

Revisiting 'The Hidden Epidemic'

A Situation Assessment of Drug Use in Asia in the context of HIV/AIDS



Gary Reid and Genevieve Costigan

**The Centre for Harm Reduction,
The Burnet Institute, Australia**

January 2002



**The Centre
for Harm
Reduction**

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The Burnet Institute, Australia
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First published by the Centre for Harm Reduction in 2002

'Revisiting the Hidden Epidemic', full report available on the Internet:
<http://www.chr.asn.au> (under publications)

'The Hidden Epidemic', full report available on the Internet:
<http://www.ahrn.net> (under assessments)

ISBN 1876644044

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Catalogue data:

Reid G and Costigan G.

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Foreword

Nick Crofts

Director, The Centre for Harm Reduction

In 1997 the Centre for Harm Reduction and the Asian Harm Reduction Network carried out a rapid situation assessment of drug use and HIV vulnerability in the south-east Asian region. Fittingly, the report from this assessment was titled '***The Hidden Epidemic***': the review found much evidence of burgeoning or mature epidemics of HIV among injecting drug users in almost all parts of southeast Asia, but very little recognition of the nature, importance or even existence of the epidemic in national AIDS strategies or the workplans of multilateral and bilateral agencies. Along with this lack of recognition there was a virtually complete lack of program responses aimed at preventing further HIV spread among IDUs: some key groundbreaking programs existed, scattered throughout the region, but all were small, reaching a tiny proportion of the at-risk population.

The Hidden Epidemic Revisited, this repeat of that regional situation assessment, carried out four years later and broadened to cover the whole Asian region including south Asia, has found enormous changes in many areas - changes in drug production and use, with a massive rise in amphetamine-type substances spreading throughout the eastern Asian region; new populations, especially younger people, becoming involved with illicit drugs and with their injection; continuing explosive epidemics of HIV among different populations of injecting drug users, one of the latest and most massive occurring in Indonesia; and rising numbers of people with AIDS as a result of infection from sharing contaminated injecting equipment.

This is no longer a "hidden" epidemic. Its existence is increasingly being recognised by and incorporated into workplans of the UN agencies, with UNAIDS initially and more recently UNDCP taking up the challenge of harm reduction in Asia; of bilateral agencies, which are increasingly seeking for ways to fund effective responses; and of national AIDS strategies, with Myanmar being the latest country in the region to recognise and prepare to scale up its response to the epidemic. The epidemic is increasingly well documented, and evidence is building about the broader impact of the epidemic among injecting drug users - for instance, of spread to their sexual partners and onwards. In some parts of Asia, an increasing crossover is being observed between injecting drug use and commercial sex work, with all the implications this has for further rapid spread of HIV infection from injecting drug users. These data are helping put to rest the iniquitous belief that HIV epidemics among injecting drug users are self-contained and do not spread to other segments of the community.

But all this increased awareness has not been matched by a similar increase in the number of harm reduction programs across the region, nor, with a very few exceptions, in the proportion of injecting drug users reached by prevention programs. The exceptions, which clearly light the way forward for the region, include two of the very poorest communities in Asia, in Manipur State in northeast India and in Dhaka, Bangladesh. Most countries are still labouring under the paralysing policy dichotomy of repressive law enforcement against drug users on the one hand, and the need for the participatory, collaborative approaches of harm reduction on the other - in the now

clear knowledge that harm reduction is *the* effective approach to HIV prevention among injecting drug users. In many countries in the region, incarceration of drug users - simply because they *are* drug users - not only continues but is being increased and strengthened. This is despite the fact that there is mounting evidence from the Asian region, confirming what has been known in the west for some time, that incarceration not only does not help drug dependent people to cease drug use but hugely increases risk for HIV transmission among and from these populations.

The Hidden Epidemic of 1997 was a call to action, to develop policy supporting effective HIV prevention and drug treatment approaches. Such policy development is well underway. The challenge presented by *The Hidden Epidemic Revisited* now is twofold: the introduction of sufficient innovative and effective programs for HIV prevention among injecting drug users, and the scaling up of the response to meet the scale of the epidemic. Without such action Asia will continue to be home to what threatens to be amongst the worst regional AIDS epidemics on earth.

Acknowledgments

The authors would like to thank the following people for their generous assistance by reviewing the draft version of the profile reports and for their input to ensure the minimising of inaccuracies: Amir Mehryar (Iran), Irwanto I, and Chris Green (Indonesia), Zanyou Wu and Lorraine Yap (China), Tariq Zafar (Pakistan), Bernard Frahi (Afghanistan), Parvez S Mallick (Bangladesh), Carmina Aquino, Arthur Jaucian and Isabel Melgar (Philippines), Samiran Panda and Jimmy Dorabjee (India), James Chien (Hong Kong), Celeste Vong (Macau), Motoko Hayashi (Japan), Aaron Peak (Thailand), Owen Wrigley and Guillaume Le Hegarat (Myanmar), Mark Barrett (Singapore), Peter Higgs, Jamie Uhrig and Serge Fabali (Vietnam), James Ross (Nepal), Dong Yul Oh (South Korea), Tina Voolman and Khorloo Enkhjargal (Mongolia), Myint Myint Kyi (Laos), Geoff Manthey (Cambodia), Joe Selvaretnam (Malaysia) and T. Lee Szu-Hsien (Taiwan).

Throughout the Asian region the support for this report and the provision of information to assist in the writing has been generally extraordinary. There are so many people to thank and rather than naming all the individuals and organisations we would like to just offer our genuine gratitude to all those who assisted in this massive undertaking.

We would like to thank our research assistant, Nick Thomson, for assisting with the literature review, cataloguing the data and performing miscellaneous tasks.

Within the Burnet Institute we would like to thank Trish Clark, Judy Brent, Anne Askew, Peter Higgs, Jane Hocking and Campbell Aitkin.

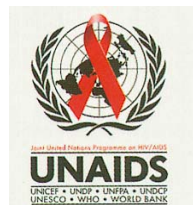
Of great importance we must pay special thanks and appreciation to Nick Crofts who from the very beginning, in true visionary fashion, saw the merit of this report and supported the project whole heartedly to its completion.

Funding for publication and dissemination of this report was provided by the East Asia Regional Office of UNDCP, the SE Asian Regional Office of the UNAIDS SEAPICT, and the Asian Harm Reduction Network.

Thank you

Gary Reid and Genevieve Costigan

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Executive Summary

Introduction

Drug use has become one of the major accelerants of the HIV epidemic in the Asian region. The lack of up to date information on the size of the problem, recent trends in drug use and HIV infection and the emerging responses represents a major barrier for program design and advocacy. Regular rapid situation assessments (RSA) and reports make a timely and influential contribution to the knowledge of and responses to drug use in the context of HIV/AIDS for this region. In May-November 2001, The Centre for Harm Reduction (CHR – a unit of the Burnet Institute, Melbourne, Australia), carried out a RSA of drug use in more than 20 Asian countries in the context of HIV/AIDS. A previous report entitled *'The Hidden Epidemic: a situation assessment of drug use in South East and East Asia in the context of HIV vulnerability'* completed in 1997 and published in 1998, was the template for an updated, expanded assessment (six extra countries are covered in the 2001 report).

Twenty-two countries and two Special Administrative Regions of China were selected for review: Afghanistan, Bangladesh, Brunei Darussalam, Cambodia, China, Hong Kong (Special Administrative Region, China), Macau (Special Administrative Region, China), India, Indonesia, Iran, Japan, Lao PDR, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Republic of Korea (South), Singapore, Sri Lanka, Taiwan (Province of China), Thailand and Vietnam.

Methods

The project consisted of a 20 week desk-based data collection and analysis exercise, and involved three researchers. A full-time project coordinator was also the senior research officer and principal author; a part-time research officer wrote country profiles, carried out a comparison between the results of the 1997 and 2001 assessments, and performed editing functions; and a part-time research assistant assisted with the literature review, catalogued data and performed miscellaneous other tasks.

During the first two months a mass mailout requesting information on drug use in Asia in the context of HIV/AIDS took place. Over 1,000 emails and 150 faxes were sent to contacts in the region, some of whom had assisted with the 1997 situation assessment. An extensive list of library databases and Internet sites were trawled during the literature review, and around 1,500 journal articles, reports, drug user profiles, abstracts, documents, conference presentations, media releases and books were collected (double the number of 1997 exercise). This represents the largest, most comprehensive collection of information on drug use in Asia in the context of HIV/AIDS compiled to date.

In the second half of the project, the collated information was used to compile country profiles. Headings used in the profiles include

- history of drug use;
- current drug use situation;

- drug taking practices and risk behaviours;
- prevalence of drug use and HIV/AIDS and profile of drug users;
- government responses to illicit drug problems;
- government response to drug use in the context of HIV;
- National AIDS Policy; and non-government response to drug use and HIV.

Drafts of each country profile were sent out to key representatives in the various countries for review before incorporation into the final report.

Findings

Regional availability and sources of illicit drugs

Afghanistan is the world's largest opium producer and accounts for 72% of the world's illicit opium supply; however, in 2000 the Taliban authorities imposed a complete ban on opium cultivation. The impact of this measure and the current civil conflict has created much uncertainty regarding opium production. Since the start of military attacks on Afghanistan by the United States in October 2001 the price of opium has dropped from US\$1,200 to US\$176 per kilogram. The opium industry of South East Asia's Golden Triangle - with Myanmar as its epicentre - continues unabated but has diversified to include the production of amphetamine type substances (ATS). Myanmar remains the second-largest producer of illicit opium (with Laos in third place) and heroin despite a sharp decline in production since 1996. Interceptions of methamphetamine tablets being trafficked from Myanmar across the Thailand border but also through to China, Laos, Cambodia, India and Vietnam have greatly increased in frequency. In 2000 an estimated 600 million methamphetamine tablets were imported into Thailand.

- The opium industry of South East Asia's Golden Triangle - with Myanmar as its epicentre - continues unabated
- Many countries in the region are criss-crossed by trafficking and transiting routes linking drug production zones to lucrative consumer markets
- Populations of drug users develop rapidly along trafficking routes, creating new drug markets and HIV threat in host countries

Both heroin and methamphetamines require precursor chemicals for their production and these are principally sourced from China and India. Many countries in the region are criss-crossed by trafficking and transiting routes linking drug production zones to lucrative consumer markets. For example, Iran is a major bridge for opium and heroin en route to the Persian Gulf, Turkey, Russia and Europe. China has recently become a major producer of methamphetamines for domestic use and has an established record of supplying to international markets - primarily Japan, South Korea, Philippines and Taiwan. The production of cannabis occurs in many countries of the Asian region; one is the Philippines, which is a major source of cannabis supplied to Japan, Malaysia, Taiwan, the United States and Europe. Populations of drug users develop

rapidly along trafficking routes, creating new drug markets and HIV threats in host countries.

Drugs of choice

- Methamphetamine use appears to have skyrocketed and is the drug of choice or fast becoming so in Thailand, South Korea, Philippines, Taiwan, Japan, Cambodia, Laos, China and Indonesia
- Ecstasy is gaining popularity throughout the region, as part of the burgeoning dance party scene found in many urban centres

Use of heroin and opium occurs throughout the region. Methamphetamine use appears to have skyrocketed in the last four years since the last assessment; it is the drug of choice or fast becoming so in Thailand, South Korea, Philippines, Taiwan, Japan, Cambodia, Laos, China and Indonesia. The use of ecstasy is gaining in popularity throughout the region, as a part of the burgeoning dance party scene found in many urban centres. Illicit ingestion of pharmaceuticals is

popular, and in India, Bangladesh, Pakistan and Nepal the use of buprenorphine (a synthetic opioid) has become widespread. Cough mixtures containing codeine are commonly used, and a plethora of other analgesics and tranquillisers are trafficked and consumed throughout the region. The use of solvents and glue is common (particularly among street children) in India, Laos, Cambodia, Indonesia, Mongolia, Vietnam, the Philippines and Thailand. Cannabis and hashish consumption is commonly found throughout the region.

Drug taking practices and risk factors

Favoured administration routes for drugs vary from place to place, over periods of time and in different cultural and social settings. Heroin is commonly (particularly in the initial stage) smoked in cigarettes or inhaled by 'chasing the dragon' (heating the drug on foil and inhaling the vapour). Injecting as a route of administration is recognised in all the countries and its popularity is increasing. Injecting is most often associated with heroin, but there are reports of amphetamine injecting in South Korea, Japan, and in small numbers in Thailand, Laos, Indonesia, Philippines and China. In India, Pakistan and Bangladesh users frequently inject a cocktail of pharmaceuticals. The transition to injecting usually occurs in pursuit of greater efficiency, especially when drug availability is limited; injecting provides a more rapid and powerful effect and results in minimal wastage of expensive drugs. Countries where drug injectors have become more apparent (compared to 1997) are Cambodia, Laos and Mongolia,

- Favoured administration routes for drugs vary from place to place, over periods of time and in different cultural and social settings
- Injecting as a route of administration is recognised in all the countries and its popularity is increasing
- Sharing of equipment is common and the methods of cleaning injecting equipment are often inadequate to prevent the transmission of blood borne viruses
- Professional injectors operate in Pakistan, India, Bangladesh, Nepal, Vietnam, Myanmar and Malaysia

although estimated numbers of injectors are still relatively small. In countries where opium is consumed (Afghanistan, Iran, Pakistan, Myanmar, Laos, China, India, South Korea and Thailand) it is mostly smoked or orally ingested (either in food or in tea) and is still used in some communities for medicinal purposes.

Among injecting drug users (IDUs) in the region, sharing of equipment is common and the methods of cleaning injecting equipment are often inadequate to prevent the transmission of blood borne viruses (BBVs). Many IDUs use cold water to clean needles and syringes; few use boiling water or bleach. Professional injectors and 'shooting galleries' operate in Pakistan, India, Bangladesh, Nepal, Vietnam, Myanmar and Malaysia and inevitably promote the spread of BBVs.

Prevalence of drug use

- In Indonesia there could be two million drug users with half of those injecting
- In China unofficial estimates of the number of drug users are close to six to seven million with approximately half being IDUs
- In Iran there could be as many 3.3 million drug users with an estimated 200,000 to 300,000 IDUs

Estimates of the number of drug users and injectors have generally increased over 1998 figures, and in some countries the rise is substantial. In Indonesia drug use was previously an extremely sensitive issue and the figures were downplayed. Now, local researchers believe there could be 2 million drug users, with half of those injecting. China currently has 860,000 registered drug users but unofficial estimates put the figure closer to six to seven million with approximately half being IDUs. Estimates for India remain extremely uncertain; figures of one to five

million opium users and one million heroin users, which date from the early 1990s, are still quoted by government official and UN sources. Unofficially the use of heroin is believed to be much greater. Drug injecting is increasingly popular, and in five major Indian urban centres there are now at least 100,000 IDUs. In Myanmar an estimated 300,000 to 500,000 people use illicit drugs and up to half are injecting. In Malaysia there are as many as 200,000 IDUs and in Iran there could be as many as 3.3 million drug users with an estimated 200,000 to 300,000 IDUs. Japan has an estimated 600,000 addicted and 2.18 million casual users of methamphetamine. Two to three million drug users (nearly 5% of the population) are believed to exist in Thailand. In the Philippines, another country where methamphetamines are popular, the number of drug users is estimated at one million but could be substantially higher; at least 10,000 people are injecting. In Laos opium use remains widespread – prevalence could exceed 2%, making it second only to Iran. In some parts of the country 5% of the population above 15 years old are opiate users. Finally, in Pakistan it has been estimated there are four to nearly five million drug users and that half are heroin users; there are currently only around 180,000 IDUs, but there is enormous potential for IDU numbers to increase substantially in coming years.

Prevalence of HIV/AIDS

Confirmed cases of HIV infection and of AIDS have increased in frequency throughout the region and several countries have serious HIV epidemics among IDUs. The countries with high prevalence of HIV infections among IDUs are Myanmar,

Vietnam, China, Thailand, Malaysia, Indonesia, Nepal, India and Iran. In 1997 China had sporadic pockets of HIV infection (predominantly among IDUs), but is now facing an epidemic. HIV appears to have spread along several trafficking routes; the main transmission pathway is injecting and IDUs now account for 70% of cumulative cases. Similarly, in Malaysia IDUs are the main group affected by HIV infection (76% of cases). In Indonesia fewer than 1% of confirmed HIV infections were due to IDU prior to 2000, but now injecting is a considerable risk factor at 19%. In Iran, 75% of HIV infections can be traced to injecting drugs. HIV infections among Vietnamese IDUs accounted for 65% of the total reported cases. In Thailand the HIV infection rate among IDUs remains high and the outlook is poor. In 2000 the national sentinel surveillance showed that among IDUs the prevalence of HIV infection was 54% and it has been estimated 5% - 10% of drug users become HIV infected each year.

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- In China HIV appears to have spread along several trafficking routes ... and IDUs now account for 70% of cumulative cases
- In Iran 75% of HIV infections can be traced to injecting drugs

The Philippines, Laos, Cambodia, Hong Kong, Macau, Pakistan, Cambodia, Afghanistan and Bangladesh all face potential HIV epidemics among IDUs. In Laos injecting is becoming more common when compared to reports of the late 1990s - a recent school survey showed that 12% of amphetamine users injected. Hong Kong maintains a low HIV infection rate among IDUs but this may be changing as IDUs seeking cheap drugs continue to cross the border into mainland China, where 70% of HIV infections are among IDUs. The prevalence of HIV

infection among IDUs in Bangladesh is currently low but there is widespread sharing of injecting equipment (55% to 75%) and the use of professional injectors, often with poor hygiene standards, is common practice.

Profile of drug users

- Data imply that increasing numbers of Asian women are using drugs
- Female IDUs are increasingly involved in commercial sex work in China, Vietnam, Nepal, Philippines, India, Bangladesh, Indonesia, Sri Lanka and Pakistan
- Throughout the region, surveys show the age of initiation into drug use is declining

The majority of drug users in the region are men but female drug users are found in all countries; taboos against women using drugs and being recognised as drug users impact upon gender representation in available data. Nevertheless, the data imply that increasing numbers of Asian women are using drugs. In some parts of China (Yunnan and Guangxi) 16-25% of drug users in treatment are

female. Female IDUs are increasingly involved in commercial sex work (CSW) in China, Vietnam, Nepal, the Philippines, India, Bangladesh, Indonesia, Sri Lanka, and in Pakistan. In Vietnam, surveys have found the prevalence of IDU among CSW ranging from 10% to 50%. Overall there is scant information about this group of drug

users and research in this area needs to be encouraged, especially given their potential importance in the development of overall national HIV epidemics.

Throughout the region, surveys show that the age of initiation into drug use is declining; drug users' rates of unemployment and levels of involvement in unskilled work are high; they tend to be poorly educated, and sexually active but infrequent users of condoms; high percentages have experienced incarceration; and many drug users were in poor health, worsening with length of drug use.

Government responses to illicit drug problems

The standard drug control policy of the countries assessed is to impose harsh penalties on people convicted of trafficking, production and importing and exporting drugs. The death penalty, mostly for trafficking, may be applied in China, Singapore, India, Indonesia, Iran, Malaysia, Brunei Darussalam, Myanmar, the Philippines, Sri Lanka, Thailand, and Vietnam. While death sentences are in fact rare, some data on executions are available. In China at least 35 people were executed for drug crimes in the year 2000; in Singapore, 190 drug traffickers were hanged between 1975 and 1997. The penalties imposed upon drug *users* are variable and depend on the type and amount of drug in possession.

- There are insufficient treatment and rehabilitation centres in most countries to cater for their drug users
- Treatment recidivism rates commonly range from 70% - 90%

It is common in this region for drug users who come into contact with the legal system to be coerced into treatment, but in some countries incarceration is the sole outcome. It is abundantly clear that there are insufficient treatment and rehabilitation centres in most countries to cater for their drug users. On the positive side, while drug use remains illegal, most countries do regard drug users as victims; China is a case in point – terminology there has recently shifted from 'illegal persons' to 'illegal patients'.

There are few treatment centres in the region that offer psychological and behavioural rehabilitation, counselling or after care services for extended periods of time following discharge. Even when drug users do receive treatment, recidivism rates commonly range from 70% - 90%. As a result some countries are becoming frustrated by this outcome and - for those with chronic relapsing conditions - a new trend is emerging to keep drug users detained for longer periods of time in the hope that this approach will prove more effective. In Singapore a person who relapses into drug use three or more times is imprisoned for five to seven years, and the sentence is increased to 13 years following another relapse. In Vietnam the average duration of treatment has been increased from six months to twelve months. Chinese drug users who relapse following rehabilitation are sent to a 're-education through labour' camp for two to three years.

Government response to drug use and HIV

Most of the countries in the region have been slow to implement HIV/AIDS prevention and control measures for IDUs or are yet to implement appropriate

responses. Injecting drug use in the context of HIV/AIDS is universally recognised as a major public health problem but is seldom accorded the priority it deserves. As a general rule governments of Asian countries are still more concerned with the legal implications of drug use rather than the public health implications of HIV/AIDS. HIV/AIDS and drug use prevention activities in this region have generally focused on information for the wider population and rarely specifically for IDUs. The available information is often lacking detail and not explicit or far reaching enough to impact on drug users.

Some countries with high HIV prevalence among IDUs have implemented HIV prevention approaches but they are often so limited and reach so few drug users that their ability to effectively impact upon the epidemics among IDUs is low. Overwhelmingly these approaches and activities are implemented by the non-government sector but are sanctioned by government authorities. Needle and syringe programs (NSPs) while few in number and small scale, are operating in Vietnam, China, Nepal, India, Iran, Bangladesh, Pakistan, Thailand and the Philippines. Methadone maintenance programs (MMP), similarly few and small, are currently found in China, Thailand, Hong Kong, Iran, Nepal and Indonesia. Only Hong Kong has completely embraced MMP with 21 clinics in operation. Substitution therapy using buprenorphine is in use in some Indian cities.

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- As a general rule governments of Asian countries are still more concerned with the legal implications of drug use rather than the public health implications of HIV/AIDS
- HIV prevention approaches are often so limited and reach so few drug users their ability to effectively impact upon epidemics among IDUs is low

National AIDS Policy

- Operational links between drug control policy and HIV prevention and intervention polices are often poor

Most countries assessed are some years away from creating or implementing specific policies that address the issue of HIV/AIDS among IDUs. Some appear to have taken the view that because an epidemic of HIV has yet to occur among their IDUs, policies and programs focusing on drug use and HIV are not

necessary. Even in countries where the high prevalence of HIV infection among IDUs (such as Thailand, China Vietnam, Nepal, Iran, Malaysia, and Indonesia) is acknowledged, risk reduction and prevention activities are held back, largely due to the constraints of narcotics legislation. Operational links between drug control policy and HIV prevention and intervention polices are more often than not poor. Even in India, where the harm reduction philosophy is officially approved, there is disquiet and reluctance among many professionals in the area of HIV prevention, and poor understanding of the concepts on the part of senior level drug and health policy makers is evident. In Laos harm reduction is a component of the National AIDS Plan (although no programs have yet been implemented). China recently announced a five year action plan for HIV/AIDS prevention and control (2001-2005) which includes

needle and syringe social marketing and promotion of the use of clean injecting equipment.

