respect.

Some Indian professionals who are highly respected internationally for their expertise and experience in the drugs policy, intervention and HIV prevention areas advise that they are not being adequately drawn upon and do not sit on high level State and Federal committees and working groups that are currently charged with the responsibility of leading India's efforts to address these

problems more effectively.

Abstinence remains the primary treatment goal at present. However, if the *National HIV/AIDS Prevention and Control Policy* is ratified, by Cabinet, this may change to some extent. Harm minimisation might then be on the table for drug policy development more broadly. Substitute drugs are also being discussed, but these discussions do not include methadone at present.

Although, now a part of the draft *National AIDS Prevention and Control Policy*, harm minimisation is not yet a part of national drug control policy and strategy. A senior officer in the Ministry of Health commented that, while harm minimisation is not official policy at present, the government is seriously considering its adoption, particularly through the work of non-governmental organisations - to supply sterile needles and syringes, cleaning of used injection equipment before re-use, aftercare, referral services including referral to medical centres, and rehabilitation services. While harm minimisation is seen as a good idea, government policy remains essentially silent on the matter.

A specific decision had not as yet been taken in relation to the principles of harm reduction. There is a perception that the issue of sharing contaminated drug injection equipment is “not as yet one of magnitude. Drug use is not at epidemic stages in India at present”. The problems of poverty, poor communication and an absence of awareness of drugs in rural areas were also cited as additional reasons for leaving the matter well alone.

Many informants in the government believe that drug injecting is only a regional problem of the Northeast and is not a significant problem in other parts of the country. Therefore, it is felt that there is no need for other types of interventions such as needle exchanges or drug substitution on a more extended scale.

Although both the government and non-governmental organisations are implementing pilot drug substitution programs, key informants expressed apprehension about drug substitution commenting that this was a complex and difficult issue as it does not eliminate the drug problem.

The Drug Controller has major responsibility for matters pertaining to pharmaceutical drug regulation, blood banking and the marketing and use of drugs. This includes the use of substitution pharmacotherapies in the treatment of drug dependence.

United Nations agencies

In the view of the government, UNDCP is the major agency that guides government planning in the area of drug policy. The perception was also expressed that the programme is not favourable towards the concept of harm

reduction. WHO is however seen as “*adopting a more open approach.*”

Concern is expressed in a number of government and non-government quarters as to the incongruity in policy and practice across UN agencies. UN input is not consistent across agencies, well integrated or co-ordinated. Rather, some UN agencies hold to the view that they should act within the boundaries of their own appointed mandates and not venture beyond. This viewpoint is argued on the basis of a “complementarity” principle, which posits that each UN agency has been charged with a specific mandate and role, beyond which it cannot venture.

The UN Theme Group on HIV/AIDS is currently organising its activities through NACO in part on the basis of recently established Technical Resource Groups that are constituted by people with expertise in each of the respective key areas identified. UNDCP will provide the UN linkage for the drugs intervention component. The drugs related Technical Resource Groups has not made much progress to date and needs to be strengthened in its membership and expertise. It includes currently representation from Manipur state where substantial experience and expertise in managing drug problems and HIV prevention among drug use populations exists.

E. HIV/AIDS

Historical overview

The first cases of HIV infection (HIV-1) were reported among commercial sex workers in Mumbai and Chennai and among injecting drug users in Manipur. HIV infection rapidly spread to adjoining areas and there are now concentrated epidemics (Types I and II respectively) in nine and low level epidemics in eleven states. HIV infection is now prevalent in almost all parts of the country and is spreading from urban to rural areas (a 4:1 ratio was reported in northern India during the period 1986-1993). HIV/AIDS began spreading from high risk behaviour groups to the general population in early 1990. One in every four cases is female and about 89 per cent of all reported cases are among people in the age group 15-49 years.

As of 31 March 1998, 3.3 million blood samples had been screened and 75,000 of these were confirmed as HIV positive. 5,200 AIDS cases had been diagnosed. The true number of HIV infected persons is estimated at between 4 and 5 million persons, establishing India the country with the highest number of infected persons in the region. This is based on an assessment that among adults, the prevalence of HIV infection is approximately 0.5 per cent. The cumulative detected sero-positive rate per thousand rose from 10.2 in 1986-1992 to 22.7 in

1998. In other words, the total number of sero-positive cases detected doubled within a period of six years.

In 1990, a parallel epidemic of HIV-1 and HIV-2 emerged. Studies in an STD clinic in Mumbai revealed a percentage distribution of HIV-1, HIV-2 and HIV-1+ HIV-2 to be 80, 6 and 14 per cent, respectively. Sub-Type C (with C-2 and C-3) is the dominant strain. There is no evidence of perinatal spread of the less virulent HIV-2 strain.

Infection among commercial sex workers increased in Mumbai from one to 51 per cent in five years. Infection among injecting drug users increased from one to 55.8 per cent in Manipur over the same time period. Reforms to blood product management saw the introduction of legislation in January 1998 outlawing payment for blood donation, however, indirect methods of payment by relatives through brokers are reportedly still occurring. It is now required that all blood supplies be screened for HIV-1, HIV-2, hepatitis B virus, syphilis and malaria. However, hepatitis C virus is not tested for.

As at March 1998, 74.2 per cent of all infections were attributed to heterosexual transmission, 7.3 per cent to injecting drug use, 7.1 per cent were recipients of blood, 0.6 per cent to homosexual contact and 10.9 per cent were unspecified.

HIV transmission among injecting drug users

In 1989, HIV was first detected in Manipur and within 6 months 50 per cent of all injectors were known to be infected. There is very little existing data on injecting drug use as it relates to HIV vulnerability in India. On certain subjects there is no data at all and on others there are gaps and discontinuity in the data that is available.

In Manipur, for example, when the spread of the epidemic was first documented, targeted interventions for injecting drug users were developed but with little emphasis on the sex partners of injecting drug users. Currently an estimate is that about 40 per cent of the wives of HIV infected injecting drug users are themselves infected.

Looking at neighbouring countries with injecting drug users and at injecting drug users in the country itself, it is clear that the situation is very varied and locally specific. In Mizoram for example, HIV prevalence among injecting drug users is reported to be 10 per cent in Nagaland it is 50 per cent and in Manipur it is 70-80 per cent. All three states share a common border with Myanmar, yet there is a vast difference in the rates of HIV prevalence.

In Calcutta, HIV prevalence has remained low at 1 per cent for the last three years. However, the intersection of injecting drug users and sex workers should also be considered given that 75 per cent of injecting drug users visit sex workers

and condom usage is minimal.

In Chennai, it is estimated that 20 per cent of injecting drug users are HIV infected while more than 75 per cent are hepatitis C positive and about two thirds have one or more hepatitis B markers.

A recent and yet to be completed sero-prevalence study undertaken among a sample of 200 drug users living in slum areas of Delhi and tested at the National Institute of Communicable Diseases, Delhi, it was found that among the first 43 people tested, 72 per cent were infected with HIV, 69.8 per cent were infected with hepatitis and 25.6 per cent had one or more hepatitis B markers (Dorabjee and Samson, 1999).

One study in Bangalore found the HIV prevalence among alcohol dependent population admitted for treatment was 2.5 per cent which is much higher than their aged matched non alcohol dependent population.

Unsafe sex is common among injecting drug users in India. 77.4 per cent of a recent rapid assessment sample stated they never used condoms during sex. Around 55 per cent (72) of the sample had little or no knowledge whatsoever of HIV/AIDS while 44.6 per cent were assessed as being aware of HIV by the interviewers. The need for intensification of intervention among the sexual partners of injecting drug users in addition to intervention among injecting drug users was highlighted by a WHO/ICMR collaborative study undertaken between 1994-97.

F. HIV/AIDS Prevention

National AIDS prevention and control policy

The draft National AIDS Prevention and Control Policy makes note of the fact that "... transmission among injecting drug users is also one of the major causes for the spread of HIV/AIDS in the country. Even though cases are more prevalent in the northeastern states, incidence of injecting drug use is evident from most parts of the country, especially in urban areas. The injecting needles, which are the principle cause of transmission in such cases, are used repeatedly by the drug users. The twin problem of drug addiction and HIV transmission pose a serious ethical and moral problem in the HIV prevention programme. Harm reduction programmes which involves exchange of syringes and needles, coupled with peer education, community outreach, access to health services and a range of treatment modalities from abstinence to oral drug substitution have been adopted by other countries to effectively reduce transmission of HIV through injecting drug use. In India the harm reduction approach is yet to find

wider acceptability because of ethical and moral considerations.”

These comments seem to suggest once again a sense of discomfort and reluctance among professionals working in the HIV prevention area to embrace harm reduction as an approach to drug use and HIV prevention initiatives.

Among the objectives of the draft National AIDS Prevention and Control Policy document is one of seeking “To promote better understanding among people at large, to generate awareness about the nature of its transmission and to adopt safer practices to prevent the disease from spreading.”

This presumably provides a lead for the provision of explicit harm reduction information and education aimed at all people at risk from drug use.

Under a section of HIV and injecting drug use, it is further acknowledged that injecting drug use poses a serious problem for HIV transmission in the northeastern parts of India and in cities such as Mumbai, Chennai, Calcutta and Delhi. It is stated that “the government considers drug-related HIV risk as a serious issue and that it is committed to the adoption of appropriate strategies for preventing the risk of transmission through injecting drug use.”

As such, it is further acknowledged that harm minimisation is the most appropriate strategy to combat the problem of injecting drug use and its serious consequences of HIV transmission. However, the definition that is adopted does not align with that which is accepted internationally. The draft policy document defines harm minimisation as follows: “Harm minimisation aims to reduce the adverse social, economic consequences and health hazards by minimising or reducing the intake of drugs leading to gradual elimination of their use.”

The draft policy goes on to state: “Harm minimisation in the context of injecting drug use would require not only appropriate health education improvement in treatment services but in most practical terms, providing bleach powder, syringes and needles for the safety of the individual. An appropriate needle and syringe exchange programme with proper supervision by trained medical doctors and counsellors, will be required. Government will encourage non-governmental organisations working in drug de-addiction to take up harm minimisation programmes as a part of HIV/AIDS control strategy in areas, which have a large number of drug addicts. Greater convergence will be brought about between programmes of non-governmental organisations for drug de-addiction and the hospital de-addiction programmes run by the government.”

Notwithstanding all of the above mentioned concerns, it is important to acknowledge official sanctioning within the *National AIDS Prevention and Control Policy* of harm reduction as a philosophy and of needle and syringe exchange in particular, as a harm reduction strategy. On the other hand,

abstinence-oriented de-addiction is mentioned several times in the document.

In contrast, the State of Manipur has officially endorsed harm minimisation as a policy and accepting needle exchange and drug substitution as major strategies. Pilot outreach work, peer education, needle cleaning with bleach, risk reduction information, education and communication materials and needle exchange projects operating in Manipur are reported to have contributed to thinking behind the draft *National AIDS Prevention and Control Policy* (Hangzo, Chatterjee, Sarkar et al, 1997).

It is relevant to note that the Ministries of Home, of Social Justice and Empowerment and of Finance have seniority over the Ministry of Health and Family Welfare when it comes to drug policy in India. Support for harm reduction will require that these ministries be persuaded as to the crucial importance of adopting harm minimisation policies if these are to be implemented to scale. Such advocacy might helpfully be built in to strategies emanating out of the *National AIDS Prevention and Control Policy*.

Information, education and information strategies

The draft *National AIDS Prevention and Control Policy* observes that there are serious gaps in knowledge and understanding of the specifics regarding HIV risk among many health and other professionals, as well as within the general community. It is noted that there are many different languages spoken in India making it difficult to reach all groups with information, education and communication strategies.

Several key informants advised that decision-makers responsible for HIV prevention are at best ambivalent about the provision of specific and explicit HIV prevention information to the public, but may feel more comfortable with interventions that target specific high risk groups, including those who use drugs.

The problem with this approach is that one can never know who the high-risk persons are, nor where and how one might best reach them with targeted interventions. The draft *National AIDS Prevention and Control Policy* signals an intent to address this shortfall, although the details are not spelled out.

One key informant provided an interesting viewpoint on information, education and communication messages that are commonly adopted: “There are no positive messages about drugs. They all say that “drugs kill” when this is clearly not generally true. There are no messages telling us that people can cope with and get over drug problems. There are no family support messages promoting family and community support for people who use and are at risk as a result of their use of drugs. The movies convey powerful images that glamorise drug

use or alternatively, that promote supply reduction rather than harm reduction..”. One can readily observe information, education and communication materials that advise people about the dangers of drug use.

Information, education and communication messages are designed to raise public awareness, salience and discussion about the risks of HIV transmission associated with drug use but no materials or strategies have as yet been developed that seek to stimulate frank discussion about the relative costs and benefits of drug use nor that advocate in favour of certain poorly understood and poorly supported health protection oriented legislative or policy reforms. Comprehensive, balanced and truthful information and education about drugs would not be favoured because it would be seen to encourage drug use.

Information, education and communication messages are not necessarily well researched, rather, they can be quite arbitrary. It would appear that more attention needs to be paid to evaluating how well information that is provided about risk and ways in which it can be reduced reaches and is well understood by people who use drugs. Some small projects have evaluated, but there has been no systematic evaluation of large-scale projects with respect to the reach, comprehension and impact of messages. Once again, the draft *National AIDS Prevention and Control Policy* signals an intent to address this issue.

Injecting drug users in Delhi report that they did not see sharing needles and syringes as a health risk. This reflects low levels of awareness among this sub-population about the risks of infection through blood-borne transmission (Dorabjee et al, 1999). However, other reports claim good levels of knowledge in other areas of India (UNDCP/ROSA, 1998). Some senior officers of government express the view that drug use prevention and harm reduction education is a futile exercise because levels of literacy are so low. On the other hand, a study undertaken in Chennai (Madras) in 1992 found that only a small minority (12 per cent of a cohort of 250 male opioid users were illiterate (Kumar, Mudaliar and Daniels, 1997). In any case, outreach work and peer education are specifically designed to overcome such barriers in implementing information, education and communication, and drug use network mediated harm reduction strategies.

Outreach, peer education and user self-organizations

While little specific attention is paid in the draft *National AIDS Prevention and Control Policy* to outreach and peer education, these have proved to be important strategies adopted in urban settings in which drug use is prevalent. National government policy remains silent on user self-groups and these groups have not as yet been established nor funded as an important mechanism for reaching drug users and for informing policy and planning decisions. However,

some non-governmental organisations that provide outreach and peer education services and these have assumed an important role in this regard.

While sharing of injection equipment is often a part of the social drug use etiquette, there are no systematic strategies in place that are aimed at altering this sub-cultural norm to one of non-sharing, for example, through peer education, outreach work or needle and syringe exchange contact. Some projects do this on an individual level. However, the *National AIDS Prevention and Control Policy* does not mention such strategies.

The government may not feel comfortable or confident to pursue these strategies. They are not nominated by government in its draft National AIDS Prevention and Control Policy and if anything, this policy document has some potential to take the government in the opposite direction, away from user involvement in decision-making and intervention and towards increased professional control and leadership in areas where international experience suggests this is not the most effective approach. For example, it is suggested that needle and syringe exchange programmes should be supervised by medical doctors.

However, Kumar (1999) reports that government recognises the importance and accepts the principle that ex-addicts should be involved in peer education and counselling, at least in the context of abstinence-oriented treatments. It is not clear that the same principles will apply in relation to decision-making about drug interventions and HIV prevention, to harm reduction approaches and to people who currently use illicit drugs.

Drug substitution treatment

There is no acceptance at a political level at present for the adoption of methadone maintenance treatment in India, however, buprenorphine reduction appears to be endorsed. Buprenorphine maintenance is offered on a limited basis in some parts of India (e.g., in Delhi, Calcutta and Chennai). The All India Institute of Medical Sciences operates a buprenorphine substitution program in a slum area of Delhi. Sharan has also provided low threshold buprenorphine maintenance in a slum area of Delhi. The doses used are modest and perhaps not optimum in terms of reducing opioid use - however, this remains conjectural at present.

One observation that the writer would make regarding the latter programme relates to the adoption of a twice-daily dosing regiment - "because this is what opioid users are used to and what they expect." While it is important to meet the treatment preferences of people whenever possible, this is one occasion where it would seem preferable to establish a treatment standard that can facilitate

pharmacological and behavioural stability while at the same time reducing the opportunity for diversion or injection of take home doses and reduce overall treatment costs. Once daily dosing is preferable.

While the half-life of buprenorphine is quite short (3-5 hours), its duration of action is long because it binds tightly to opioid receptors. Buprenorphine can be administered on a second or third daily basis if the dose is sufficiently high (16-32 mg) but in any case, once daily dosing is likely to be effective if a dose of 6-8 mg is prescribed. Whether doses as small as 2-3 mg per day can be administered to good effect on a once daily dosing is a matter for careful further evaluation.

The Drug Controller recently gave permission for buprenorphine to be used “for the purposes of de-addiction”.

A special license is required from the Drug Controller, however, the law is reportedly unclear on the duration of treatment that may be provided. There is also lack of clarity over the sale and use of opium. A medical practitioner can use opiate for detoxification, but she/he can:

.... beat the system - the judgement of prescribing doctor is never challenged.

There is also no clear policy on opioid substitution treatment in India but it appears that there is substantial misunderstanding of the scientific literature as it pertains to this treatment approach. Many government officers believe incorrectly that UNDCP is non-supportive of substitution treatment and several non-governmental organisations representatives expressed the view that this policy stance is hindering progressive policy reform in India. Moves to eradicate opium from the northeastern parts of India are seen as being responsible in substantial part for promoting the transition from opium smoking to the injection of dextropropoxyphene and buprenorphine in those areas.

The WHO Southeast Asia Regional Office is currently supporting a buprenorphine substitution project in Manipur. It purchased 40,000 tablets of 2-mg strength at a discount rate of approximately US\$ 0.70 (usual price quoted at US\$ 1.50).

The special price is still 40 times more expensive than the least expensive cost of purchasing opioid dependence bio-equivalent doses of methadone and the full price is nearly 80 times as expensive. On this basis, it is difficult to reconcile the preference for buprenorphine, particularly in a developing nation context where all resources must arguably be put to maximum cost-effective use.

An alternative to methadone and buprenorphine, which has been suggested, is

morphine sulphate. This opioid is more strictly regulated in India and is less expensive than buprenorphine and perhaps even methadone. A strip of 10 tablets of 20 or 30 mg strength costs Rs. 9 (US\$ 0.36).

This might be worth trialing given the importance of cost-effectiveness considerations, bearing in mind however that morphine has a number of disadvantages - it is not well tolerated or liked by a substantial minority of opioid dependent persons, it has a short half-life and it requires twice or thrice daily dosing. Longer acting preparations are also available and have been trialed for opioid maintenance purposes in a number of countries.

Needle and syringe exchange and availability

There are no paraphernalia provisions in the law in India which make it an offence to be in possession of a needle or syringe nor provisions outlawing needle and syringe exchange. This means there are no specific legislative barriers to implementing needle and syringe exchange and availability programmes. It has been the international experience that when the law is silent on a matter, police will sometimes allow and sometimes disallow and even harass people involved in such health protection activities, depending on their own views and sometimes, as an opportunity for corrupt opportunism. It appears that the situation is no different in India. However, police reportedly do not generally harass people over the personal possession of needles and syringes. Needle and syringe exchange services have been trialed on a limited basis in a number of cities in India, most notably in Delhi, in Calcutta and in the northeast. Chennai operated a small programme for a short period of time and is planning to re-launch a programme, not withstanding many local policy barriers and questioning of the likely effectiveness and workability of the strategy, locally.

Pharmacists are legally permitted to sell needles and syringes to people who may use them to inject illicit substances. However, injection equipment is not affordable to those living in socio-economic disadvantage. A 2-ml syringe costs Rs. 3 and a 5-ml syringe costs Rs. 3.5-4.0 (these are the most popular sizes).

One argument expressed in opposition to needle and syringe exchange is that drug users will simply on-sell any sterile injection equipment that they receive. This argument illustrates a misunderstanding of needle and syringe exchange and availability strategies. While it is preferable that the individual who accesses sterile injection equipment will use it to protect them, it actually does not matter in an environment of scarcity whether he does or whether someone else ends up using the equipment. The important consideration is whether sufficient sterile needles and syringes are placed into the drug use environment and whether a substantial majority of people who inject drugs do so in a manner that reduces the risks of transmission sufficiently to make a public health

difference.

One key informant suggested that needles and syringes provided by exchange are likely to be sold to unscrupulous pharmacies for a low price (Rs. 1), who will then re-sell them at a higher price (Rs. 5). While this may be so, it is insufficient reason to reject the needle and syringe harm reduction strategy. Needle and syringe exchange programmes have, after all, been shown to work in other developing nation contexts where economic disadvantage is commonplace among people who inject drugs.

The Calcutta needle and syringe exchange programme has a policy of one for one exchange but does not enforce this policy rigidly. The return rate is estimated at 60-70 per cent. The programme operates during office hours of 9 a.m. - 5 p.m., not the most ideal period when need is likely to be greatest. The programme serves about 350 people thrice weekly on average at an operational cost of US\$ 850 per month. This is a low intervention model and as such costs one-fourth to one-tenth per client contact in comparison with the Manipur programme. Clients are actively encouraged to reduce their drug and HIV-related risk practices. They are encouraged to dispose of used injection equipment in a safe way. There are no laws or regulations that specifically require the safe and responsible disposal of used injection equipment.

Manipur State: a case study

The first HIV positive case in Manipur was reported in February 1990 from blood samples collected in October 1989 among a cluster of injecting drug users who were in the central jail. As of 30 April 1998, a total of 6,871 HIV-positive cases (460 females) and 301 AIDS cases (94 deaths) had been reported out 54,004 blood samples screened. This provides for a sero-positivity rate of 127.23 per 1000 blood samples screened against the all India figure of 22.04.

Manipur has about 0.2 per cent of India's population but contributes nearly 8 per cent of all HIV cases reported in India to date. Manipur ranks third highest behind Maharashtra and Tamil Nadu States in terms of the total number of HIV-positive cases. However, the sero-prevalence rate per one million population in Manipur is at least six times higher than that of Maharashtra State and twenty times higher than that of Tamil Nadu State.

The HIV sero-prevalence rate in Manipur increased from 0 to 50 per cent in just one year during 1990-91 and increased further to 80.7 per cent in 1997. Similarly, the sero-prevalence rate among pregnant women increased from 0.8 per cent during 1994 to 1.97 in 1997. The HIV sero-prevalence rate among

tuberculosis patients increased from 3.3 per cent during 1991 to 14.35 per cent in 1996.

Initially, almost all cases in Manipur were among injecting drug users. Now, about 76 per cent of HIV infected persons are injecting drug users. The HIV/AIDS epidemic in Manipur is now no longer confined to injecting drug users, having spread to their female sexual partners and children. The HIV seroprevalence rate among pregnant women in urban areas increased from 1.97 per cent in 1997 to 3.5 per cent in 1999.

In the early days of the HIV/AIDS epidemic in Manipur, drug users were the targets of blame and retribution. The police resorted to mass arrest and imprisonment of drug users. Inside the jails, they were placed in leg shackles and subjected to involuntary HIV testing. Those who were found positive were placed in solitary confinement. This practice of compulsory measures was adopted widely and came to be known as the “police model”. There were many case reports of people being refused hospital treatment because they were HIV-positive.

Access to drug treatment was extremely limited. Non-governmental organisations were running drug de-addiction centres under the direct supervision of the Ministry of Welfare without any dialogue with the Ministry of Health and often offered only an abstinence goal in treatment. The relapse rate was more than 80 per cent. The State Government believed that it could not offer harm reduction services such as needle and syringe exchange or “Bleach and AIDS Education” programmes as these were not approved within the terms of a Contact Agreement between the World Bank and the Government of India.

The rapid increase in HIV seroprevalence was attributed to the fact that the policy of harm reduction was not implemented until 1996. Any activities of this nature that were implemented between 1990 and 1996 were conducted only on a small scale by a small number of non-governmental organisations. However, there is now a clear policy in support of harm minimisation, but a deficit of resources to expand harm reduction services.

The Manipur State Government does not allow any kind of discrimination in the matter of provision of health care, social benefits, employment, housing accommodation to persons who are HIV-positive. Involuntary or indiscriminate HIV testing is also prohibited. Voluntary participation is encouraged. Policy provides that people with HIV/AIDS be guaranteed confidentiality, privacy, dignity and human rights.

Leading edge policies and practices have now emerged. These are summarised as follows:

- (a) No compulsory measures;
- (b) Encourage and support harm reduction such as needle and syringe exchange programmes, “bleach and teach programmes”, drug substitution therapy;
- (c) Creating a helpful and supportive social environment in the community;
- (d) Voluntary participation of people living with HIV/AIDS;
- (e) Prevent further spread of HIV;
- (f) Protect and support those who are vulnerable to infection;
- (g) Ensure easy accessibility of people living with HIV/AIDS to quality treatment and support services;
- (h) Ensure that services are efficient, effective and evaluated;
- (i) Mobilise and unify inter-sectoral action, community initiatives, networking of non-governmental organisations;
- (j) Risk reduction information.

V. DISCUSSION

A. Constraining factors

There are unfortunately a large number of policies and other factors that are serving to constrain progress in reducing HIV vulnerability as it relates to drug use. These include the following:

- (a) The issue of drug use and the hazards that it poses for HIV transmission in India is not yet well enough recognised or addressed;
- (b) Unsafe injecting drug use and unsafe sex while under the influence of drugs are well established behaviours and are not as yet being addressed in a manner that is likely to have a generalised and sustainable public health protective impact;
- (c) Thinking about HIV prevention as it relates to drug use remains locked onto individual focused approaches while potentially more effective population-based structural and socio-cultural environmental change strategies remain relatively unexplored;
- (d) Vertical planning and action within and across Ministries and sectors continues to limit the potential effectiveness of responses;
- (e) There is confusion and misunderstanding among many decision-makers,

- opinion leaders and service providers about the evidence, meaning and methods of harm reduction, both within government and non-government sectors involved in drugs and HIV policy development and intervention;
- (f) Many drug treatment and HIV prevention personnel appear to possess inadequate knowledge and skills;
 - (g) Drug de-addiction treatment models based on models dating back to the 1970s and 1980s continue to be offered without rigorous evaluation and reform;
 - (h) Drug treatment services are often not sufficiently user-friendly in policy and practice and often do not provide adequate if any HIV prevention services;
 - (i) Inadequate attention has been paid in drawing upon drug users themselves, either individually or as representatives of user-self organisations in policy review and development and in the planning and evaluation of interventions;
 - (j) Drug treatment is largely inaccessible for a wide range of reasons;
 - (k) Undue reliance appears to have been placed on detoxification and drug-free “de-addiction” or rehabilitation programmes as a means of preventing HIV infection among drug users;
 - (l) Local and international empirical evidence has not as yet been sufficiently drawn upon in policy development or reform and other decision-making in the drugs and HIV intervention areas;
 - (m) Emerging drug use trends such as multiple drug use and the introduction of amphetamine type stimulants, when considered in conjunction with high risk drug use and drug injection techniques are likely to exacerbate HIV vulnerability in relation to drug use;
 - (n) Poor access to sterile or even clean injection equipment will likely continue to impede efforts aimed at reducing HIV vulnerability among people who use drugs and their sexual partners;
 - (o) Inequities in access to services, poverty, poor co-ordination and integration of planning and action within and between Ministries and sectors, inadequate knowledge and skills are all contributing to a less than effective response to drug use and HIV vulnerability at present;
 - (p) Inadequate pharmaceutical controls and professional standards and supervision are serving to enhance the high risk drug use environment since a wide range of pharmaceuticals are freely available without redress;

- (q) There remains an unsubstantiated belief that by increasing the severity of penalties for drug offences, governments can exert a more effective deterrent effect against drug use and drug trafficking;
- (r) The prison environment in India remains unexplored and poorly addressed in terms of the serious public health threats that unsafe sex and unsafe drug use present;

B. Facilitators, levers and opportunities

Notwithstanding the many and varied factors that presently serve as barriers to reducing HIV vulnerability in relation to drug use and drug policy, it is essential that decision-makers in India identify the facilitators, levers and opportunities for policy reforms and actions that can begin to remedy the situation.

It is sometimes useful to identify one or more entry points so as to get things moving in the right direction. It is very encouraging that the draft *National AIDS Prevention and Control Policy* is supportive of needle and syringe exchange as a HIV prevention strategy. If the definition of harm minimisation and its application can be brought into alignment with international standards and experience, there is reason for optimism that further positive reforms will come about.

The technical resource group mechanism adopted by NACO provides a vehicle for developing drugs policy and harm reduction strategies, programmes and activities, however, it would appear that the illicit drugs technical resource group needs to be strengthened. A number of people in Delhi, Calcutta and Chennai who have international experience and expertise in the drugs and HIV prevention fields and who could, if invited, contribute substantially to the deliberations of this group.

The Theme Group on HIV/AIDS provides an official avenue through which the evidence pertaining to harm reduction principles and methods can be conveyed to key decision-makers in government and further afield. At present, these officials are making decisions in the presence of incomplete and inaccurate information and they concede that these matters have never really been placed on the discussion table for careful consideration. It will be essential that the Theme Group draws upon all available expertise in developing and implementing its strategy to facilitate a move towards enhanced evidence-based decision-making in the drugs and HIV prevention area and that it brings decision-makers into continuous contact with the untapped expertise that resides in country.

CHAPTER 4
MALAYSIA

CHAPTER 4

MALAYSIA

I. SUMMARY OF FINDINGS

There are between 100,000 and 400,000 people using illicit drugs in Malaysia at present. The most commonly used drug is heroin, followed by cannabis, morphine, psychotropic substances and opium. The use of amphetamine-type stimulants has emerged as a new drug problem. The number of newly detected drug user has continued to rise during the last decade, notwithstanding strengthened government anti-drug legislation and activity, and the prescribing of severe punishments aimed at deterring drug use.

In a study of 24,230 drug users in 1995 it was found that 23.5 per cent were injecting drug users, 49.8 per cent were fume inhaling heroin users and 24.2 per cent were smoking cannabis. Another recent study reported that 77 per cent of respondents admitted to sharing needles and syringes with 10 others and 23 per cent shared with more than 11 others. Some drug injectors practice cleaning, however, it is likely to be of limited if any use in protecting them from infection with blood-borne diseases since it is usually performed with water alone.

As of the end of December 1998, the cumulative total of known HIV infected persons was 28,541, of whom 77.1 per cent were injecting drug users and a total of 8.2 per cent were reported to have AIDS.

The drug problem is generally considered to be extremely serious in Malaysia and is often referred to as “public enemy number one”. The general goal of drug policy is one of achieving a drug-free society by the year 2023. Those responsible for developing national drug strategy have focused on preventing and reducing drug use as a priority. Little attention appears to have been paid to HIV prevention as a central element of policy and action.

At present, opportunities for the application of empirically supported HIV prevention strategies are being lost because policy analysis currently precludes inclusion of certain valuable options. Similarly, the National HIV/AIDS Strategy has not as yet addressed the relationship between unsafe drug use, related unsafe sexual activity and HIV/AIDS vulnerability, in a sufficient detail.

Communication between those sectors of government and with non-governmental organisations involved in drugs and HIV/AIDS is not adequate to ensure effective sharing of ideas and perspectives and the development of a co-ordinated approach to these problems. There is a belief that enhancement of drug-free treatment and rehabilitation services, whether voluntary or involuntary in nature, can be effective in containing and reversing an HIV epidemic as it relates to drug use.

A number of laws that are aimed at reducing drug supply appear to conflict with the principles and methods of key HIV prevention approaches. Drug use is itself unlawful and is taken to be proved if a person tests positive to an illicit substance on urinalysis. Possession of needles and syringes constitutes an offence.