Non-government responses to drug use and HIV

Throughout the region it is the non-government sector that has taken the lead in responding to the issue of drug use and HIV. However, considering the size of the problem the number of non-government organisations (NGOs) working in this area is very small. NGOs in India and Bangladesh have implemented numerous harm reduction activities, but demand for their services is very large. In Kathmandu, Nepal, harm reduction outreach services exist but probably reach fewer than 10% of IDUs. The international NGO sector in Vietnam has for some years encouraged and implemented an array of harm reduction activities but these have always remained precarious and frequently ceased after the pilot phase. NGOs have instigated harm reduction programs (including outreach, peer education on safer injecting and NSPs) in Iran, Pakistan, Thailand, Indonesia, China, Myanmar, Hong Kong, Malaysia and the Philippines; unfortunately these programs are few in number and scale and are unlikely to reach most drug users. NGO-operated drug treatment centres and rehabilitation centres can be found in Hong Kong, Macau, India, Indonesia, Iran, Japan, Malaysia, Nepal, Pakistan, the Philippines, Bangladesh, Singapore, Sri Lanka, Taiwan, Thailand, and Vietnam.

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Methodology

Introduction

Over a period of 20 weeks, from May to November 2001, The Centre for Harm Reduction (CHR, a unit of the Burnet Institute, Melbourne, Australia), carried out a rapid situation assessment (RSA) of drug use in more than 20 Asian countries in the context of HIV/AIDS. A previous report entitled '*The Hidden Epidemic: a situation assessment of drug use in South East and East Asia in the context of HIV vulnerability*' completed in 1997 and published in 1998, was the template for an updated, expanded assessment (six extra countries are covered in the 2001 report).

The report is designed to strengthen the knowledge and analytical base of each country and of the region. The tasks included the following: identification of information and data focused on epidemiology, policy, law enforcement and behaviour of drug users; collation of information both published and unpublished; identification of current and planned activities by the donor sector, government and non-government organisation at country level; analysis of the data with a special focus on current situations, relationships, trends and identification of strengths and gaps in the information; a comparison between the findings of 1997 and 2001; and finally a report outlining an overview of the findings.

Methods

A total of 22 countries and two Special Administrative Regions of China were selected for review and include: Afghanistan, Bangladesh, Brunei Darussalam, Cambodia, China, Hong Kong (Special Administrative Region, China), Macau (Special Administrative Region, China), India, Indonesia, Iran, Japan, Lao PDR, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Republic of Korea (South), Singapore, Sri Lanka, Taiwan (Province of China), Thailand and Vietnam. The RSA was undertaken as a desk exercise using the most readily available information, all based on secondary sources.

The project team comprised a full time project coordinator who also took on the role as senior research officer and principal author. A part time (one day a week) second research officer who took on the role of writing country profiles, carried out a comparison between the results of 1997 and 2001 assessments, and performed editing functions. A part time (one day a week) research assistant assisted with the literature review, catalogued data and performed miscellaneous tasks.

The principal author of the project also wrote the first 'Hidden Epidemic', and this provided a distinct advantage in determining an efficient approach to acquiring information and data from the region in a short period of time. Since the completion of the first 'Hidden Epidemic' report, CHR had been committed to maintaining an ongoing link with various people in the region as well as frequently updating its own literature collection of the region. This rich source of information of the Asian region proved advantageous. A mass mail out of an urgent request for information on drug use in Asia in the context of HIV/AIDS took place. Informing people of the previous report (by including the website address of the 'Hidden Epidemic' report) allowed potential contributors not only an insight into the previous documentation, for those unaware of the report, but how the new assessment would enable monitoring of trends in the region.

The Asian Harm Reduction Network provided their contact list which contained over a 1000 names and/or organisations (government and non-government representatives). From this database approximately 250 contact addresses were selected on the basis of a proven or potential background of knowledge and understanding of this region. From the CHR contact list a further 100 contacts were notified of the study. The Inventory of HIV/AIDS Information Sources in the Asia Pacific Region provided another 40 to 50 contacts. All key representatives and focal points on HIV/AIDS from the offices of UNAIDS, UNDCP, UNDP and UNICEF were notified of the study and requested to provide information. The Ministries of Health, various Narcotic Control Bureaus and Drug Research Institutions in the region were also notified of the study. The offices of Family Health International, Save the Children, Medecins Sans Frontiers, Australian Red Cross, Asian Red Cross and Red Crescent AIDS Task Force, Asia/Pacific Council of AIDS Service Organisation (National Focal Points), World Concern, World Vision, and CARE International throughout the region were also notified. Other organisations included the Australian Federation of AIDS Organisation, the Panos Institute and the Fondation du Present.

Following the first communications with these organisations a snowballing effect commenced where a new list of individuals, organisations and associations, previously unknown became part of an expanding network of contacts. From a long

list of contacts, over 500 emails were initially sent out, accompanied by a further 150 faxes requesting information. The main mode of communication became email and throughout the project an additional 500 emails were sent out to follow up previous contacts or to establish communication with new contacts. A persistent effort was required to follow up requests for information due to the heavy workload of many of the contacts. At no stage was telephone communication required from key informants of the various countries. Postal services were not of value when the immediacy, and widespread availability, of email and fax machines were available to most informants.

A request for information was placed on SEA-AIDS. Some individuals and organisations contacted in the region had their own private email network of colleagues who further disseminated the request for information. An extensive literature review was undertaken by trawling through the various library databases within Australia and internationally. The data bases include Public Med (1990-2001), PsychINFO (1990-2001), AIDSLINE, CINCH (Criminology), Social Science Plus, Criminal Abstracts, Social Work Abstracts, Ingenta Medline, ASAP (Psychology), CINAHL (nursing data base), MAIS, INFOTRAC and the United States National Library of Medicine (online). The major libraries used to collect the documents were the Australian Drug Foundation Library, Melbourne University, and the State Library of Victoria.

The Internet was widely used to gather further reports and current papers on the region. Approximately 50 to 80 websites were used to gather information. Many English text newspapers of the region are available on line and these were accessed sporadically to check for current information. Acknowledging that documentation of information on drug use in the context of HIV/AIDS may be limited, contacts were also requested to provide any 'grey literature' or personal commentaries on what took place in their country and/or region. The task of initiating and maintaining communications with various individuals and organisations, accessing the databases and completing the literature review was undertaken by the project coordinator. The first two months of the project were solely focused on communications and literature collection. A mass of quality information from the region, amounting to around 1,500 journal articles, reports, drug user profiles, abstracts, documents, conference presentations, media releases and books were collected (double the number of the 1997 exercise). This represents the largest, most comprehensive collection of information on drug use in Asia in the context of HIV/AIDS compiled to date. While all reference materials have been read and assessed not all are cited in the profile reports. A full reference list has been provided to show what has been collected and is available.

Analysis and writing

The same formalised writing plan as the first 'Hidden Epidemic' report was adopted for cohesiveness. Unlike the previous 1997 report every effort was made to fully reference each country profile in order to support particular claims and/or statements. The headings for each country profile included the following: history of drug use; current situation; drug taking practices and risk behaviours; prevalence and profile; government responses to illicit drug problems; government response to drug use and HIV; National AIDS Policy and non-government response to drug use and HIV. While much information was found for the first 'Hidden Epidemic' report, the new

study shows a markedly improved quality and depth of information on drug use in Asia in the context of HIV/AIDS.

The country profile drafts were sent out to key representatives in the various countries for review. Reviewers were requested to fill in the gaps where information was not complete (as indicated by the researchers) and to examine the profiles for any glaring inaccuracies. There was also a request to add to the text any information that would enhance the overall profile where appropriate. Each reviewer was given a period of 10 to 15 days to return the country profile with comments, and in most instances this request was fulfilled.

Country Profile Reports

Afghanistan

History

Opium and cannabis were supposedly first introduced to Afghanistan by Alexander the Great more than 2,000 years ago. Traditionally, opium was used among minority groups, such as the Tajik Ismails and Turkmens, for a range of social and medicinal purposes (Gobar 1976; UNDCP 1999a; UNDCP 1999b). The cultivation of opium has occurred for centuries and has been a traditional crop in parts of the country since the 18th century. In 1932 it was estimated Afghanistan produced 75 tons of opium, a small amount compared to China, which was producing 6,000 tons. In 1945, opium production was prohibited but opium smuggling continued to adjoining regions and the ban was unenforceable (UNODCCP 2001). Opium cultivation continued throughout the 1960s and 1970s. Private laboratories and factories focused on drug synthesis were believed to be non-existent. Between 1960 and 1969, the only hospital in the country dealing with drug addiction recorded approximately 1000 cases, mostly to do with hashish (Gobar 1976).

In the mid 1970s an estimated 100,000 opium addicts could be found in the Badakhshan province. Hashish (*charas*) was commonly smoked through a water pipe while opium (*taryak* or *kaif*) was either ingested as food or smoked in special pipes. Opium was easily available, inexpensive and commonly used for various ailments, particularly in areas where medical facilities were non-existent. The use of cannabis and opium was mainly confined to adults with an estimated 10% of females addicted to opium. Poly drug use was reported to be rare. Although hashish was in common use, it was viewed by Afghans as a likely cause of insanity (Gobar 1976). In 1979, the war with the former Soviet Union led to the deterioration of the rural economy while opium production increased, often to generate income for large-scale arms purchases by the *mujahidden*. From the late 1980s onwards, as agriculture and other income generating activities were shattered by intense fighting and civil war, opium production increased markedly; opium became a crucial source of savings, credit and investment for large sectors of the population (Cooley 1999; Macdonald and Mansfield 2001; UNODCCP 2001).

Current Situation

Afghanistan is now the world's largest opium producer and presently accounts for 72% of the world's illicit opium supply. Since 1990, the area under poppy cultivation has more than quadrupled and in 2000 the plant was cultivated in 22 out of the 29 provinces. The province of Helmand was responsible for 39% of the world's illicit opium supply (Narcotics 2001; UNODCCP 2001). In 1999, opium production increased to 4,600 tonnes then fell to 3,300 tonnes in 2000 largely as a result of severe drought affecting most of the country (UNDCP 2001a; UNODCCP 2001). The main source of opium, morphine and heroin in Iran, Pakistan, India and Central Asia, and of heroin in Europe, is Afghanistan (UNODCCP 2001). The civil strife and lack of an effective central government allowed a faction called the Taliban to emerge in 1994. By 1996 they controlled 85% to 90% of the country. While opium poppy cultivation is officially condemned by the Taliban authorities, illicit drug production has in fact

flourished. In the late 1990s Afghan farmers were making over US\$100 million dollars growing poppies (moving away from agriculture and livestock trade) with the Taliban authorities collecting a minimum of US\$20 million in taxes (Wren 1998; Narcotics 1998; Cooley 1999; Goodhand 2000; Rashid 2000). In late 1999, the Taliban issued a decree to farmers to reduce their cultivation by a third and by June 2000 a complete ban was imposed. While opium production has decreased substantially with reports of crop eradication, confiscations and drought there has been scepticism that such actions will have much impact or be pursued with much vigour by the Taliban authorities. For many farmers there is virtually no choice but to grow opium poppies in an economy shattered by decades of war (Constable 2000; Orr 2000; Narcotics 2001; UNODCCP 2001; Gleason 2001; UNDCP 2001b). In 2001 however, the UNDCP annual opium poppy survey observed that in areas controlled by Taliban authorities there was a near total success in eliminating poppy cultivation (UNDCP 2001b).

In areas not under the control of the Taliban regime an expansion of opium poppy cultivation has taken place. According to a recent United Nation report, opium cultivation in north-eastern Afghanistan, in particular the Badakshan province controlled by the Northern Alliance, has increased from 2,458 hectares in 2000 to 6,342 hectares in 2001 (UNDCP 2001b). Opium in this area is now ten times the price of a year ago. In Taliban controlled areas, where a ban on opium cultivation is officially imposed, the price of opium has dropped from US\$1,200 kilogram in August 2001 to US\$176 in late October 2001 with the beginning of the conflict between the United States and Afghanistan (McCarthy 2001). The production of heroin and morphine in laboratories inside the country was considered rare until recently; illicit drug production laboratories have been reported in the northern areas of Afghanistan around Mazar-e-Shariff and in the Badakshan province (UNDCP 2001a; UNODCCP 2001; Macdonald and Mansfield 2001).

An increase in opium and heroin production coupled with prolonged human deprivation and widespread suffering has inevitably resulted in an escalation of drug using problems. Widespread war related mental health problems are reported and millions of Afghan refugees in adjoining countries live in often squalid conditions and up to 300,000 people are displaced within the country. (UNDCP 1999a; Macdonald and Mansfield 2001; Narcotics 2001). In the rural areas the most common drug is opium, in the urban centres, drug-producing districts and refugee camps a wide range of drugs are available and used. Opium use is found in many parts of the country and in places such as Herat, Jalabad, Kabul and Qandahar it has increased. It has been suggested that both heroin and hashish users take opium as a substitute drug if their drug of choice is unavailable (UNDCP 1999a ;UNDCP 2001a).

Heroin use has been detected in rural and urban centres of the country and reports show that most heroin users were returned refugees from Iran and Pakistan where they had been introduced to heroin (UNDCP 1999a; UNDCP 2000; UNODCCP 2001; UNDCP 2001a). High quality heroin is commonly made for export only and most heroin sold on the market in Afghanistan is of low purity, often adulterated with a range of additives and pharmaceuticals. For most Afghans living in poverty this is the only type that is affordable (B. Frahi, personal communication 2001). A study among male refugee street heroin addicts residing in the Pakistan cities of Peshawar and Quetta show the main drug of choice is heroin (UNDCP 2000). Hashish use is

common, widespread and more socially tolerated than opium and heroin' (UNDCP 1999a).

The misuse of pharmaceuticals in the rural regions, urban centres and among Afghans residing in refugee camps in adjoining countries is common. A wide range of pharmaceuticals are available over the counter without medical prescription, from pharmacies, various retail outlets and roadside stalls. Commonly used pharmaceuticals are analgesics and tranquillisers. The main analgesics are temgesic (*buprenorphine*), sosegon (*pentazocine*) and morphine. Major tranquillisers are ativan (*lorazepam*), valium (*diazepam*), mandrax (*methaqualone*), librium, phenobarbitone and temazepam. Codeine lictus, found at roadside stalls, is also reported to be misused (UNDCP 1999a; Macdonald and Mansfield 2001; UNDCP 2001a). The use of glue and other solvents has been found among Afghan youth (aged 12 years and up) in urban centres and refugee camps (UNDCP 1999a).

Drug taking practices and risk factors

Opium is mainly ingested when it is used for medicinal purposes, and in various regions of the country several different paste-like opium preparations are purchased from traditional healers. For coughs and colds it is common to boil poppy pods in water and drink the juice. In rural areas it is not uncommon to give opium, or boiled opium juice, to children for medicinal reasons or sedation: fatal overdoses among children have been recorded. Some people dilute the opium poppy, or the opium residue in water, commonly known as 'blackwater opium', and inject it: this practice probably originated from returning Afghan refugees from Iran and Pakistan. For habitual users it is also common to eat, boil the poppy pods to make tea or smoke the opium. In some areas opium is dissolved in water, a cigarette is soaked in the solution, dried and then smoked (UNDCP 1999a; UNDCP 1999b; UNDCP 2001a; UNODCCP 2001).

Heroin is mainly smoked, commonly by the 'chasing the dragon' method by burning the heroin on tin foil and inhaling the fumes through a small pipe (UNDCP 2001a). The injecting of heroin is increasingly reported among Afghan refugees outside of the country and this practice appears to have been introduced to Afghans living inside the country. Reliable reports indicate injecting in the cities of Kabul, Herat and Qandahar (UNDCP 1999a ; UNDCP 2000; UNDCP 2001a). Some drug users inject heroin in combination with pharmaceuticals such as phenobarbitone or mandrax while others dissolve the heroin in orange juice before injecting (UNDCP 1999a; Macdonald and Mansfield 2001). Ingestion of heroin is uncommon but there have been reports of young Afghan men employed in some refugee camps testing new batches of heroin by ingestion (Macdonald and Mansfield 2001). Studies of needle and syringe sharing among injectors are rare. But it is an emerging practice among Afghan refugees in the border city of Quetta (Pakistan) where the sharing of needles occurred, on average, with 4 to 6 other users at one time (UNDCP 1999a; UNDCP 2000). The literature provides no indication of professional injectors being used or any information of any cleaning techniques of injecting equipment.

Hashish is commonly smoked through a straight-stemmed water pipe (chillum) or a cigarette and is usually part of a group activity. It can also be smoked with water pipes made out of cups with plastic lids and increasingly popular is the 'chasing the dragon' method as favoured by opium and heroin users (UNDCP 2001a). It is also

eaten in a preparation called *majoun*, which contains almonds and sugar, or in other instances it may be 'sprinkled over food' (UNDCP 1999b; UNDCP 1999a; UNDCP 2001a). Most pharmaceuticals are taken orally although those that come in ampoules such as temgesic and sosegan are also known to be injected. The use of pharmaceuticals is often linked with the use of other drugs such as heroin, opium and hashish (UNDCP 1999a; UNDCP 1999b; UNDCP 2001a). A study among Afghan refugees entering a drug treatment centre in Peshawar (Pakistan) reported that over 52% of the 231 patients took between 4 to 6 tablets per day of analgesics and/or tranquillisers (UNDCP 1999a). Glues and solvents used by youth are smoked, inhaled and in some instances eaten. It has been reported that in the past oil from shoe polish was spread on bread and eaten (UNDCP 1999a; Macdonald and Mansfield 2001).

Prevalence and profile

Drug use is on the rise in Afghanistan but estimating the number of drug users is difficult. A recent study conducted in five districts (Khak-e-Jabar, Azro, Hesarak, Gardez and Sayed Karem) in the eastern part of the country collected information from key informants and self-confessed drug users. It was estimated just under 50% of households have a hashish user (it is believed 15% to 25% of adult males regularly consume hashish), that nearly 10% of households have someone with problematic pharmaceutical use and nearly 2% have an opium user although this figure is unlikely to account for those using opium for medicinal purposes. An estimated 0.64% of households reported heroin use. This figure may be much higher as draconian measures are likely to keep heroin use a clandestine activity (UNDCP 2001a). In the capital Kabul, it has been estimated there are over 700 heroin addicts but this figure is disputed by doctors who believe the figure is much higher. In the first four months of 1999, 112 heroin users were admitted for treatment in Kabul. In Herat, it was estimated that there were at least 2,000 heroin and opium addicts and in some parts of the province of Badakshan, which borders Tajikistan, 20% to 30% of the local population were reported to be addicted to opium (UNDCP 1999a).

There are no estimates of the number of injectors but a study of Afghan street drug addicts residing in the Pakistan city of Quetta showed that 4% were currently injecting (UNDCP 2000). While injecting is not widely practiced in Afghanistan, a substantial number of hypodermic needles are being found in the country. A decrease in availability and/or an increase in price could lead to high risk activity among those who do not currently inject (UNDCP 2001a; UNODCCP 2001). While hashish smoking is still widespread many drug users have switched to opium and heroin as its smell makes it harder to detect (UNDCP 1999a; UNDCP 2001a).

While most drug users are male, there is a reported rise among females, particularly refugees. A study among Afghan refugee women reported many were poly drug users using a daily combination of opium and pharmaceuticals and more than 20% were over the age of 50. Almost all the women started using these drugs to self medicate a range of physical and mental health problems, and the result was drug addiction (UNDCP 1999b). With no regulations in place to restrict pharmaceuticals, and benzodiazapines (valium) costing US1 cent a tablet, it is anticipated that drug misuse and dependency are widespread (UNDCP 2001a).

A recent study among Afghan drug users found that 40% of those interviewed started using drugs in neighbouring countries such as Iran and Pakistan (UNDCP 2001a).

Both inside and outside of the country Afghans are increasingly using drugs to cope with the various social, economic and political problems linked with the prolonged traumas and consequences of war. Widespread unemployment, abject poverty, an array of psychological problems including depression, anxiety, sadness, insomnia and post traumatic stress disorder have all impacted harshly upon many in the community. While it has mainly affected the adult population, children are not immune to drug use (UNDCP 2001a; Macdonald and Mansfield 2001; UNODCCP 2001) A study among Afghan refugees living in Peshawar and Quetta, where the favoured drug was heroin, found that most had received no formal education, many had been using heroin two or three times a day for five years and more than 80% reported health problems (UNDCP 2000).

There is no HIV surveillance testing in Afghanistan but it was estimated that by the end of 1999 there would be more than 100 adults and children infected with HIV/AIDS (UNAIDS 2001). A number of Afghan heroin injectors have been returning from Iran, where the large IDU community has a high rate of HIV infections. As of July 2001 of the 2,458 HIV infections in Iran, 1,841 (75%) were identified as IDUs and their HIV was related to injecting (MAP 2001). The rate of Hepatitis C among Afghan IDUs is unknown but a study of IDUs in Lahore, Pakistan found that although no one tested positive for HIV, 89% had Hepatitis C (UNDCP 1999a).

Government responses to illicit drug problems

In 1997, the State High Commission for Drug Control issued a declaration through the Taliban's Ministry of Foreign Affairs that the use of heroin and hashish is not permitted in Islam and that its citizens should refrain from growing, using and trading in hashish and heroin. Violating this order will result in a punishment in line with Sharia law. However, the implementation of such an edict has proven problematic and difficult (UNDCP 1999a; Macdonald and Mansfield 2001).

While the Taliban has issued instructions that drug addicts should be referred to a hospital or treatment centre, incarceration of addicts remains a common occurrence. Most drug users are traced, arrested and punished by the Taliban's Department for the Propagation of Virtue and the Suppression of Vice. A first time arrest (for which drug is not clear) would commonly result in a three month jail sentence increasing to six months for a second arrest. The treatment of arrested drug users varies throughout the country but some authorities may release drug users back into the community on the proviso they display withdrawal symptoms and/or if family members guarantee to keep the person drug free (UNDCP 1999a; Narcotics 2001).