The cost of needles and syringes, if able to be purchased from a pharmacy under the guise of need for the purposes of treating a medical condition, is in any case sufficient to substantially reduce access.

The Drug Dependants (Treatment and Rehabilitation) Act 1983 provides for both compulsory treatment and rehabilitation of any person who has been certified as dependent as well as for voluntary programmes. The period of treatment and rehabilitation at rehabilitation centres is two years. Two years of aftercare follows. This is an expensive and lengthy approach to drug treatment and is reported to dissuade people from coming forward to treatment on a voluntary basis. The relapse rate from the drug rehabilitation centres was estimated to be 70 to 75 per cent following 15-24 months involuntary treatment.

There were a total of 23,536 prisoners nation-wide as of October 1996, about 5 per cent of whom were HIV-positive at that time. At the end of 1996, 43.7 per cent of the prison population were drug offenders. Research in prisons has found that they are high-risk environments for the transmission of HIV and other blood-borne and sexually transmitted diseases. Unsafe sex is highly prevalent. Although not reported on in magnitude, drug use including injecting drug use is also occurring in Malaysian prisons and detention centres.

II. RECOMMENDATIONS

It is recommended that the Government establish intersectoral mechanisms to routinely evaluate and review drug policies.

Communication between those sectors of government and with non-governmental organisations involved in drugs and HIV/AIDS should be re-structured to ensure the development of a co-ordinated approach to drug use and HIV problems.

Consideration should be given to commissioning independent research and evaluation of drug policies and interventions. Any evaluation studies that are undertaken should include an examination of the possibility or extent to which some current drug policies may unintentionally have been causally associated with adverse outcomes.

Special attention should be paid to developing policies, mechanisms and services for helping people who have drug use problems and HIV/AIDS.

Local communities and people who use drugs should be consulted and engaged as members of drug and HIV prevention policy planning committees.

With regard to the effectiveness of treatment and rehabilitation, it is recommended that the cost-effectiveness of the involuntary treatment model be examined and compared with evidence available on voluntary models of interventions.

A review should be undertaken as to the cost-effectiveness and suitability of engaging the primary health care sector in the treatment and prevention of drug problems.

It is also recommended that public health policies and measures be implemented in prisons in relation to any unsafe drug use and sexual behaviours that occur.

Increased attention should be paid to enhancing training and formal supervision for staff in drug treatment centres. Strategies should be devised to ensure that decision-makers and clinicians can easily keep abreast of the local and international scientific literature to enable them to try out alternative clinical policies and practices. Special attention should be paid to training of police officers at operational and decision making levels in outreach, peer education and other HIV prevention strategies.

Enhanced attention should be paid to HIV infection prevention interventions within drug policy and activity. To this end the government should commit itself to outreach, peer education and user self-organisations and programmes which include the provision of explicit HIV prevention information and education, through policy, technical support, supervision, standards development, evaluation processes and funding support. The basis for policy analysis and development should be broadened to include public health measures that have been demonstrated internationally to reduce the transmission of HIV through drug use without increasing drug use.

Laws which make it unlawful to be in possession of a needle and syringe and illegal to use drugs should be re-examined, with a view to their repeal.

Greater attention should be paid to enhancing the knowledge and understanding of HIV/AIDS and related risk behaviours, within the general community and among specific high risk sub-populations, while avoiding fear engendering messages that can increase the marginalisation of people at risk of HIV infection and people living with HIV/AIDS. In this connection, the Government should support the establishment of a national user self-organisation that has a role in policy advocacy and technical support, planning and the delivery of health protection and treatment interventions.

III. INTRODUCTION

Malaysia comprises 13 states and federal territory with a total area of 329,733-sq. km. It has a population approaching 22 million, consisting of Malays, Chinese, Indian, Kadazans, Ibans and others. Malaysia has a predominantly Muslim population and the official religion is Islam. Malaysia has a relatively young population with 44.9 per cent of the population below the age of 20 years, followed by 49.3 per cent between 20-59 years and 5.8 per cent above 60 years (1997). The infant mortality rate is 11 per 1000 live births (1996) and maternal mortality rate is 80 per live 100,000 births (1990). The life expectancy at birth is 69 years for males and 74 years for females. The urban/ rural population distribution is 54 per cent: 46 per cent (1995). Malaysia is ranked 60th on the UNDP Human Development Index (UNDP, 1998). The Life Education index is 0.76. The real per capita Gross Domestic Product was US\$9,572 in 1995.

Malaya (as it was previously known), while never an opium producing country, has a long history of opium use. In 1929, there were 52,313 registered opium smokers in the Federated Malay States, all of whom were reported to be Chinese. In the newly independent Malaysia of the early 1950s, opium extended from an elderly population of opium smokers to young men who began using heroin, which was mostly imported, from the Golden Triangle countries. Malaysian authorities mounted an anti-drug strategy in 1952 in response to “rising drug-related crime”. This included the establishment of drug rehabilitation centres and the implementation of more severe punishments enshrined in law.

Notwithstanding, drug use re-emerged as an increasingly serious problem in Malaysia in the early 1970’s. At that time, opium smoking was most common among older persons. In more recent years, drug use has shifted to younger groups and to drug injection. The spectrum of drugs used has also broadened to include amphetamine-type stimulants.

The drug problem is generally considered to be extremely serious in Malaysia and is often referred to as “public enemy number one”.

IV. FINDINGS

A. Patterns of Drug Use

The most commonly used drug is heroin (65 per cent of the drug user population in 1996), (Table 4.1) followed by cannabis (17.7 per cent), morphine (14.7 per cent), psychotropic substances (1.4 per cent) and opium (0.3 per cent) (*Narcotics Report*, 1996).

In a study undertaken in 1994, it was estimated that 50 per cent of drug users preferred heroin, 15 to 20 per cent of whom injected. The street purity of heroin is estimated to be between 2 and 25 per cent. This is thought by some to reflect the “success” of street interdiction activity by police. However, it has been suggested that this interdiction activity may also have been responsible, at least in part, for a higher incidence of injecting since this method of drug administration provides for a more cost-effective and better drug effect than sniffing, snorting or smoking the drug.

The use of amphetamine-type stimulants has emerged more recently in Kuala Lumpur and appears to be on the increase. Cocaine and MDMA (“ecstasy”) were seized for the first time in 1996. Twenty-three cases of methamphetamine use were detected in that year. The injection of amphetamine-type stimulants mixed with heroin has also been increasingly reported.

Malays represent the largest proportion of drug users by ethnic origin (76.9 per cent), followed by Indian (9.5 per cent) and Chinese (9.4 per cent) Malaysians.

Table 4.1 Types of drug addiction: 1988-1996

Year	Heroin	Cannabis	Cocaine	Morphine	Pills ¹	Inhalant	Others
1988	17,179	1,824	212	1,319	139	6	18
1989	14,578	1,344	179	905	121	5	207
1990	12,068	1,323	133	1,310	86	7	336
1991	15,018	2,124	59	1,153	64	10	212
1992	18,358	2,196	72	528	36	27	289
1993	21,581	2,980	54	441	47	17	337
1994	23,408	3,445	76	1,380	73	9	365
1995	23,723	5,581	74	4,148	159	8	411
1996	19,900	5,404	78	4,489	259	11	457

¹ include ‘ecstasy’, Valium, etc

The *Narcotics Report* (1996) notes that 98.7 per cent of those arrested for drug offences during the previous year were male.

B. Epidemiology of Drug Use

Number and characteristics of drug users

It is variously estimated that there are between 180,000-400,000 drug users in Malaysia. The lower figure represents the number of persons who have been identified to the authorities since a registration procedure commenced in 1970. It has been further estimated that there are between 170,000 to 200,000 opioid users.

The Ministry of Home believes that the actual number of “active drug users” is closer to between 100,000 and 130,000. The use of amphetamine-type stimulants is on the increase, however, and estimates on the number of persons who have ‘ever tried’, who ‘use intermittently’ and who ‘use regularly’ and in a dependent manner, vary widely.

Between the years 1988 and 1996, the *National Drug Information System* identified a total of 225,000 drug use cases and 127,00 individuals when duplicate cases were eliminated. This figure comprised 65,000 new cases and 62,000 repeat cases and probably serves as the basis for the Ministry of Home estimate.

The *Narcotics Report of 1996* notes that the total number of drug users had decreased by 10.3 per cent from the previous year. A total of 16,752 persons were identified as recidivists, 54.7 per cent of the total drug user population detected during the year (Table 4.2).

Table 4.2 Number of new and relapse cases of drug user detected, 1988-1996

YEAR	NEW		RELAPSE		TOTAL	
	NO.	%	NO.	%	NO.	%
1988	10,424	41.4	14,781	58.6	25,205	100
1989	7,631	37.9	12,487	62.1	20,118	100
1990	7,389	38.3	11,921	61.7	19,310	100
1991	8,083	39.7	12,258	60.3	20,341	100
1992	8,238	38.3	13,268	61.7	21,506	100
1993	10,383	40.8	15,074	59.2	25,457	100
1994	11,672	40.6	17,084	59.4	28,756	100
1995	13,140	38.5	20,964	61.5	34,104	100
1996	13,846	45.3	16,752	54.7	30,598	100

The number of new drug users detected for 1996 was 13,846 (Table 4.2). This represented a small increase on the previous year, leading the government to conclude that it must intensify its primary prevention efforts. These data from the National Drug Agency indicates that the average number of new drug users per month is 1,154.

Urban centres like Kuala Lumpur and Penang have large populations of injecting drug users and a substantial (but imprecisely estimated) proportion of these are thought to be infected with HIV. No state in Malaysia is currently free neither from injecting drug use nor from HIV infection. Among these urban populations, 98.7 per cent of drug users identified in 1996 were male and were aged between 19-39 years. High proportions of these men are unemployed. Only 0.1 per cent of these persons had a tertiary degree, 0.3 per cent a diploma and 0.7 per cent the equivalent of a higher school certificate.

According to the *Narcotics Report, 1996*, most people who use drugs are in the 20-39 year age bracket (80 per cent). A study to examine the causes of addiction was conducted by the National Drug Information System of the National Narcotics Agency. The study examined, among others, the onset of drug use and the relation between age, types of drug use, racial background and drug addiction.

Preliminary findings of the study were that 10 per cent of drug users were first detected after one year of drug use, 15 per cent after two years and 8 per cent after 5 years. In relation to drug use, 7 per cent took their drug of choice 4 times a day, 11.5 per cent 3 times a day, 51.1 per cent 2 times a day and 26.2 per cent once a day. A small number reported that they took drugs once a week (3.5 per cent) and some once a month (0.7 per cent).

People who use illicit drugs are generally treated in the community as criminals. Local communities are generally unsupportive and are more likely to reject people who use drugs rather than accept and help them as valued members of the community. While it is government policy that people who use drugs be treated as if they have a health problem, public communications and practices are more closely aligned with the former perspective.

High risk drug use practices

A study of 24,230 drug users in 1995 reported that 23.5 per cent were injecting drug users, 49.8 per cent were fume inhaling heroin and 24.2 per cent were smoking cannabis. The sharing of needles and syringes and other paraphernalia is a common feature of drug use etiquette among groups of drug injectors in Malaysia. This is believed to be related in part at least to a relative scarcity of needles and syringes and to the harshness of the law enforcement response to drug use. A study undertaken several years ago revealed that 77 per cent of

respondents admitted to sharing needles and syringes with 10 others and 23 per cent shared with more than 11 others. In a case control study undertaken on 348 drug users in the largest treatment centre in Malaysia, more than 70 per cent of cases stated that they had shared drug injection equipment.

In 1992, a study in northeast Malaysia revealed that the rate of unsafe injecting was high (55 per cent had shared needles in the preceding month). A study undertaken during that same year at a drug rehabilitation centre found that 79 per cent had shared a needle with other users.

Professional injectors exist and are known as “street doctors”. They inject multiple customers with the same, non-sterile injection equipment. Little attention has been paid to date by government to implementing strategies aimed at altering these high-risk drug-injecting norms through outreach and peer education strategies. Anecdotal reports suggest that some interventions of this nature have been implemented by several non-governmental organisations, but only in an ad hoc rather than in response to policy, to scale and in a sustainable way. Such interventions are generally viewed as antithetical to the goal of attaining a drug-free Malaysian society.

Heroin, pre-prepared in syringes is reportedly sold in some villages, resolving a problem when access to a needle and syringe is difficult and enabling the avoidance of severe penalties associated with being caught in possession of drug injection equipment. This situation makes it much more likely that a single needle and syringe will be used on multiple occasions among many people, increasing HIV vulnerability.

Some drug injectors practice cleaning, however, it is likely to be of limited if any use in protecting users from infection with blood-borne diseases since it is usually performed with a small number of water rinses alone. Recently, a non-governmental organisation introduced the use of bleach to injecting drug users in Kuala Lumpur. Although household bleach is accessible throughout the country, it appears this method of cleaning injecting equipment is not commonly known about or used.

A needle and syringe purchased from a legal pharmacy requires a prescription; the price is approximately US\$ 0.32-0.64. A needle and syringe can also be purchased from an illegal pharmacy, without a prescription, at a higher cost. Apart from the legal barriers, the cost factor is likely to discourage the purchase and instead, encourage the sharing of injecting equipment. Since carrying a needle and syringe is in itself illegal under the Dangerous Drugs Act 1952 and can be used as incriminating evidence against a drug user, this will likely serve

as a substantial deterrent against obtaining clean injecting equipment from a pharmacy.

C. Government responses to drug use

Senior officers within the Malaysian government are highly aware and concerned about the special risks which injecting drug use poses for the transmission of HIV/AIDS. The mainstays of responses to date have centred around institutional drug free treatment and deterrence theory applied through the criminal justice system and through non-government and private sector treatment services. It has not be considered appropriate or socially acceptable to enhance lawful access to sterile needles and syringes through needle and syringe exchange and availability programmes, for the explicit purposes of making drug use safer. Concern is expressed that the distribution of sterile needles can only aid and promote illicit drug use. The government has however allowed the distribution of bleach for the purposes of cleaning of needles and syringes. This work has been undertaken by a non-governmental organisation.

Those responsible for developing national drug policies have focused on preventing and reducing drug use as a priority. Little attention appears to have been paid to HIV prevention as a central element of drug policy and action. Similarly, the National HIV/AIDS Strategy has not as yet addressed the relationship between unsafe drug use and HIV/AIDS vulnerability, in a sufficiently detailed manner.

Communication between those sectors of government and with non-governmental organisations involved in drugs and HIV/AIDS appears less than adequate to ensure the development of a co-ordinated approach to these problems. However, the view that this is an important challenge that must be met is shared across sectors, indicating a preparedness to proceed in this direction. It is relevant to note that there is a system in place whereby staff of the Ministry of Health are seconded to the Ministry of Home Affairs to provide direct services, within the drugs and HIV areas.

While the high level of concern has led the government to commit substantial resources to addressing drug problems, and has been accompanied by the establishment of a high level policy, planning and decision-making body in the guise of the National Narcotics Agency, this body does not appear to have a strong intersectoral basis for its functions and decision-making.

The government has also committed itself to addressing HIV/AIDS problems through the establishment of high level policy, technical and co-ordination advisory bodies, however, several key informants expressed the view that these

two bodies are stalled and are not making substantive progress in expanding the repertoire of responses. They felt this is particularly true in relation to the issue of the relationship between drug policy, drug use and HIV vulnerability.

Efforts aimed at preventing the further spread of HIV among those who inject drugs are limited to preventive education and involuntary treatment, based on a belief that if these elements can be strengthened, the HIV epidemic will be controlled. However, the HIV/AIDS sector is not actively involved in an ongoing manner in drug policy evaluation, reform and strategic planning. Similarly, the drug prevention, treatment and control sector(s) are not actively involved in an ongoing manner in HIV/AIDS-related policy evaluation, reform and planning.

In relation to the question of which aspects are most important as a basis of government drug policy, responses naturally varied. However, “safeguarding national security” and “safeguarding law and order” appear to rank highest and protecting, “promoting public health”, “upholding spiritual and religious beliefs, values and laws”, “maintaining socio-cultural traditions” and “protecting and promoting economic development and prosperity” ranked lower.

D. Legislation and application of laws

Malaysia is a party to the Single Convention on Narcotics, 1961, the Convention on Psychotropic Substances, 1971, Convention against Illicit Trafficking of Narcotics and Psychotropic Substances, 1988.

National legislation pertaining to the control of narcotics and psychotropic substances include the following:

- (a) Dangerous Drugs Act 1952 (Act 234) (revised 1980);
- (b) Poisons Act 1952 (revised 1989) and Poisons (Psychotropic Substances) Regulations 1989;
- (c) The Drug Dependants (Treatment and Rehabilitation) Act 1983 (Act 283) & Regulations & Rules;
- (d) Dangerous Drugs (Special Preventive Measures) Act 1985;
- (e) Code of Conduct for Pharmacists and Bodies Corporate 1989;
- (f) Sale of Drugs Act 1952 (Act 368);
- (g) Registration of Pharmacists Act 1951 (Act 371) (As at 15th December 1997);
- (h) Poisons Act 1952 (Act 366) and Poisons Regulations;
- (i) Control of drugs and Cosmetics Regulations 1984;

- (j) Sale of Drugs Act (Act 368) ;
- (k) Registration of Pharmacists Act 1951.

Under the national legislation, all narcotics including the synthetic substances and Schedule I substances listed under the *Single Convention on Narcotics 1961* and the *Convention on Psychotropic Substances 1971*, respectively, are controlled as “dangerous drugs“ under the *Dangerous Drugs Act 1952* (revised 1980). Amphetamine and methamphetamine (Schedule II substances) have also been controlled as “dangerous drugs” under the Act with effect from 18 December 1997. Under this Act, “trafficking” of any dangerous drug carries a mandatory death sentence. There is also a special provision for presumption of “trafficking”. Possession of a specified quantity of substances like heroin (15 g.), morphine (15g.), cocaine (40g.) and cannabis (200g.) shall be presumed to be “trafficking” unless the contrary is proved. Possession of up to 5 grams of opium or cannabis will result in no less than 5 years in prison and a 20,000 Ringgit fine; possession of 5-15 grams of heroin can result in a life sentence while having more than 15 grams of heroin attracts a mandatory death penalty.

Under Malaysian law, a person found in possession of drugs or drug-taking paraphernalia is recognised as a trafficker. If found in possession of illicit drugs or drug injection paraphernalia (such as needle and syringe), a person will be charged with a drug possession offence. If convicted, they are liable to receive a lengthy prison sentence. Police strictly observe their powers to arrest and detain any person for up to 14 days for urine drug testing on suspicion of illicit drug use.

The *Poisons Act 1952* is aimed at controlling the import, possession, sale and use of poisons. The term ‘poison’ refers to any substance specified in the poisons list and includes any mixture, preparation, solution or natural substance containing such substance other than an exempted preparation or an article or preparation included for the time being in the Second Schedule of the Act. The control of any drug that does not appear under the First Schedule of The *Dangerous Drugs Act 1952* would be controlled under this Act. This Act came into force in Peninsular Malaysia on 1 September 1952 and was extended to Sabah and Sarawak from 1 June 1978.

The types of poisons that fall under the control of this Act include substances used for industry, medicine and agriculture. Some poisons have been classified as psychotropic substances and can only be obtained through prescription by medical practitioners, veterinarians or dentists. Only pharmacists and doctors are empowered to sell these substances (*Narcotics Report, 1996*).

Psychotropic substances except those mentioned above, are controlled as “psychotropic substances” under the *Poisons Act 1952* (revised 1989). Special

regulations were promulgated in 1989 in order to comply fully with the requirements of the 1971 Convention. Under the existing legislation, all importation and exportation of narcotics and psychotropic substances requires import or export authorisation issued by the Ministry of Health.

The *Drug Dependants (Treatment and Rehabilitation) Act 1983* is considered to be a comprehensive piece of legislation covering treatment and rehabilitation. This Act came into force on 15 April 1983. The act provides for both compulsory treatment and rehabilitation of any person who has been certified as (drug) dependent as well as for voluntary programmes. The period of treatment and rehabilitation at rehabilitation centres is for two years. Two years of aftercare follows.

The *Dangerous Drugs (Special Preventive Measures) Act 1985*, basically a preventive detention law, came into force on 15 June 1985 replacing the Emergency (Public Order and Preventive of Crime) Ordinance 1969. It is aimed at enhancing the effectiveness of countermeasures taken by the relevant authorities against those who are involved in drug trafficking. It empowers the government to detain anyone suspected of being a trafficker without having to bring the suspect to any court of law. During 1996, a total of 1,112 persons were detained for suspected involvement in major drug activities.

As noted above, Malaysia has recently encountered use of methamphetamine, arising initially in the state of Sabah in East Malaysia. The number of cases and quantities seized by police are presented in Table 4.3.

Table 4.3 Amphetamine seizure in Malaysia

Year	No. of Cases	No. of Arrests	Quantity
1996	211	286	1184.9 g.
1997	345	458	1503.4 g.

Besides methamphetamine, Malaysia has also experienced the introduction of methylenedioxy methamphetamine (MDMA), otherwise known as 'ecstasy' in 1996, particularly within the dance scene. The import and export of anti-satiety pharmaceuticals have been closely monitored. The Ministry of Health initiated the monitoring of importation of ephedrine and pseudoephedrine in 1995.

E. Evaluation of law enforcement strategies

A total of 11,361 people were arrested under the Dangerous Drugs Act 1952, in 1996. A total of 11,361 persons were arrested under Section 39B, Trafficking in Dangerous Drugs. This represents an increase of 48.9 per cent on the previous year. The number arrested under Section 39A, increased penalty where the subject matter is the prescribed amount of certain dangerous drugs, also increased by 9.2 per cent.

It is hoped that the inclusion of methamphetamine under the control of the Dangerous Drugs Act will deter use of this drug. A study on the legitimate use of ephedrine products has also been planned with the view to discontinuing the production and sale of these products if it is found they are not essential for medical purposes. Malaysia is also considering the introduction of more stringent control over amphetamine-type stimulants in order to curtail any possible widespread increases in trafficking and use of these substances.

F. Risk of HIV infection in prisons

There were a total of 23,536 prisoners nation-wide as of October 1996, about 5 per cent of whom were HIV positive at that time. At the end of 1996, 43.7 per cent of the prison population were drug offenders. Of these, 51.4 per cent were classified as 'addicts', 33.9 per cent as 'addicts-cum-traffickers' and 15.7 per cent as 'traffickers'.

Information on the nature and level of drug treatment provided during their term of imprisonment was not accessed. However, it appears that some consideration is being given to extending the therapeutic community concept to prisons.

Prison populations are routinely tested for HIV. Mandatory HIV testing is also undertaken within the criminal justice system more broadly. Some key informants thought that confidentiality is not well protected regarding HIV test results and HIV status more generally.

Injecting and non-injecting drug use is reported in prisons. Needles and syringes are smuggled in and, given their scarcity and the unmet demand, are highly valued commodities. Each needle and syringe is likely to be used many times by many different persons, without any capacity for blood decontamination between usage. This poses substantial risk for the transmission of HIV and other blood-borne disease. As a result of these findings, correctional authorities have imposed strict policies and control measures in an effort to ensure that drug use is minimised or eliminated in their institutions.

No information could be accessed as to whether there is any evidence of spread of HIV and other blood-borne and sexually transmitted diseases in prisons. Nor was information able to be accessed about any evaluation of the effectiveness

of these measures.

A total of 5,063 inmates (including 135 women) who have served their jail sentences in the nation's prisons since 1989 have been confirmed as HIV carriers. Of this number 68 men and 4 women who developed full blown AIDS had died while another 3,850 including 127 women had been released after completing their sentences. As of January 11, 1997 there were 1,218 HIV positive prisoners including 8 women in the prisons.

Government officials suggest that the rate of HIV transmission within prisons is "not that high". However, available data shows that HIV prevalence increased in prisons from 890/ 26,000 to 1,300/ 26,000 over a period of just one-year (IMR/WHO, 1998).

While HIV screening is compulsory for all patients admitted to drug rehabilitation centres, only those prisoners who are identified as involved in the injection of drugs are screened when entering prisons. It is reported that pre-and post-test counselling is provided to all prisoners who are tested.

Non-governmental organisations may provide drug use-related risk reduction information to people in prisons but this is not part of the official programme of activities. Non-governmental organisations advise on the adoption on universal precautions in the case of blood spills and provide training to counsellors, however, the constant and rapid turnover of staff reportedly makes it difficult to build upon and sustain a high level of knowledge and skill among prison personnel.

G. Treatment and rehabilitation

Overview

The National Narcotic Agency, Ministry of Home Affairs and the Prisons Department are the main agencies responsible for the drug treatment and rehabilitation programme in Malaysia. The agency undertakes to treat and rehabilitate drug addicts confirmed under the Drug Dependant (Treatment and Rehabilitation) Act 1983. The Prisons Department treats drug related offenders who are charged under the Dangerous Drugs Act, 1952 or related laws. The main objective of treatment and rehabilitation strategy is to treat, rehabilitate and prevent recidivism amongst drug dependent persons so as to enable them to function as productive members of society.

The Ministry of Home Affairs is not viewed as one that possesses institutional expertise on matters pertaining to drug problems, nor HIV prevention in relation to illicit drug use. This is seen, as a matter of some concern in some quarters especially since this Ministry is the one that carries principal responsibility for drug control and treatment.

The government aims to eliminate drug dependency by providing treatment and rehabilitation to drug users either by way of rehabilitation in institutions (One Stop Centres), or supervision within the community. A number of key informants expressed a view that drug treatment is not generally of a specialised nature, although staff do receive some training in counselling.

Exclusion criteria for treatment programme admission include HIV positive and 'hard core' in the case of government services. Ability to pay and not being of the same religion are potential exclusion criteria within the voluntary and private sectors.

In response to the question of whether people with drug problems would actively seek out drug treatment of the type that is provided in compulsory drug treatment centres, if a programme of this nature was to be provided in the voluntary sector, key informants generally thought they would not. They believed that clients would perceive drug treatment staff attitudes as generally unsupportive and negative. Few would readily avail themselves of an institutional-based treatment and rehabilitation programme that extended for a period as long as two years.

If people in treatment relapse, they go through the whole process again, without modification of the 'treatment' they receive. Opinions differ as to whether they are punished or not. After a number of re-admissions, they will be released into the community as 'hard core addicts who cannot be helped.'

There is a drug user registration system. Police register people when taken into custody for urine testing or when found otherwise deemed to have a drug problem. It is not clear whether there are adequate mechanisms in place to minimise any double counting and the removal of persons from the list when they die or if they recover from their drug problem.

A drug user is defined as a person who has tested positive for illegal drugs through urine screening without being in possession of any drugs or drug using paraphernalia. If a person is caught in a police raid without illicit drugs in their possession and if they test positive to drugs on urine toxicology, they may be sent to one of 28 drug rehabilitation centres for a period of between 18 months and 2 years. They may be released sooner at the discretion of the Minister. This is followed by further supervision within the community that may include regular, involuntary urine drug testing.

The nature of the person's drug use - ranging from experimental and non-dependent (a person may in theory have used an illicit drug on only one occasion) to regular and dependent use, does not alter the involuntary treatment response that is applied.

It does not appear that a distinction made in legislation, regulation and public policy between people who use drugs in hazardous or ways and those who use in a dependent manner. If found to have a positive urine test, a person is treated as if they are drug dependent and require involuntary institutional treatment for up to two years. When in treatment, it would also appear that no distinction is made in the programme of activities that is prescribed. There is no treatment matching.

Some key informants suggested that the discomfort experienced by the staff of drug rehabilitation centres in treating people with dual drug problems and HIV infection is reflected by this early release policy (this occurs following the specific approval of the responsible Minister, in each case). They expressed concern that no follow-up and aftercare for the drug and HIV-related problems is offered to these people.

The drug control budget is currently set at approximately US\$270 million. About US\$60 million (22 per cent) of this budget is allocated to operating the 28 drug rehabilitation centres.

Treatment data

In 1996, 14,155 persons identified as having a drug problem were admitted for treatment and rehabilitation at a government rehabilitation centre. In addition, 9,100 received treatment within correctional centres and nearly 25,000 received non-institutional treatment at one of the 40 private rehabilitation centres, operated mainly by social and religious groups.

Religious instruction, military drill practices and a variety of physical exercises and occupational tasks are a central part of the programme that is provided in drug rehabilitation centres. Each centre houses between 600 and 1500 inmates. There is one drug rehabilitation centre for women. An offence has been committed if the person absconds from a centre and a prison sentence of up to 5 years may be imposed.

No information could be gathered on the question of whether the policies and practices of voluntary treatment services influence treatment seeking or the effectiveness of involuntary treatment. However, the following observations have relevance to this important question.

Many key informants felt that people who are admitted to drug rehabilitation centres generally feel uncomfortable with, do not like and do not value the treatment services that are provided. They often do not respect the clinical skills of staff and do not feel confident that they can help them. Some may not have a 'drug problem' (having been found positive on urine testing when not a regular or dependent user) and therefore, may not want treatment. Some respondents

felt that those seeking treatment on a voluntary basis from non-government services are more likely to value the treatment.

Negative contingency-based behavioural change approaches (removal of privileges, admonition, shaming, generating concern or fear and punishment) are favoured over positive contingency-based approaches (incentive, encouragement, recognition for achievement - no matter how small a reward) within the government drug treatment and rehabilitation sector. Many non-governmental organisations adopt the alternative view that positive approaches are more likely to be effective in reaching and helping people with drug problems and who, as a result, are vulnerable to HIV infection.

Relapse rates were estimated at 51 per cent during the period 1988-1996 (National Drug Data System). This figure relates to those who come to the attention of authorities through re-offending. In 1994, the relapse rate from the drug rehabilitation centres was acknowledged to be 70 per cent² following 15-24 months involuntary treatment. The same figure of 70-75 per cent is quoted at present. Overcrowding, insufficient staff and inadequate training are believed to have contributed to the low success rates associated with this drug-free treatment approach.

The drug rehabilitation programme

There are three elements of the drug treatment and rehabilitation programme:

- (a) Detection and detoxification;
- (b) Institutional rehabilitation;
- (c) Supervision and aftercare.

The Ministry of Health is responsible for the detection and detoxification of drug users. All facilities such as detention centres, medical services for urine test and medical examination and magistrate services are now provided in a "One Stop Drug Rehabilitation Centre (Pusat Serenti)". This replaced the old procedure whereby an individual had to go through a series of steps in different locations. There are 28 One Stop Centres.

The programme provided at Pusat Serenti is aimed at ensuring personality growth and change, equipping inmates with coping skills and social skills. Counselling is provided "so that permanent psychological change can be maintained amongst residents before they are discharged from the centre".

2 It is not clear what time frame this refers to - 3, 6, 12 and 24 months after treatment would be common periods for measurement of relapse rates. In addition, there are differing definitions of relapse. The definition adopted is not specified in reports.

The supervision programme, which is similar to the aftercare programme, is a community-based programme designed for drug users who do not need to undergo institutional rehabilitation. The implementation of this programme requires the support and involvement of the family members, neighbours, employers, employees and head of departments. Anecdotal reports suggest that stigma and marginalisation remain substantial barriers to implementing the latter feature of the programme, as conceptualised. This programme is for a period of 2 to 3 years.

In 1996, a total of 13,541 people participated in this programme.

Aftercare programme

To help recovering drug users adjust to a new life, aftercare programmes are provided. The aim of this programme is to provide recovering drug users with guidance from a rehabilitation officer and with assistance from the community in finding jobs or undertaking “beneficial economic or social projects”. Towards this end, local drug rehabilitation committees have been formed. Aftercare is seen as representing “the most crucial period in the whole process of treatment and rehabilitation of an addict”. All recovering drug users are required to undergo a two-year period of aftercare upon release from the rehabilitation centre.