In the City of Gardez hashish users are imprisoned for one week for the first offence, 20 days for the second offence and a month for a third offence. Heroin use can result in a six month imprisonment and, in some cases, the use of any illicit drug can result in being beaten, whipped and jailed (UNDCP 2001a). In Qandahar drug users are imprisoned, undertake a regular exercise regime, two cold baths a day and receive no symptomatic medications (UNDCP 1999a). In the first four months of 1999, the Mental Health Hospital in Kabul, which is the only specific facility to address drug addiction in the country, received 237 drug treatment referrals. In 2000, the hospital saw about 200 problem drug users per month, most were heroin users. Effective institutional arrangements are not in place and what does exist can only be assumed

to be inadequate to deal with the magnitude of the problem. There are some non-specialised hospitals and clinics in the country providing treatment for drug users but no further details are available (UNDCP 1999a; Narcotics 2001).

Government response to drug use and HIV

As no known cases of HIV/AIDS has been found in the country the Taliban authorities have taken no steps to address the strong potential of IDUs becoming infected with HIV/AIDS. International institutions are aware that despite IDU numbers being small the situation could change rapidly and the public health risks of the spread of blood borne viruses needs to be acknowledged. The United Nations Drug Control Program currently conducts drug awareness programs in the country but as a result of poor resources the impact is limited. The demand reduction approach has been to systematically distribute picture books on the effects and the consequences of drug use, in particular of heroin and cannabis (Narcotics 2001).

In 2000 to 2001 UNDCP provided resources and trained the staff of the Drug Dependency Treatment Centre in Kabul's Mental Health Hospital. Among the Afghan refugee communities in the North West Frontier Province (NWFP), UNDCP has developed in conjunction with partner NGOs a drop in care centre and street outreach programme for Afghan street heroin addicts in Peshawar. This includes harm reduction services, a community based drug treatment and a rehabilitation and prevention program in New Akora refugee camp. Currently UNDCP run a drug abuse/misuse information, advice and training service for Afghan refugee women in Baluchistan and NWFP (B. Frahi, personal communication 2001).

National AIDS Policy

There is no National AIDS Policy or any known strategies in place.

Non-government responses

Until 1996 UNDCP funded three detoxification centres in Badakshan (in the extreme north-east of the country and at the time not under the control of the Taliban) through *ORA International*. These were closed due to a lack of funding but were re-opened a year later by *ORA International* with their own funding. In 2000 these three centres were closed again due to a shortage of funds. In several areas of Afghanistan, private doctors are the sole providers of treatment for drug addicts but only for those who can afford it (UNDCP 1999a; Narcotics 2001; B. Frahi, personal communication 2001).

Estimated number of drug users	Unknown
Estimated number of IDUs	Unknown
Drugs that are used	opium, heroin, hashish, analgesics, tranquillisers, codeine, solvents
Drugs that are injected	heroin, blackwater opium, drug cocktails
Estimated number of HIV infections among IDUs	No HIV surveillance is performed in Afghanistan

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Bangladesh

History

As with other South Asian nations Bangladesh has a long history of illicit drug use, particularly of opium and cannabis. Before 1948, Bangladesh was a part of an undivided India and therefore much of its history mirrors eastern India, particularly Bengal. From the time of British colonisation until 1984 it was possible to purchase opium from government controlled vendors (Ray 1998). Cannabis has been widely used in Bangladesh society for many years and was often not perceived as a drug of abuse (Kabir 1998). In the late 1970s consumption of opium was strictly restricted and the scheme of compulsory registration identified about 1,600 chronic opium addicts (Spencer and Navaratnam 1981). Since 1987 production of cannabis has been banned and most is now smuggled across the Indian border (Hossain 2000). Until the mid 1980s the drugs of use, among the young, were cannabis, local wine and prescribed tablets (*Mandrax* and *Prodrom*). Heroin, generally called 'brown sugar', did not appear until the mid to late 1980s. It had low potency and became the drug of choice (Ray 1998) among the lower socio-economic sector and some students (Kabir 1998).

In 1991, the majority of drug users in treatment indicated heroin as their drug of choice, followed by *pethidine*. At this time the level of education and affluence tended to influence drug-taking practices; 15% of the poor injected compared to 42% of the more affluent (Gibney 1999). At the same time as heroin addiction increased, a shortage in supplies emerged as a result of law enforcement activities. As a result drug users turned to the pharmaceutical *buprenorphine* from India (Habib 2000, Hossain 2000). The emerging popularity of *buprenorphine* (commonly known as *Tidegesic*) stems from its cheapness, availability, longevity of effect and as a result of some pharmacies promoting the drug as a way of treating heroin addiction (Kabir 1998). By the mid 1990s individuals dependent on *buprenorphine* started to appear in treatment centres (Ray 1998).

Current situation

Bangladesh is surrounded by one of the largest drug producing regions in the world. While it is not a significant producer of narcotics, opium cultivation near the Myanmar border, albeit small, has been detected in some districts. In 1999, 90 acres of poppy fields were destroyed by the army (Narcotics 2001, Henry 1999) and 28 kilograms of heroin and 2.3 metric tons of cannabis were seized. The drug *Phensidyl* (a cough syrup containing codeine) has become increasingly popular among drug users. In 2000, 140,000 bottles were seized by law enforcement officials (International 2000). *Phensidyl* is readily available and remains the most visible illicit drug: it requires no prescription and is easily accessed by many illegal traders in various parts of the country (Habib 2001).

In 1996, a Rapid Situation Assessment (RSA) of the drug use in three major cities (Dhaka, Rajshahi and Chittagong) was conducted; 1,750 participants were selected at random. The results of this survey reported the most commonly used drugs in descending order were cannabis, cough syrup (codeine based), sedatives and heroin. For those surveyed in treatment centres the most commonly used drugs in descending

order were heroin, codeine, cough syrup, *buprenorphine*, cannabis and sedatives (Ray 1998). Among all the participants the life time use of selected drugs show cannabis at 25.8%; cough syrup at 11.3% with heroin and *buprenorphine*, 2.9% and 0.5% respectively (Ray 1998). However, a recent study in Dhaka showed *buprenorphine* as the most commonly used drug among users (70%) (Mallick and Gomes 2000). It is widely agreed among experts that there is increasing evidence of the widespread use and availability of illicit drugs (Ahmed 1999; Habib 2001; Ray 1998; Hossain and Ahmed 1999; Malibubur 1999).

In the northern part of the country, drug use, including injecting, has been reported in the cities of Cox's Bazar, Chittagong, Jessore, Khuna, Rajshahi and Chapainawabganj and drug use is common in several areas of the capital, Dhaka (Jenkins 1999a; Begg 1999). While drug use is mainly confined to the urban centres it has also been reported in several rural areas and villages (Ray 1998; Jenkins 1999a).

In 1998, a study was undertaken to assess the vulnerability of an estimated 200,000 street children (aged between 5 – 14 years) living in the metropolitan area of Dhaka. While the study found many of the children were the victims of exploitation, harassment and abuse (including sexual) it also found that some were addicted to injectable drugs and other substances. Awareness on HIV/AIDS issues was reported to be poor among this group (Milky 1999).

Drug taking practices and risk factors

While the most popular routes for taking drugs is reported as ingesting or inhalation, (Malibubur 1999) injecting does appear to be gaining popularity (Hossaine and Ahmed 1999). The injecting of drugs is believed to have commenced in 1990 (Hossaine 2000) and data recorded in treatment centres reports an increase in the rate of injecting from 6% in 1993 to 17% in 1995 (Ray 1998). The time frame from using different types of drugs before switching over to injectables ranges from six to fifteen years (Jenkins 1999a; Mallick and Gomes 2000). In 1996, a study in Rajshahi reported the injecting of sedatives as widespread (78%), followed by *buprenorphine* (21%) (Habib 2001). The behavioural surveillance study of 1998-99 showed that for those who injected, the drug of choice was *buprenorphine* which was frequently mixed in a cocktail of substances including *diazepam*, *promethazine hydrochloride* and *chlorpheniramine*. A recent study also reported that 29% of participants injected a cocktail of drugs (Hossaine, 2000; Mallick and Gomes 2000). Heroin was used by only 2% of participants, and was usually dissolved in lemon juice before injecting (Hossaine, 2000). One study shows that 90% of all injectors had once smoked heroin (Begg 1999).

Reports of drawing up blood in the syringe in order to dilute the drug and front or back loading (moving the drug from one syringe to another) occurs, albeit in small numbers (<10%) (Jenkins 2001, Mallick and Gomes 2000). In 2000, a study in Dhaka reported the average number of injections per day was two and the sites of injecting varied; 26% injected into the vein, 56% into muscle and the rest (18%) used both the vein and the muscle (Mallick and Gomes 2000). Another earlier study reported that 59% always injected into the vein (Jenkins 1999b).

In the city of Rajshahi most IDUs used the services of a professional injector in an adda: an adda is a place where IDUs gather to inject and where the drugs and the

professional injector can be found. While the same practice is likely to occur in Dhaka it is not as common (Hossaine 2000; Jenkins 1999b) It has been suggested the professional injectors are able to maintain business through a good supply of drugs, connections to wholesalers and by providing the injecting services. In 1999, in Rajshahi an estimated 50 *adda* injectors operated and there were an estimated 94 *addas* in the city. These facilities are often located in disused buildings and lane ways but some also operate in hotel rooms (Hossaine 2000). For a small additional cost, people can ask to be injected at their homes. In one study it was reported up to 90 persons a day used a single *adda* injector, often for multiple injections. Being an *adda* injector was not exclusively the domain of men as several women had also become involved (Jenkins 1999a).

Reports suggest an *adda* injector will use the same needle for 20-50 people and that it is not unusual for it to be used for 2-3 days. (SHEAS, 1996). Studies in the late 1990s reported widespread sharing of needles among all IDUs (60% - 90%) and that professional injectors did not sterilise their needles and syringes (Hossaine 2000; Begg 1999; Ashaful 1999). The sharing of injecting equipment has also been documented among street children (Gibney 1999). Among professional injectors it has been observed that a needle is only changed when it becomes blunt and glass syringes are rarely changed or discarded (Hossaine 2000). New needles add an expense that few poor IDUs can afford thus explaining the reasons for the widespread sharing (Jenkins 1999a) and why some people have been known to use syringes rejected by hospitals (SHEAS 1996). It costs an average of three Taka (US\$0.05) to buy a disposable syringe and needle. There are regulations in place requiring a prescription to buy such equipment but this is often ignored. It is not difficult to find a needle and syringe in most parts of the country (P.S. Mallick personal communication 2001). Cleaning of needles by those who shared their needles is nearly always inadequate. Some methods included using cotton or paper to clean the needle or using distilled water (Mallick and Gomes 2000). Some IDUs used saliva to clean their needles believing this would destroy any poisons found in the blood (SHEAS 1996).

The establishment of needle and syringe programs (NSP) from May 1998 has shown some behavioural changes. Results from a recent study between two surveys show the overall sharing of needles in Dhaka appears to have been reduced from 93% to 75% of people ever sharing in the last week. In Rajshahi the reduction is from 96% to 55% (Jenkins 2001). The government recognises that NSP clearly impacts on the proportion of injections shared (Government of Bangladesh 2001).

Prevalence and profile

The number of drug users has been estimated to be between 100,000 to 1.7 million (Ray 1998; Rhaman 2000; Narcotics 2001; WHO 2001). In the early 1990s it was estimated that there were 100,000 heroin users in the country but this figure is likely to have lessened as *buprenorphine* has become the favoured drug (Hossaine 2000). It has been estimated there could be 20,000 to 25,000 IDUs in the country (Hossaine 2000; Jenkins 1999a; Wodak 2001). In the capital Dhaka, reports suggest there are 7,650 injectors and at least 11,000 heroin users (Begg 1999). In northern Bangladesh there are an estimated 12,000 to 15,000 injectors, most of whom are found in the cities of Rajshahi and Chapainwabganj (Jenkins 1999b). However, these figures are disputed by others: a Rapid Situation Assessment (RSA) in 2000 found there was no

more than 2,000 IDUs in Rajshahi and 1,000 IDUs in Chapainawabgonj (Mallick and Rabbani 2000).

The majority of drug users, and those who inject, are reported to be male with less than 2.5% females (Government of Bangladesh 2001; Hossaine 2000; Begg 1999). The number of female drug users could be greater but reaching out to this sector of the community is difficult when most are very hesitant to identify themselves as IDUs (Begg 1999). One outreach program in Dhaka has contact with about 40 female IDUs most of whom are also sex workers (Begg and Nizam 1999). In one southern city a survey found 14% of street female sex workers injected drugs, and in the brothels 6% stated they were IDUs. Among male IDUs a high proportion paid for sex. A survey in various cities has shown that half to three-quarters of male injectors paid for sex and close to one in ten bought sex from men or transvestites; less than 25% used a condom the last time they paid for sex (MAP 2001).

In 1986, HIV was first detected in a foreign drug trafficker and in 1989 the first case of HIV in a citizen of Bangladesh was recorded (Gibney 1999; Hussaine 2000). While the HIV prevalence levels have remained relatively low there has been a sizeable increase since 1989 (Gibney 1999). As of December 2000 the total number of HIV/AIDS cases was 157 (127 males, 30 females). Between December 1999 and December 2000 the number of identified HIV infections was 31 cases, the highest number in a single year. A breakdown of the transmission route is not available but it is likely the majority are sexually acquired (Department of Virology 2001). In 1999 an estimated 7,500 adults and children lived with HIV infection (UNAIDS 2000) but in 2000 this increased to 13,000 (WHO 2001). It has been calculated that the annual number of AIDS cases was 1,100 in 2000 which will rise to 1,700 by 2005 (WHO 2001). A sero-surveillance of 1998-1999 reported that among IDUs coming into detoxification centres, 2.5% were found to be HIV positive and among the 880 surveyed the rate of needle and syringe sharing was about 90% (Hussaine 2000).

A follow up survey for the second national expanded HIV surveillance in mid 2000 reported that of the 418 participants from a central NSP, 6 people (1.4%) were found to be HIV positive (Government of Bangladesh 2001). The low levels of HIV infection in the two rounds of surveillance have yet to be fully explained considering widespread sharing of needles was still occurring. Studies have shown that Hepatitis C can be found in 25% of IDUs: this was associated with the sharing of needles and the longer duration of drug injecting (Shirin 2000).

Surveys conducted on IDUs have shown a wide age range (15 to 70 years) with the average age being 30 to 35 years (Mallick and Gomes 2000; Hossaine 2000, Hussaine 2000). Many have poor education and unskilled occupations, a substantial number are married, and the majority had previously been to jail, mostly for drug offences (Begg 1999; Jenkin 1999b; Hussaine 2000; Habib 2000) A recent study found most family members were aware of the user's drug using behaviour (Habib 2001). Use of commercial sex workers, particularly among the unmarried, was fairly common and the use of condoms was generally very low; condoms are rarely a consideration and are seen as mainly for family planning (SHEAS 1996; Jenkins 1999b; Malibubur 1999; Ashaful 1999; Hussaine 2000; Mallick and Gomes 2000). Many sex workers were aware of colleagues having sex with drug users without condoms (Gibney 1999). A 1997 study showed 21% of IDUs donated their blood and many did so as a

way to raise money (Jenkins 1999a). This is clearly a problem when none of the blood banks test the blood for HIV (Begg, 1999).

Government responses to illicit drug problems

In the Narcotics Control Act, 1990, there is provision for the establishment of narcotic addiction treatment centres and when it is deemed treatment is necessary the person is directed to a competent physician or a treatment centre (Ray 1998). However, detoxification and rehabilitation programs are scarce in the country and few drug users have the resources to attend them. As occurs in most countries of the world recidivism is high for those receiving treatment. A 1998-99 study showed 90% of the participants who had made attempts to stop drug use had failed (Hussaine, 2000).

It has been suggested that the drug prohibition laws enacted under the Narcotics Act of 1990 are not an effective strategy for harm reduction (Habib 2000). The government does not view drug addiction as a high priority issue and it is seen as a self-created problem (Hossain and Ahmed 1999).

If a person is found in possession of heroin, cocaine and coca derivatives, and the quantity does not exceed 25 grams, imprisonment will not be less than two years and not exceed 10 years. If the quantity exceeds 25 grams the penalty can be the death sentence or life imprisonment. For possession of pethidine, morphine or tetrahydrocannabinol, if the quantity does not exceed 10 grams, imprisonment will be no less than two years and no more than 10 years. If the quantity exceeds this amount the penalty is a death sentence or life imprisonment. There are various A class narcotics which is where buprenorphine is likely to be classified. Being in possession of this drug is also likely to incur a severe penalty. The penalty is an imprisonment of not less than two years and no more than 15 years: the possession amount is not specified (Rahman 1990). There is usually no provision for arrested drug users to be sent to drug treatment centre. The only option appears to be prison (P.S Mallick, personal communication 2001).

The Department of Narcotics Control has recently initiated a community level of coordination to streamline the activities of the non-governmental organisations (NGOs) to strengthen existing and future drug prevention activities in the country (Ahmed 2001). There are four government de-addiction centres in the country with a total of 55 beds (Ray 1998).

The traditional approach to treating drug users is in the psychiatric units of hospitals. The shortage of beds results in few being able to receive treatment. Other problems include physicians being discouraged from offering their services to treatment centres because they can lose their seniority if they are not properly released by the Ministry of Health and placed under the Department of Narcotic Control (Hossain and Ahmed 1999).

The two models of treatment are the ashram model, run by non-medical social activists, and the medical hospital model run by medical professionals. Most drug users are serviced by government health care facilities and at the Dhaka centre people stay for four weeks. There is only one program designed to cater for female drug users (Hossain and Ahmed 1999) Only one government- run detoxification centre exists in Dhaka, which has 40 beds and charges a nominal fee (Begg 1999). Many drug users

have tried various ways to stop their drug use and a study shows 68% had been in prison at least once. However, even here drug injecting occurs (Jenkins 2001).

Government response to drug use and HIV

The government is aware of the link between HIV/AIDS and drug use as has been shown in the two sero-surveillance surveys. It has been acknowledged NSP can play a role in reducing the amount of needle sharing and impact upon HIV transmission. However, there are reports of IDUs being arrested for carrying syringes and needles even though no 'paraphernalia laws' exist (Begg 1999; Hussain 2000). Substitution therapy is currently not available. Information about HIV/AIDS which directly targets drug users is reported to be unavailable.

National AIDS policy

The Ministry of Health and Family Welfare produced a National HIV/AIDS Policy which received approval by the cabinet in 1998. In the policy there is a special focus on IDU and approval of harm reduction as a useful strategy. However, the Ministry of Home Affairs, whose focus includes narcotic laws, does not approve of harm reduction believing such a policy cannot supersede the law of the land. As a result of these contradictions serious threats from the Narcotics Department and police have emerged with this policy. In recent times the Narcotics Department has indicated they acknowledge the existence of NSP and at this stage have tended to ignore the operations of such programs.

Non-government responses to drug use and HIV

In 1999, the SHAKTI project CARE-Bangladesh (NGO) operated seven drop in centres in Dhaka, which are open six hours per day, six days per week and offer needles and basic primary health care for drug users (Begg 1999). A NSP has been set up at a professional injector site in Rajshahi, reaching approximately 10-20% of the local IDUs. In 1999, SHAKTI was estimated to have access to 3,500 IDUs; peer educators distributed two new syringes and six needles every other day, per person at their drop in centres (Jenkins 2001). About 90,000 needles and syringes per month are exchanged at the DIC with a reported high return (>80%) (Wodak 2001). As there is no incinerator in Bangladesh, there has been no other option for NGOs but to burn collected needles and syringes at the drop in centres in the open air (Begg 1999). CARE-Bangladesh also has programs in Rajshahi and in early 2001 they set up a program in Chapai Nawabgonj which reaches 200 IDUs. In this latest project they have trained five adda educators who are current drug users. Their role is to educate other IDUs and professional drug injectors on STD/HIV issues and to exchange old needles and syringes for new ones (CARE-Bangladesh 2001). It has been reported there are nine NGOs focused on drug demand reduction with a total of 190 beds between them for in-patient treatment (Ray 1998).

Estimated number of drug users	100,000 – 1.7 million
Estimated number of IDUs	20,000 – 25,000
Drugs used	cannabis, cough syrup, buprenorphine, sedatives, heroin, codeine

Drugs injected	sedatives, buprenorphine, heroin, drug cocktails
Estimated number of HIV infection among IDUs	2.5% of IDUs in detoxification centres are HIV +

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Brunei Darussalam

Comparisons: 1997 Versus 2001

Although illicit drug use is not considered to be significant in Brunei Darussalam there has been a noticeable increase in drug usage and drug related arrests: in 1997, 510 people were arrested, in 2000, 672 people. In 1997 codeine was the drug of choice, in 2001 this was replaced by methamphetamines. There are still no official or unofficial estimates of drug users or IDUs. In 1997 there were 379 cases of HIV infection, in 2000 there was a cumulative total of 521 cases of HIV infection with the major transmission route being heterosexual sex.

History

Historical information has not been able to be accessed.

Current Situation

The production and consumption of illegal drugs is not considered to be significant and cultivation is not known to occur. The quantity of drugs entering or transiting through Brunei is minor. Despite the dense jungles and rivers intersecting the borders of Brunei and its coastline, the smallness of the country allows the government authorities to closely monitor the situation for any developments (Narcotics 2001). In recent years however, there has been a noticeable and gradual increase in drug usage and drug related arrests. Statistics show there was a 21% increase in drug related arrests from an average of 46.5 arrests per month to 56.4 per month between 1999 to 2000. As the population of Brunei is only about 338,000, these figures are of concern (Narcotics 2001; Narcotics Control Bureau 2001). In 1997 the number of arrests was 510 and in 2000 it was 672. In 2000 the majority of drug related arrests were male (90%) but the number of females arrested has increased slightly over the years. In the first two months of 2001, 105 people were arrested (Narcotics Control Bureau 2001).

The types of drug seizures taking place have changed over the years. In the mid 1990s heroin, cannabis and cough mixture dominated and methamphetamines, commonly called *Syabu*, were minor. In 1997 heroin seizures amounted to 1.3510 grams and by 2000 this had decreased to 0.0011 grams. *Syabu* seizures, on the other hand, have increased from 122.8153 grams in 1997 to 1649.7305 grams in 2000 (Narcotics Control Bureau 2001). In 1996 codeine, as part of cough mixture preparations, was the drug of choice. This is no longer the case as it has been replaced by *syabu*, followed by cannabis (UNDCP 2000; Narcotics 2001). Cannabis seizures in 2000 amounted to 54.3918 grams (Narcotics Control Bureau 2001). Other drugs consumed include brand name sedatives, hypnotics and glue (UNDCP 2000; Said personal communication 2001). There are no known reports of opium being consumed.