However, there is a challenge that remains to be addressed. In placing importance on community-based aftercare and support, it is problematic that people who use drugs and people living with HIV/AIDS are generally discriminated and described in derogatory ways.

Aftercare centres provide inmates with a six-month residential programme aimed at helping them reintegrate into society. In 1996, there were 7 aftercare centres in operation and offering a maximum of 50 treatment slots each.

A pilot naltrexone relapse prevention program has been implemented within the drug rehabilitation centres by the Ministry of Home Affairs in collaboration with the National Centre for Drug Research. Anecdotal reports suggest that the programme has not fared as well as many had hoped. This is attributed in part to inadequate counselling and support services. The use of methadone maintenance treatment has not been favoured hitherto, since it is perceived that it contradicts the aspirations for a drug-free Malaysian society. Notwithstanding, the Technical Committee on AIDS has signalled an intention on behalf of the government to conduct a scientific trial of this treatment modality, through the University Hospital in Kuala Lumpur.

Non-governmental organisations

There are a number of non-governmental organisations undertaking prevention

and treatment in the drugs and HIV areas. These include Pemadam, Persatuan Pengasih, IKHLAS, Malaysian AIDS Council, Pink Triangle and Malaysian Care. Their contribution is highly valued by the government. Non-governmental organisations are funded directly by government to undertake their work.

Staff of the IKHLAS Centre in Kuala Lumpur believe that they have been able to achieve some success with Malaysian officials by not challenging the boundaries of the law that have already been set down. Although not able to freely distribute sterile needles, this HIV and drug awareness program has been to distribute free bleach to injecting drug users through outreach services. However, the clampdown on drugs and its impact on injecting drug users has meant that this target group are not always easy to gain access to.

Malaysia Care and Persatuan Pengasih operate drug rehabilitation centres. Persatuan Pengasih implements what is termed a therapeutic community programme, which is voluntary and reports an 80 per cent success rate. The use of peer educators who were once drug users, working in close co-operation with those who are trying to abstain from drugs is a key feature of this program. The focus of attention is on abstinence only messages rather than harm reduction oriented HIV prevention.

The primary health care sector plays no substantive role in the treatment and prevention of drug problems and there are no plans afoot to establish any such role. People with drug problems therefore have limited or no access to community based interventions including those of an early and brief nature.

H. HIV/AIDS

Epidemiology

As of the end of December 1998, the cumulative total of known HIV infected persons was 28,541, of whom 22,006 (77.1 per cent) were injecting drug users and a total of 2,354 (8.2 per cent) were reported to have AIDS, 4.04 per cent of all HIV cases reported were women. The number of persons who had died from AIDS was 1,811. These figures represent a sudden and dramatic increase on the previous end of year figures. The cumulative total of reported HIV infections from 1996 to June 1997 was 6,091, of whom 78.3 per cent were injecting drug users. However, these figures are an over-estimate of the true population attributable risk since drug users are subject to biased selection through routine testing prior to entry into drug rehabilitation centres and when detained by police.

Sentinel surveillance of pregnant women attending antenatal clinics rose from 0.14 per cent in 1994 to 0.21 per cent in 1996 and among those attending STD clinics it ranged between 0.67 per cent and 1.68 per cent. Drug rehabilitation centres undertake mandatory HIV testing of all new inmates. The percentage of HIV infections for all residents has varied from 30-40 per cent and among more recent admissions, has been found to be about 60 per cent.

The annual detection rate increased from 0.03 cases per 100,000 population in 1986 to 22.1 cases per 100,000 in 1997. The majority of HIV and AIDS cases have remained among the male population, that is, 96.26 and 94.02 per cent respectively. It is estimated that by end of 1998, there were a cumulative total of 49,494 persons infected with HIV in Malaysia, increasing to a predicted 103,710 by the year 2003.³

HIV testing policies

Voluntary anonymous HIV testing is also available through almost all medical and health facilities. An identification code is used for each patient. Sub-type E is the most common among people who use drugs, in Malaysia.

In prison settings, it is policy that all prisoners be tested on admission, at three months and prior to their release. However, resources have not allowed this policy to be implemented reliably. All people admitted to involuntary drug treatment centres are tested. Those who test positive are separated from others when retiring to their living quarters in the evening.

The prevalence of hepatitis C infection among injecting drug users in Malaysia is not known. However, a study on hepatitis C prevalence is currently underway and the results will be available at the end of 1999.

HIV prevalence within the 28 drug treatment centres has been found to range from 10-27 per cent, supporting the conclusion that HIV infection among drug users has emerged as a major determinant of the AIDS epidemic in Malaysia. Current sero-prevalence among injecting drug users is thought to be as high as 30-40 per cent.

HIV related drug policy and legislation

In 1983, in an attempt to enhance the efficacy of the national effort to control and prevent drug abuse, the government adopted a new approach to fight the drug problem. A comprehensive National Drug Policy was formulated in 1983. The main objectives of the policy were to eliminate the demand and supply of illicit drugs and establish a 'Malaysian community free from drug abuse'.

3 Anecdotally, NGOs have suggested that the real figure is much higher, perhaps as high as 5 times the number that has been reported through testing to date.

The Prime Minister of Malaysia made this policy statement at the launch of the National Anti Narcotics Campaign on 19 February 1983. Drug use was then declared as the main threat to national security.

In an effort to enhance the efficacy of national efforts aimed at preventing and controlling the drug situation, the government, in 1996, decided to restructure the government machinery responsible for the drug problem. On 7 February 1996, the Cabinet of Ministers made a decision to disband the *Anti Drug Committee* and the *Anti Narcotics Task Force*. In its place the Cabinet of Ministers established the *National Narcotics Council*, chaired by the Minister of Home Affairs, and a new department in the Ministry of Home Affairs known as the National Narcotics Agency was established.

The *National Narcotics Agency* serves as Secretariat to the National Narcotics Council and is responsible for all aspects of the national anti drug efforts. The objectives of the *National Narcotics Agency* is to ensure that national efforts in the combating of the drug menace is carried out in a planned, integrated and coordinated manner to create a drug free society.

Several senior officers of the Ministry of Home Affairs commented on the need to communicate and collaborate more closely with the Ministry of Health in matters related to drug treatment and HIV prevention. Officers of the Ministry of Health made similar comments, however, channels do not appear to be actively open at present. The linkage between the Ministry of Home Affairs and non-governmental organisations was not mentioned in this context.

General drug policy is promoting a drug-free society by the year 2023. This time frame has been chosen on the basis that it will take a generation to achieve this outcome. It also accords with the goal of Malaysia achieving the status of a “developed nation” by the year 2020. Public health interventions such as substitution therapies and needle and syringe exchange are viewed as promoting drug use and as such, are seen as incompatible with the pursuit of a drug-free society.

The evaluation of policy is to be distinguished from the evaluation of specific approaches or interventions, for example, a longitudinal study has been undertaken to evaluate the effectiveness of the therapeutic community approach.

Great importance is placed on respecting and upholding religious principles and values, making it difficult to implement policies and practices that are seen to run counter to these traditions, even if local or international experience suggest that an alternative approach promises more in preventing or reducing drug related harm. However, some key informants thought that it was not out of the question that research supported HIV prevention interventions might be ac-

cepted if the arguments are well enough put. Also of relevance is the finding that safeguarding “national security” and “law and order” are considered more important than upholding the religious and socio-cultural traditions of the nation and public health.

Information, education, communication

The Ministries of Home Affairs and Education are responsible for the production of drug-related preventive information while the Ministry of Health is responsible for HIV prevention information.

A range of strategies has been implemented in Malaysia in the areas of drug use and HIV prevention. Although HIV/AIDS related information has been disseminated through the electronic and print media since 1988, these strategies have not generally been formally evaluated. The materials are usually pre-tested.

The focus of attention has been on teaching good moral values and behaviour and on not using drugs. Little attention appears to have been paid to date to pragmatic HIV prevention messages targeting those who use drugs. Some messages have focused on invoking fear as a method of deterrence and behavioural change.

In devising information, education and communication programmes, some specific attention has been paid to the special risks associated with unprotected sexual practices under the influence of drugs. However, respondents felt that not enough attention has been paid to this area of HIV vulnerability.

Information provided by government focuses on the types of drugs that are used, the dangers associated with their use and the degradation that people who use them will inevitably experience. There have been some public messages advising people not to share needles and syringes.

Some respondents felt that information, education and communication strategies are often framed on an assumption that individuals make rational health and social-related decisions on the basis of the perceived costs and benefits of their actions. Hence, fear-engendering messages are seen as a legitimate element of drug prevention activity.

While information, education and communication strategies may to some extent have been aimed at raising awareness, salience and public discussion about the issues, the negative messages that are conveyed may have served to further entrench prevailing negative attitudes which people in the community commonly have towards drug users. Government may feel that this is a good thing on the basis of an assumption that it will increase the deterrence impact of its drugs policy and ensure that drug use is not normalised.

Another approach is the Ministry's use of religious classes to conduct lectures on morals, sexual values and AIDS prevention. In this approach, the students are taught values that will also 'lead them away from drugs and homosexuality'. The government has concluded that the focus on economic development in Malaysia has been associated with the loss of some important values amongst their young people. In an effort to protect young people from becoming infected, the government developed PROSTAR (Program Sihat Tanpa AIDS, Health Without AIDS Programme). The objectives of PROSTAR are:

- (a) To create awareness among youth about HIV and AIDS;
- (b) To instill positive values in youth so that they will avoid getting HIV/AIDS;
- (c) To encourage youth to lead a healthier lifestyle, with a strong foundation in moral and religious values.

The programmes under the PROSTAR project targets young people aged between 13-25 years of age in secondary schools, universities, youth associations and factories. The media is used to disseminate the messages of PROSTAR (Omar, 1998). There is a PROSTAR club and magazine. Young people are taught about 'the values of abstinence, freedom from drugs, procreative sex, and abstinence before marriage including unwanted pregnancies'.

PROSTAR is aimed at creating a generation of well-informed youth in relation to issues of HIV/AIDS and at equipping them with information and skills they need to make informed decisions and practice a healthy lifestyle. It uses selected young people to act as facilitators and peer educators who disseminate information on HIV/AIDS.

Prostar might also be understood as an attempt at modifying the community, wider social and political environments in a way that encourages and supports concomitant changes at the individual level, in this case, abstinence from all drug use.

School-based programmes

Since 1994, teachers and drug preventive personnel have been trained in interpersonal skills in drug education. Interpersonal skills form a major component in the drug curricula in schools, being integrated into subjects such as moral education, language studies, physical and health education and religious studies. The teaching of interpersonal skills to teachers and drug preventive personnel is seen as essential 'because skills such as decision making, improvement of self respect, communication, assertiveness are very necessary to enable a person to reject drugs'. In 1996 a total of 120 teachers were trained.

The National Narcotics Agency conducts surprise urine screening at random on 'high risk students' with a view to enabling early intervention where evidence of drug use is found. In 1996, 163 (0.01 per cent) of pupils tested positive on random urine testing among more than 16,000 pupils. In 1996, 181 students were arrested for various offences including addiction. In the period between 1988 to 1996, there had been 2,038 arrests of school students involving 581 schools.

Students who test positive for drugs are counselled by the school counsellor, and asked to attend motivational courses to enhance their self-esteem and interpersonal skills. In 1996, 624 activities were carried out involving 24,825 secondary school students.

Outreach, peer education, user self-organisations

Non-governmental organisations such as Pengasih have adopted peer education and outreach approaches in working with drug users in the community. Pengasih is staffed by people who have recovered from a drug problem. Government also supports a drug user self-organisation which receives some funding from the Ministry of Health. However, the Government provides limited support to non-governmental organisations in undertaking outreach work.

Key informants felt that local communities and people who use drugs are not generally consulted in relation to drug and HIV prevention and treatment policies and plans. They are not engaged as active members of drug and HIV prevention policy, planning committees and working parties as a matter of routine practice. The Ministry of Health provides some funding to user self-organisations for HIV prevention activities. However, outreach work does not at present form a part of the government's HIV prevention strategy in relation to drug use. There are few self-organisations operating as part of an overall community based approach that is aimed at reducing HIV and other drug-related risk. Some receive better support than others do.

Legal and policy situation

While there are some who object, use of the term harm reduction appears generally acceptable in Malaysia. Respondents in government and in the non-government sectors seemed comfortable with the terms "harm reduction" and "harm minimisation."

There do not appear to be any laws that specifically prohibit organisations, agencies or persons from providing harm reduction information and education. However, the illegality of drug use itself could be interpreted to mean that the provision of information on safer ways of using illicit drugs is in itself an

offence, since it aids abet such illegal activity.

While the law does not appear to preclude its use, drug substitution treatments such as methadone are not supported in government policy at present. The National Technical Committee on AIDS has endorsed the idea of undertaking a trial of methadone maintenance treatment. Existing legislation would not appear to prevent this occurring.

This idea has however been placed on hold pending the securing of the necessary resources, technical support and training. The use of substitution treatment is seen by some as a sin against Islam, because it is an intoxicating substance. It is also rejected because it is seen to contradict the goal of attaining a drug-free Malaysian society by 2023.

Possession of needles and syringes constitutes an offence under Section 37 of the *Dangerous Drugs Act 1952*. The legal framework and its real life application is serving to dissuade people from easily and reliably obtaining sterile needles and syringes and related paraphernalia, increasing their vulnerability to HIV infection.

A needle and syringe costs between US\$ 0.32 and 0.64. Some people working in the drug treatment sector expressed a belief that a prescription is required for the legal purchase of a sterile needle and syringe and that some pharmacies sell needles and syringes without such prescription, on an illegal basis. The Pharmacy Code of Conduct would appear to preclude any such sales.

Government policy and legislation actively remains silent on the issue of needle and syringe exchange. Section 37 of the *Dangerous Drugs Act 1952* would appear to preclude the possibility of implementing needle and syringe exchange for reasons outlined above. Officers of the Ministry of Home Affairs advised that they did not support the idea of giving out clean needles and syringes as it is “seen as promoting drug abuse”. Prisoners with a history on injecting drug use receive some health protective information and education while in prison in the form of a video, shown prior to release. The video carries messages advising them to use condoms and not to inject, should they choose to use drugs.

About one third of registered drug users give a history of drug injection. A small number of non-governmental organisations have paid attention to strategies aimed at altering the sub-cultural norm from one of sharing to one of non-sharing, these principles have not as yet been systematically applied as a means of achieving HIV prevention among those who use drugs. Government policy is generally non-supportive of the provision of specific HIV prevention-related information to young people. For example, the promotion of condom use is not allowed.

Outreach and peer education strategies have generally been limited to abstinence-oriented work that includes encouraging positive activities, pursuing “alternate highs”, engaging in sport and other healthy recreation and have not included the development of drug use networks which encourage change in drug use norms in a way that can reduce risk more generally.

Police may use possession of a needle and syringe as incriminating evidence against people arrested for a drug-related offence, as provided for in the *Dangerous Drugs Act 1952*. Police officers do not generally receive information and training on the rationale and evidence in support of the public health benefits of outreach, peer education and other HIV prevention strategies. Police officers are generally silent on these strategies, programmes and activities, providing “nothing goes wrong.” One key informant thought that police officers would be generally supportive of services aimed at reducing the risk of HIV infection among drug users without necessarily reducing drug use itself, if well explained and if they thought it would be of help to them in doing their work.

HIV/ AIDS budget projections

Based on an average rate of progression of HIV infection to AIDS of 10 per cent per year, it is estimated that treatment alone will cost the Malaysian government US\$32.2 million per annum, well beyond the national budget for HIV/AIDS. This budget is currently about US\$16.8 million, approximately 2.3 per cent of the annual health care budget. Additional resources are made available through funding for other programmes and services, for example, counselling provided in drug treatment and social welfare services, through training and training of trainer programmes and so on. The Malaysian AIDS Council is an umbrella organisation for non-governmental organisations working on AIDS, funded by government.

The budget for 1998 was affected by the economic crisis but the actual figure was not available. The Ministry of Health administers this budget in its entirety.

AIDS prevention and control committees

Several committees on AIDS are in place to discuss issues and formulate policies in relation to HIV/AIDS prevention and management in Malaysia. A ministerial level committee on AIDS was established in 1992. This is the highest policy making body in relation to HIV/AIDS prevention. It is chaired by the Minister of Health and is comprised of Ministers from the following ministries:

- (a) Ministry of Education
- (b) Ministry of Information
- (c) Ministry of Home Affairs

- (d) Ministry of Youth and Sport
- (e) Ministry of National Unity and Social Development
- (f) Ministry of Culture and Tourism
- (g) Ministry of Rural Development
- (h) Minister in the Prime Minister's Department

There are two sub-committees under the Ministerial Level Committee on AIDS:

- (a) The National Coordinating Committee on AIDS
- (b) The National Technical Committee on AIDS

The National Technical Committee is responsible for the formulation, evaluation and review of the technical aspects of the National HIV/AIDS Prevention Programme. This committee meets twice each year.

The National Coordinating Committee on AIDS is responsible to provide a platform for various government agencies and non-governmental organisation to discuss social, economic, cultural, religious, legislative and other issues related to the prevention, control and management of HIV/AIDS. The committee is chaired by the Secretary-General of Health and is responsible to coordinate concerted effort of the government agencies and non-governmental agencies to address HIV/AIDS. The committee is also responsible for the establishment of working groups and committees to discuss and study specific issues or proposals to be submitted to the Ministerial Level Committee on AIDS.

It was suggested by a senior officer of the AIDS/STD Section, Ministry of Health, that each sector needs a focal point and unit specialising in HIV/AIDS prevention. However, the idea of having a focal point is seen as often ineffective because such persons usually have this role added to an already busy job and it is not carried through as a priority in their day to day work activities.

At state level the Director of Health Services is responsible for the implementation of HIV/AIDS prevention and control programmes.

HIV/AIDS prevention programme

Prevention is the priority of the HIV/AIDS prevention programme. A national HIV prevention strategy is currently being developed. It requires an editorial before its publication. The theme of 'positive living' has been added and emphasised in the latest version of the counselling manual.

The health education and health promotion programme is the main strategy for the prevention and control of HIV transmission. The thrust is to prevent

transmission from occurring among uninfected persons. It is recognised that activities with this objective in mind need to be undertaken without delay.

The following activities have been developed to reach these objectives:

- (a) Mass awareness campaign through electronic and printed media, public forums, workshops, talks and other promotional activities;
- (b) Small group discussion and personal approaches to motivate people for behavioural change and adoption of healthy lifestyles;
- (c) Intensification of health education through the school health education programme;
- (d) Production of health education materials, such as videos, documentary films, booklets, pamphlets, billboards, etc.

Prevention themes

Malaysia began in its early efforts in tackling HIV/AIDS by adopting a scare-based approach. However, Malaysia has moved away from this approach now, preferring instead to adopt a more caring approach. The message that is being given to the public is that HIV/AIDS is everyone's concern, that all people are affected, directly or indirectly. Community mobilisation is being adopted as a strategy of the HIV/AIDS prevention programme. We want to "open the minds of people in the community" and encourage them to "take care of their children so they don't use drugs and so they stay healthy and without AIDS".

Government representatives advised that Malaysia has not designed its prevention approaches on the basis of any one or more theoretical models of behavioural change. Rather, health education strategies are based on a mix of ideas and assumptions. The Ministry of Health has developed information, education and communication materials conveying pragmatic risk reduction messages such as 'don't share needles' and 'clean your used needles and syringes'. This information is conveyed to all, not just to small higher risk sub-populations, although there are some more targeted messages. One key informant advised: "prevention activities are focused on reducing risk rather than a moral dimension, without public protest to date". It may be that such activity has been small by dimension and reach since other key informants expressed a view that risk reduction information and education has been of a minimal nature and insufficient to make a public health difference.

Non-governmental organisations, UN Theme Group

Non-governmental organisations play an important role in HIV/AIDS prevention. Two related organisations, the Malaysian AIDS Council and the Malaysian AIDS Foundation act as the lead agencies involved in HIV prevention planning

and activity in Malaysia. They aim to create awareness and inform the public on ways that they can avoid infection. They have also been very active in working to reduce stigma against AIDS victims and their families. Non-governmental organisations are turning their attention to rural areas that have hitherto experienced reduced access to information and services of this nature.

There is, in addition, a strong link with women's non-governmental organisations, with a view to supporting them in the development of strategies aimed at creating awareness among women about HIV/AIDS and reducing their vulnerability to infection. Women are being educated about their sexuality and encouraged to be more assertive about their own reproductive and sexual health and rights.

It is not clear that the UN Theme Group on HIV/AIDS has as yet made any real inroads into HIV vulnerability as it relates to drug use and drug policy. Key informants suggested that the Theme Group has not yet addressed HIV prevention among drug users in any substantive way.

Research

Nearly all key informants agreed that drug policy research is important. They advised that there are no mechanisms for routinely monitoring and evaluating treatment policies, legislation, regulations and other strategies and activities. They did not know of any plans to establish such evaluative mechanisms.

Information or reports could not be accessed on the results that have been obtained with any drugs, herbal medicines or other traditional approaches used in the treatment of drug problems. Information or reports could not be accessed on any quantitative or qualitative information on implementation and on any evaluation of the short and longer-term outcomes following treatment of all kinds, in terms of drug use, risk behaviour, social functionality, criminality, incidence rates of HIV and viral hepatitis infection etc. Respondents did not know whether any such evaluations have been undertaken. Little ethnographic research has been undertaken in relation to the level of awareness and understanding of the risks associated with drug injection per se, with sharing of drug injection equipment and ways of reducing this risk. No information could be accessed on whether drug use networks have been studied and whether they are open to outsiders or whether they exclude them and provide relative protection to groups.

When asked about Malaysia's experience in working to prevent use of drugs, what laws, policies, strategies, programmes and activities that respondents believe are working, those which require further research or time to demonstrate a potentially positive impact and those which they believed the evidence places doubt on or does not support, in terms of their effectiveness, few expressed

confidence in the approaches that are being adopted. One key informant responded: "I think Malaysia should begin again from scratch". Several key informants were of the opinion that the policy of attaining a drug free society be reviewed, as it seemed to be acting as a constraint on planning and activity.

V. Discussion

A. Constraining factors

The drug problem is generally considered to be extremely serious in Malaysia and is often referred to as "public enemy number one". Therein lies a challenge since the concern that is expressed is accompanied by metaphors conveying a message of intolerance and military-style responses.

Possession of needles and syringes and operation of needle and syringe exchange programmes constitute an offence under Section 37 of the Dangerous Drugs Act 1952.

Drug use is itself unlawful, and is taken to be proved if a person tests positive to an illicit substance on urinalysis.

The Draft National HIV Prevention Strategy does not appear to go far enough in its strategies for addressing drug-related risk. It does not include approaches, which the international empirical evidence suggests have been most important on preventing an HIV epidemic in some countries and cities of the world.

There is a belief among decision-makers in the government and perhaps also in the community that enhancement of drug-free treatment and rehabilitation services, whether voluntary or involuntary in nature, can be effective in containing and reversing an HIV epidemic as it relates to drug use.

There is very little priority in the Draft National HIV Prevention Strategy concerning the introduction of harm reduction policies. Health education campaigns link drug use and HIV/AIDS through information, education and communication materials. Specific information about how HIV infection is transmitted by intravenous drug use is omitted. There are no attempts for HIV/AIDS programmes and HIV prevention interventions to be included at drug rehabilitation centres, in prisons or in schools.

The often countermanding or dis-empowering effects of the socio-cultural, economic, public policy, commercial and religious environments in which people live are also paid inadequate attention, environments that contradict the 'say no to drugs' messages that are conveyed, but which are often not understood to have such an effect.

One cannot ignore the tremendous influence that a globalised communications environment is now having on young people all over the world. Decision-makers cannot assume that traditional values and traditional ways of viewing problems will be embraced by younger generations, given the impact of the cable television, dance culture, video, youth magazines and the internet, on young people.

The Technical Committee on AIDS and the National Co-ordinating Committee are not making sufficient progress at present. These committees were seen as being essentially stalled in their thinking and activity.

Religious instruction, military drill practices and a variety of physical exercises and occupational tasks are undertaken by all that are detained in drug rehabilitation centres. It appears to be assumed that each of these elements of treatment (teaching self-discipline, spiritual and moral correctness, physical fitness, occupational skills building and recreation) will contribute towards the enhancement of personal capacity to stop using drugs and to stay abstinent

The feeling expressed by one senior government official that “It is almost impossible to teach these people”, no doubt reflects the feelings of frustration and concern that current strategies are not proving sufficiently effective if at all in helping people to remain abstinent following treatment.

Malaysia has placed great emphasis on the deterrence value of harsh penalties for using and selling illicit drugs, and over a lengthy period of time. That the problems continue to escalate in the face of ever more severe penalties should sound warning bells for the government. Decision-makers might ask themselves whether they are willing to accept unquestioningly the notion that these strategies can work, if and when they are applied with greater vigour and more reliably.

B. Facilitating factors

There is a substantial investment in drugs policy and intervention and indicates serious commitment in government to addressing the problems. This commitment provides opportunities for the trialing of new approaches to drug treatment and HIV prevention. This may require re-allocation of financial and other resources from less effective programmes and strategies.

The government recognises the potential benefits of utilising the non-governmental sector in reaching out to marginalised groups of people who use drugs. The engagement of the non-government sector in the delivery of HIV prevention information and education to hidden at-risk populations is one that has much to offer. However, there are counter-arguments, which identify with the need for governments to commit themselves to such HIV prevention policies

and to implement and be seen to implement these policies through government-run agencies. According to this argument, governments have a responsibility to provide technical support, to lead the way in standards development, and to monitor, evaluate and regulate service provision across all sectors.

The use of substitution treatment is seen by some as a sin against Islam, because it is an intoxicating substance. If this is the most important barrier to trialing methadone maintenance treatment, it is one that might easily be overcome since it can be demonstrated that people receiving this treatment experience no drug effect. Methadone simply removes opioid withdrawal symptoms and makes people in treatment feel normal and able to get on with their daily lives. Towards this end, there has been some discussion within the Technical Committee on AIDS on the possibility of adopting a trial of methadone substitution treatment.

There is a need and an opportunity for enhanced co-operation among Ministries and with non-governmental organisations in research, developing policy, planning strategies and delivering interventions related to drug use and HIV/AIDS vulnerability.

CHAPTER 5
MYANMAR

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MYANMAR

I. SUMMARY OF FINDINGS

Myanmar is experiencing a continuing increase in injecting drug use, currently estimated at around 300,000. There is a major ongoing shift from smoking opium to injecting heroin.

There is equivocal evidence about the availability of injecting equipment. It is probably available but considered too expensive by the average drug user.

The Narcotics and Psychotropic Substances Act of 1993, Section 15, states that drug users must voluntarily register and enter treatment or else be liable for a three to five year mandatory period of imprisonment.

The 1945 'Burma Excise Act' regulates the provision of needles and syringes and prohibits the selling or possessing of hypodermic needles or any other apparatus suitable for injecting any intoxicating drugs without license. Contravention of this section is punishable with six months imprisonment or with a fine or with both.

The law as it stands militates against early prevention and effective peer education approaches with active drug users

There was an expressed interest at Central Committee for Drug Abuse Control to review both Section 15 of the Narcotics and Psychotropic Substances Act of 1993 and the 1945 Burma Excise Act

Treatment is oriented towards total abstinence but failure rates are high. At a conservative, estimates are at 60-70 per cent relapse within a month of discharge.

The rates of HIV infections among injecting drug users are high; on an average 60-70 per cent. In some states of the country the rates are even higher.

II. RECOMMENDATIONS

It is recommended to establish an expert committee in Myanmar to debate the impediments to prevention of HIV/AIDS among drug users, presented by Section 15 and to suggest ways forward. UNAIDS can assist the work of this committee by the provision of information on strategies to reduce the harm from injecting drug use, by servicing this expert committee if called upon to do so. If a change in the regulations can be achieved then many other options for prevention are opened up for which UNAIDS may be called upon to support (training, pilot projects, budgets etc.).

Further consideration should be given to diverting addicts from the criminal justice system to the treatment system - to follow on the opening of the new Correctional Rehabilitation Centre.

It is recommended to provide the drug treatment health staff with better and more up-to-date information about options for drug treatment (this was requested at the Drug Treatment Centre in Yangon).

Of all the possible strategies to reduce the risks of HIV/AIDS from drug use, effective peer education directed at injecting drug users (including those in the jade mining areas of Prah Kant) must be urgently expanded. Peer educators should have the option of distributing needle and syringes, condoms, and be free to provide information about safe drug use (as well as information about the abstinence option).

Despite the obvious financial constraints in Myanmar, some consideration should be given to long term substitution therapy, particularly for people who repeatedly failed treatment.

III. INTRODUCTION

The Union of Myanmar includes the parts of the so-called 'Golden Triangle', which lies on the mountainous border regions of Myanmar, Lao People's Democratic Republic and Thailand and where much of the world's illicit opium and heroin is produced. Myanmar borders on five countries, two of which (India and Thailand) have the highest rates of HIV infection in the region. Furthermore, there are high concentrations of drug trafficking, drug use and sex work along Myanmar's common borders with Northern Thailand and Yunnan province. In many cases the same ethnic groups live across these international borders bound by family and kinship ties. Drug users and sex workers routinely cross the borders. There are many women from Myanmar working in Thai

brothels and women from the border villages of China who make their ways to Thailand via Myanmar. Many of these women become infected and eventually return to their villages. Some also inject drugs. The interface between drugs and HIV is nowhere more evident than in Myanmar.

Historically, opium use and opium cultivation was not a problem in Myanmar. It was after Britain's annexation of Lower Burma in mid 19th century that the importation of opium from India for sale nominally to registered addicts (most of them Chinese) began. The opium trade continued for half a century and ceased only in 1906 when the House of Commons in Britain declared the trade immoral. Despite the apparent ending of the opium trade, a Commission of the League of Nations visiting Burma in 1930 found about 100,000 opium addicts. Though imports of opium from India ceased much of the internal revenue of the Shan states derived from home grown opium sales. Although the Shan rulers agreed in 1923 to regulate and reduce opium production, opium growing in the Shan states was never eradicated.

Among the opium growers in rural Myanmar, opium use was an integral part of the culture; used in religious festivals and for medicinal purposes. Surplus opium from these producing areas was exported but there was little evidence of indigenous drug abuse or excessive use until the 1970s. Increased production designed for export was linked to Cold War politics more than to local affairs. The defeated Chinese Nationalists who took refuge in Burma needed funds to continue their struggle against the communists and the opium trade helped to finance this. When the Chinese forces left in 1961 at least some of the illicitly produced opium (now turned to heroin) went towards supplying US troops in Viet Nam. The large scale increase in the 1960s and early 1970s of the manufacturing and refinement of heroin led to increased local availability and to non-medical non-ceremonial use among local people both in the urban and rural areas sometimes by injection.

IV. FINDINGS

A. Drug Use in Myanmar

Myanmar has long been associated with drug production and trafficking and the government is undertaking vigorous actions to stem cultivation and local drug use. Domestic consumption has increased steadily throughout the 1990s and drug preference is gradually shifting from the traditional opium smoking to injecting heroin.

The Central Committee for Drug Abuse Control has initiated a combined baseline data collection on opium poppy cultivation and drug abuse during the first half of 1998. Findings from the survey suggest that opium and heroin remain the main drugs of use in the country and account for 91 per cent of all drugs of abuse in Myanmar. Local opiate consumption, which was traditionally confined to producing areas, has now spread along the drug trafficking routes and beyond into the large population centres. The trend is for increasing use of heroin and for more drug users to inject drugs. The survey revealed that heroin abuse predominates in Kachin state, in the Northern Shan state and in all the large cities while opium use still predominates in the Eastern and Southern Shan state and in Kayah state. There is a high level of needle and syringe sharing.

There is growing concern about young people's vulnerability to drugs particularly in the urban areas. Most universities have been closed for the past three years, and there are many unemployed and under-employed young people waiting for the opportunities to resume their education. There is some scattered evidence that amphetamine use is spreading inland from the border areas.

The total number of registered drug users¹ as of November 1998 was 60,076 of whom 60 per cent were opium users and 30.7 per cent were heroin users. However, of the 383 new users admitted to the Drug Treatment Centres in Yangon from January to June 1997² the majority were using heroin. (Heroin users: 97.6 per cent in Yangon, 100 per cent in Lashio, 96 per cent in Mandalay, 95 per cent in Myitkyina, 43.5 per cent in Taunggyi and 10.3 per cent in Kyaing Tung and 100 per cent in Monywa) Indeed the switch from opium smoking to heroin use has been dramatic. Figures from Myitkyina demonstrate this. In 1991 heroin users represented 0.7 per cent of the total but in 1997, 95 per cent were heroin users.

Other drugs used in Myanmar include marijuana, tranquilizers and some stimulants. Unofficially it is estimated that there may be 300,000 drug users in Myanmar.

B. Mechanisms for drug control

Myanmar's drug control legislation is the Narcotic Drugs and Psychotropic

1 The addict register is a cumulative record, which was begun in 1993. In theory is possible to de-register after staying off drugs for approximately 2 years. However, in practice the treatment authorities seem to lose contact with registered users before de-registration can take place. Dr. Kyaw Win from Myitkyina at a talk in January 1999 remarked that in 9 years of working in Kachin state no detoxified person has ever been able to complete the after-care and be de-registered. This means that information about 'registered' drug users does not necessarily reflect the contemporary situation in Myanmar.

2 Source: Yangon Drug Treatment Centre report, 1998

Substance Law (1993) which replaced an earlier 1974 law. That law established the Central Committee for Drug Abuse Control which is chaired by the Minister of Home Affairs and consists of representatives from relevant ministries, government departments and organisations. The main function of the Committee is to formulate policies on all aspects of drug control.

The law provides for the following guidelines in respect of drug users:

- (a) A drug user shall register at the place prescribed by the Ministry of Health or at a medical centre recognized by the Government for this purpose, to take medical treatment;
- (b) De-registration shall be carried out in accordance with the stipulation (does not say which).

Under Section 15 of the act the following regulations apply to drug users:

‘A drug user who fails to register at the place prescribed by the Ministry of Health or at a medical centre recognised by the Government for this purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment shall be punished with imprisonment for a term which may extend from a minimum of 3 years to a maximum of 5 years’

In addition, the registration and treatment process is to be supervised by the State/Divisional Committee for Drug Abuse Control. Treatment shall be available in Drug Treatment Centres in Yangon, Mandalay, Taunggyi, Myitkyina, Putao, Thayetmyo, Wethikan Pyay, Kathekwin Phekhone Township (Shan State) and also in some state and divisional hospitals dispensaries licensed by the Ministry of Health. A drug user is obliged to appear with his parents in order to register for treatment and carry a card that confirms his registration. The registration is to be kept confidential.

A law dating from 1945 the ‘Burma Excise Act’ regulates the provision of needles and syringes. Its regulations state that:

This act prohibits the making, selling, possessing or use of hypodermic syringes or any other apparatus suitable for injecting any intoxicating drugs without license. Contravention of this section is punishable, under section 33 with six months imprisonment or with a fine or with both.³

The drug laws outlined above are intended to be in line with the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which states (paragraph 2) that: ‘... each party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, the possession, purchase or cultivation of narcotic drugs or psychotropic

3 Section 13, Excise Act 1945

substances'. Drug users in Myanmar are obliged by law to register for treatment or else be penalised by imprisonment. However, when the law was first drafted, allowances were made for the possibility of later amendments and additional regulations as they become necessary or feasible (e.g., when mechanisms for money laundering are in place that the legislation on this will be added). The progress of drug control efforts is regularly reviewed by the Central Committee for Drug Abuse Control but not so the narcotic legislation since it is considered to be satisfactory on the whole.

C. Approaches to treatment and rehabilitation

Treatment

Before the 1974 Drug Law was promulgated, the treatment of drug users, most of whom were opium users, was mostly in the hands of traditional healers, indigenous physicians and monks who used herbal medicines and tincture of opium to detoxify their patients. After the establishment of specialized drug treatment centres a variety of methods were employed, including narcosis, methadone and opium tincture detoxification (opium tincture is produced locally and is inexpensive), and other symptomatic methods.

Currently the most widely used method for detoxification is opium tincture withdrawal, followed by a further short period when other drugs may be prescribed (especially stelazine, analgesics and diazepam). Altogether patients remain in drug treatment centres on their 1st admission for about 5-6 weeks. Results of detoxification treatment are universally disappointing. At a conservative estimate 60-70 per cent relapse within a month of discharge. High relapse rates were observed in a follow up study done in 1995 on 173 addicts treated in 1990. The research found that 7.5 per cent were off drugs, 7.5 per cent have substituted drugs with excessive alcohol consumption, 34.1 per cent had relapsed, 31.2 per cent were dead and 19.7 per cent were not traced (information from MANA ref. unknown).

The 1993 Narcotic Act allows for re-admission to treatment while previously those who relapsed were dealt with in the courts. When patients are re-admitted for the 2nd or 3rd time they stay in the drug treatment for longer than the 1st time (about 2-3 months) although the treatment programme is the same. Altogether there are six major drug treatment centres and 22 minor centres in the country. The majority of patients are aged between 16-35. Information from the Yangon treatment centre suggests that in that centre patients are provided with information about the dangers of injection, safe sex and condom use. However, it seems that the information provided is 'technical' and sometimes indirect and, therefore, it is unclear whether it is fully understood. The treatment centre in Yangon

has trained some ex-users to become peer-educators, and they run groups at the centre several times a week. They do not work in the community. Needles and syringes are easily available in the urban areas and can be purchased cheaply, however, availability of needles and syringes in outlying areas is uncertain. Treatment is free.

Some drug users are treated by general practitioners in their communities, including some private practitioners. These doctors have to be licensed to do so and are responsible for registering the user and forwarding the information to the local health authorities

Rehabilitation

According to the Narcotics Drugs and Psychotropic Substance Law (1993) it is the duty of the Ministry of Social Welfare to provide rehabilitation and after-care. At present there is only one rehabilitation centre in Myanmar that offers social and practical skills training. The drug treatment centres select people for rehabilitation and in general chose those who are chronic drug users and have been through treatment on a number of occasions.

Prisons

Many drug users (figures not available) who have not sought treatment and are caught are sent to prison. It is the obligation of the Ministry of Home Affairs to provide for the teaching of skills as may be necessary to persons serving sentences under Section 15 of the Narcotic legislation. However, there is no available information about preventive activities within the prison system. A second rehabilitation centre is planned and will be used as a correctional centre, i.e. as a treatment centre for convicted drug users and will constitute a diversion from the prison service.

D. HIV/AIDS

The emergence of the HIV epidemic in Myanmar is closely linked to injecting drug use. The epidemic of HIV developed unnoticed and although testing began on a small scale in 1985 there were very few drug users among those tested. It was in 1989 that evidence emerged of high levels of infection among injecting drug users. For example in the Drug Treatment Centre in Myitkyina in Kachin State 95 per cent of patients in 1989 were HIV-positive. In Mandalay a year later 72 per cent of drug patients were positive. However, by 1992 sentinel data demonstrated evidence of the emerging spread of HIV among other high risk groups such as male and female sexually transmitted diseases patients and even

among pregnant women in some parts of the country (e.g. Tacheleik and Kawthaung).

Limited ad hoc screening of high-risk population and of blood donors began in Myanmar in 1985 in response to accounts of HIV in neighbouring countries. However, the first case of HIV infection was identified in 1988. Data on detected cases of HIV in Myanmar reveal a steady yearly increase from a total of 323 cases in the year 1989 to 2,001 in 1993 and to 3,689 in 1998. The total detected cases stands at 21,535 as of December 1998 (women represent 14 per cent of the total). Likewise the number of AIDS cases increase year by year and as of December 1998 stand at a total of 2,854. The majority of AIDS cases are in Yangon, the Shan and Tanintharyi states. However, as in many other countries accurate figures about the levels of HIV infection in the country are difficult to determine and estimates of the actual situation in the country far exceed the figures of detected cases. It has been estimated that at the end of 1997 there were 440,000 adults and children living with HIV/AIDS in Myanmar and that some 86,000 people in the country may have already died of AIDS and that about 14,000 children have been orphaned.⁴

HIV infections in prisons

There is little information about the prevalence of HIV/AIDS in the prison but it may be considerable since the prison population contains many drug users. The National AIDS Committee has in 1993 trained medical and other prison staff about HIV issues but since that time there has been little dialogue between the Committee and the prison authorities.

Clinical reporting and ad hoc studies

HIV case reporting began in 1992 for suspected hospital patients and AIDS case reporting using the WHO clinical diagnostic guidelines started in 1991 in Yangon. Periodic studies of groups that are not included in routine testing also take place, e.g., studies of seafarers and of truck drivers have been undertaken. To date there has been no voluntary HIV testing within the National Health system. Private tests were available but are considered to be unreliable and do not provide pre- and post-test counselling. Voluntary testing centres will be set up in the near future in Yangon and Mandalay.

Sentinel surveillance

Sentinel surveillance began in 1992 in just nine sites amongst seven high-risk groups. It has continued bi-annually ever since and is now conducted in 21 sites covering all the States and Divisions of the country though not all risk groups

4 Figures are quoted by the UNDP and UNAIDS.

are tested in each site. For example drug users are routinely tested in just four to six sites and sex workers, military recruits and blood donors are routinely screened in just two of the 21 sentinel sites, so the data is incomplete. As far as possible it is aimed to achieve a sample of one hundred for each of the risk groups. Furthermore some of the high-risk areas for HIV infection for example, the Jade mining areas, or the border area with India are not included as sentinel testing centres.⁵

The HIV sentinel surveillance data provides partial information on infection trends. It clearly demonstrates the steady increase of infection in the general population, which is reflected by the data on pregnant women attending antenatal clinics. Information from the majority of sites has been collected twice yearly since testing began and the percentage of sero-positive women has risen steadily. Thus in March 1992 599 women were tested in five sites and none was positive for HIV. However, by 1998, 3,126 women were tested in 17 sites and overall 1.79 per cent were positive for HIV. There are considerable variations across sites. Thus, in some sites, particularly in the Shan State 4 per cent of women tested in Lashio, 3 per cent in Muse and 2.53 per cent in Tacheleik were found to be positive for HIV. Behavioural data collection as part of the Sentinel Surveillance was added in 1997 in two sites only (Yangon and Mandalay) and consists of four questions on behaviour among risk groups including one on sharing practices among drug users.

HIV among injecting drug users

HIV infection among injecting drug users in Myanmar remains one of the highest in the world and is consistently higher than among any other identified

Table 5.1 Sentinel surveillance data for September 1992 to September 1998 for injecting drug users⁶

Year	Number of Sites	Number. tested	% HIV-positive
1992	4	366	62
1993	6	549	69
1994	5	471	7
1995	6	475	63
1996	6	461	65
1997	5	445	56
1998	5	399	62

5 Dr. Hla Htut Lwin of the NAP conducted a study on the border between India and Myanmar in 1994 and found that 90% of drug users on the Myanmar side of the border were infected with HIV.

6 AIDS Prevention and Control Project, Department of Health, Myanmar

Table 5.2 Sentinel data for different sites 1992-98 (September data): Percentage of HIV-positive injecting drug users

Site	1992	1993	1994	1995	1996	1997	1998
Yangon	66	66	46	47	64	65	61
Mandalay	57	86	83	79	67	80	85
Taungyi	44	27	33	23	29	19	22
Myitkyna	79	95	84	93	86	73	84
Lashio	-	28	-	68	-	28	70
Bamaw	-	-	99	-	-	-	-
Muse	-	-	-	88	86	-	-

risk group (Tables 5.1 and 5.2). It is not clear however, what proportion of the total infection rates in the country can be reasonably attributable to injecting drug use.

These national figures represent the average for the country and although they conceal regional differences the rates of infections are consistently high. Clinical reports suggest that some drug users are highly mobile so that, for example, drug users who come for treatment in Myitkyna in Kachin State may have contracted HIV while working at the mines in Phar Kant or could have come from anywhere in the country.

In a study conducted by Care Myanmar with AusAID, UNICEF and the National AIDS Programme in 1998, men who were interviewed in Mandalay and Yangon confirmed that disposable needles and syringes are available but are expensive and that they continued to share even though they were aware of the dangers. Many noted that they were fearful of carrying injecting equipment with them in case they were stopped by the police. They had this to say about their injecting habits:

We knew through school health that the disease can be transmitted to another if the needle is shared but when we use drugs ... as the drug eater is not a doctor, the needle cannot be with us whenever we go. At that time, when we are in a state of great desire, we never care about whose needle it is, we all share.⁷

Injecting drug users in Myanmar become infected early in their injecting career, a pattern that is rarely seen elsewhere. The national surveillance data point to the young age of the HIV infected injecting drug users. A group that is particularly at risk are the rural seasonal migrant workers in the jade and ruby mining areas who move back and forth between the mines and their homes. Many are infected

7 'Like a Moth Chasing the Fire', Umemoto 1998

with the HIV after a brief history of drug use. Drug use patterns in these locations pose a particularly high risk for HIV infection. Drugs are injected with a variety of improvised equipment such as eye-droppers with an attached needle or a polyethylene tube with a needle attached. Some of this equipment is impossible to sterilise even if the attempt were made. Moreover most addicts share their injecting paraphernalia and are often injected by professional injectors who also supply the drugs. The mining areas also have a thriving sex industry.

Response to HIV/AIDS

The National AIDS Technical Committee was set up in 1989 and was later restructured to become a multi-sectoral National AIDS Committee under the chairmanship of the Minister of Health. However, in practice the HIV/AIDS plan is subsumed under the overall leadership of the National Health Committee, which is the supreme decision-making body in health matters in Myanmar and the current strategy for HIV/AIDS/STD is incorporated and subsumed within the overall National Health Plan for 1996-2001. There is little collaboration between line ministries on HIV/AIDS matters.⁸ A draft UNAIDS strategy to support HIV/AIDS prevention and care in Myanmar for 1999-2001 was prepared by in collaboration with all its sponsoring agencies in the country and in close collaboration with all the relevant line ministries and is awaiting government approval.⁹

The National AIDS Committee has undertaken large-scale training of health staff and over 40,000 health care workers have been trained (including community volunteers). It has also conducted prevention campaigns within the permitted parameters. In general the State media only permits general information about HIV/AIDS. Thus campaigns about condom use are not permitted and there is little open discussion about sexual matters since pre-marital or extramarital sex are condemned. However, some targeted interventions among high-risk groups (including sex workers and injecting drug users) are ongoing. Myanmar is extremely sensitive to criticisms about its HIV/AIDS policy. However, the National AIDS Committee asserts that the population is in fact well informed about the dangers of HIV/AIDS.

Officially, the government considers HIV to be the third highest health priority in the country following malaria and tuberculosis. The budget allocated specifically to HIV/AIDS prevention is small: approximately US\$ 1 million annually plus external assistance of some US\$ 1.2-1.5 million, and the National AIDS

8 National HIV/AIDS/STD Prevention Programme in Myanmar. National AIDS Programme, Department of Health, 1998

9 Draft UNAIDS National Strategy to support HIV/AIDS prevention and care in Myanmar 1999-2001, November, 1998 (not for circulation)

Committee's staffing is minimal: just 4 1/2 people (two of whom have been 'lent' to the Committee from other divisions of the health ministry). The financial constraints reflect both the chronic lack of funds in the country and perhaps also the ambivalence about HIV/AIDS among policy makers.

The National AIDS Programme identified the following specific objectives:¹⁰

- (a) The general community as well as high-risk groups are to be given appropriate information to increase awareness on HIV/AIDS and to promote behavioural change;
- (b) Transmission of HIV infection through needles, syringes and surgical equipment are to be prevented;
- (c) Training of community leaders, peer educators, health workers and volunteers for health education counselling and provision of care.

The strategies include the reduction of narcotic use and the provision of education programmes including peer training. The activities designed to focus specifically on drug users are at the discretion of those directly involved with drug treatment.

UNAIDS draft National Strategy for 1999-2001 identifies youth as a crucial target for preventive interventions and highlights the issue of AIDS in the context of overall development issues. The recommended strategic approach is to target those groups with the highest known HIV prevalence in the geographical areas with the largest concentrations of such high-risk populations. Thus attention should be given to men with multiple sex partners and their wives, to commercial sex workers and to 'indirect' sex workers, to Injecting drug users and their families and to young people leaving their families to seek work and to cross-border migrants. It is hypothesised that such a targeted approach is likely to have the maximum impact and be most cost effective. The overall objective is to broaden Myanmar's response to HIV/AIDS and to establish a truly multi-sectoral approach. So far the response has been largely a Ministry of Health response. There is little ongoing co-ordination between the National AIDS Programme and the Central Committee on Drug Abuse Control or the Drug Treatment Services.

E. HIV/AIDS and drug use

Non-governmental organisations

Non-governmental organisations in Myanmar are making a substantial contribution to the prevention of HIV/AIDS. There is one major local non-govern-

10 National HIV/AIDS, STD Prevention Programme in Myanmar, National AIDS Programme, 1998

mental organisations working directly with drug users and some of the international non-governmental organisations working in Myanmar have also identified HIV/AIDS preventive work in the drug field as one of their priorities.

The Myanmar Anti-Narcotic Association (MANA) is the local non-governmental organisation most active in the field of drug use prevention in Myanmar. The association was formed in 1994 and aims to support and participate in all the drug control and prevention. It has several branches and over 100 members. The organisation is run by a team of retired men and women who come from a variety of academic and business backgrounds, bringing a wealth of different experiences to the organisation.

MANA aims first and foremost to educate the community about drugs, to improve rehabilitation services thus preventing the spread of HIV among injecting drug users. Among its many activities are information programmes directed at communities as well as at drug users (mostly in the context of drug treatment centres). The association hopes to discourage injecting drug use and to educate drug users and their sexual partners. It also promotes operational research about drug use in Myanmar. It does encourage abstinence from drugs pointing out the dangers of drugs. MANA has an extensive training programme directed at teachers, community volunteers and others and to assist in the development of new information, education and communication materials. It also opened youth care centres in a few townships and promotes school competitions.

The international non-governmental organisation *World Concern* is developing a peer education project which is supported by the United Nations International Drug Control Programme and targeted at injecting drug users in the community in three population centres in Kachin State. The project aims to develop and implement preventive education to increase awareness of the risks of injecting drug use and to discourage injecting drug use among other high-risk groups in the state.

This joint work was approved in 1998 and preparations for the project implementation are underway. World Concern has hired local staff, conducted extensive training in participatory skills, peer education, process evaluation and in conducting participatory research on the target community. Information about the project sites already gathered confirms that in Phar Kant there are 'shooting galleries' where drug users come to be injected by 'professional injectors', however, information about the other two project sites in Bamo and Hopin are still lacking. The availability of needles and syringes is variable and depends largely on the level of law enforcement activities. Thus drugs as well as needles and syringes are easily available in the jade mining area of Phar Kant

and there is considerable drug trafficking in Kachin and other border provinces.¹¹ However, there are shortages of needles and syringes in other areas. It is clear that the heavy penalties for drug use impacts and restrains their ability to offer out-reach and peer education to injectors.

Medicine du Monde has been working in Kachin State since 1996, where there is a large concentration of drug users, many of whom are heroin injectors. *Medicine du Monde* works closely with the local treatment centre and provides preventive education about HIV/AIDS and on how to use a needle and syringe safely. They have a plan to begin bleach distribution particularly in the 'shooting galleries' in Myitkyna and Monya. *Medicine du Monde* would like to do more to prevent the spread of HIV/AIDS among injecting drug users.

Some of the other international non-governmental organisations such as *Care Myanmar* and *World Vision* have also identified drug use and HIV prevention as priorities but have no current projects targeting drug users. The *Young Crusaders*, is another non-governmental organisation which is active in Myanmar; run by ex-addicts on Christian principles it aims to help people come off and stay off drugs by embracing the Christian faith.

Population Services International is in its fourth year of operation in Myanmar and has been successful in developing a programme of social marketing of condoms in the country. Since 1997 it has focused on HIV/AIDS prevention. Their activities are not specifically targeted on drug users.

On the whole, the international non-governmental organisation community is small and its resources are severely limited at the present time.

United Nations agencies

United Nations agencies in Myanmar operate under some duress because of restricted international funding. The lead agency that deals with drugs in Myanmar is the UNDCP, which has an office in Yangon and is working mainly on opium supply reduction. Some of the activities of UN agencies are as follows:

UNAIDS draft strategic proposals for HIV/AIDS for the years 1999-2001 has already been described above. It should be noted however, that only four of the UNAIDS co-sponsors are active in Myanmar, i.e., UNDP, UNICEF, WHO and UNDCP. These agencies are severely constrained financially. UNAIDS faces

11 Some of the businessmen who are in control of the mines are believed to be also involved in the drug trade. Drugs are probably transported in ethnic army trucks, which are exempt from regular searching, by the cease-fire agreements. Incidentally, the Kachin Liberation army takes a hard line against drugs and has even executed traffickers. They fine villages who grow opium. The Kachin independent army has signed an agreement with the government in 1994 and has begun reducing opium production beginning in 1990.

difficulties in trying to co-ordinate and facilitate national and international activities.

UNDCP has very limited resources for country projects on demand reduction. It focuses mostly on training and awareness raising about drug problem in general and works to promote community based responses. It is supporting a number of small-scale activities in country and collaborating with a number of line ministries. Several ministries within the government deal with drug issues. The Ministry of Health provides drug treatment, the Ministry of Social Welfare provides drug rehabilitation, school based education is the responsibility of the Ministry of Education and the Ministry of Information deals with preventive information for the population as a whole.

UNDCP works closely with the Ministry of Health on drug demand reduction and supports the work of World Concern in Kachin State and also of the Drug Treatment Centre in Myitkyina. The Ministry of Social Welfare is the focal point for the Demand Reduction Highland Project in East Asia and assists in providing rehabilitation, follow-up and after-care to former drug addicts. UNDCP works with the Information and Education Ministries in the development of preventive education programmes

UNDP/UNOPS has been working on a project to 'enhance Capacity for HIV/AIDS Prevention and Care in Myanmar'. It is one of ten projects under UNDP Human Development initiative and is a collaboration with the National AIDS Programme. The project aims to build institutional capacity and links with civil society, to introduce innovative models to respond to the needs of infected and affected individuals, families and communities, to enhance the capacity of the National AIDS Programme, to strengthen collaboration and co-ordination through UNAIDS mechanisms. This project enables UNDP to fund and support some local or international non-governmental organisations as well as the Drug Treatment centres to provide some HIV preventive activities.

UNDP supports Myanmar Anti-Narcotics Association, Medicine du Monde, the Young Crusaders, Care and others who are working with drug users, and assists the Yangon Drug Treatment Centre in its peer-education programme.

WHO provides technical assistance to the National AIDS Committee, had been advising on the sentinel surveys, and on the treatment of sexually transmitted diseases. It has in the past funded some specific expert inputs.

UNICEF focuses largely on children and women. Work in Myanmar includes the development of preventive drug education for primary and middle schools.

V. DISCUSSION

The military government presently develops and implements policies in Myanmar. The government has recently changed its name from the 'State Law and Order Restoration Council' known as the SLORC to the 'State Peace and Development Council', signalling new policy direction which followed upon the cease-fire agreements with insurgent groups in the border provinces. The overall government policy objectives are iterated daily in the press.

Criticism and advice from abroad are not welcome in Myanmar. In the English language newspaper the 'New Light of Myanmar' the 'People's Desire' is published daily and the same messages appear on many billboards throughout the country. It exhorts the people to oppose those relying on external elements, acting as stooges, holding negative views and to oppose foreign nations interfering in internal affairs of the State. The paper also publishes daily the government's four political objectives, the four economic objectives and the four social objectives. Included among its major social objectives is the 'uplift of health, fitness and education standards of the entire nation': objectives that include better health education and health services, both of which have important implications for HIV and drug use prevention and treatment services.

The image of Myanmar that is promoted locally is that of a unique, deeply religious and conservative country where problems such as HIV/AIDS and drug use are out of character with the nature of its people and the nature of the society. It is apparent therefore that Myanmar is divided about the extent to which the HIV epidemic should be publicly acknowledged despite the evidence of the sentinel surveillance and other data. The following recent report in the 'Bangkok Post' newspaper is illustrative.

"The Burmese government said it had no sex industry and had AIDS under control. It rejected fears by the United Nations that the epidemic could explode in the military run state. The junta said it has taken great steps to control the epidemic. The UN said an HIV/AIDS epidemic was growing in Burma and that the junta was largely ignoring it."¹²

It would seem that policy and activities in respect to HIV/AIDS are driven by Myanmar's ambivalence about the subject. There is a reluctance to admit to any social problems and coyness about discussing sexual matters or speaking openly about the necessary measures to prevent the spread of HIV/AIDS in the community. As a result there is little if any sex education at school (except in the context of life skills or reproductive health education). There have not been any campaigns promoting condom use or public information about how to prevent

12 Bangkok Post of 18.4.99

HIV/AIDS. Only general warnings about HIV/AIDS are allowable. Despite the inroads made by Population Services International condoms are still largely associated with commercial sex and women caught with condoms are charged as prostitutes under the Suppression of Prostitution Act 1949.

A. Constraining factors

Because of the nature of the political and social situation in Myanmar and because of the difficulties of identifying who the real decision makers are and who is charged with formulating and reviewing policies it is difficult to assess clearly what drives social policy. However, discussed below are some issues that may have a bearing on this issue:

Resources: Myanmar has scant resources with which to deal with social and health problems. The UNDP's Human Development Report for 1998 indicates that 40 per cent of the population has no access to health services. Myanmar has undergone many years of political and social turmoil and isolation since it gained independence in 1948 and there is reluctance by the international community to provide development assistance at the present time. This situation has a marked effect on Myanmar's efforts to address AIDS.

Myanmar suffers from a lack of resources for all aspects of HIV/AIDS control and care: HIV testing and diagnostic tools are limited and there is no voluntary HIV testing. The facilities for treating AIDS patients are inadequate and the population as a whole has only general information about how to protect themselves against the disease. There are also insufficient resources for adequate prevention, treatment and rehabilitation for drug addicts and no budget for follow up support after treatment nor for research and experimentation. The HIV/AIDS programme is subsumed under the National Health plan and the needs for funding and resources for the AIDS programme has to compete with other pressing priorities. Indeed the budget allocated to HIV/AIDS is insufficient to meet the needs.

Legal constraints have already been discussed above. The regulations (Section 15 of the Narcotics Law of 1995) that severely penalises drug users who do not voluntarily come forward for treatment militates against active outreach and peer education programmes.

Regulations allow only for abstinence oriented treatment objectives meaning that intermediary treatment goals are not allowable and thus the opportunities for interventions to keep drug users safe from becoming infected are limited. These regulations limit crucially necessary early preventive interventions.

B. Facilitating factors

There are many in Myanmar that have a good understanding of the issues of reducing the risks of HIV/AIDS among injecting drug users and numerous workshops have already examined these issues. There are well-trained professionals in the country especially medical doctors and other health workers, and there is an active drug treatment system in the country. There are non-governmental organisations in the country who are interested in HIV and drugs and who are willing to develop projects to reduce the risks from injecting drug use. Furthermore some personnel within the Central Committee for Drug Abuse Control share the view that Section 15 is an impediment to the prevention of drug use as well as to HIV infection among drug users.

CHAPTER 6
NEPAL

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NEPAL

I. SUMMARY OF FINDINGS

Buprenorphine has replaced heroin as the drug of choice among opioid dependent persons and among initiates to drug use in Nepal. It is increasingly administered by injection given the availability of the injectable form.

The National Centre for STD and AIDS Prevention estimates that there are between 40,000-50,000 drug users in Nepal. Other government officials feel this is a substantial over-estimate of the true situation.

There is no specialized drug treatment sector in Nepal. Non-governmental organizations provide all drug treatment services in Nepal with the exception of the methadone maintenance programme. These organizations generally receive no government funding, policy direction or technical support. They are reliant on donor agencies for these inputs.

The law that has most relevance to drug policy and legal response to drug use is the *Narcotic Drugs (Control) Act, 2033 (1976)*. This law is limited in its coverage of drug-related matters, simple in form and content and could benefit from a re-structure and updating.

Under section 14 (c) of the *Narcotic Drugs (Control) Act, 2033 (1976)*, drug use is itself illegal in Nepal. The stated goal of the Government is to achieve “zero drug use” in Nepal. These two factors serve to inhibit public health responses and open engagement of people who have drug problems with health and other human services.

Senior officers of the Ministry of Home Affairs express the view that needle and syringe exchange and methadone maintenance treatment is against the law.

Close examination of the relevant laws suggests that needle and syringe exchange programmes are not unlawful since there are no paraphernalia laws prohibiting the possession of a needle and syringe and no laws that might be taken to mean that the provision or sale of sterile needles and syringes breaches any legal provisions.

The public health rationale behind the distribution of sterile needles and syringes is not accepted by many senior officers in government and instead, is seen as counterproductive. The public health arguments may be inadequately understood or alternatively, they may be accorded low weighting in policy analysis and decision making.

The specialized HIV/AIDS sector is not involved at any level in the development, review and reform of drug policy in Nepal and the absence of attention to HIV prevention is reflected in this gap in collaboration. The converse also applies - the Ministry of Home has not been involved in HIV prevention planning.

Ninety-eight per cent of drug users stated that they shared needles and syringes in a survey of 150 drug users in Dharan. While 74 per cent of drug users were aware of the protection which condoms can afford them, only 10 per cent knew how to use a condom correctly. Forty per cent were found to be HIV positive.

Following outreach education, there is reportedly very high awareness of HIV, sexually transmitted diseases and knowledge of how to use a condom correctly. One third of the sample stated that they had moved from drug injecting to oral use.

Commercial sex work is illegal in Nepal. It is estimated that as many as 50 per cent of women returning from India where they have worked in the sex industry, are HIV positive.

II. RECOMMENDATIONS

It is recommended that:

- (a) The legal context of illicit drug use in relation to HIV prevention activities be reviewed, with a view to reforming the law in a manner that can facilitate HIV prevention as opposed to current emphasis on the punishment of those who use and traffic drugs;
- (b) The legal situation regarding needle and syringe exchange and availability programmes and possession of needles and syringes be clarified and the situation made known to all in the government, non government, private, international aid agencies and general community sectors;
- (c) Government implement the proposal articulated within its *Strategic Plan for HIV and AIDS in Nepal, 1997-2001* to provide sterile needles and syringes to injecting drug users through non-governmental organizations;

- (d) Peer education for drug users be encouraged, facilitated and promoted in legislation, policy and practical support;
- (e) The capacity of the National Centre for AIDS and STD Control be strengthened and that it pay increased attention to monitoring, evaluation and co-ordination of government and non-governmental organization planning and activity in the area of drug use and HIV vulnerability;
- (f) The specialized HIV/AIDS sector be actively engaged in the development, review and reform of drug legislation, policy and planning in Nepal, with a view to ensuring that high priority is accorded to supporting HIV prevention approaches;
- (g) The Ministry of Home be actively engaged in the development, review and reform of HIV prevention policy and planning, with a view to ensuring that drug prevention and intervention is enabled while also ensuring that effective HIV prevention approaches can be implemented.