Drug taking practices and risk factors

Methamphetamines, or *syabu*, are believed to be swallowed and smoked but the potential for injecting cannot be discounted. Cannabis is usually smoked. Heroin is believed to be inhaled, 'chasing the dragon', or injected. Government sources report that there is no injecting in Brunei yet the HIV prevalence statistics indicate about 3.8% of infections are due to injecting (UNDCP 2000). Information about the sharing

of injecting equipment, and the cleaning techniques undertaken among IDUs, has not been able to be accessed.

Prevalence and profile

There are no official or unofficial estimates on the number of drug users in Brunei and uncertainty concerning the number of IDUs (UNDCP 2000). Drug use is mainly confined to the Malay population and most drug users arrested are aged between 21 and 30 years (UNDCP 2000).

HIV infection was first identified in Brunei in 1986. By August 2000 the reported cumulative total of HIV infections was 521 and the number of AIDS cases was 16. Most HIV infections have been reported to be among immigrants, mainly men and the major transmission route is heterosexual sex (UNAIDS and WHO 2000; WHO 2001).

Government responses to illicit drug problems

The Misuse of Drugs Act (MDA) Chapter 27, 1984 is the principle legislation for drug trafficking and possession in Brunei Darussalam. The Drugs Act covers a range of controlled drugs including narcotics and psychotropic substances. In 1998 an amendment witnessed an upgrade of methamphetamine from a class B drug to a class A drug. Similar to its neighbours Singapore and Malaysia, Brunei has enforced a provision for mandatory death penalty for trafficking of the following amount of drugs: heroin (15g); morphine (15g); opium (1,200g); cannabis (500g); cannabis resin (200g); cocaine (30g); and methamphetamine (200g). There is a presumption clause that stipulates that anyone caught in possession of a certain amount of controlled drug is presumed to be trafficking the drug and the onus is on the person to prove the drug of possession is not for the purpose of trafficking (Narcotics Control Bureau 2001).

Under Section 15 of the MDA a person is presumed to be trafficking if in possession of more than the following: 2g of heroin; 3 g of morphine; 100 g of opium; 15 g of cannabis; 10g of cannabis resin; 3g of cocaine; or 20g of methamphetamine. To control the use of inhalant substances there is the Emergency (Intoxicating Substances) Order, 1991, in which the penalty is a fine of not more than BND\$3,000 (US\$1,628) or imprisonment for a term not exceeding one year or both (Narcotics Control Bureau 2001). In a recent example of drug possession a local drug user was fined BND\$1,700, (US\$922) or four months imprisonment in default, for consuming methamphetamine and being in possession of a utensil used for drug consumption: this was the person's first offence (Borneo Bulletin 2001).

Currently there are two drug rehabilitation facilities which can accommodate approximately 250 (voluntary and involuntary) residents: the Al-Islah Rehabilitation Centre and the Al-Islah Intoxicating Substances Rehabilitation Centre. The control of these centres is under the Prisons Department, Ministry of Home Affairs (Narcotics 2001; Narcotics Control Bureau 2001). The three ways of admission are by Court Order, Minister's Order and on voluntary order. Upon admission the person is required to undergo a detoxification treatment for a period not exceeding 14 days. After detoxification the inmate undertakes an orientation programme for a week. The rehabilitation programme includes physical, psychological, social, moral and civic rehabilitation (it is not clear how long the program runs). After a conviction by the court, or release from prison or a rehabilitation centre, a person must be enrolled in a

supervision scheme. Regulations include reporting to a supervision officer at a particular time and place, providing urine samples when required and the possibility of having a blood sample taken when requested. The duration of drug supervision is from 6 to 24 months while for those with an inhalant conviction the supervision is for 6 to 12 months. If the person is able to successfully follow the program they can be recommended for release. If a person is found to have committed an offence while under supervision they will be brought to a court for prosecution (Narcotics Control Bureau 2001). There are no known reports, or assessments, of how successful such rehabilitation and supervision programmes are.

Government response to drug use and HIV

The Government of Brunei does not consider the drug problem to be widespread and, in particular, there is little acknowledgment of IDUs. As a result there has been little or no response to this issue. There are no known substitution therapy programs in operation nor are they a consideration. There is a strong belief the draconian laws imposed against drug use should be a suitable deterrent. All Information, Education and Communication materials are strongly focused on a demand reduction approach. It does not appear that there is any information specifically targeting drug users to minimise their risks except the message 'say no to drugs'.

National AIDS Policy

There is no known specific policy on drug use and HIV

Non government response to drug use and HIV

There are no known NGOs focusing on drug users. The government runs the rehabilitation centres operating in Brunei.

Estimated number of drug users	Unknown
Estimated number of IDUs	Unknown
Drugs that are used	methamphetamines, heroin, codeine, sedatives, hypnotics, glue
Drugs that are injected	heroin
The number of HIV infections among IDUs	unknown, 3.8% in 1998

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Cambodia

Comparisons: 1997 Versus 2001

Since 1997 Cambodia has increased its role as a major drug transmitting and trafficking country with recent reports of clandestine amphetamine laboratories being established on the Thai border. More drugs are being used by wider groups of people with an increase in the use of amphetamines and inhalants. We still have no estimates of the numbers of drug users in Cambodia and it is not considered a problem of great significance. However a public education campaign about the dangers and consequences of drug use was launched by the government in 2000. A few NGOs have begun to give attention to drug use as part of their work with street children, commercial sex workers, fishermen, prisoners and migrant workers. There are still no drug treatment or rehabilitation centres in Cambodia. Injecting is still the preferred method for receiving medical treatment. The government recently announced a decline in the rate of people newly infected HIV from 3.9% (210,000) of the 15 to 49 year olds in 1997 to 2.8% (169,000) in 2001. In Cambodia the major route for HIV is through heterosexual sex.

History

In the nineteenth century opium was a commodity of economic importance and a monopoly and source of revenue which the Cambodian monarch was keen to maintain. Generally Khmer society did not much favour opium and its use was confined to the Chinese business community and foreigners: accounts of opium dens and the ritual use of opium in Phnom Penh at this time exist. During the French colonisation of Cambodia autonomous opium monopolies were established in 1863 to raise considerable revenue (Spencer and Navaratnam 1981; Oppenheimer 1997). Following Cambodia's independence from France, and up until the Lon Nol period during the 1970s, scattered accounts of opium dens continue (Oppenheimer 1997). Between 1975 and 1978 Cambodia lost nearly two million people as a result of the Khmer Rouge genocide and large scale exodus of refugees. Opium use was eradicated until the Vietnamese invasion in 1978 (Oppenheimer 1995).

Current Situation

Cambodia shares borders with Thailand, Laos and Vietnam and lies near the major drug trafficking routes for South-East Asian heroin. Some heroin and marijuana are believed to enter and exit Cambodia via the deep water port of Sihanoukville, along the coastline Koh Kong (near the Thai border) and Kampot (near the Vietnamese border) and the river port of Phnom Penh (Narcotics 2001). Cambodia is not a major producer of opiate or coca-based drugs however its cannabis production is significant and is cultivated for export and domestic consumption (Narcotics 1998).

Cambodia has been unique in South-East Asia for its lack of a significant local drug abuse problem due largely to poverty, political turmoil and isolation (Narcotics 2000). Until the mid 1990s cannabis, and to a lesser extent, methamphetamines were used primarily by some affluent Cambodians and foreigners, with small pockets of heroin and opium users mostly in Phnom Penh (UNDCP 2001). However, by the late 1990s there was a significant rise in the use of amphetamines by large groups of the population including students, commercial sex workers and labourers. Surveys have also revealed an increasing use of glue sniffing and other inhalants by street children and the rural poor, and an increase in the injecting of opium solutions (UNDCP 2001,

Narcotics 2001). There are currently between 600 to 1,000 street children in Phnom Penh who have severed all ties with their family. It is estimated there are another 10,000 street children who maintain precarious ties with family and home, regularly and irregularly spending most of their time on the streets (Guillou 2000).

Cambodia is increasingly being used as a trafficking/transit country for illicit drugs due to the lack of an adequate law enforcement and criminal justice system and the increased suppression of trafficking activities in the region, especially in Thailand, China and Vietnam. Corruption and money laundering are increasingly common: Cambodia is basically the only country in the region where one can still deposit a suitcase of cash without any questions being asked or reports being filed (UNDCP 2001). There are reports of mobile clandestine amphetamine laboratories being set up along the Thai-Cambodian borders by foreign crime syndicates and Cambodian nationals (Narcotics 2001). Cambodian law enforcement agencies have very few resources and generally lack even the most basic training in law enforcement techniques and drug enforcement measures. Three decades of warfare and factional fighting has severely hampered any sustained effort against illegal drugs. In 2000 a number of cannabis plantations and fields of varying sizes were destroyed and authorities seized 1,108 kilograms of cannabis (Narcotics 2001).

Drug taking practices and risk factors

There are very few reports of drug taking practices in Cambodia and injecting drug use appears to be on a small scale (Phalla *et al.* 1999). The use of opium and heroin is limited to small pockets of users in some of the major towns. There are reports of limited injecting drug use involving ethnic Vietnamese using blackwater opium, a practice widely used in Vietnam. The major drugs used in Cambodia appear to be amphetamine-type substances (ATS). An NGO survey of street children in 2000 found that 75% were using inhalants and they were also increasingly using other drugs including ATS and blackwater opium (UNDCP 2001). Of concern is also Cambodian fishermen working with Thai fishermen known to be injecting heroin. Sex workers take Yaba (amphetamine) by swallowing but also sometimes crush the tablets and smoke them (Kellen E, personal communication 2001). A recent report commented that an amphetamine called '*maya*' is used by some Cambodian fishermen to increase energy levels and reduce the need for sleep (Greenwood 2000).

Most restricted prescription drugs are openly available nationwide from over 750 pharmacies. Cambodians commonly use injections for pharmacy medicine. There is a growing concern that the preference for injections as a form of treatment for many illnesses coupled with a lack of sterile syringes, and the means to sterilise, is a pathway for HIV infection (National Authority for Combating Drugs (NACD) 1999). Syringes can be purchased across the counter, without a prescription, for around 200 Cambodian Riel (US\$0.05 cents) (G. Manthey, personal communication 2001).

Prevalence and profile

HIV vulnerability factors in Cambodia are numerous. Economic liberalisation and intermittent political upheaval have increased exposure to HIV as have large numbers of incoming visitors, the movement of refugees and ex-soldiers and people from the countryside to the capital city. The increased availability of commercial sex, cultural changes regarding extra-marital sexual practices, low levels of education, poverty and

inadequate responses from government agencies, as well as the preference for using injecting forms of medication, are but some of the factors (NCHADS and UNDP 2000).

There are no estimates available of the number of drug users in Cambodia. The National AIDS Authority recently completed a situation and response analysis (SRA) in relation to HIV/AIDS in Cambodia: it found there was little evidence of injecting drug use in Cambodia and that this is an area where more research is required (G. Manthey, personal communication 2001).

The first case of HIV/AIDS in Cambodia was detected in 1991 by a man donating blood in Phnom Penh (WHO 1999). The seriousness of the epidemic was only realised with the completion of the first round of HIV sentinel surveillance in 1995 (Phalla *et al.* 1998). Individuals infected with HIV were found in every province in which sentinel surveillance was conducted (National Authority for Combating Drugs 1999). It is estimated that 169,000 Cambodians, or 2.8% of the population, are infected with HIV/AIDS (UNAIDS Cambodia Office, personal communication 2001). Recently there has been a decline in HIV cases which is believed to be a result of successful efforts to increase condom use among those most at risk (National Centre for HIV/AIDS *et al.* 2000; WHO 2001; Ministry of Health (MoH) *et al.* 2001). Ninety per cent of HIV cases are transmitted through unprotected heterosexual contact (UNDCP 2001). The major contributing factor is unprotected sexual intercourse with commercial sex workers whose HIV prevalence rate is estimated at 31% (MoH *et al.* 2001). It is reported that approximately 14,000 women work in brothels with tens of thousands of others working as freelance prostitutes (UNDCP 2001). The sex industry is widely patronised by men spanning a wide variety of socio-economic strata (Phalla *et al.* 1998). The government has vigorously pursued the promotion of condoms during high-risk sexual encounters, in particular through the national 100% Condom Use campaign in all sex establishments. From 1997 to 1999 the percentage of female sex workers reporting consistent condom use in commercial sex increased from 42% to 78% (WHO/WPRO 2001).

The national HIV surveillance system, initiated with WHO and USAID support in 1994/1995, is now largely funded by the government from a World Bank Loan. The surveillance system conducts annual blood and behavioural surveys at specially designated sentinel sites in 21 of Cambodia's 24 provinces, and behavioural surveys in five provinces (WHO/WPRO 2001). While HIV infections may be declining the number of people dying from AIDS each year is increasing. The number of people dying from AIDS is already greater than the total number of hospital beds in Cambodia's public health services (WHO/WPRO 2001).

In 1998 the prevalence of HIV among male blood donors was 4.1% and among female blood donors 2.5% (WHO 1999). HIV prevalence among blood donors increased from 0.1% in 1991 to 3.6% in 1997 (NCHADS and UNDP 2000). The latest figures were unavailable.

Several groups have been identified as particularly vulnerable to drug abuse including homeless people, internally displaced people, children alone in cities, unemployed youth, street vendors, porters, cyclo drivers, fishermen working on Thai fishing boats and commercial sex workers (Oppenheimer 1997).

In 2000 the population of Cambodia was 11.6 million people with one million of these living in the capital city Phnom Penh. The age structure of the population reflects the heavy toll war and genocide have had on the Cambodian people: 45% of the population are aged 1 to 14, 52% are between 15 and 64 years and only three per cent are 65 years or older. Only 20% of the urban population and 12% of the rural population have access to safe drinking water (UNDCP 2001). The per capita income is less than 1,208,280 Cambodian Riel (US\$300 per year). Cambodia is one of the poorest countries in the world with four out of ten of its citizens living below the poverty line. The government is only able to commit 3% of GDP to health and education (compared to 5% for other low-income countries). The literacy rate is as low as 37% of the adult population and 57% for those between 15 and 24 years of age (UNDCP 2001).

Government responses to illicit drug problems

One hundred and twenty four people were arrested for various drug-related offences in 2000, up from 78 in 1999 (Narcotics 2001). The National Anti-Narcotics Department has approximately 200 personnel on paper assigned to its headquarters and it is responsible for overseeing the anti-narcotics police assigned within the provinces (UNDCP 2001). Many Cambodian and foreign observers believe that the Cambodian military, at various command levels and in various locations, are actively involved in promoting or protecting the production and trafficking of drugs (UNDCP 2001). The recent arrests of Ministry of Interior officials for drug trafficking is an example of this (G. Manthey, personal communication 2001).

Government responses to drug use and HIV

Until recently, drug abuse has not been given much attention or priority in Cambodia and given the many pressing issues facing the government, this is not surprising. In March 2000, the National Authority for Combating Drugs (NACD), which makes decisions on drug control policy and supervises drug control operations, launched a public education and information campaign to inform people of the dangers and consequences of drug use. This has in part been sparked off by Cambodian officials' concern about one of the main groups at risk, teenage middle-class students, that is, their children (UNDCP 2001).

Cambodia's health care system is one of the poorest in the world (Oppenheimer 1997). Cambodia does not have separate rehabilitation centres for recovering drug addicts. The NACD has asked the Ministry of Health to establish treatment and rehabilitation centres and for other agencies to provide vocational training. But, given other health and social problems, it is unlikely that sufficient resources will be available to have any significant impact (UNDCP 2000).

National AIDS Policy

The national response to the HIV epidemic in Cambodia has been hampered by continued instability within the government. In 1993, a National AIDS Committee was established with representatives from 12 ministries and the governors of provinces, cities and the Phnom Penh municipality. The role of this committee was to provide policy guidance to the government. In 1995, after the release of the first seroprevalence surveys, the National AIDS Committee was reorganised and the First

Prime Minister became the Honorary Chairman. In 1999 the National AIDS Authority was established comprising representatives from 15 ministries and all provincial governments. It has developed a comprehensive and multisectoral strategic plan on HIV/AIDS prevention and care 2001 to 2005. The chair of the National AIDS Authority (NAA) recently indicated a desire to include the NACD in to the Policy Board of the NAA (G. Manthey, personal communication 2001). HIV prevention activities focus on sexual transmission and include conducting HIV prevalence and risk behavioural surveillance. International donors provide the vast majority of funding for HIV prevention, surveillance and care (Phalla *et al.* 1999).

Non government responses to drug use and HIV

A number of foreign and domestic NGOs have given increasing attention to drug abuse as part of their work with groups such as street children, commercial sex workers, fishermen, prisoners and migrant workers. In 1999 a number of these NGOs, along with UNDCP, established a drug abuse forum to promote understanding of drug abuse issues and coordination of field activities (UNDCP 2001).

Estimated number of drug users	Unknown
Estimated number of IDUs	Unknown
Drugs that are used	cannabis, methamphetamines, heroin, opium, solvents
Drugs that are injected	blackwater opium, heroin
Number of HIV infection among IDUs	Unknown, rate of HIV via all routes 2.8% or 169,000 people

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China

Comparisons: 1997 Versus 2001

Since 1997 China has moved from pockets of HIV (predominantly among IDUs) to a country facing a massive explosion of HIV. It has spread along the various trafficking routes and HIV has now penetrated into areas that were previously untouched. In 1997 of the reported cases of HIV infection roughly two thirds were due to IDU: in 2001 70% of all HIV cases are due to IDU. In late 1996 the cumulative total of HIV cases was 5,157 (unofficial figures put it closer to 200,000 people). By June 2001 the cumulative total was 26,058 people infected with HIV, the Ministry of Health suggests 600,000 is closer to the actual figure while UNAIDS suggests one million people may be HIV positive.

In 1997, unlike other countries in the region, many parts of China, including the capital Beijing, were not experiencing major drug use problems but by 2001 this rapidly changed; estimates suggest there are 50,000 to 60,000 drug users in Beijing alone. In 1996 there were 560,000 registered drug users in China, by 2000 this figure was 860,000 but unofficial estimates put it closer to six to seven million drug users with approximately 3 - 3.5 million of them IDUs. Heroin remains the drug of choice with methamphetamine gaining popularity as it is cheap and easy to get. In 1997 there was rising transition from chasing the dragon to injecting heroin: this has continued to increase in the years in between. Various studies suggest that at least 60% of IDUs continue to share their injecting equipment and in one part of the country (although the practice could be more widespread) it is common practice to mix heroin with blood, shake it and pass the syringe to other users.

In 1997 drug users were imprisoned and/or fined and forced into the 400 to 500 compulsory rehabilitation centres in the country. In the past five years China has had to quadruple its capacity of rehabilitation centres to meet the increasing numbers of registered drug users. If a person relapses after rehabilitation, and relapse rates are 70 to 90%, he/she is sent to a re-education labour centre for an average of two years.

The government's official response to drug use has been zero tolerance but as the seriousness of the epidemic becomes clear, acceptance of harm reduction measures increases. While in 2000 at least 35 people were executed for drug crimes the terminology for drug users shifted from 'illegal persons' to 'illegal patients'. The National AIDS strategy has recently changed from no focus on drug users to a position of targeting high risk groups, IDUs, and is anticipated to actively market clean needles and syringes and increasing methadone and other substitution programmes throughout the country. Small pilot programmes of NSP and methadone have been operating and a few NGOs have targeted drug users but these need to be greatly expanded if they are to have any impact on the epidemic.

History

The word opium (*'yapian'* in Mandarin) first appeared in Chinese texts in the 8th century although the use of opium at the time was likely to be small. This all changed in the 16th century when European merchants discovered its commercial appeal and exported increasing amounts of opium from India to China. After 1650, the Dutch were exporting more than 50 tons of opium per year to China; at the time the Dutch introduced the practice of smoking opium in a pipe which expanded its popular appeal (McCoy 1991). In 1729, an imperial edict, the first to outlaw opium smoking and its associated activities, was introduced and lasted until 1858. However, the smuggling of opium continued as did its consumption (Walker 1991). On the eve of the first Opium War in 1840, opium use and its cultivation became more widespread; an estimated 10

million opium addicts were spending nearly half their income on opium. By the end of the 19th century China was home to an estimated 15 million opium addicts. By the early 20th century China harvested 39,000 tons of opium to supply a growing number of addicts: an estimated 100 million people smoked opium with 15 to 20 million being addicted (Wu 1998; McCoy 1991; UNDCP 2000).

In 1949, an estimated 20 million people (about 5% of the population) were addicted to opium. Following the founding of the People's Republic of China, concerted efforts were made to eliminate the availability of opium and eradicate the cultivation of opium. Between 1950 and 1952, drug traffickers were executed, opium dens were closed and opium addicts were forced to attend detoxification centres (McCoy 1991; Walker 1991; UNDCP 2000). For the next three decades illicit drug use was controlled. The free market economic policies introduced in 1979 produced resurgence in illicit drug use. The combination of China's proximity to the Golden Triangle (it borders Myanmar, Laos and Thailand) and the introduction of an open border policy for international trade has contributed dramatically to the increase in the use of drugs (McCoy 1991; Wodak 1999; UNDCP 2000; UNAIDS and UNDCP 2000). By the mid to late 1980s the Yunnan Province, which borders Myanmar, became a principal trafficking route for drugs entering China and a focal point for serious drug problems (Bessey 1995; Zhang *et al.* 1994; Wu *et al.* 1996; McCoy 1997; Wu *et al.* 1999; UNDCP 2000; McCoy 2001).

Current Situation

China continues to be a major transit country for the illegal narcotics produced in the Golden Triangle. While most heroin originates from Myanmar, (which shares a 2,000 kilometre border with China) smaller amounts come from Laos, Vietnam and South-West Asia (Narcotics 2001; National Narcotics Control Commission (NNCC) 2001). From 1991 to 1999 nearly 40 tons of heroin, 16 tons of opium and 23 tones of methamphetamine were confiscated by Chinese authorities (Information Office of State Council 2000a). In 2000, 6,281 kilograms (kg) of heroin was seized compared to 5,364 kg in 1999. Methamphetamine production and trafficking has substantially increased with 20,000 kg seized in 2000, compared to 1,608 kg in 1999 (NNCC 2001). In the northern parts of the country the ephedra plant grows wild: the drug ephedrine (a precursor for methamphetamine) can be extracted from this plant. The commercial production of ephedrine is estimated at 350 to 400 tons per year, much of which is used for legitimate purposes, but it is also used extensively in the illegal production of amphetamine type substances (ATS). Currently, China is a major source of ephedrine in the manufacture of ATS in Myanmar, a major producer of this drug since the mid 1990s (Narcotics 2001; UNDCP 2000). China has recently become a major producer of methamphetamines fuelling domestic use and supplying international markets primarily Japan, South Korea, Philippines and Taiwan (UNDCP 2000). The government maintains a focus on the eradication of small-scale cultivation of opium, generally in the remote northeastern and northwestern areas of the country. In 2000, it focused on the Henan Province and uprooted 120,000 stalks of poppies (Narcotics 2001; NNCC 2001).

The connection between heroin use, trafficking routes and the spread of HIV/AIDS in China is documented by recent research. The use of advance molecular epidemiology, linking HIV subtypes to specific trafficking routes, has proven that HIV infection in China has spread along the various trafficking routes and has now penetrated into

areas that were previously untouched by the infection. In 2001, a total of 27 provinces have identified HIV among their IDU population and of these seven have serious epidemics among this group. The spread of HIV infections among IDUs is hitting new provinces each year. In 1989, Yunnan was the first province affected by an HIV epidemic among IDUs. Since then serious epidemics among IDUs have been located in Xinjiang (1996), Guangxi and Sichuan (1997), Guangdong (1998), Gansu (1999) and Jiangxi (2000) (Yu *et al.* 1998; Beyrer 1999; UNDCP 2000; Yu *et al.* 2001; UNAIDS 2001).

Statistics show drug use has become widespread in China: 2,033 out of the 2,143 counties have reported drug problems and 140 counties have more than 1000 registered drug users (Wu 2000). Until relatively recently many parts of China, including the capital Beijing, had not experienced anywhere near the severity of drug use found in the provinces in South-West China. This is rapidly changing with a recent study estimating 50,000 to 60,000 drug users are living in Beijing (NCAIDS 2001).

Heroin and opium are still the main drugs of choice although it is acknowledged opium has become less favoured in recent years. Cannabis is popular in some regions of the country but its use is generally not regarded as widespread even with an increase in seizures from 106 kg in 1999 to 4,493 kg in 2000. The increasing amount of ATS being produced, trafficked and used in the country suggests methamphetamine may become a drug of choice due to its cheapness and availability. There are reports of an increasing amount of ecstasy use, mainly in urban centres, and there are a variety of pharmaceutical medications consumed such as diazepam, tramadol, pethidine and buprenorphine. Other drugs are dihydroetorphine, cocaine, morphine, ketamine, triazolam and illegally acquired methadone (NNCC 2001; UNDCP 2001; NCAIDS 2001; Z. Wu, personal communication 2001).

Drug taking practices and risk factors

The favoured administration route for drugs varies from place to place, over periods of time and in different cultural and social settings. Opium is usually smoked either in cigarettes or a bamboo water pipe, or it can be chewed and ingested. The smoking and chewing of opium are long standing traditions in the border area of South-West China. Cooked opium juice can be injected and has been identified among drug users who live on the border of Myanmar (Zheng *et al.* 1994; Wu 1998; Wu *et al.* 1996; UNDCP 2001). Heroin is either smoked in cigarettes, inhaled by being heated on foil or, as has been the case in recent years, by injecting. It is believed the injecting of heroin emerged in the late 1980s and that many opium smokers adopted heroin injecting as a result of the relative ease of handling heroin powder compared with bulky opium. Injecting of methamphetamines does occur (sometimes by mixing it with heroin) but at this stage it is difficult to gauge how widespread this practice is (Zheng *et al.* 1994; Wu 1999; Anderson and Hua 1998; Li *et al.* 2000; Yan *et al.* 1997; Wei L. personal communication 2001).

The popularity of injecting drugs has certainly increased over time and many studies are now showing no less than 50% of drug users are injecting and in many reports the figure rises to over 80% (Zheng *et al.* 1994; DOH and UNAIDS 1997; UNDCP 2001; Anderson and Hua 1998; Jianhua *et al.* 1998; Xiahong *et al.* 1999; Yu 1999; Wu 1999; Peng *et al.* 1999; Wu Caiyang *et al.* 1999; Chen Xi *et al.* 2000; Hong 2000;

Yunnan Provincial Health Bureau 2001; Health Department Guangxi 2001). A study in China's compulsory rehabilitation centres found that 35% of the drug users had been taking drugs for 1-3 years and 25% for more than 3 years. The transition period from smoking to injecting was also lessening, particularly among the younger drug users (NNCC 2001). Another recent study shows that half of the heroin users who have been using drugs for less than a year commenced injecting within 8 months: in some instances it can be just a few months and some move on to injecting immediately (Lai et al 2000).

The sharing of needles and syringes is a common practice, frequently 60% and greater, in various regions of the country. In most instances the cleaning of equipment involves washing in cold water which is inadequate for protection against blood borne viruses. Some drug users do however clean their injecting equipment in hot water, alcohol or bleach (Zheng *et al.* 1995; Yu *et al.* 1996; Wu *et al.* 1997; Liao 1998; UNAIDS 1999; Beyrer 1999; Yu 1999; UNDCP 2001; Lai *et al.* 2001). The 'ritual' of injecting is varied with scant documentation of this process. Needle flushing, which entails the drawing of blood into the syringe and then re-injecting is a common practice (UNDCP 2001).

In PiagXiang City, (a town that borders on Vietnam) Guangxi, a common ritual of injecting is to remove the plunger of the syringe, place the heroin inside and then dissolve in water or fruit juice. However, it is not uncommon to mix the heroin with blood, shake the syringe to assist in dilution and then pass it around to the other drug users (L Wei, personal communication 2001). It has also been shown that in Nanning, Guangxi, a group of IDUs will allow drug users with a new syringe to be the first to draw from the heroin solution before IDUs known to reuse old needles and syringes. They are aware of how HIV/AIDS is transmitted and have developed their own culture to minimise blood transmission from one drug user to the other, although those reusing old injecting equipment still remain at risk of blood borne viruses (Z. Wu, personal communication 2001).

Injecting equipment is reported to be easily accessible from either medical clinics or pharmacies in most urban centres. However, it has been difficult to determine whether this equipment is available in the more remote villages where anonymity would also be an issue. No prescription is required for purchasing needles and syringes. Currently needles and syringes are priced at 0.6 to 1.5 RMB (US\$0.07 – 0.18) and are regarded as relatively cheap but this depends if a drug user has an income or not. No studies on the disposal of injecting equipment are available but it has been noted that in smaller communities equipment is buried in the ground, burnt to prevent discovery by family members or usually thrown away wherever the drug user injects (Z. Wu, personal communication 2001).

Prevalence and profile

The number of registered drug users has dramatically risen throughout the 1990s. In 1990, the country had 70,000 registered drug users and in 2000 it was 860,000. However, the number of drug users is not reflective of the true situation: drug use is severely punished and such activities are clandestine. The numbers are believed to be much greater and an estimated 6 to 7 million drug users is more likely (UNDCP 2000; UNAIDS and UNDCP 2000; NNCC 2001; NCAIDS 2001). Current HIV/AIDS sentinel sites indicate that 53.3% of drug users inject (MOH 2001); in some provinces

the level of injecting is greater as in Yunnan and Guangxi where 80% to 90% of drug users inject (Yunnan Provincial Health Bureau 2001; Health Department Guangxi 2001). Calculations from the HIV/AIDS sentinel sites figures suggest there are likely to be 3 to 3.5 million IDUs in China.

Reports from China's compulsory rehabilitation centres (January to September 2000) shows that large number of drug users are unemployed (60%) or employed as factory workers, in sales or are self employed. Many had gone through primary and middle school education but illiteracy is a problem for some (4.4%). The vast majority is under the age of 30 years and nearly 40% are under 25 years of age (NNCC 2001). Such a profile is supported by other studies (Wang 1999; Zhou and Li 1999).

Most drug users are male but the number of females using drugs is increasing and in Yunnan and Guangxi for example they make up 16% to 25% of all drug users in treatment (World Bank Health Nine Report 2000; Health Department Guangxi 2000; Yunnan Provincial Health Bureau 2001). Female drug users tend to be younger and in Guangxi, for example, five years ago they were usually aged 20-23 years but in 2001 most in treatment are now aged 17-18 years. The level of involvement in prostitution among female drug users has increased and in Guangxi it is estimated at 80% (W. Xianoning personal communication 2001). Previous studies have also found the involvement of female drug users in prostitution to support their habit is high (Anderson and Hua 1998; World Bank H9 Report 2000).

The HIV epidemic in China has developed in three stages. The first identified HIV/AIDS case was in 1985 and up until 1988 all cases were among foreigners or among overseas Chinese; the cases were mostly found in seven provinces and generally located along the coast. From 1989-1993 HIV/AIDS had spread to 21 provinces and in 1993 the number of HIV infected cases was 274. While there was prolonged unequal geographical distribution of HIV infections, by 1998 a rapid expansion saw the epidemic spread to the 31 provinces, municipalities and autonomous regions in China. This spread had now moved from the concentration among ethnic minority groups to the majority Han population and, while still mainly affecting the IDU population (70% of all infections), it is increasingly being transmitted sexually (Yuel et al 1996; Ministry of Health (MOH) and UNAIDS 1997; Liao 1998; Wu 1998; Anderson and Hue 1998; UNAIDS 1999; UNAIDS and UNDCP 2000; Yunnan Provincial Health Bureau 2001; MOH 2001; WHO 2001).

By June 2001, the cumulative number of people with HIV/AIDS was 26,058, with a total of 1,111 AIDS cases and 584 related deaths. Injecting drug use accounted for 70% of the total reported cumulative cases although the three transmission routes of blood, sexual contact and mother to child have also been identified. National sentinel surveillance shows that the average prevalence of HIV infection among prostitutes increased from zero in 1995 to 1.32% in 2000. In the first six months of 2001 there have been 3,541 infections reflecting an increase of 67% compared to the same period in 2000 (MOH 2001). The Ministry of Health (MOH) estimates there are now 600,000 people infected with HIV while UNAIDS estimates the figure is more likely 1 million; by 2005 UNAIDS believe the figure will be 5 million and increase to 20 million if no successful countermeasures are put into place (UNAIDS 2001; MOH 2001). The prevalence of hepatitis C among IDUs has been reported to be 60% (Baozhnag et al 1997).

Government responses to illicit drug problems

Anti-trafficking activities are largely in the hands of the National police organisations and are coordinated by the Ministry of Public Security. A legal framework for drug control was established in 1979 and it imposed severe punishments for the manufacturing, trafficking and supply of illicit drugs. In 1990 a meeting of the Standing Committee of the 7th National People Congress set out a series of regulations and penalties for trafficking, possession and use. The overall position of Chinese law enforcement is one of zero tolerance. Possession of 50 grams of heroin, or 100 grams of opium, can result in an imprisonment of no less than seven years. The smuggling, trafficking or manufacturing of illicit drugs can result in either the death sentence or a life sentence; between 1995-1996 a total of 2,800 people received life sentences (UNAIDS and UNDCP 2000; UNDCP 2000). In 2000, at least 35 people were executed in various parts of the country for drug crimes (NNCC 2001).

Recently, there has been a shift from describing illicit drug users as 'illegal persons' to 'illegal patients' demonstrating that there is an emerging understanding that illicit drug use is at least partly a health issue. However, it is acknowledged such a change is new and much will need to be done to implement this shift into practice (China AIDS Network, personal communication 2001).

According to Chinese law, drug users must be rehabilitated and consequently the country has adopted compulsory measures as their main principle. It is the role of local government to organise Public Security, the Judiciary and Public Health Department to undertake the tasks of running the compulsory rehabilitation centres (CRC). A registration system and monitoring networks of drug use have been established throughout the country, regularly collecting data and materials and monitoring the conditions of drug users. (UNDCP 2000; UNAIDS and UNDCP 2000; Information Office of State Council (IOSC) 2000a; IOSC 2000b).

A drug user is first sent to a CRC for 3-6 months. Detoxification is usually provided through a mix of western and Chinese medicines. In 2000, China had a total of 746 CRCs administered by the Public Security Department (PSD). In the past five years the country has been forced to quadruple its capacity as a result of increasing number of registered drug users. In 2000, CRCs received nearly 250,000 drug users throughout the country. In some circumstances drug users deemed unsuitable for treatment are placed under the guardianship of family members and the education of and administration of the local PSD. The Ministry of Health is involved in some treatment centres that are positioned within hospitals. There are over 100 treatment facilities managed by the State Drug Administration treating 100,000 patients annually. Most of these facilities are located within psychiatric hospitals and while treatment is termed voluntary, discharge cannot occur until treatment is complete (the PSD also maintains a close collaboration with these establishments). The cost is on average 2,000 to 5,000 RMB per treatment, a considerable amount for most people. (UNDCP 2000; UNAIDS and UNDCP 2000; IOSC 2000b; NNCC 2001).

If a person relapses following discharge from CRC they are then sent to a re-education through labour centre (RELC) for an average of two years and a maximum of three years. Residents are forced to undergo re-education coupled with physical labour. Currently there are 168 RELC in the country administered by the Justice Department. In 2000, RELC accommodated 120,000 people (UNDCP 2000; UNAIDS

and UNDCP 2000; IOSC 2000b; NNCC 2001; Z. Lin personal communication, 2001). Nationwide there are few activities aimed at drug users to assist them to reintegrate into the community following treatment. Evaluations of current treatment practices are scant and systematic follow-up data is poor. It is generally agreed the relapse rates are very high with estimates ranging from 60% to 100% (Zhou and Li 1999; Wu 1999; UNDCP 2000; UNAIDS and UNDCP 2000).

Government response to drug use and HIV

As drug cultivation, trafficking, selling and use is an illegal activity, regulated by PSD and accompanied by serious social censure, the government has been slow to implement HIV/AIDS prevention and control measures for IDUs. Prevention activities have essentially focused on the display of posters, outlining the harms of drug use, while television and radio simply report on the supply and demand reduction approach. However, it is increasingly acknowledged the HIV infection rate among IDUs has not diminished and in fact more IDUs are at risk of becoming HIV infected (UNAIDS and UNDCP 2000; State Council 2001; NNCC 2001). Even so, effective approaches to HIV prevention among drug users in China is limited and as a result their ability to effectively impact upon the current HIV/AIDS epidemic among IDUs is low.

Nationally there is a growing acceptance of the importance of using peer education and outreach approaches to reduce the risks associated with injecting. One approach is to provide and disseminate information, education and communication (IEC) materials about the risks of sharing needles and syringes. Some of these IEC programs are implemented within treatment and re-education facilities. Funding of such material is mainly through the National Centre for AIDS Prevention Control, under the Ministry of Health. However, most HIV prevention information and peer education is non-specific and insufficient to meet the needs of IDUs (UNAIDS and UNDCP 2000). Currently possession of a needle and syringe does not appear to be illegal but it could be used as evidence of drug use (Z. Wu, personal communication 2001). Possession of a condom (by a woman) may be used as evidence of sex work (R Yip, personal communication 2001).

Needle and syringe programs are not in operation nationally but they do operate in Yunnan and have been piloted in Guangxi. In the capital Kunming, Yunnan, a NSP and methadone program has been established and is administered by the Yunnan Institute for Drug Abuse in collaboration with the Health Bureau. Currently there are 14 clinics throughout Kunming that offer a voluntary methadone program with a fee for a set period time, not usually for more than three weeks. In four out of the 14 clinics there is also a NSP. In 2000, in the Biase prefecture, Guangxi, a pilot project of needle social marketing was established operating both as a fixed site and on a peer outreach model. Funding was from the Guangxi Health Department and Ministry of Health (J. Chen, personal communication 2001). While it was shown to be successfully reducing the sharing of needles and syringes by 50% (Wu *et al.* 2001), the project was not maintained due to a shortage of funds (J. Chen, personal communication 2001). Currently there are other needle social marketing projects in Guandong funded by the World AIDS Foundation (Z. Wu, personal communication 2001).

Substitution therapy (such as methadone maintenance programs) is rare in the country and is strictly regulated; the focus is on detoxification and the medical treatment of addiction symptoms rather than long term maintenance. Currently, the medical authorities believe that long-term methadone maintenance is prohibited. Methadone maintenance is supported by the Chinese government but has not been legislated yet. It is understood that methadone is only available for those attending voluntary rehabilitation centres where there is a substantial fee and not inside CRC (although in a Beijing detoxification centre they claim to be giving some methadone to drug users). Methadone is produced in the northern part of China and it is expensive largely because few people are permitted to prescribe the drug; the price is likely to drop considerably if and when it becomes more widely prescribed (UNAIDS and UNDCP 2000; Z. Wu personal communication 2001).

National AIDS Policy

The National Program for AIDS Prevention and Control was produced in 1987. Two medium term plans were drafted in the early 1990s and in 1995 the government issued a document “Recommendations on strengthening AIDS Prevention and Control”. In 1998, the State Council approved a National ‘Medium and Long Term Plan for the Prevention and Control of HIV and AIDS (1998-2010)’. In May 2001, the State Council issued a five-year action plan for HIV/AIDS prevention and control (2001-2005). There are seven actions and two are given priority. These are as follows: health education to develop a basic understanding of HIV prevention in the general population; and behavioural interventions among high risk groups which include the use of effective approaches to prevent HIV transmission among and from injecting drug users. As part of the action plan a program of needle and syringe social marketing will be actively conducted and clean needle and syringe usage will be promoted. The medical approach to treatment, detoxification and rehabilitation will be investigated, which implies the potential implementation of a national methadone, and other substitution therapies, program (State Council 1998; State Council 2001).

Non-government responses to drug use and HIV

In China an NGO means an organisation registered with the Ministry of Civil Affairs. Other forms would be an organisation not registered as an NGO but under a government department. Some NGOs also register themselves as companies and then finally some do not register at all (B. Stewart, personal communication 2001). The sensitivity of illicit drug issues in China has resulted in few NGOs implementing activities that focus on drug users. The Chinese Association of STI and AIDS Prevention and Control established in 1993 claims to be the largest NGO working in this area. While their work is focused on society in general they have had pilot projects on cleaning needle and syringe schemes in minority tribal villages. The China Preventative Medical Association hopes in the future to promote needle and syringe exchange among IDUs. The All China Women’s Federation established in 1949, is mainly focused on the wider HIV/AIDS and community. However, recently in Guangzi they have carried out some HIV/AIDS IEC work among drug users in detoxification and they provide support for female drug users after they have been discharged from rehabilitation centres.

The Red Cross Society have been very active in Yunnan with the Australian Red Cross coordinating training workshops targeting drug users inside rehabilitation

centres throughout the province. By mid 2001, they had conducted workshops with over 2,000 residents of rehabilitation centres. The PSD have acknowledged high relapse rates and fully accept the Red Cross coming into CRCs to provide both theoretical and practical demonstrations on how to clean injecting equipment with bleach, alcohol, soap and boiling water. The Narcotics Control Bureau has assisted in organising these courses and fully accepts the harm reduction component of the workshop (Y. HaiLin, personal communication). The Xinjiang Red Cross who have also implemented small projects among drug users (Z. Wu, personal communication 2001). The Department for International Development (DFID), United Kingdom, will collaborate with the MOH from 2000, over five years, on a series of HIV/AIDS prevention and control programs. Among the activities is the piloting of social marketing of needles and syringes, the training of police and doctors in PSD on HIV/AIDS and IDU and in the funding of two pilot methadone maintenance programs (MMP). The MMP guidelines have still to be finalised (B. Stewart personal communication 2001).

Estimated number of drug users	860,000 registered drug users, unofficial estimate 6 to 7 million drug users
Estimated number of IDUs	3.5 million
Drugs that are used	heroin, opium, cannabis, methamphetamine, ecstasy, diazepam, tramadol, pethidine, buprenorphine, dihydroetorphine, cocaine, morphine, ketamine, triazolam and illegally acquired methadone.
Drugs that are injected	heroin, methamphetamine and most likely diazepam mixed with heroin. Cooked opium juice and ketamine.
Estimated number of HIV infections among IDUs	HIV prevalence rates range from 1% to 80% according to the region

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Hong Kong (Special Administrative Region, China)

Comparisons: 1997 Versus 2001

Heroin remains the drug of choice in Hong Kong and injecting the favoured way of taking it. There has also been an increase in the use of ecstasy and ketamine as part of the burgeoning Hong Kong dance party scene. In the mid 1990s needle and syringe sharing appeared to decline but recently there has been an increase which may be the result of complacency among IDUs to high risks activities due to the relatively low HIV infections among IDUs. The vulnerability of IDUs is further increased by trips into mainland China to buy, use and commonly inject drugs: China's HIV prevalence among IDUs is 70%. Shooting galleries, called divans, have also recently re-emerged: 20 were identified by police in 1999. These divans provide a safe haven for buying and consuming drugs and eliminate the need for IDUs to carry needles and syringes or wait around on the streets to buy drugs.

In 1997 the Central Registry of Drug Abuse recorded 12,342 drug users, in 2001 the figure was 18,275. Unofficial estimates place the figure closer to 30,000 to 40,000. The cumulative total of HIV infections in 1997 was 855 with 274 AIDS cases, in 2001 the figures are 1,586 HIV infections and 509 AIDS cases. The major route of transmission of HIV is through sexual contact however HIV positive cases among IDUs have jumped more than sixfold in the past two years. It is estimated there may be 2,500 to 3,000 HIV infected people in Hong Kong.

The Hong Kong government has been targeting IDUs about HIV prevention since 1987. Methadone Maintenance clinics have been operating since 1972 and in 2001 the daily average was 6,501 clients and the payment per visit (HK\$1.00) has remained the same for many years. It is reported there are some peer educators practicing outreach, disseminating information about safer injecting and cleaning procedures but the numbers are too small to have much impact. The government has run mass media campaigns about drug use and HIV. A variety of treatment and rehabilitation centres exist which are available to drug users without delay. Since the Pillar Point refugee camp for Vietnamese closed there have been no NSPs. There still appears to be some reluctance to fully embrace harm reduction principles and the sharing of injecting equipment has not been addressed adequately.

History

It has been said that Hong Kong was founded upon opium, almost by accident, during the course of the First Opium War in 1841 between the Chinese and the British (Laidler *et al.* 2000). It was in the best economic interests of Britain to maintain the opium trade with China and when the Chinese Emperor banned opium, a war emerged. After losing, China ceded the Hong Kong Island and Kowloon Peninsula to Britain in 1842, to which the New Territories were added in 1898 under a 99-year lease. The British colonial government established, through Hong Kong, one of the largest business centres for prepared opium flowing into China (Mc Coy 1991; Cheung and Ch'ien 1996). In 1918, opium accounted for nearly 45% of the colonial government's revenue and it continued to contribute a significant proportion of its revenue until the beginning of World War II. The ease of opium availability resulted in a high prevalence of opium addiction and in 1909 an estimated 13% of the male population smoked opium. By 1924 this had risen to 20-25% of males and 1 to 2% of females (McCoy 1991). In 1927, heroin use was identified with the supply of crude heroin pills. Consumption of these red coloured heroin pills peaked in 1939 and the Hong Kong Government estimated 110 million pills were manufactured illegally. At

the time it was estimated there were over 5,000 opium addicts obtaining supplies from legitimate sources, 40,000 opium addicts obtaining supplies from illegitimate sources and about 30,000 people addicted to heroin pills (Laidler *et al.* 2000).