III. INTRODUCTION

The population of Nepal is estimated at 20.9 million (1997). The urban to rural population distribution is 91 to 9 per cent. Nepal is ranked 154th on the UNDP Human Development Index. Life expectancy at birth is 54.5 years. The literacy rate is estimated at about 40 per cent and the infant mortality rate is 97 per 1,000 live births. The economy is largely agricultural based, although tourism is growing as an important source of national income.

The average annual per capita GNP is about US\$ 200, placing Nepal in the bottom decile of per capita income, globally. Figures provided in the South Asia Report on Drug Demand Reduction suggest that annual health expenditure is currently about US\$ 505 million, 9.25 per cent of total public expenditure. Per capita expenditure on health is Rs. 58 (US\$ 0.92). Annual per capita expenditure on education is currently about US\$ 742 million, 13.6 per cent of total public expenditure.

There is generally little or no information available on the budget break-up in terms of the range of drug-related strategies and interventions (supply reduction, demand reduction, harm reduction, research, training, policy review and development). Government funding for HIV/AIDS has increased during the last several years.

Table 6.1 HIV/AIDS Budget (1997/98)

HMG	US\$ 29,800,000
WHO	US\$ 200,000
UNAIDS	US\$ 100,000

IV. FINDINGS

A. Epidemiology of Drug Use

Heroin was introduced into Nepal in the mid-1960s and the drug was mainly smoked or chased, until the late 1990s and early 1990s when injection emerged as a method of drug administration among a substantial minority (estimated at about 25 per cent during that period). The introduction of buprenorphine in Nepal in 1990 brought about substantial changes in the drug use culture. By 1991 buprenorphine had replaced heroin as the drug of choice among opioid dependent persons and among initiates to drug use. It was increasingly administered by injection given the availability of the injectable form. Injection of buprenorphine soon spread from Kathmandu to other areas.

The major populations of heroin users are in the Kathmandu and Pokhara valleys. Formerly, the most commonly used form of heroin was “brown sugar”, of Afghanistan, Pakistan and Indian origin. This form is mostly smoked or inhaled. However, a more pure form of heroin that has appeared on the streets in recent years is commonly injected. Apart from isolated cases, very little opium is grown in Nepal.

Cannabis has and continues to be used as part of the culture in many rural areas of Nepal. It was estimated by the government that in 1995 that up to 0.5 per cent of the population in some areas of the Terai use cannabis daily.

Number of drug users

The number of people who use drugs is subject of some debate in Nepal. While there is no persuasive data, it is estimated by the National Centre for STD and AIDS Prevention that there may be somewhere between 40,000-50,000 drug users in the country. Some government officials state that this is a substantial over-estimate of the true situation. There are plans afoot within the National STD and HIV Prevention Centre to attempt a more accurate estimation.

Characteristics of drug users

In Nepal, young people may begin using drugs at the age or 15-16 years. There are some anecdotal reports that the use of drugs is occurring at a progressively younger age but there is no quality baseline or follow-up data that would allow any valid or reliable conclusions of this nature to be substantiated. A major problem is the trend towards multiple drug use, one that is of course also observable in other regions of the world. These other drugs included pentazocine, codeine, nitrazepam and diazepam.

This problem appears to have been magnified by the absence or inadequacy of formal dispensing controls, enhancing access to the point where supplies can be readily obtained without the need for a prescription. Pharmacists may sell pharmaceuticals, often at inflated prices, without clinical evaluation or the provision of legal documentation.

It appears there is limited capacity for formal monitoring, regulation and maintenance of professional standards in pharmacy retail. As noted above, Tidigesic (buprenorphine) has become a drug of choice and it is commonly used in combination with heroin and alcohol. There are no formal reports of use of amphetamine-type stimulants in Nepal, however, there are some isolated anecdotal reports of its recent introduction.

The economic situation is an important factor influencing drug use and HIV vulnerability in Nepal. It is thought that the gap between the small number of economically well to do and the poor is widening, however, the government has implemented social policies in an effort to address this problem. In an environment where per capita health expenditure is less than US\$ 1.00 and average per capita GNP is about US\$ 200 resources for addressing drug problems are naturally limited.

The government recognizes that drug use and dependence can exacerbate poverty and make it very difficult for people to extricate themselves from their disadvantaged economic circumstances (*National Drug Control Policy of HMG/Nepal, 1995*). It has also paid recognition to the effects which drug use may have on the quality of personal and family of life, on productivity and on economic development.

High risk practices

One estimate was that 75 per cent of buprenorphine users were injecting in 1995. A survey of a methadone treatment seeking population in Kathmandu found that 82 per cent were injecting in 1994, increasing to 96 per cent in 1996.

While there are no reliable data on drug-related overdose and mortality in Nepal,

anecdotal reports suggest that the incidence of these events is high. One can fully expect this to be the case where multiple drug use is highly prevalent, including the use of alcohol in combination with opioids and benzodiazepines. Low levels of knowledge and understanding of drug toxicology can only increase the risks faced by people who use drugs in a hazardous context.

Rapid assessment and response survey

A Rapid Assessment and Response Survey was carried out during early 1999 covering most of the urban area of the southern part of the country, Kathmandu and Lalitpur cities and the tourist area of the Pokhara valley (Upreti, 1999).

Until this survey was carried out it was generally accepted that there were about 50,000 drug users in the country out of which 20,000 used injection and possibly about 50 per cent of them were already HIV positive. The survey was aimed at determining the prevalence and nature of substance abuse in different urban areas in Nepal.

A central core group prepared a detail plan for the survey. The survey sites included 19 major urban areas with a total population of 1.8 million. Following the training of FRCs and Field Research Assistants (FRAs) advocacy meetings were organized in 17 of the 19 sites that were surveyed. There very high interest and support for the project in most areas but it was notable that this same interest and support was not shown in Kathmandu where many key informants did not attend the pre-arranged interview. Great disappointment was expressed by researchers from the National Centre in response to this outcome.

In other areas of Nepal, many key informants expressed their support for harm reduction and made promises to begin services of this nature in their local areas. On this core, the data from Kathmandu was noted to be “quite discouraging”. The best responses were obtained from the Eastern Region of Nepal, which might reflect a greater sense of concern about the issues.

Over 1,100 current drug users were interviewed. Surprisingly, only four women were identified or came to interview. The majority of drug users interviewed (36.5 per cent) had education up to 9-10 class, 17 per cent up to 6-8 class and 9.8 per cent up to intermediate level. Almost 7 per cent of drug users were illiterate.¹ Most of the respondents felt that peer pressure and unemployment were the main determinants of drug use.

1 This finding is likely to be influenced by selection bias (those with better education may be more likely to agree to be interviewed)

About 24 per cent of drug users started taking drugs at the age of 15, 51.2 per cent at the age of 16-20 years and 17.8 per cent at the age 21-25 years. The majority (46.4 per cent) started with marijuana, 28.3 per cent with Phensidyl, 11.6 per cent with heroin, 2.4 per cent with Tidigesic or 5.4 per cent with Nitrazepam. Users stated that the decision to begin using drugs was largely that of peer pressure (80 per cent), curiosity (44 per cent) or frustration for one of a number of reasons (30 per cent). At the time of interview, the majority of drug users were taking Tidigesic (65.2 per cent), Nitrazepam (46.1 per cent), Phensidyl (30.3 per cent) and marijuana (42.3 per cent) (Table 6.2).

A large proportion of drug users (72.7 per cent) administered drugs by injection while 63.5 per cent used the oral route and 41.4 per cent smoked. The frequency of daily drug use was found to be once: 35 per cent; twice: 35.3 per cent and three times: 25.5 per cent. About 74.8 per cent admitted to injecting and 65.1 per cent of them freely shared injection equipment with others because they had insufficient financial resources to purchase their own needles and syringes or because they could not easily access them in the market place. Most respondents reported attempting to clean their used injection equipment with ordinary water (77.2 per cent), sometimes by boiling in water (2.7 per cent), sometimes with bleach (20.9 per cent) and sometimes with sputum (44.6 per cent) or urine (4.2 per cent). About 35 per cent of drug users stated that they did not share their needles and syringes mainly because of fear that they might get STD or HIV.

A minority of respondents (26.4 per cent) stated that they had attempted to enter drug treatment. About 14.7 per cent went for counselling, mainly on advice of their parents and friends although some went on their own accord. A small

Table 6.2 Types of drugs currently being used

Name	Number of drug users	Percentage
Tidigesic (Buprenorphine)	722	65.2
Nitrazepam	511	46.1
Phensidyl (codeine containing cough syrup)	336	30.3
Marijuana	469	42.3
Heroin	176	15.9
Hashish	113	15.9
Tidigesic and Nitrazepam	76	6.9
Phensidyl and Nitrazepam	47	4.2

percentage (8.8 per cent) had ever been admitted to a facility of some kind for detoxification, mainly in Kathmandu (28.8 per cent), Pokhara (18.2 per cent), India (16.7 per cent), Lalitpur (12.1 per cent) and Dharan (4.2 per cent). Their parents or friends prompted most of these treatment-seeking episodes. Of those who attempted detoxification, only a small percentage was able to access these services locally. 7.6 per cent stated they withdrew in their own house.

Most of the respondents (72.2 per cent) admitted to premarital sex with multiple partners and most of these sexual encounters (64.7 per cent) were without a condom. At the time of interview, 51.7 per cent admitted to unsafe sex, 67.8 per cent had no knowledge of sexually transmitted diseases and their risk of infection. Twenty seven percent of the respondents had experienced a sexually transmitted disease and most of them (68 per cent) attended a private clinic for treatment. It was of surprise to the researchers to find that 89.9 per cent had knowledge of HIV/AIDS and its mode of transmission.

Of the drug users interviewed, 33.2 per cent were found to be positive for HIV and 53 per cent for hepatitis C, 8.1 per cent of the non-drug injectors were found to be positive for HIV whereas among injecting drug users, the prevalence was 40.4 per cent. The odds ratio for HIV infection among those who inject compared to those that do not was 14.5:1.

The researchers observed that one of the major objectives of this study was to estimate the total number of drug users and among them the number of injecting drug users. For different reasons this activity could not be carried out and remains an objective for the near future. The researchers added that the study proved to be a most difficult one. They lamented that: “lots of (the) difficulties (were) mostly man-made (and yet) so much could be achieved”.

B. Treatment and rehabilitation

Role of the Government

There is no specialised drug treatment sector in Nepal. Treatment and rehabilitation of drug dependent persons are almost exclusively undertaken by non-governmental organizations although two governmental hospitals in Kathmandu have reserved a small number of beds for inpatient detoxification. A methadone maintenance programme also operated from at the Mental Hospital in Kathmandu. Two non-governmental organizations also provide a very limited detoxification service but the majority of drug users are placed in safe custody at police stations or confined in jails, often referred by their families. Rehabilitation services are provided by non-governmental organizations both in institutions and on an outpatient basis. Aasara, is a non-government involuntary drug rehabilitation programme in Kathmandu, which receives police support for security purposes.

It receives limited external funding, so it must charge for its services.

Non-governmental organizations providing drug treatment and rehabilitation services receive no financial support from the Government. Many of these services are therefore highly reliant either on the financial and technical support of external donor agencies or they survive by charging patients for services. This policy creates an unfortunate inequity in access to services between those who can afford treatment and those who can not (HMG/N, 1992).

At Pokhara Valley, detoxification is carried out at the General Hospital. Although drug problems are prevalent in all parts of the country, people must either come to Kathmandu or go to India, given the absence of treatment facilities, depending on their ability to pay. It is estimated that treatment and rehabilitation services are available for approximately 10 per cent of the drug dependent population.

In some drug treatment settings those who are HIV or HBV positive are not admitted. Those with a history of repeated relapse (five times) and those who are not accompanied by a family member may also be rejected.

Treatment services may not necessarily be seen as user friendly and young people may often only come for treatment under substantial pressure if not coercion from their family. Notwithstanding, there are often waiting lists for entry into these drug treatment programmes. Whether this is due to family requests and pressure or demand from people with drug problems is unclear.

Staff attitudes towards patients are reported to be generally supportive. However, staff may often have unrealistic expectations for drug free outcomes and feel frustrated when their hopes and expectations are not met. Staff is reported to be 'burning out' quickly. Relapse rates among patients are invariably high.

If patients are found to have used drugs during their admission they will often be discharged. Alternatively, their treatment plan may be re-negotiated and their freedom limited. Treatment programmes are generally of a uniform nature for all patients rather than being tailored to meet the individual patient's assessed problems, needs, intellectual and contextual capacities and deficits, coping styles and treatment preferences. There is an assumption that the duration of inpatient treatment needs to be extensive and that a longer admission is likely to be better than shorter admission in terms of treatment outcome. Questions relating to treatment efficacy *per se* and of cost-effectiveness of one approach versus another do not appear to have been examined in any serious manner.

The Master Plan (HMG/N, 1992) reported as follows:

However, the relapse rate is high. Addicts are often rounded up by the police and put into Dhulikhel Jail as mentally disturbed persons or in the district or zonal jails. Treatment here is being done by the 'Cold Turkey'

method due to the lack of other facilities. Rehabilitation and social reintegration programmes which are more difficult to manage are being carried out by the non-governmental organizations after detoxification. It is encouraging to note that due to the lack of available resources in terms of capacity, manpower and funds, the non-governmental organizations have developed programmes complimentary to each other

The situation does not appear to have changed. A senior government officer from the Ministry of Health observed that detoxification has invariably been associated with high relapse rates within 3 months. A trial of methadone reduction (over 6 weeks) was abandoned when it was realized that relapse rates were so high.

The Master Plan also made the following observations regarding respective roles and responsibilities in addressing drug problems:

The Ministry of Home has so far acted as a technical ministry for the implementation of its drug abuse policies, as drug abuse was mainly perceived as a problem of law enforcement. With the increase in the rate of addiction, the abuse problem has shifted its main focus to the treatment and rehabilitation of drug addicts, an area where the Ministry of Home has little technical competence, having to rely on other ministries for implementation of its policies and programmes. The Ministry of Health and the Ministry of Education should therefore assume a more active role, not only in the formulation of policies and strategies, but also in providing technical expertise in the formulation of standards of service, supervision of programmes and implementation of projects. In addition certain institutional arrangements to reflect this new role should be contemplated.

There has been little attention paid to training health care personnel in the area of drug treatment. Some training was provided as part of the UNDCP Master Plan related projects.

Non-governmental organizations

There is a very extensive network of non-governmental organizations in Nepal. One estimate is that there are over 1,600 non-governmental organizations involved in the HIV/AIDS area and 102 international non-governmental organizations, although many of these organizations are inactive. The government has, as in many other countries, adopted a policy of outsourcing many of its programmes and activities to these national and international non-governmental organizations, without any ongoing technical support and supervision of activities and without programme monitoring and evaluation, or standards development. The Government does not appear to possess the technical and financial resources at present to provide the necessary level of external service provider screening, direction, supervision and support.

There are only a very limited number of non-governmental organizations

working in the area of drug-related HIV prevention in Nepal: A larger number of non-governmental organizations are working in the area of drug demand reduction.

Punarjiwan Kendra, Kirat Yakthung Chumlung (KYC), ('Revival Centre') is a drug treatment and rehabilitation programme in Dharan. It provides non-medical supported withdrawal (detoxification) and rehabilitation services over a period of six months. The programme has received funding support from SCF/US, as a pilot.

Staff of KYC believes that the essence of overcoming drug dependence is "will power" and self-confidence. The programme incorporates many of the elements of an American-style therapeutic community, including confrontation, work therapy, recreational therapy, group counselling and individual counselling. It is stated that "psychotherapy" is offered but staff are not adequately trained or formally qualified to offer such treatment.²

Importantly, the programme also provides harm reduction information and education through peer support and outreach. Bleach and clean water is also distributed. The outreach workers received training from LALS Kathmandu and at present, are each seeing 5-6 people who use drugs, each day. They work from two centres in Dharan and keep a log on their daily activities.

There is a waiting list for people wishing to enter this treatment setting and police say they could bring many people to the centre each day, if more beds were available. There are plans to double the current bed capacity of ten. A random survey undertaken in 1997 identified 2,450 persons in the Dharan area who use illicit drugs.

A police inspector stated that police are very supportive of this treatment program and have reportedly moved from a view that drug use is essentially a criminal problem towards the view that it is more a social and health problem. In this context, they are also supportive of the idea of establishing a needle and syringe exchange programme. They like the harm reduction programme offered by LALS in Kathmandu and do not believe that punishment-based approaches are effective in helping people with drug problems.

Aasara Sudhar Kendra Drug Rehabilitation Centre ('Aasara') is a secured reform camp for drug dependent persons. It was established in Kathmandu in June, 1997 with the objective of "giving a new lease of life to those youths who comprise an important force of our society but who have deviated from their

2 It is relevant to note that there is no evidence in the western research context that psychotherapy is effective in altering drug use behaviours, except where in the presence of mental co-morbidity that may respond to such treatment (e.g. depressive illness).

path by falling into the bog of drug addiction, and establishing them as reputed citizens.” It is operated by the Police Women’s Association and Police provide 24 hour security services to the camp. The programme includes work and recreational therapy, group therapy, personal, spiritual and family counselling, yoga, work and personal skills development, moral education, social work and psychological interventions of an unspecified nature. Patients must advance Rs 14,000 (US\$ 210.00) prior to admission to cover the costs of the programme for the first three months and thereafter, a further Rs 3,500 (US\$ 52.00) is levied per month.

Life Giving and Life Saving Society (LALS) is a non-governmental organization that has worked with injecting drug users in Kathmandu since 1991. It enjoys an international reputation for its harm reduction work which has included information and education of drug users on ways that they can reduce their risk of HIV infection, outreach work, distribution of bleach, sterile water and condoms and needle and syringe exchange services. It has also provided counselling to drug users, drug treatment referral services and primary health care. An early evaluation of the drug use situation in Kathmandu was that knowledge of HIV prevention had increased among drug users and that the HIV sero-prevalence had remained low - falling from 1.6 per cent in 1991 to 0 per cent in 1994. However, a more recent assessment has revealed that this situation has changed dramatically.

Up to 45 per cent of injecting drug users tested have been found to be HIV positive and the proportion of all HIV positive cases attributable to drug injection is similarly high (although this is without doubt an over-estimate of the true sero-prevalence given the over-representation or selection bias of people who use drugs among populations tested).

A HIV sero-prevalence survey was undertaken in Kathmandu in 1997 on 200 persons randomly selected for voluntary admission (‘given an option to leave’) to Assara from a population of drug users found on the streets, in shooting galleries, in hotels and in temples. They were tested for HIV using a single ELISA method and the results were analysed in terms of whether they had attended the LALS needle and syringe exchange programme at some stage. While one would need to be very cautious about these results of this analysis, what it suggests is that those attending the LALS needle and syringe exchange service experienced a degree of protection from HIV infection. This data suggests that needle and syringe exchanger programmes have not contributed to the recently detected rapid increase in HIV sero-prevalence among injecting drug users as claimed by some opinion leaders in Nepal. Rather, this data suggests that the needle and syringe exchange services of LALS has if anything exerted a discernible public health impact, notwithstanding its very limited

reach in terms of the proportion of injecting drug users attending the services and in terms of the number of sterile needles and syringes provided.

While UNAIDS has described the LALS prevention programme as one that is illustrative of the manner in which harm reduction can work, its survival is on the basis of this series of events, quite uncertain. The Director of the National Centre for AIDS and STD Control expressed the view that the closure of LALS would be both painful and regrettable given its achievements and international standing.

It is important to make it a priority to secure new and sustainable funding for LALS and to consider expanding its role to one of a national training centre in harm reduction. LALS has played an important role in advocating for harm reduction policies and practices in Nepal. Government could helpfully formalize this role.

C. Current drug policy

Drug related legislation

The law that has most relevance to drug policy and legal response to drug use is the *Narcotic Drugs (Control) Act, 2033 (1976)*. This law is limited in its coverage of drug-related matters, simple in its form and content, and could benefit from updating. It was last amended in 1993 (2050).

The *Narcotic Drugs (Control) Act, 2033 (1976)* states that a person convicted of transacting more than one hundred grams of opium poppy or coca bush shall be punished with imprisonment for a term of fifteen years to life imprisonment and with a fine of between five hundred thousand rupees and twenty five hundred thousand rupees (US 7,500 to US\$ 37,000). One key informant in government stated that the maximum penalty for drug trafficking in Nepal is 33 years imprisonment, greater than “life imprisonment” which is 20 years. This statement is inconsistent with the provisions listed in the *Narcotic Drugs (Control) Act, 2033 (1976)*. There are no provisions for the death penalty in Nepal. Section 11C(e) of the *Narcotic Drugs Control Act* states that anyone who consumes opium, coca or any other narcotic drug made there from shall be punished with an imprisonment for a term of up to one year or with a fine up to ten thousand rupees.

The laws on drug use and treatment in Nepal are seen by some clinicians as being quite vague at present. One key informant advised that the laws

“...allow a doctor to treat drug dependent persons with substitution treatment for many months without necessarily seeing the patient. The doctor can merely advise the patient over the telephone to continue taking the medication and that is sufficient for the purposes of professional accountability”.

Reference to the *Narcotic Drugs (Control) Act, 2033 (1976)* reveals that there are provisions for a bond that replaces imprisonment with an undertaking to enter and remain in treatment for three months and for the treating agency to submit fortnightly reports on the individuals concerned.

The *Narcotic Drugs (Control) Act, 2033 (1976)* also contains provisions for withholding or remitting punishment for minor and first offences. Specifically, if a person is found to have purchased or possessed cannabis or medicinal opium, without commercial motive and in a small quantity, or has consumed only a small dose and if he has committed such an offence for the first time, the Narcotics Drug Control Officer may, after keeping a record of such person, make him sign a bond undertaking not to commit such offence again and release him after recording the reason for withholding the prosecution. Even when prosecution has already commenced, the court may, if it deems the offence to be of a minor nature and if the person has committed the offence for the first time, fulfil the above processes and release him without applying any punishment.

It is not clear that the criminal justice system has played any substantive role in HIV prevention in Nepal. Rather, some aspects of the criminal justice system would appear to be adding to HIV vulnerability among people who use drugs and their sexual partners. A number of key informants observed that police officers may sometimes use the illegal status of specific drug to their own financial advantage, harassing people and coercing bribes or personal favours in lieu of their arrest.

HIV risk in prisons

Drug dependent persons are not generally provided with any medication for symptom relief or clinical safety when imprisoned. They withdraw “cold turkey”. They may be discriminated against while in prison and generally receive no specialized treatment. No aftercare is available following their release.

Prisoners are not routinely tested for HIV. The Ministry of Home Affairs concedes that illicit drug use does occur in Nepalese prisons and where detected, it is met with increased punishment. When asked about the risk of HIV transmission through unsafe sex in prisons, it was suggested that: “This is not a problem because men are separated from women in prisons”.

Senior officers of the Ministry suggested that men having sex with men does not occur in Nepalese prisons and that indeed, it is uncommon in Nepalese culture. The questions of drug use and unsafe sex in prisons are matters that, as in this case, government officials may not feel comfortable in discussing. However, advice received from a non-governmental organization working within three prisons in Nepal confirmed that both risk behaviours do occur.

It is important to note that condoms are now available in these three prisons following extensive discussions between staff of these non-governmental organizations and prison officials. 1,500-2,000 condoms are now reportedly distributed each month. However, the great majority of prisons do not allow condoms and the risk of HIV transmission appears real and substantial. The absence of drug injecting that is thought to exist in these three prisons may not exist in others in Nepal, but this is of course conjectural.

International frameworks for drug control

The Narcotic Drugs (Control) Act was passed in 1976 and amended in 1981 and 1987 and Nepal became a party to the 1961 *Single Convention and the 1972 Protocol* amending that Convention. In July 1991 it became a party also to the 1988 Convention against *Illicit Traffic in Narcotic Drugs and Psychotropic Substances*. A Drug Control Unit was established within the Ministry of Home and a nation-wide network for drug abuse control was created with the Chief District Officers designated as drug control officers. The Police Department, which carries the main burden of narcotic drug enforcement in the country and makes virtually all the seizures and drug-related arrests, established a drug section within the Crime Investigation Department that currently supervises drug squads and drug seizures and enquiries in seventy-five district police offices. The Department of Customs is also nominally responsible for drug enforcement activities at customs posts along the borders and the airports, however with few seizures to its credit (HMG/N, 1992).

D. Drug policy development

The responsibility for drug policy planning in Nepal resides solely within the Ministry of Home Affairs. The Ministry of Health has had no direct involvement hitherto and the Ministry of Home Affairs has not as yet placed substantial emphasis on the public health aspects of drug use.

Drug legislation and HIV prevention

Senior officers of the Ministry of Home Affairs expressed the view that needle and syringe exchange and methadone maintenance treatment are against the law. They observed that the Ministry would however be comfortable with the use of methadone as a reduction treatment (drug-free treatment goal).

The public health rationale behind the distribution of sterile needles and syringes is not accepted by many senior officers in government and instead, is seen as counterproductive. The public health arguments may also be inadequately understood or alternatively, they may be accorded low weighting in policy analysis and decision making. Reasons given for rejecting the idea of sterile needle and syringe exchange and availability programmes included:

“...because they share the needles that are given.”

“Drug users cause problems to whole society. Therefore, they are more dangerous than a murderer. We don’t allow users or pushers early release as we people who commit other crimes. However, we pay most attention to punishing pushers.”

On a more positive note, one senior officer of the Ministry of Home Affairs noted that the laws of drugs were drafted more than 10 years ago and at a time when HIV/ AIDS was not at issue in Nepal. Consideration was now being given to whether needle and syringe exchange programmes should be made legal, or not. While the Ministry of Home Affairs does not agree with the implementation of needle and syringe exchange programmes, the Ministry of Health has advocated for this strategy to be implemented. The Ministry of Home Affairs indicated that it: “...might re-examine the law in relation to needle and syringe exchange and methadone maintenance treatment” (with a view to making them legal).

Close examination of the relevant laws suggests that needle and syringe exchange programmes are not unlawful since there are no paraphernalia laws prohibiting the possession of a needle and syringe and no laws that might be taken to mean that the provision or sale of sterile needles and syringes breaches any legal provisions. However, that drug use is itself an offence might be interpreted to mean that any activity that promotes or facilitates the use of illicit drugs is also illegal, including education about safer ways of injecting drugs and strategies which increase access to sterile injection equipment.

The main emphasis on drug strategy within the Ministry of Home Affairs remains in the area of “demand reduction”. There is growing concern about the rising number of illicit drug users, however, the Ministry of Home Affairs does not accept the Ministry of Health estimate of 40,000-50,000 drug users. They view this as a gross over-estimate of the true number, although the officers concerned did not articulate the basis upon which had arrived at their own estimate.

The specialized HIV/AIDS sector is not involved at any level in the development, review and reform of drug policy in Nepal. The converse also applies - the Ministry of Home has not been involved in HIV prevention planning. The concept of inter-sectoral responses developed through integration, collaboration and co-ordination has not as yet impacted on government planning and activity in the areas of drug policy and HIV prevention. However, an intention has been signalled to do so in the *National Drug Control Policy of HMG/Nepal, 1995*, which was formulated in 1995 by the Ministry of Home Affairs, in collaboration with UNDCP, together with a National Drug Demand Reduction Strategy.

The *National Drug Control Policy of HMG/Nepal* notes “the tendency for drug-related problems to be considered as sectoral issues, mostly bordering health”. It adds that there is often a “tendency towards sectoral and indeed compartmentalized and isolated action”. It also notes that there has been a tendency to equate prevention with preventive education and that “reduction of harm, especially in the face of emerging threats such as AIDS, has failed to adequately enter the ambit of prevention.”

Harm reduction is mentioned as one of the goals of the policy alongside law enforcement, demand reduction, social support, treatment and rehabilitation, legislative support, international obligations and attention to implementing agencies and systems. Preventive education has often been based either on moralising or scaring, it adds. The aims of this *National Drug Control Policy of HMG/Nepal* are stated as the creation of a climate: “... where the non-medical use of drugs is virtually non-existent.”

The Master Plan for Drug Abuse Control

The Master Plan for Drug Abuse Control in Nepal (1992) was drawn up by the Ministry of Home in Co-operation with the United Nations International Drug Control Programme and was signed by HMG/N and UNDCP in July 1992. Key issues in the Master Plan were as follows:

- (a) Revision of existing legislation
- (b) Upgrading of the drug control administration
- (c) Strengthening of law enforcement
- (d) Policy changes for demand reduction
- (e) Preventive education and information
- (f) Key Areas for government Intervention
- (g) Revision of current narcotics legislation
- (h) Strengthening of the law enforcement
- (i) Expansion of treatment and rehabilitation services :
- (j) Elimination of illicit cultivation and production
- (k) Policy formulation in the field of preventive education and information
- (l) Key areas for external assistance

The Master Plan comprised two project plans for external support in the sectors of legislation and law enforcement, and treatment, rehabilitation and other demand reduction activities, with a total contribution of US\$ 1,003,700.

The Master Plan made the following observations in relation to policy changes required for demand reduction:

- (a) The policy of placing drug addicts in the custody of police or confining them in jails is acceptable as a short-term interim measure, but its medium and long-term viability is open to questioning on legal, medical and moral grounds. This issue is closely linked to the lack of capacity for detoxification and rehabilitation in the present system and, obviously, the difficulties for the families in handling drug dependent family members. The problem of who should provide this additional service must also be addressed.
- (b) At present, the Government has largely delegated the responsibility for detoxification and rehabilitation to the non-governmental organizations, which is a commendable policy consistent with experience elsewhere in the region. However the current policy of relying on these services without moral or financial support needs to be revised so that the present capacity problem is to find a more permanent and satisfactory solution.
- (c) Rehabilitation and after-care services are not provided within the government sector whereas the non-governmental organizations, without compensation, provide an insufficient variety of services. This situation does not provide any encouragement to private organizations to support the drug demand reduction policies of the Government.
- (d) The lack of support by the Government also has other consequences of which a lack of supervision of the standard of services provided by the non-governmental organizations is one result. The Ministry of Health which in other countries takes a direct and active role in the formulation of policies and advocacy and acts as a repository of technical knowledge on treatment and rehabilitation has in Nepal not yet assumed a similar role.

Mid-term and terminal evaluations were carried out and reported on in September 1996. There are two significant observations to be made about the Master Plan and its impacts and outcomes.

The above Plan contained no reference whatsoever to HIV prevention as a central element of drugs policy, planning and action. The opportunity costs of committing a government to a programme of action while ignoring this aspect of drug policy and action is substantial and difficult to reconcile with the local and international experience.

Senior government officials state that drug problems are accorded high priority by Government, however, other key informants expressed concern that this expression of intent has not as yet been translated into practice. Nothing of a serious nature, it was suggested by some, is happening to address drug use and

drug-related harm at present. The Master Plan of UNDCP ran its natural course during the 1992-1996 period but does not appear to have made an impression. Several small scale training projects for drug treatment and law enforcement officers were held recently drawing upon some funds that were left over from the Master Planning process, but nothing of a sustainable nature continues.

Intersectoral mechanisms

Since 1992, the National AIDS Project has come under the umbrella of National AIDS Co-ordination Committee. At this committee, chaired by the Minister for Health and various sectors, national and international non-governmental organizations are represented as members. The committee which is the highest policy making body was restructured in 1995 with a total of 40 members and is supported by an executive committee under the chairmanship of the Secretary of Health.

An Executive Committee carries out its activities through the National Centre for AIDS and STD Control, Department of Health Services. It is semi-autonomous and functions as a focal point for AIDS and STD prevention activities.

District AIDS Co-ordination Committees have been established as a means of decentralising and building capacity at grass root level with a view to promoting sustainability of AIDS and STD prevention activities.

A co-ordination mechanism has been established between the Narcotic Drug Control Division and the National Centre for AIDS and STD Control. The Under Secretary of the Narcotic Drug Control Division is appointed as a focal point for drug abuse and HIV/AIDS related matters.

A high-level drug control co-ordination committee has been constituted under the chairmanship of the Home Minister. This committee is comprised of the Secretaries as member from the Ministries of Health, Finance, Industry, Foreign Affairs, Social Welfare, Home Affairs, National Planning Commission, the Chief of the Police and others. The Narcotic Drug Control Division is headed by the Joint Secretary, who also serves as the chief Narcotic Control Officer, in the Ministry of Home Affairs. This officer has responsibility for policy, planning and programme formulation and for co-ordination of activity. An Executive Committee has representation from the Department of Drug Administration, Commerce, Costumes, Industry, Civil Aviation, Police Head Quarters and Narcotic Drug Control Law Enforcement Unit (Shrestha, 1999).

The Narcotic Drug Control Division has responsibility for a Drug Demand Reduction Project that aims to promote drug awareness within the community. It involves non-governmental organizations and various training programmes

have been provided for school teachers. A curriculum “against drug abuse” has been developed and is currently being implemented.

While the intersectional mechanisms for HIV/AIDS prevention appear both extensive and comprehensive, there is in truth much work to be done before consistent and evidence-driven intersectoral policies, strategies and activities are in place. Knowledge, attitudes and practices remain inadequate and out-dated. Some District level officials with dual drug control and HIV responsibilities are also unsympathetic to the principles of HIV/AIDS prevention that have been shown to work best internationally and continue to believe that repressive measures are more appropriate. These repressive measures continue to hinder effective HIV prevention activity targeting people who are at risk.

E. HIV/AIDS

Epidemiology

Thirteen per cent of HIV cases to date are attributable to drug use. However, the recently implemented rapid assessment suggests that the sero-prevalence among IDUs may now be as high as 45 per cent. This is viewed as extremely worrisome to officers in the Ministry of Health. The projected number of persons infected with HIV was 27,000 by end of 1997.

Table 6.3 Cumulative HIV and AIDS infection

	Males	Females	Total HIV +	AIDS Cases (M/F)	AIDS Cases
31 January 1999	811	395	1206	-	-
31 March 1999	860	402	1262	-	213
30 April 1999	870	406	1276	160/ 94	254

Table 6.4 Cumulative HIV Infection by sub-group and sex

Sub-groups	Male	Female	Total
Sex workers		306	306
STD patients	701	15	716
Housewives		78	78
Blood Transfusion/Transplant	1/	/1	2
Injecting Drug use	160	1	161
Perinatal transmission	8	5	13
Total	870	406	1276

Table 6.5 Detection of HIV infection by year and sex

Year	Total Sample Tested	HIV Infection		
		Male	Female	Total
1988	9,016	3	1	4
1989	5,9180	0	2	2
1990	8,619	2	3	5
1991	17,000	12	14	26
1992	33,995	39	38	77
1993	38,228	41	40	81
1994	16,523	18	22	40
1995	21,867	71	39	110
1996	10,457	50	85	135
1997	9,475	394	95	489
1998	39611	166	54	220
Total	263,971	796	393	1,189

Legislation, policy and planning

Current government priorities in health reform are focused on developing primary health care services, addressing communicable diseases and improving hospital services. It is conceded that government has not as yet examined the interface between empirical evidence and policy decision-making in any focused or detailed manner. Government is generally more responsive to the “demands” and “wishes” of its citizens. There are no processes by which government policy is reliably guided by best available scientific evidence. There is no system whereby research is undertaken to inform decision-makers. However, there is a government co-ordination committee mechanism through which reports can be received and discussed. Government is said to be receptive and willing to discuss new ideas, although progress may be slow.

Strategic plan for HIV/AIDS

The issue of drug use as it relates to HIV transmission is addressed within the *Strategic Plan for HIV and AIDS in Nepal, 1997-2001*. This plan provides a broadened view of the determinants of HIV vulnerability. It points out that strategies focusing on individual behavioural change are limited in their vision and in their likely impact in preventing or containing HIV transmission. It raises the issue of systemic factors that lay the foundation for HIV vulnerability including the “values of the economic, educational, cultural, social, legal and political systems which structure the world, within which HIV is transmitted and within which the epidemic has its impact.” While these matters “cannot all

be addressed given the limits on resources, this does not mean these factors cannot be changed through public policy”, adds the report.

The plan proposes that institutions for drug treatment be strengthened and that policy development includes:

- (a) Strengthening access to drug treatment and rehabilitation for injecting drug users;
- (b) Provision of sterile needles and syringes to injecting drug users through non-governmental organizations;
- (c) Strategies for preventing initiation to drug use through school curricula;
- (d) Reviewing the legal context of illicit drug use in relation to HIV prevention activities.

Institutional strengthening activities proposed are as follows:

- (a) Expansion of counselling services for drug treatment and rehabilitation;
- (b) Encouraging peer education for drug users;
- (c) Involving the Sports Council in prevention activities;
- (d) Training police officers to refer injecting drug users to non-governmental organizations involved in prevention, care and support for injecting drug users;
- (e) Convening a legal workshop to examine the legal aspects of current Nepali law for HIV prevention efforts with a view to reforming the law in a manner that can facilitate HIV prevention as opposed to current emphasis on the punishment of those who use or traffic drugs;
- (f) Assessing the adequacy of current HIV counselling and testing services;
- (g) Strengthening training programmes for counsellors addressing issues pertaining to the specific problems of female injecting drug users who are also sex workers.

UNAIDS, WHO and UNDP supported the National Centre for AIDS and STD Control in developing this plan. UNDCP was not involved. Nor was the Ministry of Home Affairs.

Outreach and peer education

There are no policies on peer education, outreach work and user self-organizations in Nepal and these strategies do not appear to have been actively considered for adoption. There are no government operated or government funded peer education, outreach or drug user self-organizations. There are

however examples of peer education and outreach work being undertaken in Kathmandu by LALS, in Pokhara and in Dharan.

Police are supportive of the outreach work that is being carried out in Dharan. However, there is a perception that police in Kathmandu are not necessarily supportive of this aspect of the work undertaken and that they may sometimes place barriers before those undertaking HIV prevention work.

Drug substitution treatment

The legal situation pertaining to the use of methadone or other opioids for the purposes of drug substitution treatment is unclear. While some government officials believe that the use of drug substitution treatments is not sanctioned by the government of Nepal at present, the law is silent on this matter. The *Narcotic Drugs (Control) Act, 2033 (1976)* makes no specific reference to methadone treatment. However, there are a number of sections which give reason to conclude that methadone maintenance treatment is legally sanctioned and legitimate practice for the purposes of medical treatment and scientific investigation in Nepal, consistent with the provisions and intent of the *Single Convention on Narcotics, 1961*.

It is of relevance to note that the National Drug Demand Strategy of Nepal has as an indicator of "...appropriate and affordable services of treatment and rehabilitation: fifty per cent of hard core and chronic addicts will avail of methadone and other drug substitution therapy in the mental hospital." The inference one might safely draw from this is that government policy is generally supportive of methadone substitution treatment.

A small methadone maintenance treatment programme has been operating out of the outpatient services of the Mental hospital in Kathmandu, since 1994. At present, there are about hundred patients on the programme. A senior psychiatrist established and continues to manage the programme.

The programme has been well accepted by patients and the doctor in charge feels that the programme now needs to be extended in capacity in Kathmandu and also in other parts of Nepal. However, the government has signalled its wish that the programme first be independently evaluated by an international agency such as WHO or UNAIDS.

In response to specific questions, the following situation is apparent in relation to opioid substitution treatment in Nepal. Government policy is supportive in a limited and non-formalized sense, but there is no written policy on the matter. There are no laws that specifically prohibit the use of methadone or other opioid substitution treatment. While methadone is only used in one location in Nepal, from an outpatient programme operated from the Mental Hospital in Kathmandu,

buprenorphine has been offered in the context of supported drug withdrawal and in a limited sense in the context of a maintenance programme, in Pokhara. The latter programme is provided by an international non-governmental organization.

Availability of clean needles and syringes

Administration by injection and sharing of drug injection paraphernalia is, as mentioned above, commonplace in Nepal. These practices place many people who use drugs and their sexual partners, at high risk of HIV infection. An attempt of sorts may be made to clean contaminated syringes with water, sputum or urine. Few drug injectors appear to have sufficient knowledge, personal skills and access to practical means of effectively cleaning used drug injection equipment. The legal and policy environment is also not conducive to strategies aimed at promoting access to sterile needles and syringes and effective cleaning of used injection equipment.

As noted above, there is no specific mention within the law to needle and syringe exchange. The possession of a sterile needle and syringe is not in itself an offence, however, some respondents suggested that police may sometimes arrest people found in possession of injection equipment. These reports could not be verified.

There is no specific government policy on needle and syringe exchange programmes. The LALS programme has a policy of one for one exchange but does not adhere rigidly to this policy. The actual return rate is estimated to range from 50 per cent to 65 per cent. Staff endeavour to meet the preferences among clients for injecting equipment as much as they are able, within the limitations of available resources. Female injecting drug users remain largely hidden and are not accessing these services.

Pharmacists are often unwilling to sell needles and syringes to people whom they believe use illicit drugs. Others are reported to sell needles and syringes at inflated prices. A one millilitre plastic disposable needle and syringe costs Rupees. 10-15, which is expensive given average earnings. People who use drugs will always prefer to expend such sums on the drug itself rather than on sterile injection equipment.

There is differing opinion as to whether pharmacies are lawfully able to sell sterile needles and syringes to people who intend to use them for the purposes of drug injection. It may be that it is not widely known that there are no paraphernalia laws in Nepal. However, there may be a professional code of conduct, which precludes such action. In the absence of alternative means needle and syringe availability, it is often very difficult for people to obtain

sterile needles and syringes. Once again, that drug use is in itself an offence could be taken to mean that any action, which is seen to encourage, or facilitate illicit drug use including safer drug use, is illegal.

There are two needle and syringe exchange programmes in Nepal - one operating out of LALS in Kathmandu and a second operating out of INF in Pokhara. The Pokhara exchange is not officially recognized and it was suggested by some that it is better to avoid speaking publicly about this service, least it attract attention and force the government's hand in closing the service. Services at LALS and INF are only open during the business hours of 9 a.m. to 5 p.m., Monday to Friday. This means that injecting drug users must plan ahead and ensure that they obtain their supplies during these hours. Forward planning is not a behavioural trait that is commonly exhibited by people who are drug dependent and living a disorganized way.

In summary, while needles and syringes might be said to be available in urban and provincial (but not rural) settings in Nepal, they do not appear to be accessible in the broadest sense of the meaning of the term. This would serve as a substantial disincentive to the use of sterile needles and syringes and would add to HIV vulnerability. In many circumstances, people are simply unable to access sterile needles and syringes regardless of any intentions they may have to avoid using or sharing contaminated injection equipment.

The primary health care system

The primary health care sector does not play any substantive role in the prevention or treatment of drug problems in Nepal and there are no plans to build such capacity at present. However, LALS does provide primary health care services of a minor nature as part of its outreach work. It also refers people to primary and secondary health care services as appropriate to the circumstances.

Effective mobilization of the local institutions (Village Development Committee and District Development Committee) is seen as essential by government:

“because these agencies are working in the development and social arena of the grass-root level. These agencies can mobilize local leaders, social volunteers and local non-governmental organizations to aware the people against the drug use and HIV/AIDS. We have experienced that the results so far found are encouraging where the HIV/AIDS programmes were implemented in collaboration with local institutions.”

Increases in the number of people with HIV/AIDS are already placing pressure on health care services, which are not geared to provide the necessary services. There are limits in terms of the availability of diagnostic facilities, trained personnel and other medical services in both urban and rural settings.

The concept of harm reduction

Senior officers in government in Nepal are said to react to the terms “harm reduction” and “harm minimization” in different ways. Some react quite adversely. Many believe the terms refer only to drug substitution treatment and needle and syringe exchange programmes. It was suggested that it is important that they be educated that the term refers to strategies that go beyond this.

Notwithstanding, there is serious doubt about the effectiveness of harm reduction strategies within the Ministry of Home:

Some of the non-governmental organizations have introduced harm reduction activities for the drug addicts to prevent them from HIV/AIDS, hepatitis B and C through needle exchange and drug substitute programmes. The government has been closely watching the procedures and results of these programmes although these programmes have no government approval. But it is found that in the absence of effective follow up, on going monitoring and evaluation, the programmes do not seem effective to discharge desired results - Shrestha, 1999

On the other hand, the Ministry of Home believes that law enforcement and interdiction are proving to be effective, although the precise outcome indicators to which this conclusion applies remain unstated.

It is believed that with the effective surveillance of law enforcement unit and seizures of drugs show that the trafficking of hard drugs in the kingdom is in the decreasing trends.

It is conceded that interdiction effort levelled against plant-based drugs is being circumvented by a reversion towards the use of synthetic drugs:

But the addicts have changed their habits towards the psychotropic substances and synthetic drugs due to its easy availability and cost involvement. His Majesty's Government of Nepal has banned some drugs under the Drug Administration Act and has regularized some of the drugs to be sold only under the prescription of the doctor from the limited drug stores.

The following observations (Shrestha, 1999) suggest government intends to pursue harm reduction activities and amend legislation and policy so these activities are sanctioned and supported by government. These activities will be closely monitored and evaluated, as is appropriate in the circumstances.³ This signals pro-active intent to foster approaches that can provide health protection to the people of Nepal.

“Lack of effective monitoring, follow up action and evaluation mechanism on needle exchange and drug substitution programme, drug depend-

3 This principle ought to be applied in relation to all drug policies and interventions including those in the areas of drug treatment and law enforcement

ency of addicts remains and thereby increases economic burden for the government. Therefore an effective monitoring and evaluation mechanism along with practically designed follow up action should be established while launching the harm reduction programmes. To regularize the activities mentioned above, necessary amendments on acts and regulation should be made.”

V. DISCUSSION

A. Constraining factors

The *National Drug Control Policy of HMG/Nepal, 1996* is the current policy in Nepal. This policy does not clearly describe the drug policies of Nepal. It is more a series of statements on some of the determinants and harmful effects of drug use, the sectors that have a role to play in addressing drug problems and the mechanisms of proceeding. Most of the goals that are as described are not really goals in a formal sense. They might be better described as areas in which certain outcomes are to be sought.

A goal of “attaining a climate where the non-medical use of drugs is virtually non-existent” is one that has particular importance for policy development and planning. It would be of concern if this ideal were to inhibit the implementation of less ambitious but nevertheless important public health measures. In the context of the difficult economic and other social challenge in Nepal today, this goal would seem far distant, particularly in a local, regional and global environment where drug use appears to be increasing.

Although UNDCP was able to provide substantive technical support to the government in developing these policies and its associated strategy, there is not as yet sufficient technical and financial capacity within the country to implement these policies and strategies.

As noted above, police officers may sometimes arrest persons found in possession of a needle and syringe on the basis of a argument that since the use of a narcotic drug is illegal, the possession of a needle and syringe can be seen to aid and abet this illegal act. However, this argument is not supported in law by paraphernalia provisions and could not in any case be verified. This uncertain legal situation merits close attention by government. The best solution in terms of facilitating the development of strategies which can serve to reduce HIV vulnerability among people who use drugs would be to repeal the law which renders drug use illegal. Possession of drugs could remain an offence without interfering with benefits that would arise with this change in law.

The government has adopted a policy of outsourcing many of its programmes

and activities to national and international non-governmental organizations. This may be seen to offer a number of benefits, for example, it allows government to facilitate the implementation of politically controversial and sensitive programmes (such as needle and syringe exchange) while at the same time avoiding politically motivated controversy. Non-governmental organizations can usually mobilize more rapidly and at lesser cost because they usually face less “red tape” in acting upon decisions.

On the other hand, a strategy of outsourcing may be associated with a number of undesirable outcomes. Governments adopting this strategy may lose their opportunity for ensuring that adequate interventions are implemented. Outsourcing may make it difficult to implement programmes and activities to scale and in a sustainable manner. Outsourcing may foster a policy decision-making environment that avoids formal commitment to strategies, even if they have demonstrated public interest benefits. Many non-governmental organizations do not possess the necessary institutional and individual capacity to offer interventions in a manner that can make a public health difference.

This is not to suggest that non-governmental organizations working in the drugs and HIV/AIDS areas are not often effective and are not important sources of service delivery. Clearly, they are in so many cases. However, it is to signal the need for the establishment of more comprehensive and analytical mechanisms for evaluating the technical and other competence of non-governmental organizations seeking to undertake the work that is tendered out. It may often be preferable to decline an offer of support from a non-governmental organization if its intentions are based on personal opinion, beliefs and values rather than empirically supported or plausible strategies, programmes and activities.

There are only a very limited number of non-governmental organizations working in the area of drug-related HIV prevention in Nepal. There are a larger number of non-governmental organizations working in the area of “drug demand reduction”. These non-governmental organizations offer a sound foundation for HIV prevention among people who use drugs. However, a closer engagement between government and these non-government and international non-government agencies would help maximize their collective input in a way that is not occurring at present. Review of certain laws and policies would also clarify matters and would be important in enabling these national and international non-governmental organizations to offer services that work best in preventing or containing HIV transmission.

One senior officer in Government explained that he perceived people who use drugs as criminals. As such, they deserved to be severely punished. He believed they should be imprisoned for lengthy periods without the option of early release.

The public health rationale behind the distribution of sterile needles and syringes is not well accepted or understood by many senior officers in government. Rather, this approach may be seen as counterproductive. Alternatively, the arguments may be accorded low weighting in policy analysis and decision making. One government officer stated that he rejected the idea of sterile needle and syringe exchange and availability programmes: "... because they share the needles that are given."

There is the assumption that drug treatment must always be provided in an institutional setting and that a longer admission is likely to be better than shorter admission in terms of treatment outcome ("more is better"). These assumptions do not accord with evidence that has amassed in both the highly industrialized nations of the world and in developing countries. The Government of Nepal might usefully revisit this issue in the context of its evaluation of progress to date and in its forward planning.

It is often hoped that drug-free treatment programmes provide governments with a means of preventing a drug-fuelled HIV epidemic. The international experience clearly indicates that they cannot. The universal experience with drug-free treatment approaches internationally is that they reach only a small minority of those with drug problems, manage only limited throughputs due to the long duration of programmes (2 years or longer in some countries), have high drop-out rates (when of a voluntary nature), and high relapse rates following treatment.

There are few treatment programmes in Nepal. The Dharan situation provides a reasonable example of this mismatch between treatment 'need' and treatment provision. The rehabilitation centre has only 10 beds and if it offers a 12-month treatment programme, it will only reach 15 people in any 12-month period (assuming a 50 per cent dropout rate). There is a waiting list for people wishing to enter this treatment setting and police say they could bring many people to the centre each day, if more beds were available. There are plans to double the current bed capacity of ten.

Contrast this with the findings of a random survey undertaken in 1997, which identified 2,450 persons in the Dharan area who use drugs. Many of these will not need or benefit from residential treatment. Indeed, many will benefit just as much from information, brief counselling and social support as they will from extended inpatient treatment. On the other hand, it is likely that this survey identified only a minority of those who use drugs, some of whom would benefit from specialized treatment.

B. Facilitating factors

The *National Drug Control Policy of HMG/Nepal, 1996* notes the challenge of addressing drug-related problems in an inter-sectoral manner, the need to address the harms associated with alcohol, tobacco and some medicinal drugs alongside those arising from the use of illicit drugs. It also notes that there has been a tendency to equate prevention with preventive education and that “reduction of harm, especially in the face of emerging threats such as AIDS, has failed to adequately enter the ambit of prevention.” These are important observations that deserve priority attention in future policy development and planning. These aspects of the policy provide opportunities and levers for action of a positive nature.

Comment is made on the importance of building the conditions for comprehensive collaboration both within the community of non-governmental organizations and between government and non-governmental organizations. This requires among other things a substantial strengthening of the capacity of the NCASC and improved co-ordination of non-governmental organizations’ planning and activity.

The plan proposes that institutions for drug treatment be strengthened. However, a serious barrier to the advancement of these aspects of the National HIV prevention strategy would appear to be that their development did not involve key Ministries such as the Ministry of Home Affairs. These Ministries may not accept yet alone own these strategies. That is a serious deficit in this planning process, one that must be overcome as a priority by the government of Nepal.

The *Narcotic Drugs (Control) Act, 2033 (1976)* contains provisions for withholding or remitting punishment for minor and first offences (Chapter 2, sub-section 19). Similarly, other provisions (Chapter 2, sub-section 14 (Penalties), sub-sub-section (e), provide for a bond in place of imprisonment providing an undertaking is made to enter and remain in treatment for three months and for the treating agency to submit fortnightly reports on the individuals concerned.

The Government of Nepal wishes to have an external independent review of its methadone programme before expanding the strategy in Kathmandu and in other parts of the country. This raises an important issue more generally. To what extent is it necessary to replicate research and evaluation of strategies such as methadone treatment, where these have been demonstrated to be effective and acceptable across numerous countries and cultures internationally, particularly in an environment where health resources are invariably so scarce?

Bearing this caution in mind, it would seem desirable that any evaluation that is to be undertaken in relation to methadone maintenance treatment should focus on process, with a view to ensuring that the intervention is being implemented

in a manner that is congruent with internationally demonstrated good clinical practice methodology.

For example, are the doses that are being prescribed adequate to suppress craving for additional opioid use? Are clinical responses empathic, non-judgmental, supportive and of a nature that engenders trust and confidence among patients? Is treatment retention maximized by current clinical policies and practices? Is supportive counselling available to those in crisis? Can and should counselling be made available as a core component of the programme? If so, what are the technical, human and financial resource implications?

The cost of urinalysis may be the most expensive and difficult element of any evaluation and the need for its utilization depends upon the purpose of any evaluation that is undertaken. If the emphasis is to be on process evaluation and it is well understood by clients that there are to be no negative contingencies for self-disclosure of drug use, self-report supplemented by collateral report and clinical examination would be acceptable surrogate measures. It would be important for those undertaking an evaluation of the methadone maintenance treatment programme to ascertain the requirements of decision-makers including the effect size that would be accepted as constituting “effective” and “worthwhile” under what circumstances, before embarking upon any such evaluation.

The methadone prescriber tentatively suggested that an effect size of 50 per cent reduction in opioid use would be viewed a worthwhile treatment effect. That is very reasonable. He added that wives and mothers often asked him to put their husbands or sons back on methadone because they fared so much better when in treatment previously. This is a low tech but good surrogate indicator of treatment effectiveness in his experience.

The government might consider approaching WHO/ SAB and UNAIDS-APICT in a formal manner, requesting technical support in undertaking a review of its methadone programme. This represents an opportunity for advancing the implementation of HIV prevention policies and strategies in Nepal.

There has as yet been little attention paid to training health care personnel in the area of drug treatment. Some training was provided as part of the UNDCP Master Plan related projects. The observation that staff are “burning out” suggests that training and ongoing professional development would help and support staff in their often difficult work. This would provide an important opportunity to introduce, enhance and strengthen HIV prevention interventions within the context of drug treatment and rehabilitation programmes in Nepal. ‘Burnout’ is often the result of unrealistic expectations among staff in terms of clinical outcomes and the application of inflexible clinical policies and practices

which are inevitably associated with conflict and resistance among patients. These are important issues for ongoing training, supervision and experienced clinical mentorship in any drug treatment setting.

It is important to add that failure to respond early and adequately to drug problems and HIV risk can lead to a reversal of the increase in life expectancy and development gains made over many years. Effective HIV prevention among people who use drugs and their sexual partners is not only a crucial public health issue, it is also a key development issue.

A key informant from a non-governmental organization working in prisons observed that unsafe sex is a matter of substantial concern in the three prisons in which they currently work, adding however that there is no evidence that drug injection is occurring. Following extensive discussions between this non-governmental organization, government officers, condoms were made available in these three prisons, 1,500-2,000 condoms are distributed each month.

This is a commendable situation and if the reports of no injecting drug use have veracity, it augurs relatively well for avoiding or at least limiting any spread of HIV that might otherwise occur within these three prisons. However, the great majority of prisons do not allow condoms and the risk of HIV transmission appears real and substantial. The absence of drug injecting that is thought to exist in these three prisons may not exist in others in Nepal, but this is of course conjectural. Nevertheless, that health protection measures have been accepted in three prisons offers hope that these and other interventions might be introduced in all prisons and detention settings through appropriate intersectoral situational and policy analysis and planning processes.

CHAPTER 7
THAILAND

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I. SUMMARY OF FINDINGS

Thailand has well-developed drug control programmes and a great deal of experience in HIV/AIDS prevention and control. However, at present there is little dialogue or collaboration between the two sectors.

There are few if any impediments in Thailand that would inhibit more and better provisions for the prevention of HIV/AIDS among drug users. It is noteworthy that in Thailand:

- The overall approach to drug demand reduction is pragmatic
- Drug users are generally sent to treatment and not to prison and are regarded more as patients than as criminals
- Methadone maintenance is available albeit limited in scope at the Bangkok Metropolitan Clinics
- Although needle and syringe exchanges schemes are not available, there is no shortage of syringes to buy.

There is a great deal of expertise in the country in treatment and prevention methods.

Outreach and peer approaches are widely used in HIV/AIDS prevention (though not at present in the drug field).

Thailand has considerable research and evaluation capabilities and considerable human resources. These could be used more effectively to study the drug demand problems and to improve interventions.

II. RECOMMENDATIONS

Better inter-sectoral communications should be promoted between the drug control and HIV/AIDS prevention and control agencies in Thailand. This will ensure that drug users are recognised as a group vulnerable to HIV infection that

has special needs.

It is important to ensure that adequate funding support be given to demand reduction and HIV/AIDS prevention activities to facilitate improvement and the necessary development and expansion of current responses.

It is recommended that the Ministry of Health reviews the current approaches to methadone treatments in Thailand and make changes as appropriate.

It is also recommended that the Ministry considers the establishment of needle and syringe exchange schemes.

The promotion of peer education approaches and self help organisations is to be encouraged.

It is also recommended that better training be given to those working in the drug field. Thailand needs more specialists and researchers focusing on drug issues.

Thailand should give consider consideration to the special needs of drug users in prisons.

III. INTRODUCTION

Opium smoking was legal in Siam (Thailand) since the 1850s and opium was distributed under a royal monopoly that produced substantial tax revenues. In 1921 the number of opium addicts in Siam was estimated to be some 200,000. It was in 1958 that the Thai government banned opium smoking and selling throughout the country and all paraphernalia for opium smoking were incinerated on July 1 1959. Opium users were required to register at the Excise Department and seek treatment within 6 months - over 70,000 drug users registered for treatment. However, the revocation of laws allowing opium smoking and the opening of new trafficking routes created new trends of drug abuse and trafficking. Morphine and heroin rapidly took the place of opium and in recent years there has been an explosive increase in amphetamine use. These increases in drug use must be seen against the background of rapid social and economic growth, new communication and trade links in the region in recent years, which led to an increased movement of goods, populations and drugs within countries and across borders.

A further contributory factor to the increase in drug use is Thailand's geographic location at the centre of what is known as the 'Golden Triangle'. This area saw major increases in drug production in recent decades and is now one of the world's largest opium cultivation regions. Historically, opium cultivation and opium smoking was relatively commonplace in Thailand's Northern Highlands. However, since the Government's extensive development and crop

substitution efforts, which began in 1973, there have been substantial reductions in the total area under cultivation. Drug law enforcement has also been vigorous in Thailand. Arrest data show an increase in drug-related cases from 86,603 in 1992 to 101,849, 105,546 and 117,364 cases in 1993, 1994 and 1995, respectively.

In order to deal with the problem of increasing drug problems, the Thai Government established the Central Narcotics Board in 1961. This board became the present Office of Narcotics Control Board (ONCB) in 1976 under the provision of the Narcotics Control Act of 1976 and is the lead drug control agency in the country.

The first AIDS case was identified in September 1984. But the first wave of rapid epidemic spread of HIV infection begun in the beginning of 1988.

IV. FINDINGS

A. Epidemiology of Drug Use

There is limited reliable data and documentation on the drug situation in Thailand. The most frequently referred to data is that compiled by the Thailand Development Research Institute (TDRI) in 1993. These data indicated there are approximately 1.29 million drug users in Thailand (approximately 2.2% of the population). The Office of Narcotics Control Board estimates that there is an increase of about 25,000 new drug users every year. In the early 1990s it was estimated that 60% of those in treatment were injecting drug users¹ and in 1994 it was estimated that there were between 100,000 -240,000 injectors in the country. There is a marked lack of information about drug use in the rural areas.

The principal drugs of abuse are heroin, methamphetamine, marihuana and volatile substances while cocaine and ecstasy are gaining popularity among foreign visitors and youth from wealthy families in Thailand. The Northern Treatment centre where many people from the northern highlands are treated report that while in 1988 only 9% of the treatment population used heroin, the number increased to 42% by 1995. Injecting drug use also increased from about 20% in 1995 to 37% in 1998.

B. Trends of Drug Use

In the absence of nationwide data a number of recent studies are used to provide indicators of drug use trends. Thus data collected in 1996 from provinces

1 The Hidden Epidemic (1999)

throughout the country indicated that almost half of the village communities nationwide faced drug problems. Treatment centres statistics suggest that the major drugs used by their patients are: Methamphetamine (39.8%), marihuana (22.5%), inhalants (19.5%) and heroin (13.2%), while 5.0% reported using other drugs. Among those in treatment in 1997 a large number of patients reported that they were truck drivers or agricultural labourers.

Thai fishermen were also identified as vulnerable to both heroin injecting and amphetamine use. A study among fishermen in southern Thailand found that 70.6% believed they experienced increased sexual potency in association with the use of heroin, while only 22.2% thought the same about amphetamine (this study was undertaken mainly among occasional users). They reported that heroin delays ejaculation and gives them more prolonged sexual pleasure. Moreover, it was noted that in-school and out-of-school young people are increasingly using drugs and are now considered the most vulnerable group in Thailand. Urine tests of 118,375 school children conducted by the Ministry of Education in collaboration with the ONCB in 1996 found that 1,375 children (1.16%) were positive for amphetamines.

Overall trends suggest an increase of heroin use²: the 'old' users are mainly from congested city areas and from the hill tribe people in the northern highlands. Many of these 'old' users continue heroin use but some also use methamphetamines since these are easily obtained. Furthermore, there is a growing trend of methamphetamine use in many sectors of the population and the scale of use in 1998 is believed to be 3-4 times higher than the earlier estimates provided by the Thailand's Development Research Institute (TDRI) in 1993. It is asserted that there is a serious problem in northern Thailand where methamphetamines are smuggled into the country. Methamphetamine is also the main drug of abuse in southern Thailand. It is a drug, which is widely used among people from many different occupations e.g. truck drivers, public transportation operators, fishermen and agricultural workers.

Not much polydrug use has been reported in Thailand. In fact there is a greater likelihood of alternate patterns of drug use. Recorded switching from amphetamine use to heroin use is low - probably around 10% and the incidence of switching from heroin use to amphetamine use is also low.

Since 1996 Ecstasy abuse has spread among local youth aged between 18-25. Ecstasy abuse is often found in entertainment places.

2 Thailand Country Report, presented at the APICT Inter-country workshop on drugs and HIV vulnerability (May 1999, Bangkok)

Table 7.1 Drugs of use in treatment population, 1987-1997

Treatment Population	1987	1989	1991	1993	1995	1997
Total admissions	57,874	60,000	66,465	82,620	101,145	62,212
Total new cases (%)	25.7	22.9	27.7	35.7	38.1	36.5
Number of new heroin cases	11,190	9616	13,321	22,996	32,657	10,512
% injectors (of new heroin cases)	70.6	66.1	58.7	51.9	54.4	68.6
Number of new amphetamine cases	40	40	115	297	980	7475
% of injectors (of new amphetamine cases)	35.0	7.5	23.5	16.3	2.9	0.7

Sources: Thailand Ministry of Public Health (1998)

The Ministry of Public Health collects anonymous linked data from all the treatment centres, both public and private. These data are cumulative. Data is also available on yearly admissions to treatment centres, which may include repeat attendees.