In 1946 when opium was reclassified and placed under the Dangerous Drugs Ordinance, heroin soon became the drug of choice and by 1955/1956 heroin offences exceeded opium offences by nearly three to one. Heroin was less bulky, easier to ship, more profitable for the supplier, cheaper to purchase and for heroin users, offences usually resulted in the form of a custodial sentence rather than a fine as was the case with opium. Heroin offences rose substantially from 400 in 1952 to 12,000 in 1956 (McCoy 1991; Laidler *et al.* 2000). For the first time serious attention was drawn towards those addicted to heroin and in 1961 the Drug Addicts Treatment and Rehabilitation Ordinance was passed giving rise to the establishment of large voluntary addiction treatment centres on the island of Shek Kwu Chau. At that time the number of addicted people was estimated at 100,000 to 200,000. The relative inaccessibility of injecting equipment encouraged drug users to smoke heroin or 'chase the dragon' but by the late 1980s this had changed. For more than four decades heroin has continued to be the most popular drug (Westermeyer 1976; McCoy 1991; Cheung and Ch'ien 1996; Lam 1997; Narcotics Division 2001a).

Current Situation

The CIA recently reported that Hong Kong remains a transshipment base for South-East Asian drugs despite President Clinton's announcement in 2000 that Hong Kong be removed from the Black List of U.S. Narcotics Control. The Hong Kong government is demanding evidence from the CIA to substantiate their claim or retract it (J. Ch'ien, personal communication 2001). As drugs are not produced or manufactured in Hong Kong, all supplies are imported. Heroin and methamphetamine are usually smuggled by land. Heroin and methamphetamine for local consumption is usually supplied from the Golden Triangle, trafficked into mainland China through the Province of Yunnan and Guangxi then often via Guangdong Province before entering Hong Kong. It can also be smuggled by land across the Shenzhen – Lo Wu border. Methamphetamine emerged in the mid 1990s and is usually shipped into Hong Kong in a crystalline form but recently there have been liquid versions (Woo 1996; Narcotics 2001; Laidler *et al.* 2000).

In 2000, authorities seized nearly 340 kilograms (kg) of heroin, a rise from the 287 kg seized in 1999 and the 209-kg seized in 1998. Cannabis seizures have also increased from 35kg in 1999 to 219 kg in 2000. Seizure of methamphetamine has decreased with nearly 88 kg in 2000 compared to 102 kg seized in 1999. In 2000, nearly 379,000 ecstasy tablets were seized (a rise of 1000% compared to 1999) and a substantial quantity of other drugs such as cocaine and ketamine. The use of cough medicines or 'cough water' diminished in the mid 1990s but is again in steady use as it is widely available. Other drugs that are used include opium, diazepam, flunitrazepam, triazolam/midazolam, solvents, methadone and psychotropic substances (Narcotics 2001; Narcotics Division 2001b).

Most heroin available at street level has purity ranging from between 15% to 65%. While most heroin users are known to go to their dealer and purchase in public spaces, those that deal in methamphetamine are known to go to the users and transactions are commonly done in a private setting where the drug is often bought as

a group. Given the stability of the heroin scene over the years it is likely ecstasy and ketamine are part of the diversification of the drug market and inextricably linked to the burgeoning dance party scene in Hong Kong (Laidler *et al.* 2000; Narcotics Division 2001b).

Drug taking practices and risk factors

Recent data shows the principal way of taking heroin remains injecting among the majority of heroin users but among new users it tends to be fume inhalation. In 2000, data showed that among previously reported users, 54% preferred injecting to fume inhalation (40%) and smoking (18%). In 1997, 60% preferred injecting, 37% fume inhalation and 15% smoking. In 1997, 67% of new heroin users reported that fume inhalation was their preferred way of taking heroin, by 2000 this had dropped to 49%. At the same time 19% of new users preferred injecting, by 2000 this had increased to 31% (Narcotics Division 2001a).

Smoking involves placing a small amount of heroin onto the tip of a cigarette and once lit the user smokes the cigarette in a vertical position to ensure the heroin remains on the tip, which is known as 'firing the ackackgun'. Fume inhalation is commonly through the 'chasing the dragon' method which involves placing the heroin on a piece of foil, heating the outside of the foil, and then inhaling the fumes through a paper or glass tube. Another method can be inhaling the fumes from a matchbox instead of a tube known as 'playing the mouth organ'. A typical pattern of heroin consumption is via smoking or chasing and over time the transition to injecting commences, often as a result of efficiency, enhanced effect and the economic benefits (Laidler *et al.* 2000). Other studies have also shown injecting heroin is still the preferred method but has declined significantly since the early 1990s when it was frequently above 80% (Lee *et al.* 1998; Ch'ien *et al.* 1998).

The main way of taking ecstasy is by swallowing and ketamine by snorting. With methamphetamine, called 'ice', a common method is to chip off a piece of the crystal and dissolve the drug in a drink. However, the main method is via fume inhalation and the approach is similar to 'chasing the dragon' (Laidler *et al.* 2000).

After nearly two decades police authorities have reported the re-emergence of 'divans', which are similar to shooting galleries. The distinguishing characteristics of divans are as follows: operators provide clean injecting equipment; observational devices are used to verify potential customers and avoid police scrutiny; drug users manage the space and only known and regular customers are allowed to consume on the premises (in one raid 20 people were found at a divan). In 1999, the police identified 20 such establishments. It is believed these places offer an efficient safe-haven for buying and consuming and the users no longer need to carry injecting equipment or wait on the street to purchase the drug (Laidler *et al.* 2000). The potential for risky behaviour may be high without the appropriate HIV prevention mechanisms in place.

The risk behaviours found among those people injecting generally remain high with needle sharing and widespread inadequate cleaning of used injecting equipment. The Annual Street Addicts Survey (ASAS) first commenced in 1992. Over the past five years approximately 70% of all respondents were injecting. In 1998, among the IDUs, 57% reported sharing needles compared to 67% in 1996. In 2000, this has dropped to

9.4% but occasional sharing remains at about 22% usually as a result of late evening unavailability of new injecting equipment. Those IDUs who use only private or disposable needles and syringes increased from 17.8% to 34.9% (J Ch'ien, personal communication 2001). Other studies have shown much lower rates of needle sharing, sometimes as low as 10% - 20%. While the rate of equipment sharing over the years has declined, current sharing may be also be a result of a complacency among IDUs towards the high risks associated with sharing and/or the continuing low incidence of HIV infections among IDUs (Ch'ien *et al.* 1998; Department of Microbiology *et al.* 2000; Choi and Lee 2000).

Of concern is the continuing unsafe cleaning practices of injecting equipment as shown in the 1998 street survey; 65% of IDUs do not clean their injecting equipment appropriately (Ch'ien *et al.* 1998). The use of alcohol and bleach for cleaning requires continuous promotion. Many people assume needle and syringe sharing is rare as a result of disposable needle and syringes being available without a prescription at pharmacies for HK\$1 for a 10 cc (US\$0.13) and HK\$2 for a 20cc (US\$0.26). However, surveys among drug users show sharing occurs mainly as a result of the non-availability of needles in time of need, for example at night when pharmacies are closed (Ch'ien *et al.* 1998). Approaches to 24 hour convenience stores to stock needle and syringes has not been successful as store owners are afraid drug users may frighten away ordinary customers from their premises at night (J. Ch'ien, personal communication 2001). In December 2000, the street drug addict survey found 16% of the 500 respondents were vulnerable to contracting HIV as a result of cross border cheaper drug seeking into mainland China (which has a prevalence of 70% HIV infection among IDUs). Other studies have also shown similar behaviour and of those using drugs in mainland China, 60% had injected (Department of Health 1999; Ch'ien 2000).

Prevalence and profile

In 2000, the number of drug users on the Central Registry of Drug Abuse was 18,275, an increase of 12% compared to 1999. Of these, nearly 13,000 are previously reported persons and the rest are newly reported cases; in 2000 there was a 71% increase of newly reported cases. In 2000, most of those on the registry were males (84%) although the number of female drug users registered increased by 37% from 2,166 to 2,969. Since 1999 there has been a 61% increase in young people, under 21, using drugs (from 2,481 in 1999 to 4,000 in 2000) (Lee *et al.* 1998; Narcotics Division 2001a). In 2000, the estimated number of drug users was calculated, through the indicator dilution formula, to be 36,384 (J Ch'ien, personal communication 2001). The estimated number of heroin users was 21,000 (UNODCCP 2001) of whom some 60% were IDUs (J. Ch'ien , personal communication 2001).

Examining the characteristics of the reported individuals in 2000, the average age of all users was 32 (although among women it was 25 years). While heroin was the drug of choice, 19% claimed to use more than one drug. Of those under 21 years, polydrug use was 41% and among the older groups, multiple use of methadone and other drugs is common. In 2000, most of the drug users claimed to have started using drugs when aged between 15 and 24 years, with 22% starting when they were under 15 years (in 1997 it was 20%). In 2000, while many were employed (43%) a substantial number were unemployed (49%). Many drug users were single (65%) and a substantial number (56%) lived in public and aided rental blocks. In 2000, the geographical

concentration of drug users was found in the districts of Kwun Tung (10.4%), Sham Shui Po (9.4%), and Yau Tsim Mong (8.4%). The usual daily expenditure on drugs ranged from HK\$100 to HK\$400, with the average reported to be HK\$240 (Chou and Ch'ien 1997; Narcotic Division 2001a).

The first HIV infection in Hong Kong was reported in 1984. At the end of March 2001, there was a cumulative total number of 1,586 confirmed HIV infections and 509 AIDS cases. As of the first quarter of 2001 (January to March) there have been 44 HIV and 9 AIDS cases. The major route of transmission by exposure category is through sexual contact accounting for 81% of the cumulative total. Of the cumulative total, 39 HIV infections and 9 AIDS cases are linked to IDUs. From January to March 2001, there were six new cases due to IDUs, the highest figure ever recorded within a single quarter. Street screening for HIV through saliva sampling and testing was practised in the mid 1990s but suspended pending a technical review (J Ch'ien, personal communication 2001). The HIV sero-prevalence has increased in the last three years even though the number of drug users undergoing voluntary HIV testing has remained small; HIV positive cases among IDUs have jumped more than six fold in the past two years (Department of Health 2001). It is estimated that there could be 2,500 to 3,000 HIV infected people among the 6.7 million population of Hong Kong (Department of Microbiology *et al.* 2000; UNAIDS 2000; WHO 2001).

Government responses to illicit drug problems

The Hong Kong Government has gone to great efforts to suppress illegal drug supply by vigorously imposing various sentences from the Dangerous Drugs Ordinance for those in possession of illicit drugs. For major offences involving trafficking or manufacturing of dangerous drugs, the maximum penalty is a fine of HK\$5 million (US\$641,040) and life imprisonment. The maximum penalty for possession of dangerous drugs is a fine of HK\$1 million (US\$128,208) and seven years imprisonment (Narcotics Division 2001b). Possession of 10 grams of heroin can result in a two to five year sentence and up to 12 grams of methamphetamine can bring about a three to seven year sentence. The cannabis guidelines show possession of over 500 grams of cannabis resin can result in a four to eight month sentence and the cultivation of cannabis or opium poppy brings a fine of HK\$100,000 (US\$12,821) and 15 years imprisonment (Laidler *et al.* 2000; Narcotics Division 2001b).

While there are strict penalties for trafficking, the government has also focused upon demand reduction, particularly in the area of treatment and rehabilitation. The Correctional Services Department (CSD) administers mandatory treatment programs. Drug users who are sentenced to prison can be made by the court to enter compulsory treatment: the length of stay can be from two months to a maximum of 12 months. This is followed by 12 month statutory aftercare supervision. The CSD operates two treatment centres, one for men (capacity for 964 inmates) and the other for women (capacity for 190). Since 1997, there had been a decrease in the number of people being sent to compulsory programs. But this trend reversed in 2000, with a total of 1,414 inmates admitted: an increase of 3% compared to 1999. There are also facilities for people who voluntarily seek treatment and rehabilitation and the 12 residential centres are operated by NGOs. The overall aims of the residential programs are for detoxification, treatment, rehabilitation and the after care of users requesting help to stay drug free. Currently the total number of voluntary residential beds is 1,122 for

males and 138 for females. The number of people admitted into these establishments has increased in recent years (Laidler *et al.* 2000; Narcotics Division 2001b).

Methadone treatment programs have been in operation since 1972 and both maintenance and detoxification options are available for out-patients. There are 21 clinics scattered throughout Hong Kong, which are operated by the Department of Health. Maintenance entails a dose each day and the price has remained stable for many years at HK\$1 (US\$0.13). The operating times of the service are extensive and available seven day a week. In 2000, the daily average attendance was 6,501 (Narcotics Division 2000; Narcotics Divisions 2001a; Narcotics Division 2001b).

Government response to drug use and HIV

Since 1987, the government, through the Advisory Council on AIDS (ACA) and the AIDS Prevention and Care Committee (APCC), and with the support of NGOs, has been organising AIDS education programs targeting all high risk groups. It has been suggested the relatively low rate of HIV infection among IDUs, compared to neighbouring countries, can be attributed to a variety of government introduced measures. Of key importance has been the availability of a multi-modality treatment system which includes 21 methadone clinics and a variety of treatment centres available to most drug users without delay. Although no needle and syringe program is in operation, Hong Kong has, in the past, permitted such a program (operated by the NGO Medicins Sans Frontiers) inside a refugee camp of Vietnamese boat people where high risk injecting drug use occurred. While the operation was successful it was never implemented for drug users outside the camp (Ch'ien 2001; Nemayechi and Taveaux 1997).

Regional AIDS Policy

Since 1990 the Advisory Council on AIDS has been developing AIDS strategies for Hong Kong. In 1994, a comprehensive strategy document was produced for policy formulation in the government and community organisations on various issues associated with AIDS. The guiding principles are regularly under review and for 1999-2001 the three objectives identified to guide the development of HIV/AIDS strategies include a focus on prevention, ensuring quality and care and strengthening partnerships with NGOs and target groups. The prevention strategy efforts are to be expanded and focused on risk and vulnerability reduction, covering different target groups including frequent travellers, sex workers, homosexuals and IDUs (Hong Kong Advisory Council 1999, Ch'ien 2001). However, while it has been suggested that there should be an open adoption of harm reduction principals, and that they should be advocated in parallel with supply and demand reduction policies, this balance has yet to be achieved. Currently, there remains a reluctance to accept the concepts of harm reduction in the drug policy arena. Educational campaigns targeting drug users are ongoing but prevention measures regarding the sharing of equipment have not been addressed adequately. The introduction of needles and syringe programs has yet to be endorsed.

Non-government responses to drug use and HIV

There are a number of NGOs offering treatment and rehabilitation services on a voluntary basis. The Barnabas Charitable Service Association provides residential

treatment and rehabilitation services for female drug users. Other treatment and rehabilitation centres include the *Caritas Wong Yiu-nam Centre*, *Christian New Being Fellowship*, *the Christian Zheng Sheng Association*, *the Drug Addict Counselling and Rehabilitation Services*, *the Hong Kong Christian Services PS33*, *Ling Oi Youth Centre and Operation Dawn*. The oldest and largest NGO, *The Society of the Rehabilitation and Aid for Drug Addict (SARDA)*, operates four residential treatment centres (for male and female patients), five halfway houses and post discharge socio-medical care to more than 2,000 people each year. Through an affiliated organisation, the *Pui Hong Self Help Association*, SARDA also runs a supportive employment service providing direct work opportunities to those rehabilitation patients in need. SARDA also provide counselling services to each of the 21 government methadone clinics focusing on both demand and harm reduction.

The other NGOs working with treatment and rehabilitation include the *SER Foundation for Humanitarian Aid*, *St Stephens Society* (serving the homeless) and the *Wu Oi Christian Centre*. The Pillar Point refugee camp for Vietnamese has closed which resulted in the end of Hong Kong's only harm reduction clinic which included a needle and syringe program. All the residential programs in Hong Kong offer differing services depending on the needs of the client, such as religious conversion, intensive counselling, peer support and prescription drugs for detoxication. The concepts of harm reduction however, do not appear to be included (Narcotics Division 2001b; Laidler *et al.* 2000). In addition to PHSHA, the Caritas Lok Heep Club and the Kelly Support Group also focus on prevention for current drug users not in treatment (J Ch'ien, personal communication 2001).

Estimated number of drug users	36,384
Estimated number of IDUs	Of 21,000 heroin users, 60% are IDUs
Drugs that are used	heroin, ecstasy, methamphetamines, cannabis, cocaine, ketamine, opium, methadone, solvents, psychotropic substances, diazepam
Drugs that are injected	heroin
Estimated number of HIV infections among IDU	Cumulative total, 2.5% of HIV infections found among IDUs. In first quarter of 2001 HIV among IDUs is 13.6% (highest ever).

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Macao, Special Administrative Region, China, (MSAR)

Comparisons: 1997 Versus 2001

HIV prevalence in Macao is low but the government is concerned about the spread among high risk groups such as IDUs and CSWs. A special working group has been established to assist and prevent HIV among IDUs but there is no specific policy on drug use and HIV. Methadone is not permitted in Macao and there are no NSPs or peer outreach programs. Treatment at rehabilitation centres is voluntary although drug offenders may have their sentence reduced or suspended on the condition of attending a centre. Drug users in treatment centres are given information about the risks of sharing needles and syringes.

Macao continues to import all its drugs, largely from mainland China, and heroin remains the preferred drug. Cannabis and psychotropic drug use has been increasing since 1997. Injecting is still the preferred method for taking heroin although treatment centres show a substantial decline in injecting since 1997: 82% injected in 1997 and this has dropped to 58% in 2001. There were no estimates of drug users in Macao in 1997 while in 2001, 400 people are registered as drug users. From 1986 to 2001, 235 HIV infections and 21 AIDS cases were recorded. Seventy one per cent of these were among temporary residents working in the entertainment industry. When these are excluded from the data IDUs count for 15% of HIV infections (in 1997 reports varied from 0% to 6% of HIV infections being due to IDU).

History

Drug use has been a long-standing issue in Macao society, as it has in Hong Kong situated just 60km South-West of Macao, and historically opium was the drug of choice. In 1946, the Macao government banned the use of opium, and all narcotic drugs, except those used for legitimate medicinal purposes. By the 1960s the main drug of choice was heroin, which was either injected or smoked and commonly mixed with barbiturates. At this time there were approximately 1000 heroin addicts according to police sources but the numbers were likely to be larger. Between 1947 and 1960 there were over 6,000 narcotic users treated either in government hospitals or in prison (Reves and Cotta Guerra 1963; Belo 1996; MSAR, Social Welfare Institute (SWI) 2001). Since that time there has been increasing drug legislation to control the production, distribution, commerce and use of both narcotics and psychotropic drugs. A series of drug conventions were introduced in 1961, 1971 and 1988 in Macao. In 1990, as a result of the persistence of drug using problems, the Office for Prevention and Treatment of Drug Dependence was established. In December 1999, Macao became the Special Administrative Region of the Peoples Republic of China and is under the principle of one country, two systems (Belo 1996; MSAR, Social Welfare Institute (SWI) 2001).

Current Situation

There is no evidence to indicate Macao is a drug producing region: the problems are of drug consumption and trafficking. Currently, the main source of illicit drugs entering Macao is from mainland China where the origins of the narcotics are the Golden Triangle; there are also some cases of narcotic smuggling from Hong Kong. Throughout the 1990s the dominant drug of choice has been heroin and this has not changed. However, the use of cannabis and psychotropic drugs appears to be an increasing problem. Drugs such as MDMA (ecstasy), Midazolam, Triazolam and Flunitrazepam are used by the young and those people involved in the entertainment

industry. In 2000, the amount of heroin seized dropped but ecstasy and ketamine seizures (commonly detected in nightclubs) increased. As a result of the variety of drugs used in Macao, the drug laws have recently been amended to include ketamine and 18 other psychotropic substances in the controlled dangerous drug list (MSAR, SWI 2001). According to registration data from voluntary treatment centres there has not been a significant increase in methamphetamine use, with few cases reported in 2000. Less than 3% of newly reported cases are for stimulant use, including ecstasy and 'ice'. It needs to be reported, however, that most methamphetamine users seldom seek voluntary treatment. In the past two years police in Macao have reported a 30% increase in the trafficking of ice. In 2000 the biggest increase in drug seizures was MDMA and psychotropic drugs, which rose by 600%, from 8,493 to 60,193 pills (MSAR, SWI, personal communication 2001). In 2000 there were only 89 newly reported voluntary cases to treatment centres and the various drugs used were; heroin (93%), stimulants (3%) and benzodiazepines (1%) (MSAR, SWI, personal communication 2001).

Drug taking practices and risk factors

Heroin is still the drug of choice and the method of administration favoured by many is injecting. Statistical reports from drug users registered in treatment centres show that currently 58% inject which is a substantial decline from 82% in 1996/1997. Fume inhalation is the next favoured method and this commonly takes the form of 'chasing the dragon' (Belo 1997; MSAR, SWI 2001).

Studies on drug users examining knowledge, attitude and practices have not been conducted. Information about the purchasing of injecting equipment, of how widespread the sharing of needles and syringes is and the cleaning techniques used by this group is unavailable. It is likely that many drug users in Macao experience the same risks as drug users in Hong Kong: the sharing, and widespread inadequate cleaning of, injecting equipment. Needles and syringes are easy to buy from pharmacies without a prescription. Currently the cost of a syringe is about the same as in Hong Kong, approximately HK\$1 (US\$0.13) per needle and syringe. They are viewed as being relatively cheap. Injecting drug users in Macao, as in Hong Kong, have problems finding injecting equipment at night when the stores and pharmacies are closed and consequently their risk of sharing increases (MSAR SWI, personal communication 2001).