The Table 7.1 indicates that:

- (a) There has been a steady rise in the numbers of illicit drug users in treatment in Thailand;
- (b) There has been a steady increase in the total ‘new cases’ although the numbers of heroin users and heroin injectors has been declining;
- (c) The numbers of amphetamine cases entering treatment has been increasing;
- (d) However the percentage of patients who inject amphetamines appears to have declined. But, the majority of those who use heroin continue to inject.

C. Drug Policy in Thailand

The 5th National Narcotics Control Plan (1997-2001) which is the basis of the present drug policy in Thailand, was developed as a master plan for drug control, and gives direction to all activities undertaken by participating agencies and officials. It seeks to engage academicians and professionals as well as relevant government officers in planning. During the policy making phase, the ONCB was chaired by the Deputy Prime Minister and assisted by seven working groups that examined issues concerning the control of opium, heroin, marihuana, methamphetamine and volatile substances and also matters of overall co-ordination, monitoring and evaluation.

The objectives of drug policy in Thailand are in line with the objectives of the UNDCP, which are to balance, demand and supply reduction. The plan includes

provision for an integration of drug prevention measures, drug treatment and rehabilitation and narcotic crop control. But, the main focus is placed on drug prevention measures. These include plans:

- (a) To create negative attitude to drugs in the public and improve the capabilities of communities to prevent and solve drug problems;
- (b) To develop complete treatment and rehabilitation programmes for drug users with emphasis on quality service and participation from families and communities;
- (c) To improve the legal and justice systems and procedures to efficiently and continuously intercept producers and dealers of drugs and related chemicals.

Acknowledging the severity of drug problems and their long term effects in undermining stability and economic development the government Office of the Prime Minister issued a proclamation (order 141/B.E.2541 [1998]) 'Narcotic Drugs Prevention and Suppression Policy'. The proclamation stated that:

'Realising the severity of the problems and their long term effects which undermine stability and economic development of the country, the Royal Thai Government determines to control the drugs problem and reduce them eventually in order to safeguard the country's stability. The government considers it an emergency to control the problems'

According to this order there are two main plans of action. The first operational plan, emphasizes the reduction of narcotic use in four main target areas, focusing on communities with extensive drug problems, border areas, academic institutions at secondary, vocational and university levels labourers and public transportation companies. The prime objective of the Order is to prevent people who are not currently using drugs from initiating to drug use and to prevent relapse among those who have been treated for drug dependence. Drug users are to be treated as patients and there is reference in the Order to the importance of tailoring private and governmental treatment and rehabilitation services to meet the needs of patients. Collaborative efforts to destroy the supply and distribution of drugs are to continue.

The second operational plan specifies preventive strategies with the whole community aiming at building the strength, effectiveness and capacity of people's organization to conduct activities to prevent and solve drug problems in their communities.

The ONCB is the authority that has been assigned responsibility for implementing the Order. The ONCB is also empowered to declare an 'accelerated

operational area' in any areas identified as requiring special attention if required. The ONCB may determine which organisations or specially appointed task forces shall be responsible to implement the task identified. The Thai government sees co-operation and unity from every sector of the society as crucial to moving forward and has identified communities and educational institutes as having a role in responding to behavioural problems relating to drugs. This strategy has been described as a "state-civil alliance".

No mention is made in the plan of the prevention of HIV/AIDS among drug users.

Legislative Mechanisms for Drug Control

The 1979 Narcotics Law stipulates that those who are addicted to heroin or amphetamines are subject to a fine of between 5,000-100,000 baht and may receive a sentence of between 6 months and 10 years. However, those apprehended for the first time are most likely to be referred to treatment and then put on a two year probation.

The existing Narcotic Control legislation pays no attention to the prevention of HIV among injecting drug users. The Demand Reduction Bureau within the ONCB directs prevention, treatment and rehabilitation in Thailand. Their mandate is to:

- (a) Co-ordinate, discourage and carry out research work for the benefit of drug control
- (b) To develop and advise on measures, models, techniques and strategies on drug control including publicizing anti-narcotics messages for each target group.
- (c) To set up the system for collecting, compiling and analysing and dissemination information of the drug addiction situation and act as the central database on drug abuse within the country.
- (d) To formulate pilot projects and special projects in order to strengthen the treatment and rehabilitation works.
- (e) To cooperate with and support other concerned agencies in solving drug problems or take any action as assigned.

However, the Ministry of Public Health is preparing to put forward a proposal to the ONCB recommending a public order reform to the narcotics regulation to allow certain activities to help prevent HIV infection among drug users. The principal change is to enable clinicians to treat heroin users by methadone maintenance. Although this is already happening in practice in Bangkok clinics,

this proposed reform is an attempt to legitimate this activity in law. At present drug users have to be re-registered officially every 3 months even if they are in continuous treatment. The Ministry will suggest that maintenance be available for 1-2 years under special conditions and then drug users will be assisted to become drug free. The proposed submission for change will include the possibility of needle and syringe exchanges.

Policy on drug prevention

Drug prevention in Thailand is conceived as a co-operative effort between government agencies, non-governmental agencies and people's organisations. The main groups targeted for drug prevention are: school children, community-based groups, workplace groups and other special groups. School based preventive education has been in place in Thai schools for the past decade and many preventive interventions have already been employed in the community and are still ongoing. By 1998 the work on drug prevention was carried out in accordance with the following guidelines:

- (a) Creating a complete circle of drug prevention among youth groups both in-school youth, community and workplace groups;
- (b) Campaigning to publicise the drug issue, providing drug knowledge on the dangers of drugs to every target group by using multiple media;
- (c) Co-ordinating and monitoring sports ground anti-drug projects;
- (d) Co-ordinating with government, NGO and people's organisations who work in treatment and rehabilitation on improving treatment and data collection;
- (e) Supporting the setting up of treatment centres.

Preventive measures are directed both at the individual and the environments, which influences personal drug consumption. This is described in terms of developing "drug immunity" within the Thai community.

Some specific measures include:

- (a) Teachers training courses on counselling techniques - under this project 625 health personnel are responsible for training, supervising and supporting 9,000 school teachers from 3,000 schools in 30 provinces in counselling techniques to deal with students with drug problems;
- (b) Life-skills education and peer facilitator training for students. Members of peer groups will be trained in life skills, communication skills, coping with stress, problem solving skills and basic counselling skills;

- (c) The provision of advisory and telephone counselling services.

The Ministry of Health is planning to develop community based preventive interventions using the Primary Health Care system and increasing its role in education about drugs and HIV (One pilot project has already been started). The plan is to assist drug users during the treatment and rehabilitation phase and to train members of the community (including the police) in helping drug users who have completed treatment to maintain abstinence. Thus, the objective is to establish partnerships between local health authorities and the community

Overview of drug treatment

Most of the treatment population (50%) is based in Bangkok. The methods and objectives for the treatment of drug users are outlined in the Narcotics Control Plan and aim to develop a complete treatment and rehabilitation programme. The emphasis is on quality service and on ensuring the participation of families and communities.

- (a) Voluntary treatment is provided by 247 treatment centres (197 belong to the government under the Ministries of Public Health, Defence, Interior, University Affairs, the Municipality and the Bangkok Metropolitan Administration (BMA). The other 50 treatment centres belong to the private sector). The treatment consists of both western and traditional Thai medical treatments.
- (b) The correctional treatment system is designed to treat drug users who have been found guilty of drug charges. Treatment for these people is the responsibility of the Department of Correction, Ministry of Interior and the Department of Probation at the Ministry of Justice.
- (c) Compulsory treatment has not yet been enforced but it is envisaged that a suspect in a drug addiction case will be required to get treatment for a specified period of time in a place set up under the National Addict Rehabilitation Act of 1991.

The treatment provided by the Ministry of Health consists of four stages:

- (1) Pre-admission stage - is designed to prepare the drug user and his family for treatment
- (2) Detoxification stage -is designed to deal with the physical aspects of addiction. This can be conducted either in hospital or in an outpatients department, using substitution medicines such as methadone or herbal and other traditional medicines.
- (3) Rehabilitation stage - is designed to strengthen the individual both mentally and physically to remain abstinent from drugs and prevent relapse. It

offers career and other supportive activities such as individual and group counselling as well as religious counselling.

- (4) After Care stage - consists of monitoring drug users who have returned to the community. Providing advisory and supportive services and generally of keeping in touch with recovering drug users.

Among the major problems encountered in the treatment plan outlined above is that most of the drug users do not complete all four stages of the programme. Most undergo only the pre-admission and detoxification phases of treatment and very few undergo the rehabilitation and after care phases. The result is that treatment outcomes are very disappointing.

Methadone treatment

Methadone was first introduced in 1976 at Health Centre No. 16 in Bangkok. Methadone is now routinely provided in Bangkok clinics as the principal method of drug withdrawal. Sometimes clonidine (an alpha adrenergic agonist drug) is also used for detoxification in a low dose. Patients can re-apply for methadone treatment within a week of completing the previous treatment but most that require additional methadone simply go to another clinic to re-register immediately. If patients are known to be injecting while attending methadone treatment, the staff will provide them with information about cleaning needles and syringes and prevention of HIV/AIDS.

Those who repeatedly fail treatment are considered for methadone maintenance. There are approximately 2000 patients receiving methadone treatment at any one time. However, stringent criteria are employed. In general if a patient is young, the clinic will encourage detoxification because there are real concerns about addicting young people unnecessarily to methadone. However, certain patients are considered for long-term methadone treatment.

The guidelines for registering someone on long-term methadone treatment are as follows:

- (a) That the drug injector is already HIV positive
- (b) That the patient be older than 20
- (c) That the patient has enrolled at the clinic for drug-free treatment on more than 3-5 occasions
- (d) That the patient has been using more than 200 milligrams of heroin daily
- (e) That the patient injects drugs and has a history of drug use extending over a period of more than two years and is thus considered to be at risk for HIV/AIDS. (Non-injectors are sometimes included but on a very low dose).

Despite these stringent precautions it is reportedly easy to obtain methadone from private doctors. Needle and syringes are not distributed or exchanged in any treatment programme³ but are easily obtained and cheap (costs less than drinking water- about 8 baht for a 1 cc syringe). Drug users are not actually shown how to inject - but the procedures are discussed. Bleach for cleaning of needles and syringes are available at the Bangkok clinics.

On average, a methadone maintained patient receives a dose of about 70 milligrams daily, the maximum dose is about 120 milligrams daily. Low voltage stimulation (a form of acupuncture) is sometimes used together with methadone. Methadone treatments are virtually free for those who cannot afford to pay.

Findings from clinical data gathered in Bangkok suggest that about 80% of patients “cannot stop drug use”. But data from the methadone maintenance programme at the Tanyarak hospital in Bangkok also reveals that retention rates in methadone treatment are poor. Naltrexone is sometimes used for relapse prevention⁴ but this treatment requires a high degree of motivation (patients must first withdraw from opioids and subsequently naltrexone maintenance is prescribed for 3-12 months). This naltrexone programme has been in operation for 3 years but has not yet been evaluated, as the programme is not fully operative because there are not many suitable patients for admission to programme.⁵

It is clear that the treatment system faces several difficulties. Prominent is the high relapse rate and the lack of compliance where methadone is available. The low retention rates in methadone maintenance programmes are striking. The lack of research to assess and evaluate ongoing programmes and the limited technical capacity to carry out the rehabilitation and after care programmes are probably factors that impact these treatment failures.⁶ Besides, as already indicated methadone treatments are, with few exceptions, available in Bangkok only. Amphetamines users do not often seek treatment and in fact no specialised

3 It is noteworthy however, that a pilot needle and syringe exchange programme and methadone substitution is provided by a pilot project in Mai Cham among the Akha hill tribe

4 Naltrexone is a pure and long acting opioid antagonist

5 Perayaot Trongswad, Tawee Chotinuchit, La-or Sooksomboon, Kalayanee Tunsaringkarn, Piyalamporn Havanond, Pailin Srisookko, and Khemika Yamarat (1994) The Efficacy of Clonidine Treatment in Heroin Addiction. *Thai J Health Research* 8 (1): 1-20.

6 p.9 Narcotics Control Plan 1997-2001

interventions are available at this time in Thailand.

D. HIV/AIDS

The first case of HIV infection was identified in Thailand in 1984. But the rapid increase in the epidemic particularly among injecting drug users first became apparent in 1988.

Sentinel surveillance was introduced in Thailand in 1987 and to date some 850,000 cases of HIV had been recorded⁷. The predominant modes of transmission have altered over time. In 1984 the first recorded cases were among gay men but three years later, Thailand experienced a rapid increase in infection among injecting drug users and sex workers. A third wave of the epidemic then appeared among the clients of sex workers followed by a fourth wave among their wives and partners. The annual number of new HIV cases started to increase rapidly in 1992 and reached a peak in 1996 (31,844 cases) From September 1984 to December 1997 the HIV registry of the Ministry of Public Health recorded 106,344 cases of HIV/AIDS infection. These cases are unevenly distributed across the country. The highest range of 21-34 cases per 10,000 population is found in 3 provinces in the upper northern region of Thailand and in a province in the eastern region. One province in the southern region recorded 19 cases per 10,000 population. All provinces in the north-eastern region had rates of between 0.6-4.6 cases per 10,000. Most of those infected by heterosexual transmission commonly contracted the HIV-1 subtype E while the injecting drug user population who became infected through the use of contaminated injecting equipment was generally infected by the HIV-1 subtype B.

Sero-surveillance data from the Division of Epidemiology of the Ministry of Public Health derived from biannual HIV sentinel surveillance have been used as indicators of the situation of HIV/AIDS in Thailand. Thus for example:

- (1) The prevalence rate among 21 year-old male Royal Thai military conscripts began to increase steadily from 0.5% in 1989 to a peak of 3.7% in mid 1993 before levelling off at 1.9% in 1997;

7 Phoolcharoen W. Experience from Thailand. In: Partners in prevention: International case studies of effective health promotion practice in HIV/AIDS. UNAIDS Best Practice Collection 1998.

- (2) Testing of pregnant women attending ante-natal clinics in all 76 provinces indicated that HIV seroprevalence among them was about 0.5% in 1990, climbing to 2.4% in 1995 before declining once again to 1.7% in 1997.

Additionally, among a cohort study of repeat blood donors undertaken in the northern provinces there was a decrease in HIV infection from 1.7 per 100 person-years in 1989 to 0.5 per 100 person-years in 1994. National surveys of sexual behavior indicate that exposure to extra marital sex and to sex with sex workers decreased from 22% in 1990 to 10% in 1997. Importantly, these studies have suggested that changes in sexual behavior have occurred among vulnerable individuals who act as a bridge between a high-risk group and the general population. This change may have contributed significantly to the declining HIV incidence rate in the general population

However, despite an apparent stabilization in the spread of HIV in Thailand projections suggest that by the year 2000 there will be some 1.3 million infected people in the country.⁸ The number of cumulative AIDS cases reported in Thailand from 1988 to 1999 is 111,108 of whom 88,376 are men and the rest women (a ratio of male to females of 4:1) and a total of 5104 are aged 4 or under. About a quarter of AIDS cases are aged between 25-29. Approximately 30,000 people have already died of the disease. Most of those infected with the HIV die of TB or pneumonia. In the past two years (1997-1998) there has been a large increase of HIV/AIDS infections in prisons caused by both sexual transmission and drug use.

The National HIV/AIDS prevention Plan (1997-2001)

The National Plan for Prevention of HIV/AIDS 1997-2001 proposed by the National AIDS Committee focuses on human resource development and on the creation of enabling environments conducive to HIV/AIDS prevention. The plan proposes a holistic approach. Among the key strategies and measures the following is proposed:

‘Developing and upgrading public health services to support more effectively the potential of care-seekers to shape their behaviour to avoid the risk of HIV infection’

These include treatment for drug addiction, sexually transmitted diseases, family planning, occupational health services for labourers and general health services in all health facilities.

The HIV prevention program in Thailand adopts two main approaches: an intensive public campaign through various mass media and a variety of

⁸ National Economic and Social Development Bureau (NESDB) Working Group, 1994.

educational and behaviour modification interventions targeted on high-risk groups and on the vulnerable sectors of the general population. The aims are to reduce the risk of HIV transmission from sexual promiscuity, unsafe sexual practices and the sharing of injecting paraphernalia. The strong and continuous promotion of safer sex by sex workers and their clients can be seen through the Ministry of Public Health (MOPH) 100% condom use in brothels programme, which is among the largest national prevention program in Thailand. The programme was first piloted in November 1989 and implemented nation-wide in 1992. Specific strategies that may be indirectly relevant to drug injectors include the following:

- (a) Strategies for developing the full potential of individuals, the family and the community to prevent and alleviate the AIDS problem and reduce its impact, by strengthening the community's awareness of the HIV/AIDS. Promoting a spirit of mutual assistance, preserving community culture, maintaining ways of life that could help avoid the problem, changing values, which may lead toward increased risk. (e.g. involvement in the sex industry, tolerance of child prostitution, the practice of selling children, involvement in the procurement of young people for commercial sex, and such harmful social activities as heavy drinking).
- (b) Strategies for developing the social environment so it is conducive to preventing and alleviating AIDS problem; these strategies emphasis the development of more suitable socio-economic environments. (e.g. through promoting and strengthening business undertakings, generating opportunities so that underprivileged members of society can earn a living without having to migrate to urban areas, raising awareness of employers to enable them help their employee to avoid HIV infection and cope with AIDS).

However, notwithstanding the government's formal acknowledgement of the need for strengthened inter-sectoral and state-civil alliance, there does not appear to be any conceptual and operational linkages between drug control and HIV prevention and intervention policy, decision-making and planning.

HIV among injecting drug users

The overall increase in drug use in Thailand over the last decades is the backdrop to the severe early epidemic of HIV disease among drug users. It was between 1987-1988 that surveillance among injecting drug users at Tanyarak hospital in Bangkok and in the Bangkok Metropolitan Administration clinics revealed the sudden and explosive increase in HIV among drug users. The percentage infection rose from less than 1% in 1987 to over 40% just 12 months. A similar rapid increase in infection occurred nationally. For instance In Chiang Mai in

Northern Thailand the increase in infection rates was from 1% in 1988 to 61% a year later. High rates of increases of HIV infections were also reported from the Northern Highlands where a major heroin epidemic was beginning to take root. Moreover, in contrast to the declining trend of HIV infection among the general population HIV prevalence rates among injecting drug users remain high and averages 30-40% (Tables 7.2 and 7.3).

Overall HIV infection rates remain high among all sentinel populations of drug users. Figures from drug users tested throughout the country for June 1998 indicate that of 6047 drug users tested, 2623 were found to be positive for HIV (43.38%). It is important to note that the above data are indicative of very high prevalence of HIV infection, which have however stabilized around the 35-40% level. But although overall prevalence remains high incidence continues at a lower rates and at present, about 5-10% of drug users become infected each year. It is important to note also that relatively stable HIV prevalence does not imply zero incidence but is simply an equilibrium state in which some die and others are becoming newly infected. These observations were further supported by studies undertaken in Bangkok by Vanichesni and her colleagues who found that in a sample of 1500 drug users drawn in 1996, about 10% of the cohort are sero-converting every year. An AIDS vaccine is now being tried experimentally among 2500 drug users in Bangkok and this cohort will be followed at the BMA

Table 7.2 HIV prevalence among drug users in Thailand - mean rates of infection

	1988 Jan	1988 Sep	1989 Apr	1989 Nov	1990 Jun	1991 Jun	1993 Feb	1994 Jun	1994 Dec	1995 Jul
Prevalence	15.6	42.7	44.6	38.5	44.1	37.3	20.6	33.4	25.9	31.8

Table 7.3 Mean rates of HIV infection among injecting drug users: regional data from sentinel surveillance data in Thailand (June data)

Region	1989	1990	1991	1992	1993	1994	1995	1996	1997
Central ⁹	40.0%	37.7%	35.1%	37.2%	29.9%	33.4%	33.3%	33.5%	35.6%
North ¹⁰	19.7%	18.5%	28.7%	30.7%	38.9%	30.4%	30.8%	41.4%	39.9%
N. East	45.7%	25.9%	34.9%	27.2%	23.1%	43.7%	19.9%	46.1%	24.7%
South	41.4%	42.3%	39.8%	42.3%	46.8%	37.3%	40.3%	44.9%	46.0%

9 Includes Bangkok

10 Includes Chiang Mai, Chiang Rai

clinics over 3 years.

There is some evidence that following the dramatic onset of the HIV epidemic among drug users in 1988 that many changed their injecting behaviour particularly in Bangkok where intensive interventions to educate drug injectors about the dangers of HIV were implemented. However, there is insufficient confirmatory evidence as to whether this reduction of has been sustained. In a study in Bangkok Metropolitan Clinics undertaken in mid 1995 (Kitayaporn et al 1996) 43% of clients were reported to be sharing injecting equipment and a 1995 study in Bangkok showed that 91% of injecting drug users were positive for Hepatitis C.¹¹ Furthermore as can be seen from the Table 7.3 above there are notable regional differences in HIV infection rates among drug users. In Bangkok HIV infection rates reached a plateau around 30-35% but are closer to 45-50% in the south of the country.

AIDS cases due to drug use:¹² Between 1984-1990 a total of 35 AIDS cases were due to drug use. Since then a total of 5836 AIDS cases have been causally associated with injecting drug use. The data for the following years is present in Table 7.4.

Year	Number of cases
1991	45
1992	141
1993	508
1994	887
1995	1,278
1996	1,058
1997	1,016
1998	856
1999 - (to March)	14

11 Quoted in the Hidden epidemic - AHRN

12 Division of Epidemiology, Ministry of Public Health

This represents a cumulative total of 5.25% of all AIDS figures in Thailand. This compares with just 2% of AIDS cases in the north of Thailand.

V. DISCUSSION

A. Constraining factors

Approximately 30-40% of all injecting drug users in Thailand are infected by HIV/AIDS. But as the majority of infections in Thailand have been caused by heterosexual transmission it is understandable, that most resources are directed at vulnerable groups other than drug users. HIV infections among drug users peaked early in Thailand's AIDS epidemic and are not regarded any more as a priority for action. It is evident, however, that the effect of neglecting this group goes beyond drug users themselves. There are now an estimated over one million drug users in Thailand many of whom are engaging in a variety of high-risk behaviours.

There are number of matters that at present inhibit the development of better provision for HIV/AIDS prevention among drug users. The most serious of which is the lack of dialogue and communication between the AIDS control authorities, the ONCB and those working in drug treatment. Consequently there is no joint planning or action. Thailand is a country with a long experience in drug control and is often held up as an example of good practice to others in the region. However, despite very successful opium and cannabis crop eradication, its drug problems continue to increase, and demand reduction efforts are disappointing. Outcomes in Bangkok's clinics where methadone maintenance is available are poor and of particular concern is the low treatment compliance and early treatment drop out. Considering that entry criteria to these programmes is stringent and that those who are admitted to maintenance treatment are considered the most needy, this is a matter of concern.

There is little ongoing evaluation of the treatment and rehabilitation efforts and little research on the precipitants of relapse. Very little specialist training is available for those working in drug treatment. Furthermore, drug treatment is not always easily accessible especially in the rural areas and methadone substitution treatments are so far only available in Bangkok.

Although many therapeutic approaches are used in Thailand few of them have been translated to the drug field. For example:

- (a) Peer approaches (known to be useful in the prevention of HIV/AIDS among drug users) is commonly used in the HIV/AIDS prevention for

vulnerable groups (e.g. with sex workers) but is not used as a method to prevent risky behaviours among drug users;

- (b) Self-help and advocacy organizations are active in the HIV/AIDS field in general but not among drug users;
- (c) Although non-government agencies proliferate in Thailand and are extremely active and effective in the general AIDS field there very few working with drug users.

Views about the utility of needle and syringe exchange programmes are overwhelmingly negative and although there are no serious legal impediments to their implementation are nevertheless ruled out at the moment because of lack of interest. Comments about the inadvisability of needle and syringe exchange schemes at present include the following observations:

- (a) There is no shortage of needles and syringes in the country. There is a popular preference for using medicines in injectable form. The availability of injecting equipment is not regarded as an issue;
- (b) Sharing of needle and syringes has declined and injecting drug users are well informed about the risks of HIV/AIDS;
- (c) New HIV infection among drug users seem to have been predominantly transmitted sexually;
- (d) Drug users do not like to carry needle and syringes because of the attitude of the police. Although paraphernalia is not used in itself as evidence of drug use it may be used as collaborative evidence. Indictments are generally based on possession of drugs but the possession of needles and syringes can be used as an excuse to search people for drugs.

Many of these assertions are however made with little supportive evidence. Although Thailand has a substantial research capability, not much has been done to study the psychological or social aspect of drug use. There is therefore little research documenting drug-use behaviours in the country and there is inadequate knowledge about changes, if any, of drug use behaviour in the light of the HIV/AIDS epidemic.

B. Facilitating factors

There are few impediments to drug and HIV/AIDS preventive activities targeting injecting drug users. In general drug users are seen more as potential patients than as people to be punished. When drug users are sent to jail it is usually because they have committed offences (over and above using drugs). The possession of needles and syringes though illegal is not generally used as evidence against a drug user (except as collaboration of other evidence of

misdemeanors). Drug users are routinely sent to treatment and the Ministry of Public Health is the lead agency dealing with drug problems.

Other enabling factors include: well established treatment structures, experience in a wide range of drug prevention and treatment approaches. These include: pharmacotherapies, a range of therapeutic and motivational skills (e.g. peer approaches, out-reach, community based approaches). Furthermore, no serious political or ideological impediments to broadening the scope of substitution treatment exist and proposals to change the regulations that govern drug treatments are soon to be considered by the Office of the Narcotic Control Board. Although at present only available in Bangkok there are no legal impediments to extending methadone maintenance to other parts of the country.

Monitoring and evaluation capabilities: Thailand has considerable experience in both biological and social research (Some of the Bangkok clinics are at present participating in an international AIDS vaccine trial) and excellent monitoring and evaluation capabilities. It should be possible to attract more competent researchers to the field, so that different approaches to drug and HIV prevention could be tested and a better understanding of the problems faced by drug users is gained.

To summarise, there seem to be no serious impediments and many enabling factors for improving provisions for HIV/AIDS prevention among drug users. Thailand is the only country included in this study, in which methadone maintenance is available, albeit in a limited form and where other needed interventions are unlikely to be met with official sanctions. Despite a strong commitment to a drug free society there does not seem to be major philosophical conflicts between the main drug control agency the Office of Narcotic Control Board and the Ministry of Public Health which runs most of the treatment services. It would appear that in Thailand pragmatic adjustment to policy are eminently feasible

CHAPTER 8
VIET NAM

CHAPTER 8

VIET NAM

I. SUMMARY OF FINDINGS

The HIV/AIDS epidemic is spreading rapidly amongst certain groups of injecting drug users in some of Viet Nam's northern provinces.

The concept of 'harm reduction' is well understood and accepted in Viet Nam. Both the National Drug Programme and the National and Provincial AIDS Committees have identified 'reducing the risk of HIV infection through harm reduction' as top priorities

Despite a range of ongoing existing 'harm reduction' projects, many of which supported by the national and provincial AIDS authorities, it is still difficult to implement such projects in Viet Nam. Some of the constraints include:

- (a) A financial crisis in the health care sector, which worsened since 'Doi Moi': many competing health and welfare priorities;
- (b) The 'social evils' approach, which aims to eradicate all drug use, is in direct conflict with 'harm reduction' approaches;
- (c) Some cities/ provinces in Viet Nam are more in favour of 'harm reduction' than others;
- (d) The ambivalence of the local communities to harm reduction especially in the countryside where support for the 'social evils' campaign is strong;
- (e) The drug laws have not yet been passed so there is some confusion about what can be done;
- (f) There is a severe lack of human and financial resources for all drugs and HIV/AIDS activities;
- (g) Projects often suffer from short-term funding, under-funding and a general lack of sustainability.

II. RECOMMENDATIONS

UNAIDS to play a role in consensus building in Viet Nam and in the bringing closer together of all those dealing with drugs and HIV/AIDS.

UNAIDS and UNDCP to use the opportunity afforded by the revision of Viet Nam's Drug Control Master-Plan by increasing advocacy and funding for 'harm reduction' approaches, and to extend treatment and rehabilitation options for drug users.

It is recommended that the revised master-plan give a bigger role to public health approaches and to the Ministry of Health and that the Ministry of Labour should focus more narrowly on skills training and rehabilitation.

Existing harm reduction projects should be expanded. There is a need for more extensive peer-led approaches that include needle and syringe and condom distribution particularly in the northern provinces of Viet Nam. The emergent epidemic in these regions provide a unique opportunity for rapid and timely interventions.

Ho Chi Minh City (HCMC) is experiencing a temporary lull in the HIV/AIDS epidemic with most of the new drug users smoking heroin. The south of Viet Nam and especially the epicentre of the epidemic in HCMC needs to prepare for the expected shift from smoking to injecting

In order to expand and consolidate the existing prevention and harm reduction programmes it is important to:

- (a) Provide more training to law enforcement, welfare, health and other relevant personnel particularly at the local level;
- (b) Obtain the support local mass organization in prevention activities;
- (c) The 'social evils' focal points should be mobilized to provide real assistance in drug and HIV prevention;
- (d) Conduct better and more systematic evaluation, provide good comparative evaluation and demonstrate the efficacy of different approaches;
- (e) Provide good information on best practice in 'harm reduction' to all stake holders;
- (f) Provide more financial assistance to enable these programmes to develop;
- (g) Allow for local difference and work first in provinces that already favourable to 'harm reduction'.

Special attention should be given to the prevention of HIV/AIDS among vulnerable groups in prisons.

III. INTRODUCTION

There is a long history of opium cultivation and smoking among ethnic minority in the mountainous areas of North Viet Nam. Opium was also used medicinally and as a means to alleviate hunger. It has been estimated that in 1945 approximately 2% of the entire population were addicted to opium including almost 20% of Vietnamese elite. The patterns of drug use changed during the Viet Nam War when heroin use by injection became a widespread problem among American troops and South Vietnamese soldiers. By 1974 it was estimated that in Saigon alone there were as many as 150,000 drug users. However, heroin use largely disappeared when the war ended.

IV. FINDINGS

A. Drug Use in Viet Nam

During the Viet Nam war there were approximately 100,000 heroin users in Ho Chi Minh city (Saigon), but when the war ended and drug supplies were scarce the problem seems to have all but disappeared. Drug use began to reappear following the Doi Moi (renovation) policy, which began in 1986. Some of those who had been addicted before 1976 made an appearance in treatment centres and there was also emerging evidence of many new drug users. However, precise data on the nature of the overall increase is equivocal.

It has been estimated by the Ministry of Labour, War Invalids and Social Affairs (MOLISA) that there are between 185,000 and 200,000 drug users in Viet Nam of whom approximately 135,000 are opium smokers and the rest injecting drug users. However, the Viet Nam National Drugs Control Committee (VNDCC) the chief government organ for drug control in Viet Nam contradict these estimates. The VNDCC have information (including names and other personal details) collected by focal points on 'social evils' at the commune level on just 90,000 drug users in Viet Nam. The data for 1999 shows a rise of 10,000 over last year's figures. Included in the figures are opium and heroin users, both injectors and non-injectors. The VNDCC believe that these figures are an accurate representation of what is happening in Viet Nam and believe that there may be a real decline in numbers of users because previously quoted estimates are highly unreliable. They cite the following reasons:

- (a) Many of the drug users who were included in previous estimated data referred to elderly opium users who have since died;

- (b) Some local authorities routinely inflated the number of drug users in order to attract more resources;
- (c) Drug users are mobile and may be double counted.

A 1996 report by the Viet Nam National Drug Control Programme reported that 70% of drug users are under 30 and that most injecting drug users were men. Female injecting drug users represent but 2-5% of the total.

Drugs of abuse: Opium remains the most popular illicit drug in Viet Nam and it is both smoked and injected (in the form of black-water opium). There is also widespread use of numerous pharmaceuticals products such as pethidine, morphine, promethazine and diazepam. As in other countries in the region there have been some unsubstantiated reports of increased amphetamines use. Cocaine is rare in Viet Nam but has made a recent appearance in Ho Chi Minh City and marijuana is sometimes found along the Cambodian border in South Viet Nam.

Injecting drug use: Although there is no precise information on this matter, it is reported that injecting is more prevalent in urban areas and among marginalized groups. As already alluded to above, the north of Viet Nam has seen a major change from its traditional opium smoking to an explosion of heroin injectors. Reports of new injectors in north Viet Nam near the China border indicate the enormous scale of the increase. In 1996 Quang Ninh province has just a few injectors but the numbers began to increase in 1998. To-date over 1500 drug users have been identified and 90% of them are HIV positive.¹ The drug users are very young and nearly all are injectors

In Ho Chi Minh City the picture appears to be reversed. It is mostly the older drug users who are injectors while the numerous new heroin users are young and generally tend to smoke heroin. Data suggests that 58% of drug users in Ho Chi Minh City are 25 or under and the percentage of drug using students/pupils has increased from 0.92% in 1996 to 3.25% in 1998.²

Availability of injection equipment: Information about the availability and affordability of needles and syringes in Viet Nam was equivocal. Some reports from the rural areas suggest that injecting equipment is not readily available so that injectors go to 'shooting galleries' to be injected by 'professional injectors'. In the larger cities injecting equipment is readily available but is considered to be too expensive by the older opium users who tend to be extremely poor. It is not clear to what extent the numerous 'professional' injectors that operated in

1 National AIDS Committee data 1999

2 Department of Labour Invalids and Social Affairs: Report on the Social Evils Prevention Activities for 1996-1998

Ho Chi Minh City are still active. Some evidence suggest that there may be fewer now but it is possible that they have gone underground to service the many older drug users who still inject black water opium.

National trends conceal large geographic variation, which will become evident from the information on Quang Ninh Province and on 5 other northern provinces as well as the information from Ho Chi Minh city described below.

Quang Ninh Province

Information from some northern provinces particularly Quang Ninh, a province which has achieved rapid economic growth in the last few years, and has the 2nd largest number of HIV infected people in the country, show dramatic increases in drug use and particularly in injecting drug use.

A baseline study of 297 drug users in Quang Ninh Province³

Most of the respondents started drug use after 1993 and the most popular pattern of drug use is injecting heroin in shooting galleries. All respondents were injectors, and data on HIV (1997) suggests that all of those tested were infected. The survey found that 87% of users were between 18-30, 70% were single and male 65% were of local origin, 58% were unemployed.

The reasons for the high infection rates become clear from the following data:

- (a) Needing more drugs and 54% found injecting more enjoyable than smoking and 46% said injecting was cheaper
- (b) 48% injected several times a day
- (c) 93% borrowed needles and syringes from friends
- (d) 60% injected in 'public places'
- (e) 30% said they never cleaned their needle and syringes

Hoa Binh, Lai Chau, Quang Ninh, Hai Phong and Son La

A survey in 5 northern provinces and cities (Hoa Binh, Lai Chau, Quang Ninh, Hai Phong and Son La) revealed that the numbers of workers and their relatives who are using drugs increased by 67% last year against 1997. 'Hundreds of post office staff, primary school teachers in mountainous provinces, forestry labourers and management staff are drug users. A survey in the transportation sector

95 Vu Thi Minh Hanh and research team (July 1998). Report on results of KABP baseline survey on drug addicts in Quang Ninh Province (Pertaining to Viet Nam-Germany Technical Cooperation Project for AIDS Prevention

alone revealed 9,000 drug users. Furthermore in 1998, 3,218 pupils and students were found to be drug users.⁴

Ho Chi Minh City

In the Ho Chi Minh City a different pattern emerges. Estimates from Ho Chi Minh City indicate a change in the drug use situation. In 1996 a study in Ho Chi Minh City in 1996 estimated 3000 professional injectors (generally they are also the dealers) and that 51% of drug users visited a shooting gallery and 41% injected at home. Furthermore it has been estimated that 50-80% shared needles and syringes and only a minor number of injectors took the correct actions to clean their injecting equipment. However, it seems that a new generation of drug users is emerging and most of them are young people smoking heroin. The Provincial AIDS Committee (PAC) and the drug treatment personnel expect that these young smokers will soon begin to switch to heroin injecting but so far this has not happened.

B. Mechanisms for Drug Control

The government of Viet Nam has acknowledged that HIV infection among drug users is a serious concern. In 1995 the Government approved the National Drug Control Master-plan. One of its major objectives is:

To measurably reduce drug abuse and to promote harm-reducing and preventive drug abuse/HIV programmes, to develop a national plan for prevention of drug abuse and related harms, and for the plan to be closely correlated and where appropriate integrated with the National Plan for HIV/AIDS prevention.

The Committee on Ethnic Minorities and Mountainous Areas (CEMMA) and the Viet Nam Control Programme initially dealt with drug control issues. However, in August 1997 drug control was upgraded to become the responsibility of the Viet Nam Drug Control Committee (VNDCC) under the chairmanship of a Vice-Premier. The responsibility for drug control coordination was moved to the Ministry of Public Security. The director of the office of the VNDCC is the former chief of the Vietnamese Interpol. The VNDCC consists of representation from 14 ministries. It began functioning in March 1998 but is not expected to reach full capacity until the year 2000.

4 Viet Nam News- Thursday, April, 1999. 'More Officials and employees dabble in drug trafficking'. Report on a meetings of the Viet Nam General Confederation of Labour in Thanh Hoa Province

By the end of Oct. 1998 the VNDCC developed a National Action Plan which stipulated that the National Drug Programme for 1998-2000 should aim at:

- (a) Raising the awareness of the entire population about drug trafficking and addiction by the development of improved information education and communication materials;
- (b) Using the family as the basic unit for preventing young people from participating in drug trafficking and abuse;
- (c) Increasing efforts at opium eradication;
- (d) Dealing effectively with precursor chemicals;
- (e) Increasing efforts to enhance law enforcement, collaborate with relevant ministries and empower the legal system;
- (f) Limiting drug use in society and providing treatment and rehabilitation to drug users;
- (g) Increasing international co-operation in drug control.

The narcotics legislation has not yet been approved by the government but has been formulated and the regulations in respect to drug use are clear. Although drug use is illegal (a decree on May 1997) drug users are regarded as victims to be treated and rehabilitated rather than criminal to be punished. Very few drug users are convicted and sent to prison for drug use.

The 3-year programme will be followed by a National Action Plan featuring prevention, education in and out of school as well as increased efforts in community-based treatment and rehabilitation. However, comments in the UNDCP's Annual Report for 1998 suggests that although the Government shows commitment to drug prevention and has adopted a number of regulations designed to meet these objectives, that in practice Viet Nam still lacks the specific measures to translate these intentions into practice.

C. Treatment and rehabilitation

There are 11 drug treatment centres in Viet Nam that were established exclusively for drug users. However, every province in Viet Nam is supposed to have a centre established under the social evils campaign⁵ to provide education and rehabilitation to both drug users and sex workers. The city or provincial departments of labour, invalids and social affairs runs all these facilities. In

5 Was launched in 1993 to wipe out prostitution and drug use (Directive No 52-CT/TW)

addition there are in Viet Nam numerous other private treatment centres many of them employing traditional treatment methods (herbal medicines).

Everywhere, drug users have a choice between voluntary treatment for which payment is required and compulsory treatment, which is free. Evidence from the largest treatment centre in Viet Nam (Bien Trieu in Ho Chi Minh City) indicates that over 75% of patients in the last 3 years have entered treatment voluntarily (although they may be coerced by their families or local mass organizations). Voluntary treatment is expensive, but those who cannot afford to pay can apply to the local People's Committees for assistance.

Getting into treatment and the 'social evils' dimension: Drug treatment in Viet Nam is closely intertwined with the 'social evils' regulations. In January 1993 the government issued Resolution 06/CP on the prevention and control of drugs and a year later the Central Communist Party issued instructions on leading the social evils control force. This legislation gave considerable impetus to the provision of large-scale labour rehabilitation for drug users and the establishment of what is known as the 06 centres throughout Viet Nam.

It is a lengthy process to admit a user for compulsory treatment. The local Departments of Labour, Invalids and Social Affairs (DOLISA) who are charged with the social evils campaigns, operate through focal points in each ward and largely rely on the local community to inform them about drug users. From time to time families report directly to the focal point about a drug user in the family. In the first instance the focal points will generally suggest re-education for the user which may take the form of workplace meetings and criticism sessions or warnings from the local People's Committee. Only if these are not heeded is compulsory treatment instigated. The process of admitting someone to a treatment centre will generally take more than 55 days and is a complex procedure and the final decision is in the hands of the People's Committees. For compulsory treatment to be instituted actual evidence of drug use has to be produced. Quite a small proportion of those identified as drug users are sent to treatment compulsorily. For example in Ho Chi Minh City it would seem in 1998 that over 4000 people were educated at the work level and only 900 were sent to compulsory treatment.

The registration process which forms the basis for the data on the numbers of users nationwide is initiated by the focal point of the 'social evils' campaign and DOLISA and the records are expanded as a person undergoes the different stages in the rehabilitation process. The records are continually upgraded and finally find their way via the local departments dealing with Social Evils in DOLISA to the National Drugs Committee in Hanoi.

The treatment programmes the treatment and rehabilitation process is generally divided into 4 phases. In the 1st phase the objective is to detoxify drug users. This process takes approximately one month and drug users are given symptomatic treatment only. During the 2nd phase drug users are given psychological and moral education for 2 months. In the 3rd phase drug users are given vocational training and the final phase is devoted to social integration which can last as long as 3-6 month. Only those who are receiving compulsory treatment are expected to go through all 4 phases. Drug users stay in the treatment centres for anything between 3 months to a maximum of 3 years. Many voluntary patients stay only for the first 2 phases. However, experience shows that if drug users stay only for the detoxification phase, they are almost certain to re-use drug. All centres have reported relapse rates of between 80-90% incidentally, all centres employ some medical staff.

D. HIV /AIDS

After the first case of HIV infection was identified in Viet Nam in 1990 none were identified in 1991 and only 11 in 1992. However in 1993 there was a sudden increase of cases and 1148 new cases were reported, most among injecting drug users in the south of Viet Nam in Ho Chi Minh City and Nha Trang. By March 1999 HIV positive cases were reported from all 61 provinces in Viet Nam a total of 12,410. The epidemic has been spreading particularly rapidly in the northern provinces and in some has multiplied by between 5 to 22 between 1997-1998. The most heavily affected province in the north is Quang Ninh (which now ranks 2nd in Viet Nam after Ho Chi Minh City, a centre of Vietnamese and foreign tourism). This province has seen a rise from a single case in 1994, one case only in 1995-1996 to 1,451 cases during 1997-1998.

Over 65% of all reported infections in Viet Nam are among injecting drug users, followed by sex workers (4.0%) and patients with sexually transmitted diseases (2.7%). HIV infection has been reported mainly among males who account for 85.5% of all cases and most of the infections are in the 20-29 age group. To March 1999, 2404 AIDS cases had been reported and among them 1,280 have died. The main clinical manifestation of AIDS in Viet Nam is tuberculosis.

The National AIDS Committee estimates that there are approximately 75,000-80,000 people in Viet Nam who are infected with HIV and Vietnamese epidemiologists and WHO estimate that by the year 2000 there will be 200,000 individuals with HIV in Viet Nam.⁶

6 National AIDS Committee data 1999

The National AIDS Programme

The Government established the National AIDS Committee (NAC) in 1990 with multi-sectoral representation that included 11 ministries and 5 mass organizations. The Chairman is a Deputy Premier and his deputy is the Minister of Health. The executive organ of the NAC is the National AIDS Bureau (NAB) in Hanoi. Provinces and districts have their own AIDS committees, which mirror the national structure. The NAC developed and implemented the first Medium Term Plan for HIV/AIDS control 1991-1993 and developed the 2nd plan for the years 1994-2000 that is currently being implemented. The plan's major objectives are:

- (a) To prevent and mitigate the spread of HIV/AIDS;
- (b) To minimize and reduce morbidity and mortality from HIV/AIDS and to reduce the socioeconomic consequences of HIV/AIDS;
- (c) To mobilize the whole society in pursuit of the above objectives.

Furthermore the plan calls for the separation of the HIV/AIDS issues from the government's social evils campaign to eradicate drug use and prostitution.⁷ The key priorities identified in this plan include: promoting safe sex behaviours, providing condoms, encouraging STD patients to seek treatment and implementing education programmes targeting injecting drug users.

Out of all Viet Nam's national health programmes, HIV/AIDS has received the highest funding, even so funding is critically limited and insufficient. In 1998 the financial support to the programme from the government was just \$4.8 million.

HIV among injecting drug users

In Viet Nam HIV is predominantly being transmitted among injecting drug users. The provision of education to injecting drug users is now one of the major priorities of the 1994-2000 strategic National AIDS plan. To quote Prof. Chung A:

7 In 1995 the Central Committee of the Party issued a directive on HIV/AIDS that calls on all levels of the Party to strengthen HIV/AIDS control through promoting health, clean and faithful lifestyles and abstinence from drug abuse and prostitution - thus linking HIV/AIDS to the social evils campaign

“I would say that the biggest challenge ahead is the expansion of drug use. If we cannot combine the point of view on HIV/AIDS control and prevention with drug control, we cannot solve the problem”

*Prof. Chung A, National AIDS committee Vice Chairman, NAB Director
(Quoted in Partnership in Action: HIV/AIDS in Viet Nam)*

As can be seen in the table below (Table 8.1) the last few years has seen a rapid increase in the prevalence of HIV among injecting drug users in many provinces. However, the prevalence and incidence of HIV disease is still considerably higher in the south of the country than in the north. The prevalence of HIV among drug users in Nha Trang in 1998 was 85%, in Da Nang 80% and in Ho Chi Minh City 27.5%. The HIV prevalence in the north remained low for a long time however, by the end of 1996 and in early 1997 there were HIV epidemics among injecting drug users in some northern provinces. HIV prevalence among drug users increased from 0% in 1996 to 12% in Lang Son and to 32.55% in Hai-Phong in 1998.

Responses to HIV/AIDS

Viet Nam has created a national surveillance system that encompasses all 61 provinces in the country and extensive screening of blood products has minimized the risk of transmission through blood products. The government has also made educating the public on HIV/AIDS a high priority. Over the last few years information has been increasingly distributed through the mass media, schools, universities and Information Education and Communication campaigns are adjusted yearly to reflect changing trends and strategies. IEC in Viet Nam has had a demonstrable impact. A 1995 survey found that 96% of those surveyed know about HIV/AIDS and the majority said they were aware of transmission modes, knew how to protect themselves from HIV and had a good attitude towards HIV/AIDS positive people.⁸

Table 8.1 HIV sentinel surveillance in Viet Nam among IDUs (1994-1998)

	Year				
	1994	1995	1996	1997	1998
No. provinces	7	11	19	20	20
No. tested	4240	3996	8050	7558	8362
No. Positive	774	592	757	1009	1415
Aggregated rate %	18.25	14.81	9.40	13.35	16.92

8 Partnership in Action 1998

Non-Government organisations (NGOs)

Both Vietnamese and International NGOs fund and carry out HIV/AIDS prevention and care in Viet Nam. NGO activities cover a broad range of issues including condom promotion (by DKT International) and programmes to reduce the harm from injecting drug use. A number of NGOs have focused specifically on drug users. These include Save the Children UK, Care International, GTZ and others.

A number of NGOs have been working in Ho Chi Minh City for several years. NGOs working in close collaboration with the Ho Chi Minh City Provincial AIDS Committee have developed a vigorous pro-active peer-education programme in that city. In the north of Viet Nam, the GTZ, (Vietnamese- German Technical Cooperation) for HIV/AIDS /STD Control in Viet Nam (Hanoi) has responded to the emergent HIV/AIDS epidemic among drug users in the northern provinces of Viet Nam. GTZ is funding new projects in several northern provinces (Quang Ninh, Hoa Binh, Lai Chau, Hai Phong and Son La) employing peer education approaches, in a project that is implemented jointly with the National AIDS programme.

The international response

In 1994 as a result of discussions between the government, UN and multi-lateral non-government agencies developed a co-ordinated programme of external assistance, which provided a three-year framework through which international assistance could be funnelled. In 1996 six UN agencies launched UNAIDS and this programme now co-ordinates UN activities in the HIV/AIDS field in Viet Nam. UNAIDS objective is to support the national response - not to replace or duplicate it.

In March 1999 the National AIDS Programme in Viet Nam identified the following as a priority requiring international assistance

‘Promoting strategies to reduce the harm from injecting drug use (encouraging, mobilizing to use personal syringe or clear syringe and condom) among DUs, CSWs and their clients, and homosexuals’.⁹

Among the major projects funded by the international community in Viet Nam is the UNDCP funded project which aims at ‘Strengthening the National

9 HIV/AIDS in Viet Nam situation - National Response and Priorities NAC Jan 1999

Capacity for Prevention of Drug Abuse and HIV/AIDS among High-Risk Target groups. This three-year project began in 1998 (see the details below).

Risk Reduction: Policy and Practice

As has been already noted both the National Viet Nam Drug Programme and the National AIDS programme include reducing the risk of HIV infection among drug users as a major objective.

However, there are some undeniable tensions between the 'social evils' campaign that aims to eliminate all drug use in Viet Nam along with other social evils and the attempts to reduce the harm from injecting drug use. Despite the advice by the NAC that the government should consider the HIV/AIDS issue as separate and distinct from 'social evils' the campaign still forms the backdrop to many activities in drug and HIV prevention.

Background to strategies for risk reduction: Activities to reduce the harm from injecting drug use began in Viet Nam in 1993 when the National AIDS Committee in collaboration with some international agencies (WHO, Care International, SCF (UK)) piloted a peer-led model of 'harm reduction' aimed at preventing the transmission of HIV/AIDS among high-risk groups (sex workers and injecting drug users) in Dong Da district in Hanoi and in District I in Ho Chi Minh City. When the project was reviewed the following year it was endorsed by the National AIDS Committee and recommendations were made that the approach should be extended and included in the National AIDS plan. Indeed in the 1995 National Plan the model was extended to cover 14 provinces and cities. In order to implement this a number of workshops and training courses were conducted. These activities are ongoing.

The UNDCP Project: The UNDCP in Viet Nam plays a key role in assisting the government shape its drug control policies and will assist the VNDCC to revise the Drug Control Master-Plan (1995) to take account of changing conditions. As already noted above the UNDCP has been supporting a project to 'Strengthen National Capacity for Prevention of Drug Abuse and HIV/AIDS among High-risk Target Group' which began in 1998 and is due to end in the year 2000. This project represents a close collaboration between the National AIDS Bureau, the UNDCP and UNAIDS (which provides some of the funding), and activities focus on prevention of harms among drug users in the community. The project aims to improve the institutional capacities of the national, provincial and district level to carry out community-based HIV prevention programmes. The objective is to raise awareness among policy makers, law enforcement and drug abuse/HIV prevention personnel, to conduct baseline surveys in each site, and

finally to train and implement peer education in all sites. It is the aim of the project to experiment with the possibility of needles and syringe exchange schemes and this has only just been started. At present peer educators distribute some needle syringes and condoms.

Policy and practice in Ho Chi Minh City: In Ho Chi Minh City the Provincial AIDS Committee has taken a lead role in Viet Nam in the development of preventive approaches to curb the epidemic. Working closely with a range of local organizations. It conducted many educational campaigns and safe behaviour programmes. One of the key players in Ho Chi Minh City is Save the Children SCF (UK) who developed an effective and extensive outreach and peer-education programme in the city. SCF has had an HIV/AIDS programme since 1992 supporting a number of high-risk groups including injecting drug users, sex workers and men who have sex with men. SCF collaborated extensively with central institutions in Viet Nam including the National AIDS Bureau, the Viet Nam Red Cross, the Hanoi Medical College, the mass media and with a range of city, provincial and district institutions, who all contributed to the work. The programme using participatory approaches focused on the development of capacity to provide peer education and develop supportive networks in the community, information campaigns, and the promotion of self-help groups and training for home care and self-care. SCF has been employing a 'harm reduction' approach and the teams distribute both needles and syringes to injecting drug users..

The Ho Chi Minh City Provincial AIDS Committee also manages 2 fixed sites in the city (located in cafeterias) where needles and syringes are distributed and where there are facilities for checking on sexually transmitted diseases. The two projects were funded by WHO but funding has been discontinued (March 1999) so there is some uncertainty about the future of this activity. Approximately 3000 needles and syringes were distributed each month in each of the sites. However, because of the way the project is set up there was little 'exchange' or follow up activities in these 2 sites. There are also a number of mobile teams operating in the city. No pressure is exerted on the drug users to enter treatment or to become abstinent.

The 'Friend to Friend' club is an activity of the Ho Chi Minh City Provincial AIDS Committee. It was founded in 1995 and now has 500 members throughout the city. It is one of many other clubs in the city that has similar objectives and uses the same model. All its members are HIV infected and the permanent staff consists of just 12 people (2 of whom are women). The large majority of club members are injecting drug users or ex-users. The club works through a wide local network. Club members provide social support to each other, learn together about HIV/AIDS and about self-care and help educate families how to

care for infected members. Their major concern at the moment, as more and more people become AIDS patients, is how to build a better capacity in the community for dealing with seriously sick members.

It is clear therefore, that there are distinctions between the national objectives and activities in the field. Furthermore, there are regional differences in both practice and policy. To-date activities in the south of Viet Nam are different from those in the north.

Opioid-agonist pharmacotherapy treatment e.g methadone maintenance treatment was briefly tried in Viet Nam, implemented by the National Institute of Mental Health in Hanoi and planned to expand to sites in Ho Chi Minh City and Nha Trang. A review of this trial in Hanoi was conducted in July 1997 and at that time the programme had some difficulties in recruiting sufficient patients because of stringent entry and compliance requirements. It seems to have been discontinued at the moment for lack of support and funding.

Recent development: From 1999 the Viet Nam National AIDS committee has decided to devote a significant proportion of its budget to 'harm reduction' programmes. With the support of the Ministry of Planning and Investment and the Ministry of Finance, the National AIDS Committee officially extended harm reduction to 24 out of Viet Nam's 61 provinces. The National AIDS Committee of Viet Nam plans to maintain and broaden and strengthen the capacity on harm reduction targeting provincial staff.

V. DISCUSSION

The concept of 'harm reduction' is well understood and accepted in Viet Nam. However, in practice, because there are so many competing demands on scant resources, strategies to reduce the harm from injecting drug use, are not as widespread or comprehensive as may first be thought. Moreover, those projects that are in place often suffer from short-term funding, under-funding and a general lack of sustainability.

A. Constraining factors

Drug users in Viet Nam are targeted by the Social Evils Regulations and considered an anti-social group who by their very drug use commit social evils. Many believe that anything short of stopping this anti-social behaviour is intrinsically unacceptable. Although some involved in the social evils campaign admit that Viet Nam does not really hope to stem all social evils only to ensure that drug use and prostitution does not increase. However, many believe that

caution needs to be exercised in the provision of strategies to reduce the harm from injecting drug use, in case it gives drug users and potential users the wrong message.

Following the economic restructuring 'Doi Moi' and the recent economic downturn in the region, health and social services are seriously under resourced. It is unsurprising therefore that developing better services for drug users is not a high priority. At present although many undergo treatment unsuccessfully the relative cost effectiveness of different approaches is not examined. It may be that the need for public sector employment makes such calculations redundant. Moreover, the costs to the community of HIV/AIDS in Viet Nam are as yet small so that it is not seriously taken into consideration during the planning process. It is difficult to understand the process of policy review in Viet Nam, but what is clear is that the process of decision making is painfully slow.

Nevertheless, as indicated above, some 'harm reduction' approaches are actively implemented in Viet Nam and many have argued that quite simply the only restraining factor is the lack of more financial and human resources.

B. Facilitating factors

Both the National Drug Programme and the National and Provincial AIDS Committees have identified 'reducing the risk of HIV infection through harm reduction' as top priorities.

In general, the government of Viet Nam allows 'harm reduction' pilot projects to go ahead if they are deemed to be useful and there is little reason why these cannot be expanded if funds were available. The government is due to reconsider and revise its first Drug Control Master-plan in the light of the current situation. In the Master-plan of 1995 views on harm reduction were favourable. Both UNAIDS and UNDCP have an opportunity to help ensure that the government at the central level does not go renege on that position. Indeed there is probably room for improvement and change in the treatment and rehabilitation system. At present it is almost entirely run by the Ministry of Labour, Invalids and Social Affairs (MOLISA). It may be prudent to move drug treatment and HIV prevention closer together by giving a bigger role to the Ministry of Health and thereby strengthening the links with the AIDS programme.

By all accounts some provincial /district authorities are more favourable than others to 'harm reduction' so that it may be possible to work in those provinces without too much delay. There is no reason why different approaches and programmes should not be used in different provinces. For example methadone treatment may be easier and more acceptable in urban rather than a rural areas.

There are indications that the 'social evils' campaign is more actively pursued in the countryside than in the urban centres.

The drug use patterns in Viet Nam are changing rapidly and therefore the need for appropriate and timely interventions is paramount. The fast growing epidemic of injecting drug use and concomitant HIV in northern provinces necessitate urgent interventions to stop this accelerated and as yet unchecked epidemic. It seems that the whole range of 'harm reduction' strategies including peer approaches, education about safe drug use and sexual behaviour coupled with better needle and syringe distribution and availability as well as condom distribution are indicated in these provinces. On the other hand the epidemic seems to have slowed down somewhat in the south of Viet Nam but there are indications that the south must prepare itself to a new epidemic among young drug users who as yet do not inject.

Opioid agonist pharmacotherapy (methadone maintenance / substitution treatments): The overwhelming view in Viet Nam is that although methadone maintenance has been under discussion since 1995 it is not a timely intervention. So far the proposal to provide methadone for maintenance treatment lacks consensus backing from stake holders. The problems cited are those of obtaining, supplying and regulating methadone and of ensuring that methadone does not reach the black-market.

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ANNEXES

ANNEX 1

Terms Used in This Report

In order to ensure clarity and consistency, terms used in this report are described below. Whenever appropriate these followed the definitions of the WHO and UNDCP.

Drug laws	refers to the rules and regulations about drug control
Drug policy	refers to the programme for public action, which supports and facilitates the implementation of the drug laws. ¹ Operationally it was taken to mean all the expressed views and official pronouncements that were intended as a guide to action including official statements of intent and objectives, programme decisions by government bodies and other agencies, and strategies and action at the national, provincial and local levels.
Harmful use	is used as defined by WHO: ‘a pattern of psychoactive substance use that is causing damage to health.... physical or mental’. ²
Substitution treatment	was defined as: For people dependent on a psychoactive substance, the administration of a prescribed psychoactive substance, pharmacologically related to the one producing dependence, to achieve defined treatment aims, usually improved health and well-being. ³
Treatment	is used to define the process that begins when psychoactive substance users come into contact with a health provider or other community

1 UNDCP World Drug Report 1997 (p. 155)

2 WHO Expert Committee on Drug Dependence 28th Report, 1993

3 WHO Expert Committee on Drug Dependence 30th Report, 1998

service, and may continue through a succession of specific interventions until the highest attainable level of health and well being is reached.

Treatment and rehabilitation is used in reference to the comprehensive approach to identification, assistance, health care and social integration.⁴

Vulnerability to HIV/AIDS consists of the interaction of a range of factors including personal factors which include the quality and coverage of services and programmes aimed at prevention, care, social support and impact alleviation and societal factors that include cultural norms, laws or social practices that act as barriers to essential prevention messages such as the importance of always using clean injection equipment and clean drugs and the promotion of condoms and safer sex messages. As well as other social and environmental factors that shape human behaviour and increase the chances of HIV transmission within and beyond at-risk populations such as drug users.⁵

4 WHO Expert Committee on Drug Dependence 30th Report, 1998

5 UNAIDS (1998), Expanding the global response to HIV/AIDS through focussed action - reducing risk and vulnerability: definitions, rationale and pathways

ANNEX 2

How Prevalence and Incidence Data are Derived

Drug use data

Different procedures are used in each country to collect drug use data. Definitions of who constitutes a drug 'user' or 'addict' are not always clear and are not employed uniformly throughout the study-countries. (e.g. in some countries these may include not only dependent or regular users, but also occasional users, once only users, those testing positive in random urine testing programmes, those caught with drugs on their person, marijuana smokers, amphetamine users and others who may not strictly be 'addicts'.

China:

Local police operating on a commune level provide information to the Ministry of Public Security. Theoretically the figures are continuously updated.

The Ministry of Public Health has a computerised database in 16 provinces. All admissions to the voluntary drug treatment centres run by the Ministry of Health are recorded.

India:

There are no reliable estimates of the number of drug users in India and no register is kept. In 1989 the Ministry of Welfare undertook a study in 33 cities to ascertain the nature and extent of illicit drug use. The samples were drawn from official records of police, jails and welfare agencies and from police officers, lawyers, chemists, teachers, journalists and community leaders. Based on these reports, the Ministry projected the number of drug users to be 2.25 million, nation-wide. The Ministry of Social Justice and Empowerment plans to undertake a national household survey with the technical support of UNDCP, to arrive at an estimate.

Myanmar:

The 'addict register' is a cumulative record, which was begun in 1993. In theory it is possible to de-register after staying off drugs for approximately 2 years. In practice the treatment authorities seem to lose contact with registered users before de-registration can take place. This means that information about 'registered' users or addicts does not necessarily reflect the contemporary situation in Myanmar.

Malaysia:

There are no reliable estimates of the number of drug users in Malaysia. However, there is a National Drug Information System which provides a cumulative register of persons identified for treatment through the law enforcement sector.

Nepal:

There are no reliable estimates of the number of drug users in Nepal and no register is kept.

Thailand:

Data on drug use in the community is derived from local /occasional studies. Ongoing data is gathered on drug users attending treatment only.

Viet Nam:

Names and other details are collected by the focal points on 'social evils' at the commune level and provided via the district/provincial authorities to the Viet Nam Drug Control Committee. Included in the records are opium and heroin users, both injectors and non-injectors

HIV/AIDS data

These data are derived from a variety of sources but are generally based on sentinel surveillance data or on the unsystematic testing of hospital patients or both. It is difficult to determine the level of HIV/AIDS among injecting drug users because often only drug users known to the authorities or presently in treatment are tested.

Thus for example in **China** drug users in compulsory treatment centres (run by the Ministry of Public Security) are rarely tested, and data is derived from local studies and from testing in voluntary treatment centres (run by the Ministry of Public Health). In **Myanmar** drug users are routinely tested in 4-7 sites of the 21 sentinel sites so the data is incomplete. Likewise in **Thailand** only drug users in treatment are tested for HIV/AIDS. In **India**, it is not clear how many drug users are tested for HIV because the routine sentinel testing does not specifically include drug users although they are recognised as a high risks group and sometimes included among STD patients. However sentinel testing begun in India's North Eastern states in 1994.

The samples upon which HIV/AIDS among drug users are based are thus derived from non-random and highly selected populations.