Prevalence and profile

In 2000, there were an estimated 400 registered drug users (the population of Macao is 438,000) which included all reported cases from voluntary outpatient treatment centres, from the prison and the treatment services run by NGOs. All data collected by the Social Welfare Institute is entered into a centralised computer program to check for overlapping cases. From October 1991 to the end of 2000, 662 drug dependents were registered in the government treatment services. There are, on average, about 70 new cases per year. An estimate of how many drug users exist has not occurred. According to data from an outpatient clinic, the rate of IDU has decreased in recent years. In 1991 more than 80% of drug users injected but in the past two years it has dropped to around 50% (MSAR, SWI 2001; MSAR SWI, personal communication 2001). The government is planning to undertake a study in 2002 of drug users from Macao crossing into mainland China to use and inject drugs, as occurs in Hong Kong.

A recent study in Hong Kong showed that 16% of the participants crossed into mainland China to buy/use drugs: the figures in Macao actually may be higher as it is easier to cross into mainland China from Macao (MSAR, SWI, personal communication 2001).

Most of the drug users registered in Macao are single (60%), male (85%), many aged between 20 and 29 years (38%), have limited education (54%), are unemployed (67%) and many are from poor socio-economic backgrounds. The main reported reason for drug use was a combination of peer pressure and curiosity (MSAR, SWI 2001).

The first HIV infection in Macao was reported in 1986 and the first AIDS case in 1989. Since the end of 1986 until the end of March 2001, 235 HIV infections and 21 AIDS cases have been reported: 71% of these are diagnoses were among temporary residents working in the entertainment industry. In 1996 there were no HIV infected cases among IDUs: in 2001, 13 HIV cases were among IDUs which is 5% of the total figure (Belo 1996; MSAR SWI 2001; Public Health Laboratory 2001). However, when the temporary residents working in the entertainment are excluded from the data, the drug use transmission accounts for 15% of infections. There is a progressive increase in detected HIV infection among IDUs although the absolute number remains small. Data show the HIV spread among Macao's general population has been limited, despite the tendency for an increase among some groups such as IDUs. An estimate of how many people in Macao are HIV infected has not been made (WHO 2001; Public Health Laboratory 2001).

Government responses to illicit drug problems

Drug control is aimed at supply control and demand reduction and is mainly implemented by public entities, under the supervision of the Under-secretaries for Administration and Justice; Security and Social Affairs and Culture (Belo 1997; MSAR, SWI 2001)). Capital punishment is not imposed for trafficking of illicit drugs. According to Law Number 5/91/M the highest penalty for trafficking drugs is 12 to 20 years imprisonment (when teenage victims are involved) or a fine of Macao Pataca (MOP) \$900,000 to MOP\$3,000,000 (US\$116,863 – US\$395,545). Trafficking small amounts of drugs results in a two-year prison sentence or a fine of MOP\$225,000 (US\$29,216). For drug users caught with a small amount of drugs for self use, a three month prison sentence or a fine of MOP\$10,000 (US\$1,298) may result. Providing a public place for illegal drug use can result in eight years imprisonment or a fine of MOP\$1,500,000 (US\$194,772). In Macao there is no specialised compulsory treatment centre or program. Those people convicted are sent to a general prison. There is only one prison and it has is a special unit created for people with drug related problems. Inmates with drug related problems are encouraged to attend this unit and to accept a rehabilitation treatment program before discharge. When people are found using drugs, the court or the police can also have the person transferred to the government outpatient centre or an NGO program which provides treatment. Sometimes the court can request a drug user to stay in voluntary treatment for one year. All long-term treatment centres are run by NGOs and the Macao government only provides outpatient treatment programs. It is anticipated that a government operated detoxification centre will open in 2002 (MSAR SWI personal communication, 2001). No studies have been undertaken to measure the recidivism of drug users discharged from treatment centres although there are plans to examine this

issue at some stage (MSAR SWI personal communication, 2001). The relapse rate is probably high, as is the case in most parts of the world.

The Prevention and Treatment of Drug Dependence Department provides prevention education to the wider community in various ways including the Life Education Program for the young. Children aged from 5 to 12 years are the target and the program has been operating since September 2000. The Department offers outpatient treatment for drug dependents and their families (medical care, psycho-social support and economical support). The treatment services offered by the government are voluntary and free (MSAR, SWI 2001).

Government response to drug use and HIV

It is reported that all drug users treated by government agencies or NGOs must be encouraged to learn about the health issues associated with drug use and HIV/AIDS and the inherent risks of needle and syringe sharing (MSAR, SWI 2001). Information linking drug use and HIV/AIDS has been incorporated within the IEC material made available to the wider community. Drug users are tested for HIV/AIDS, STDs, and Hepatitis A, B and C before entering treatment and rehabilitation centres and outpatient clinics. At the same time they are given HIV prevention education by the HIV/AIDS control unit of the Laboratory of Public Health. Regular lessons are provided by experienced HIV educators in each treatment centre about prevention techniques. Nurses and social workers in outpatient centres provide information about safer sex and provide free condoms. Clients with HIV are transferred to a special unit for treatment and counselling in the public hospital (MSAR SWI personal communication 2001). It is likely that the focus of the information is on abstinence rather than risk reduction in case the drug user returns to injecting drugs. For example, it is unlikely that practical displays of adequate cleaning techniques for injecting equipment, or the provision of literature on this activity, is given.

There is one NGO, government funded, peer education/outreach program for drug users not in treatment but the details of its operations are unclear. This outreach group, with the support of the government, also provides a type of welfare service (although not directly to drug users) where people are provided with a free lunch, clothes, and a place to wash. There are no plans to introduce a needle and syringe program. Methadone maintenance programs do not exist. Clonidine is provided in treatment (MSAR, SWI, personal communication 2001). The Social Welfare Institute has a type of harm minimisation program run by an outreach team. They give advice and knowledge to people in the street drug scene but it is difficult to determine how explicit and specific the information is.

National AIDS Policy

While the HIV infection spread among the general population remains low the government is concerned about the spread among high-risk groups such as commercial sex workers (CSW) and drug users. A special working group for the prevention and control of AIDS and STDs has been established in the Laboratory of Public Health (LPH). A function of the LPH is to cooperate with drug treatment agencies and to assist and prevent such infections among drug users (MSAR, SWI 2001). Drug control is aimed at supply control and demand reduction and it appears no specific policy on drug use and HIV has been created.

Non-government response to drug use and HIV

There are six NGOs providing in-patient treatment for drug users. It appears that all the NGOs follow the traditional 'spiritual' detoxification model which in essence means the 'cold turkey' approach of massage, hot baths and prayer. However, some NGOs are accepting the use of medications during detoxification. In addition there is one Self-Help Association, one group doing outreach (although the details are not available) and one Half-Way House. Most of these are Christian based and largely operated by ex-users. The Prevention and Treatment of Drug Dependence Department maintain a close relationship with the NGOs and offer technical and financial support where it is deemed appropriate (MSAR SWI 2001). There are no NGOs that have a focus on harm reduction.

Estimated number of drugs users	Unknown, 400 are officially registered
Estimated number of IDUs	Unknown
Drugs that are used	heroin, cannabis, ecstasy, benzodiazapines, methamphetamines
Drugs that are injected	heroin
Estimated number of HIV infections among IDUs	HIV prevalence is low in Macao but IDUs account for 15% of HIV infections

Reference List – Macao (Special Administrative Region, China)

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India

History

Around the 9th century Arab traders first brought opium to India via the west coast and its primary use was for medicinal purposes. By the 10th century opium use was widespread and included social use. The first recorded mention of opium as a product, and its cultivation, was in the early 14th century; the poppies were grown along the west seacoast at Cambay and Malwa (Machado 1994). Historically the use of cannabis products predates the use of raw opium (Roy and Rizvi 1986; Mohan *et al.* 1996). After the founding of the first Moghul dynasty under the reign of Babur (1524-1530) poppy cultivation and sale of opium became state monopolies and soon were an important article of trade with China and other eastern countries (Machado 1994). The British East India Company took over the opium monopoly in 1757 and the British attempted to popularise its use to increase revenue. In Bengal, the land designated for opium growing stretched for 500 miles with more than a million registered farmers growing opium plants for the East India Company in 500,000 acres of prime land (McCoy 1991; Machado 1994).

In 1720 the importation of Indian opium to China was 15 tons, increasing to 75 tons by 1773 and by the early 19th century it had stabilised at around 250 tons. However, by 1840 when all restrictions were lifted, it had increased to 2,555 tons. The country derived substantial revenue from the sale of opium and the total revenue over 39 years was £375,000,000 (McCoy 1991; Hodgson 1999). Opium smoking only began in the 19th century and remained less popular than oral consumption (Ray 1998). By 1893, attempts to pressure the government for the suppression of the opium trade led to a Royal Commission: its conclusion being that it was not possible to effectively enforce prohibition. By 1946 the eating and smoking of opium was prohibited; exceptions were made for registered addicts who had to produce a medical certificate to receive their supply of opium. By 1959 the sale of opium was totally banned and oral consumption was prohibited except for registered addicts on medical grounds (McCoy 1991; Machado 1994; Haque 1996). In 1959 the number of registered opium addicts was 4,32,609 and by 1975 it had fallen to 80,000 (Ray 1998).

By the late 1960s and early 1970s a variety of drugs were available and increasingly used by younger people. Cannabis became more popular as did hypnotics, sedatives, stimulants and hallucinogens. Pethidine and morphine was used, albeit in small numbers (Spencer and Navaratnam 1981). Between 1969 and 1978 various authors reported that epidemiological studies of mental illness showed that 0.04% to 17% of the patients used various drugs including cannabis and opium (Ray 1998). Until the early 1980s, India was the main opium producing country and became the only supplier of licit opium for the world's requirements (Machado 1994). By the late 1980s and early 1990s legally cultivated opium was being diverted and converted into heroin. In the early 1990s it was estimated there was one to five million opium addicts and 750,000 to one million heroin addicts. At the same time it was estimated 100,000 people were addicted to 'brown sugar' in Bombay alone (West 1992). By the late 1980s, and throughout the 1990s, injecting of drugs became increasingly prevalent: this was accompanied by an explosion of HIV infections, first detected in the north-eastern State of Manipur (Naik *et al.* 1991; Sarkar *et al.* 1993).

Current Situation

India is the sole producer of opium gum and one of the world's top producers of licit opium, all of which is monitored by the Indian Central Bureau of Narcotics. Opium poppy is grown in the states of Madhya Pradesh, Rajasthan and Uttar Pradesh. In 2000 the Indian government licensed nearly 160,000 farmers to cultivate opium on 35,000 hectares. The result was just over 1,300 metric tons of opium was harvested in 2000, the largest amount in many decades. The diversion of licit opium to illegal markets has been documented: in 1999 an estimated 300 metric tons may have ended up on the black market, converted into heroin 'brown sugar' and sold. Just a 10% diversion of opium gum would make India the world's fourth largest producer of illegal opiates. The illegal growing of opium poppies can be found in Kashmir, Uttar Pradesh and in the states of Manipur, Mizora, Nagaland and Arunachal Pradesh (Narcotics 2001).

Heroin use has been spreading rapidly in the major metropolitan cities of India (New Delhi, Kolkata, Chennai and Mumbai) since the early 1980s and most of what is available is impure and crude. However, in the states of Manipur, Nagaland and Mizoram, which are closest to the source of heroin, a purer variety is found known as 'white sugar' or 'number four'. Some of the heroin available in India is trafficked from the Golden Triangle in particular from Myanmar. In the northern eastern states of India, such as Manipur, heroin has been sold since 1973 and its use has become widespread (Eicher 1996; Dorabjee *et al.* 1996; McGirk 1996; UNAIDS and UNDCP 2000). By the 1990s an epidemic of injecting pharmaceuticals, in particular buprenorphine often used as an alternative among heroin users, could be found in all the major metropolitan cities and this has not abated (Dorabjee and Samson 1998; Dorabjee and Samson 2000). India still remains a transit route for heroin, hashish and morphine base from Afghanistan, Pakistan, Myanmar and to a smaller extent Nepal. It has been estimated that 32% of heroin seized in India has its origins in Afghanistan or Pakistan (Narcotics 2001).

In 2000 authorities seized over 1,000 kilograms of heroin, up 27% from 1999. Opium seizures amounted to 2,218 kilograms mainly in the poppy growing areas. Hashish seizures amounted to 3,258 kilograms and morphine totalled 24 kilograms. Up until November 2000, a total of 2,129 people were convicted of drug trafficking (Narcotics 1999; Narcotics 2001). Currently there is a broad range of drugs used including; opium, heroin, morphine, buprenorphine (Tidigesic), diazepam, pheniramine (avil), promethazine (Phenergan), nitrazepam, spasmorproxyvon, codeine phosphate, various cannabis preparations, cough mixtures containing codeine (Phensedyl) and among the more affluent there has been the introduction of cocaine, ecstasy and other amphetamine type substances (UNDCP and UNAIDS 2000; Dorabjee *et al.* 2001; Panda 2000; Kumar 2000). Common drugs used by street children are cannabis, 'brown sugar', crude alcohol and the sniffing of petrol, glue, paint thinner, kerosene and xerox and paper correction solutions (Ray 1998; Tellis *et al.* 2000).

Drug Taking Practices and Risk factors

Opium is usually swallowed or smoked. In rural Rajasthan it comes in two forms either as a nugget or a powder. The nuggets are first dissolved in water and what is extracted in the filtering process is swallowed. The powdered form is placed into an earthen clay pipe and smoked (Ganguly *et al.* 1995). Heroin, 'brown sugar', appeared

on the Indian market in the early 1980s and it effectively displaced opium and cannabis as the drugs of choice (Dorabjee and Samson 1998). It is believed the introduction of the Narcotics and Psychotropic Substances Act 1985, which criminalized opium use, had an impact in influencing drug users to shift from cannabis and opium to inhaling heroin (Dorabjee *et al.* 2001). The most popular way of taking heroin is through inhalation or ‘chasing’ the fumes emitted from the heated heroin through a small pipe. A small number of drug users are known to have converted smokeable heroin into an injectable preparation using citric acid, vitamin C tablets or lemon juice (UNAIDS and UNDCP 2000). In Mumbai heroin users tend to cook up heroin with *avil* in the belief that the impurities found in heroin will be removed (Dorabjee and Samson 2000). Over time the low prices for heroin were not maintained and for many street drug users it became too expensive. By the late 1980s and early 1990s, the pharmaceutical buprenorphine gained popularity and its availability in ampoule form allowed it to be injected; this drug and mode of administration quickly spread throughout most major cities of the Indian subcontinent (Kumar and Danials 1994; Eicher 1996; Panda *et al.* 1997; Dorabjee and Samson 1998; Ray 1998; Basu *et al.* 2000).

Many people who injected buprenorphine found that the ‘high’ was lacking and as a result created a cocktail of other pharmaceutical drugs which has proven popular. For example, many drug users administer by injection a combination of diazepam, avil and phenergen with the buprenorphine. Although these drugs require a prescription, they are often easy to purchase on the black market or by paying additional money to a pharmacist to dispense with a doctor’s permission (Kumar 2000; Reid 2001). As a general rule poly drug use is widespread in India and is believed to be associated with an increase in fatal drug overdoses (UNDCP and UNAIDS 2000). Generally each ampoule of the pharmaceutical drug is two mls and the users will take 1 ml from each ampoule and then inject. The preferred needle is a 26 gauge which has a small bore. Drug users tend to pool their money to buy heroin and pharmaceutical mixes, sharing not only the same common solution but the same injecting equipment. Sharing groups of drug users range on average from between two to five people (Kumar 1996; Kumar 2000; Panda 2000; Basu *et al.* 2000; Dorabjee *et al.* 2001).

It has been reported that while heroin injectors may use the drug two to four times per day, those that use buprenorphine and the pharmaceutical mixes tend to inject less frequently as a result of the long acting nature of these drugs (Kumar 2000). Administration of drugs would commonly be intravenously but intramuscular injecting also occurs. It has been found that some IDUs pull and push the blood several times in the syringe before the final administration (Panda *et al.* 1997).

In India drugs are often used in open public places such as the roadside, parks, playgrounds and market complexes. Other favoured sites include abandoned or under-construction buildings, public toilets, at home, offices, railway yards, and burial grounds. While India does not appear to have a widespread culture of professional injectors, or ‘street doctors’, as in some other Asian countries, there do appear to be ‘shooting galleries’ where IDUs come to a site and inject (Panda 2000; Kumar 2000; Sharma *et al.* 2000; UNAIDS and UNDCP 2000; Singh 2001). As a general rule injecting equipment is discarded inappropriately. Often they are thrown onto garbage heaps in the neighbourhood, and even though they are a risk to the local communities,

they are frequently collected by people, washed and sold to others at a cheaper price (Kumar 2000).

Cannabis is frequently mixed with tobacco or it can be made into a powder by removing the seeds, placing them in a chillum made of earthen clay and then lighting it (NEIDAC 2000).

Syringes and needles are generally purchased from pharmacies without any need for prescriptions and although they are regarded as inexpensive many drug users tend to focus on buying the drug rather than purchasing new injecting equipment. Disposable plastic syringes are the preferred choice and glass syringes are regarded as unpopular (Kumar 2000; Panda 2000). The average price of a needle and syringe is about Rs 5 to 12 (US\$0.10 – 0.25). Where hypodermic needles and syringes are not available, the use of improvised injecting equipment such as ink droppers fitted with syringes has been identified (Sarkar *et al.* 1996).

The sharing of injecting equipment among India's IDU community is widespread and in many circumstances it is considered normal. The recent RSA in India showed that most IDUs had at some stage (often within the past 6 months) shared their needle and syringe. The rates of ever sharing are as follows; Chennai (76%), Delhi (50%), Imphal (86%), Kolkata (78%) and Mumbai (61%) (Manning 2001). Analysis of the Delhi participants showed that in the past 6 months 17% of IDUs shared their injecting equipment almost always (Dorabjee *et al.* 2001) and in Kolkata 52% of the IDU participants shared during their last injecting act (Panda 2000). While many IDUs clean their injecting equipment, the majority did so inappropriately for protection against blood borne viruses such as HIV/AIDS and Hepatitis C. Many IDUs cleaned their equipment with any available water and only a small number used boiling water, and fewer used household bleach (Sathiamoorthy 1996; Kumar *et al.* 1996; Panda *et al.* 1998; Kumar 2000; Panda 2000; NEIDAC 2000). Indirect sharing is also common among IDUs with the use of common spoons, solutions, cotton swabs and the dipping of a needle into an ampoule of a pharmaceutical drug (Kumar *et al.* 1998).

Prevalence and Profile

Estimating the number of drug users in India has for years proven elusive and this still remains the case. The figures of one to five million opium users and one million heroin addicts remarked upon in the late 1980s and early 1990s is still used by government officials and UN sources. However, among unofficial sources from NGOs, the level of heroin use is considered much higher and while no figures are supplied few disagree that in north-east India and in most urban cities drug use is increasingly a problem (Mudur 1999; Narcotics 2001; UNAIDS and UNDCP 2000). In early 1990 it was estimated that there were 50,000 IDUs in India (Jain *et al.* 1994). By the late 1990s figures from a rapid situation assessment (RSA) of injecting in India at various sites showed a major change in the estimates of IDUs and they are as follows: New Delhi 25,000-30,000; Manipur 15,000-20,000; Mumbai 38,000; Kolkata 10,000-15,000 and Chennai 10,000-15,000 (Dorabjee and Samson 2000). When examining the percentage of opiate users who are current IDUs the extent of injecting varies from one city to another. The recent RSA data from the following cities shows this clearly: Chennai (66%), Delhi (27%) Imphal (90%), Kolkata (12.5%) and Mumbai (15%) (Manning 2001).

The majority of drug users in India are male and in many drug treatment centres female drug users range from 1% to 10% depending on the city and geographic region (UNAIDS and UNDCP 2000). However, drug treatment data may not be such a good gauge of gender representativeness. There is a great stigma attached to women seeking assistance and many cannot go into treatment for long periods of time because they need to look after their children. A recent survey in Mumbai showed that among the participants in the drug survey, 15% were female (Tellis *et al.* 2000). A recent study in New Delhi of female drug users (N=35) shows that 30% are involved in commercial sex work (CSW). While 15% of the respondents admitted to being IDUs it is not clear if these same people are also CSW (Dorabjee *et al.* 2001). A recent study of female CSWs found the HIV prevalence among IDU CSWs was nine times higher than among non-IDU CSWs (Agarwal *et al.* 1999). A cross sectional survey was conducted between April and October 1997 at the time of the ethnic clash in Imphal, Manipur. The prevalence of HIV infection in female IDUs was 57% compared to 20% among non IDUs: a statistically significant difference, although the prevalence of hepatitis B surface antigen was similar in the two groups (48% and 56% respectively). Eighty per cent of the respondents, many of whom migrated following ethnic clashes, reported having sex with non-regular partners, two thirds reported having sex in exchange for money or drugs (Panda *et al.* 2001).

Recent data from the RSA study on drug use shows the onset of drug use in various major cities ranged from 15 to 18 years. The ages of starting injecting are similar in the following cities; Chennai (26 years), Kolkata (28 years) and Mumbai (25 years) (Manning 2001). Many drug users are from a lower socio economic background with substantial numbers having poor education and they work in insecure positions or experience high levels of unemployment. In Kolkata a survey among IDUs found 42% could not read or write: it was nearly 50% among the non-injectors. Similar figures can be found in New Delhi, although in Mumbai it was around 35% (Panda 2000; Manning 2001). However, in other places such as Meghalaya among both injectors and non-injectors it was 3% (NEIDAC 2000).

The health condition of drug users in India is often poor. Many IDUs do not inject properly and as a result suffer from ulcers, abscesses, cellulitis and thrombophlebitis. Many are undernourished and a substantial number have experienced a drug overdose (Dorabjee *et al.* 1996; Panda *et al.* 1998; Panda 2000; Tellis *et al.* 2000; Gokhale 2000). Sexual risk behaviours, often with multiple partners, are common and a substantial number of IDUs and non-IDUs visit CSWs. There is frequent reluctance to use a condom with either a non-CSW or a CSW (Narain *et al.* 1994; Sarkar 1996; Panda *et al.* 1997; Kumar 2000 *et al.*; Kumar 2000; Manning 2001).

HIV arrived in India in the early to mid 1980s and was first identified in a CSW in Madras in 1986; the first case of AIDS was detected in 1986 (Jain *et al.* 1994; WHO 2001). By the end of 2000 the number of HIV infections stood at 20,304 and up to 82.6% were from sexual transmission and 4.16% were from IDU. In 1997 it was estimated that 2.5 million were HIV infected and by the end of 2000 it increased to a total of 3.9 million living with HIV AIDS, aged 15-49 years. Currently India is the country with the largest HIV/AIDS epidemic in the region (Kumar 2001; MAP 2001; WHO 2001; NACO 2001).

HIV infections among IDUs first appeared in Manipur and increased from 0% in September 1989 to 50% within six months (Naik *et al.* 1991; Sarkar *et al.* 1993). In

Manipur City HIV increased from 61% in 1994 to 85% in 1997 and in 1998 it was 80.7% (Salunke *et al.* 1998; Dorabjee and Samson 2000). In 2000, HIV infections among IDUs in other cities and regions are also generally high as follows; Delhi (44.8%), Chennai (31%), Mumbai (23.7%) Kolkata (2%), Mizoram (9.6%), Nagaland (7%), and Bangalore (4.2%). Many places are experiencing a prevalence nearing or above the critical levels of 10% and this is causing great public health concerns (Dorabjee and Samson 2000; Manning 2001; Kumar 2001). Of increasing concern is the transmission of HIV infection among IDUs to their non-injecting wives increasing from 6% in 1991 to 45% in 1997 (Panda *et al.* 2000). Manipur state has also witnessed an increasing rate of pregnant mothers with HIV infection; increasing from 1.3% in 1994 to 2.7% in 1999 (Mehra 2000). Among IDUs in Chennai the prevalence of hepatitis C was 93% (Kumar *et al.* 2000).

Government response to illicit drug problems

The Narcotics Drugs and Psychotropic Substances Act 1985, and its amendment the Prevention of Illicit Traffic in Narcotics Drugs and Psychotropic Substance Act 1988, outlines the legal management of illicit drug use. It is through these two Acts that the punishments for various drug related offences can range from 10 to 20 years plus a fine of Rs 0.1 to 0.2 million (US\$2,088 – US\$4,176). The latter Act has resulted in less draconian punishments in some cases where possession can be proved for personal use only. The death penalty can be imposed for certain offences for those with a previous conviction. For example, a person convicted of involvement in production, manufacturing, possession, transporting, importing or exporting an amount equal or in excess of 10 kilograms (kg) of opium, one kg of heroin or 20 kg of hashish can be sentenced to death although the death penalty has yet to be carried through. Those convicted of possession or consumption of a small quantity of drugs for their own use are allowed to be released as long as they attend a de-addiction centre and within one year provide court evidence of their medical follow up. Section 64 A of the Act allows for no prosecution to be imposed for a first time offender if the offence is related to possession of a small amount of drugs and the person agrees to seek drug treatment on a voluntary basis from a recognised institution and any other requirements (UNAIDS and UNDCP 2000). As a general rule the criminalisation of drug use has forced many drug users to choose drug treatment in order to evade imprisonment (Dorabjee *et al.* 2001).

In 1992 there were 145 counselling centres, 86 de-addiction centres and 14 after-care centres. At that time there were over three million registered drug addicts (Ray 1998). The government has been keen to see the NGO sector involved. The current approach adopted by the Ministry of Social Justice and Empowerment is to recognise drug use as a psychosocial-medical problem. The government, where possible, is encouraging community participation as part of the process as it is not only cheaper but also maintains the link between the drug users, their families and the community. Currently there are 72 government de-addiction centres, 218 NGO de-counselling centres and 123 NGO de-addiction centres. In each major city there are approximately 300-450 beds but as a result of a large drug using population getting treatment is often difficult. Many such centres charge prohibitive fees and this further limits access. In 1998, around 90,000 people were admitted for detoxification. Admission is generally on a voluntary basis but coercion by others is widespread. Involuntary treatment can result in being sent to a psychiatric hospital, or the courts can also send people to

prison where drug treatment is generally unavailable. Symptomatic medication for opioid withdrawal is by the use of clonidine, codeine or dextropropoxyphene, which often needs to be paid for by the individual. Relapse rates are considered to be high with figures of 80% and greater quite usual (UNAIDS and UNDCP 2000; Panda 2000). Generally, detoxification lasts for 6 to 20 days on an in-patient basis and rehabilitation can last from one to six months (Dorabjee *et al.* 2001).

Government response to drug use and HIV

While the government does acknowledge that drug users, in particular IDUs, are at risk of HIV infection, prevention activities by the government are generally poor. This may be because the HIV epidemic in India is still largely driven through heterosexual sexual transmission. It appears there are no known government funded or implemented programs dealing with HIV/AIDS and drug use. Information on drug use, and its associations with counselling and blood borne viruses, appears to be negligible. What is available is focused on the deadly dangers of drug use and is not designed to raise public awareness or increase understanding of the issues. It also appears, in many drug treatment centres, that there is a paucity of information about HIV/AIDS and sexually transmitted diseases. HIV/AIDS prevention activities inside prisons, an environment where drug use happens, are rarely carried out (UNAIDS and UNDCP 2000; Manning 2001; Kumar 2001; Dorabjee *et al.* 2001).

Methadone and LAAM are not available in India. Naltrexone is available but its expense prohibits many drug users from using such treatment. Substitution therapy with the use of sublingual buprenorphine is currently taking place in five major Indian cities: New Delhi, Kolkata, Imphal, Mumbai and Chennai. This pilot program is being offered to around 1,500 opiate users and funding is from the international donor community. The program should be completed in 2002 (Kumar 2001). Among those able to get such therapy the response has been optimistic among both the drug users and those running the program (Reid 2001). The National AIDS Control Organisations has approved needle and syringe programs (NSP) and they are now operating in Manipur, New Delhi, Mumbai, Kolkata and Chennai. However, there are not enough programs and the coverage is inadequate to impact substantially on the HIV infection rate among IDUs. They are all currently run by the NGOs and none receive any direct funding from the government (Kumar 2001). India has no paraphernalia laws that make it an offence to be in possession of injecting equipment and there are no specific legislative barriers to implementing NSP (UNAIDS and UNDCP 2000).

National AIDS Policy

The draft National AIDS Prevention and Control Policy (1999) notes that one of the major causes for the spread of HIV/AIDS in India is injecting drug use particularly in the north-eastern and metropolitan regions. However, there appears little acknowledgment that IDU can potentially propel a HIV/AIDS epidemic into the provincial parts of the country (Dorabjee *et al.* 2001). The policy suggests the government does consider drug related HIV risk as serious, and is committed to the adoption of an array of strategies that can prevent the risk of transmission through IDU with the most appropriate strategy being to adopt being harm reduction (UNAIDS and UNDCP 2000). However, among senior level drug and health policy makers across the country there appears to be little understanding of what the concept

really means and of the rationale behind the term. While there may be an official sanctioning of harm reduction philosophy, a disquiet and reluctance remains among large numbers of professionals in the area of HIV prevention and drug use: this is largely to do with a range of ethical and moral considerations (UNAIDS and UNDCP 2000). However, since 1996, the State of Manipur has approved and implemented a broad ranging harm reduction policy and program (Makunga 1998).

Non government responses to drug use and HIV

Considering the size of the drug using problem in India there still remains a limited number of NGOs working in the drug use and HIV prevention area. While a harm reduction approach is not an officially endorsed government policy it is through the NGO sector that implementation of harm reduction activities has occurred. In New Delhi many of the harm reduction activities are carried out by *Society for Service to Urban Poverty* (SHARAN). In Kolkata it is the *Society for Community Intervention and Research* (SCIR) and *Calcutta Samiritans* and in Mumbai it is the *Sankalp Rehabilitation Trust and MUKTI Sadan*. In Chennai it is the *Sahai Trust*. In Manipur it is *Society for HIV/AIDS and Lifeline Operation* (SHALOM) and SASO. Common activities found among all of these NGOs are NSP, substitution therapy, de-addiction, peer education and outreach, primary health care, counselling, drop-in centres and vocational rehabilitation programs. Many of the NGOs are staffed by former drug users (UNAIDS and UNDCP 2000; Eicher *et al.* 2000; Reid 2001; Dorabjee *et al.* 2001). Many of these NGOs operate with limited resources to meet the many demands upon their services. It has been suggested that the government has, as a general rule, made no serious attempts to build up the capacity of these organisations and nor has it assisted them further with increased training in order for them to deliver more effective services (Dorabjee *et al.* 2001). There are many other NGOs working with drug users in different parts of the country who have limited harm reduction options.

Estimated number of drug users	Difficult to assess, well over 5 million
Estimated number of IDUs	In 5 cities alone well over 100,000
Drugs used	opium, heroin, morphine, buprenorphine, diazepam, cannabis, pheniramine, promethazine, nitrazepam, spasmoproxyvon, codeine phosphate, cocaine, ecstasy, ATS
Drugs injected	heroin, buprenorphine, drug cocktails
Estimated number of HIV infections among IDUs	Overall the rate of is 4.16% but it is much higher in certain areas, e.g., 80% in Manipur, 44.8% in Delhi, 31% in Chennai

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Indonesia

Comparisons: 1997 Versus 2001

In 1997 injecting drug use was an extremely sensitive issue for the Indonesian government, with little or no data available about the extent of IDU and associated HIV/AIDS risks. By 2001, major assessments had been undertaken and public debate was increasing. In 1997 no statistics were available about the numbers of IDUs in Indonesia, though an estimate had been made of 30,000 to 40,000 users, most of whom were urban and middle class. In 2001, with the use of drugs indisputably on the rise, police estimate 130,000 Indonesians use illicit drugs. Other drug assessors suggest the figure is much closer to 2 million, with over a million of them being IDUs. Before 2000, HIV infection due to IDU was less than 1% of total cases: in 2001, 19% of cases were in people with histories of IDU. In July 1997 the official cumulative HIV figure was 558, with six being IDUs. By September 2001, 2,313 cases of HIV had been identified with 449 being IDUs. Other estimates suggest Indonesia may have 80,000 to 120,000 cases of HIV/AIDS by 2001.

In 1997 the major drug used in urban areas was ecstasy with reports in 1998 of methamphetamine use. These are still the favoured drugs and now laboratories are manufacturing both methamphetamines and ecstasy. It is estimated that in Jakarta there is one death per day from a drug overdose. Heroin use and injecting has been increasing since 1997 and glue sniffing is still prevalent among street children. Although needles and syringes require a prescription they are easily available both from pharmacies and at street markets. However they have increased in price by up to five times since the Indonesian economic crisis began.

The government has moved from a position of complete denial of drug use in Indonesia (and subsequently no mention of drug use and HIV in the National AIDS strategy and no education or treatment for drug users save a few detoxification beds) to an acknowledgement of its existence. The National AIDS strategy mentions IDUs as requiring targeting but there is no evidence that this is happening. The number of beds available for detoxification and rehabilitation has increased and there are plans to introduce a methadone substitution therapy in a Jakarta hospital. But there are no NSPs or peer education programs provided by the government. In 1999, in the Greater Jakarta area there were 10 private institutions caring for drug users; this has increased to 40 in 2001. Since 1998, an NGO in Bali has implemented Indonesia's first broad harm reduction approach to address drug using problems.

History

Like many other countries in the Asian region, Indonesia is a country with a long history of drug use and cultivation. In the early 17th century opium was introduced to Javanese Sultanates and Dutch merchants recorded incidences of many Chinese and Javanese smoking opium-tobacco. During this period the colonial Dutch government controlled opium imports from India and a number of Sultans had established opium monopoly agreements with Dutch companies (McCoy 1991; Irwanto 2001). By 1862 the ruling Dutch established their own opium plantations in Java and Sumatra (Yatim and Irwanto 1987). While the cultivation of opium and its use was expanding, the growing of coca plants occurred in the latter part of the 19th century. It took until the start of the 20th century for a superior coca plant to flourish and by 1912 the export of coca leaves reached 1 million kilograms (equivalent to over 15 tons of cocaine), overtaking the Peruvian market. Coca does not appear to have been used by the local population and was produced for an export market only (Musto 1998). The situation was different for opium, which became important socially and economically; by 1929

there were over a 1,000 opium dens and 100,000 registered smokers, most being Javanese (McCoy 1991). Prior to the Japanese invasion in 1942, opium could be obtained through a rationing system under Dutch rule (Setyonegoro 1978; Setiabudhi 1996). During the war of Independence an illicit trade of opium for weapons and ammunition was reported (Sidharta 1997).

By the late 1960s heroin, morphine, marijuana, barbiturates, amphetamines and small amounts of cocaine were available and in use in Jakarta and Bali; poly drug use was identified to be fairly common (Widjono 1979; Spencer and Navaratnam 1981; Gordon *et al.* 2000). In the early 1970s the injecting of morphine was reported in several cities, although it was thought to be heroin (Gordon *et al.* 2000; Irwanto 2001a). In 1971, an estimated 2,000 to 3,000 cases of substance dependence were receiving treatment in various hospitals throughout the country but there was no separation in the statistics between those using illicit drugs or alcohol (Yatim *et al.* 1999). In 1985, it was officially reported an estimated 80,000 people abused drugs (UN 1991) and a few years later the figure was 750,000 (Irwanto and Lewis 1988). Research undertaken in rehabilitation centres at the time showed many drug users came from small towns and that they were both from the middle and lower socio-economic classes (Yatim 1999). The late 1980s and early 1990s saw the arrival of amphetamine type substances like ecstasy (commonly brought in from the Netherlands). In the late 1990s crystal methamphetamine (commonly known as *Sabu-sabu*) and heroin (commonly referred to as *Putauw*) have emerged as popular drug choices, while the use of marijuana and alcohol continue to increase (Yatim 1999; Tantoro and Fidiansjah 1999; Gordon *et al.* 2000; Irwanto 2001a).

Current Situation

While Indonesia is not a major producer of drugs (except for marijuana), it has been identified that heroin from South-East Asia (particularly Myanmar) is being smuggled into the country. It is likely that heroin is being brought in from the Golden Triangle, through the extensive coastline, by the Thai fishing fleet (La Depeche 1995; Crofts 1999; Narcotics 2001). Ecstasy is recognised as a major drug of choice, particularly in the urban areas. In 1998, methamphetamine was introduced into Jakarta from the Philippines, and now much ecstasy found in nightclubs is in fact methamphetamine (Narcotics 2001; Irwanto 2001a). There is now an increase in methamphetamine and ecstasy laboratories and these are being discovered producing for domestic consumption and potentially for export (Crofts 1999; Narcotics 2001). In 1998, a clandestine factory discovered 120 litres of methamphetamine liquid, enough for 2.5 million tablets or 120 kilograms of methamphetamine powder (Narcotics 1999). Drug seizures by the authorities are reaching record levels providing some indication of the amount of drugs entering and in use in the country. In 1999, authorities seized 39,000 ecstasy pills from an individual and in 2001, 1.3 tonnes of marijuana was confiscated in a single raid (Green 2001; Narcotics 2001). Following a long tradition marijuana (*Ganja*) is cultivated in Northern Sumatra and Aceh province, with production mainly for domestic consumption (Karamoy 1996; Narcotics 2001).

The subject of illicit drug use and in particular injecting drug use (IDU) was previously an extremely sensitive issue. Poor documentation and data suggested assessments were often very restricted and too problematic for government authorities to openly discuss (Reid and AHRN 1998). This is not generally the case any more, with major assessments taking place and public debate on the issues increasing. The

current drugs used as shown in medical records, rehabilitation centres and rapid situation assessments (RSA) throughout the major cities of the country are heroin, crystal methamphetamine, ecstasy, marijuana, benzodiazepines and the small amounts of cocaine seen in Jakarta and Surabaya. The use of glue as an inhalant is common among street children (Izrizal and Pramudyo 1999; Yatim *et al.* 1999; UNDCP 1999; FHI 1999; Gordon *et al.* 2000; Irwanto 2000; Irwanto 2001a). In 2000, a RSA in eight cities (Jakarta, Bandung, Yogyakarta, Surabaya, Denpasar, Medan, Makasar and Manado) reported the drugs of choice were heroin and crystal methamphetamine, with widespread poly drug use (Irwanto 2001b).

Drugs are reportedly easily accessible from food stalls, shopping malls, beauty salons and University campuses (Gordon *et al.* 2000; Irwanto 2001b). Overdose deaths (some suggested in relation to heroin while others claim as a result of poly-drug use and/or chemicals which cause anaphylaxis) are recorded routinely throughout various hospitals in Jakarta. In 1999, the major referral hospital in Jakarta recorded six drug-related deaths over a single month and it has been suggested currently there is a death per day from drug overdose in Jakarta alone (Djauzi *et al.* 1999; Green 1999a; E. Widjono, personal communication 2001). The number of people arriving at the emergency room suffering from drug overdoses tripled between 1998 and 1999 (MAP 2001).

Since the late 1990s the country has been faced with an unstable political environment. Although the use of illicit drugs is increasing, political conflict, power struggles and widespread corruption are influencing how the drug related HIV/AIDS crisis should be tackled (Irwanto 2001c).

Drug taking practices and risk factors

Ecstasy is normally swallowed as a pill and commonly linked with entertainment venues (Yatim *et al.* 1999). Methamphetamine is commonly sniffed or inhaled and it is suspected injecting is not common practice (determining the latter route is difficult as no known data is available nor have studies on this drug alone been undertaken). Injecting drug use has been on the rise in the past decade currently becoming a normal practice for many drug users (Yatim *et al.* 1999; Tantoro and Fidiansjah 1999; Irwanto 2001; Gordon *et al.* 2000). A survey in two sub-districts in central Jakarta revealed of those aged between 15 and 25 years about 60-70% were using drugs and about 60% of these were IDUs (Djauzi *et al.* 1999). In 2001, an organisation in Bali assessed that of the 670 drugs users they are in contact with, half were IDUs (Reid 2001). In 2000, a RSA reported 30-60% of all institution-based participants were IDU (Irwanto 2001b). The major reasons for the transition to injecting are to save money (the economic crisis has generally seen the price of heroin double from 1998 to 2001), to receive a stronger effect from the drug, and as a result of peer pressure (Setiawan *et al.* 1999; Yatim *et al.* 1999; Gordon *et al.* 2000; Reid 2001; Irwanto 2001b).

The literature available to this review has not revealed the existence of professional injectors; it appears friends inject drug using novices. In 2000, a RSA reported a high prevalence of risky behaviour among drug users. The sharing of injecting equipment was widespread and often took place between two to eleven other drug users (Setiawan 1999; Gordon *et al.* 2000; Irwanto 2001b). The cleaning of injecting equipment properly is either non-existent or generally inadequate among most IDUs:

on average 80% did not clean properly before reuse (Setiawan 1999; Gordon *et al.* 2000; Irwanto 2001b). A recent study found that 61% of the sample never knew how to clean their injecting equipment (Gordon *et al.* 2000). In Bali, a peer education approach with drug users has shown an increase in the practice of cleaning re-used needles with bleach from 0% to 29% (Desembriartista and Mansrianto 2001).

Ministerial Regulations state that needles and syringes are only to be distributed by licensed pharmacies and stores selling health equipment; all sales are officially to list the name and address of the buyer and the licence of practice (for medical professions) (Minister of Health letter no. 195/Menkes/SK/VII/1997, dated 22 August 1997 – C Green, personal communication, 2001). However, in reality such regulations tend to be ignored and injecting equipment is purchased easily without any prescription either from a pharmacy or from unofficial sources such as foodstores and street hawkers (Gordon *et al.* 2000). While there are no legal sanctions against carrying needles, in practice many drug users are fearful of the consequences of discovery of possession of injecting equipment (Setiawan *et al.* 1999; Reid 2001). A further deterrent to the purchase of needles is their price. Currently they are Rs 4,500 to 6,000 each (US\$0.40-0.54), five times greater than before the Indonesian economic crisis (Setiawan *et al.* 1999; Reid 2001).

Prevalence and profile

Drug use is on the rise throughout the country, as far afield as Ternate in the Moluccas and Maumere in East Nusatenggara (Green 1999a). The police have estimated that 130,000 Indonesians are using illicit drugs, based on police records and hospital bed occupations. These figures are strongly disputed by others who claim the lowest figure is 500,000 with drug assessors more comfortable with the figure 1.3 million to 2 million current users. It has been estimated that there are 130,000 drug users in Jakarta *alone* (Tantoro and Fidiansjah 1999; Gordon 1999; Yatim *et al.* 1999; Green 1999a; Irwanto 2001a). The number of IDUs is difficult to determine but it has been suggested there are over a million (Green 2000a). In early 2001 at a workshop held by the Health Department it was assumed that the figure was likely to be 600,000 IDUs, of whom 70% are sharing needles and 15% are HIV infected (F. Silfanus to C. Green, personal communication, 2001). Demand placed upon drug treatment services has increased substantially. In 1996 the Drug Dependence Hospital in Jakarta received 2,000 of both in and out-patients, rising to 9,000 by the end of 1999 (Irwanto 2001a). Data from 2000 tends to be low since many patients now choose to go to other rehabilitation services that are privately managed (Irwanto I, personal communication 2001).

Surveys and drug dependency data report drug users are mostly male with females on average making up 8-20% of the total (Tantoro and Fiiansjah 1999; Irwanto 2001). It has been suggested that in Jakarta up to 35% of IDUs are female (Gordon and Gordon 1999) but verifying such figures is difficult as females are reluctant to self-identify with this behaviour. The age of drug users seems to be decreasing, with most aged 16 to 25 years (60-80%) and many from junior and senior high school (UNDCP 1999; Tantoro and Fidiansjah 1999; Gordon *et al.* 2000; Irwanto 2001b).

The recent RSA in eight cities found that the majority of drug users experimented and used drugs for two to three years before beginning to inject, and that this time frame was decreasing. It also found that 90% of the participants injected at least once a

week with as many as 20% injecting daily. While the majority was sexually active and many had more than one sexual partner, only 10% reported always using a condom; up to 40% reported sexual activity under the influence of drugs (Irwanto 2001b).

By September 2001, 2,313 cases of HIV/AIDS had been reported in Indonesia, and in 449 cases (19%) the recorded mode of transmission was IDU (Ministry of Health 2001). Prior to 2000, HIV/AIDS infection due to IDU constituted less than 1% of the total cases (Jalal *et al.* 1994; Irwanto 2001a). In 1999 sentinel surveillance among IDUs in RSKO, a treatment centre in Jakarta, identified 37 people as HIV positive among a group of 249 IDUs (14.9%). In the follow up survey in 2000 it had risen to 58 HIV infections among 157 IDUs (37%) (C. Green, personal communication 2001). Recent HIV entry testing in a treatment centre in Bogor found 16% of IDUs were HIV positive (Yayasan Kita 2001). In late 2000, in Denpasar, Bali, 187 prisoners at the Kerobokan Prison were tested for HIV; 67 prisoners were known to be IDUs and of these, 35 were diagnosed as HIV positive (56%) with almost all having a history of sharing needles outside the prison (Reid 2001). Recent studies show that 35% to 40% of injectors in treatment in Jakarta are HIV infected (WHO 2001; MAP 2001). The rate of hepatitis C infection among IDUs is much greater, ranging from 60-80% (Irwanto 2001a; Yayasan Kita 2001).

To date 24 of the 30 provinces have reported HIV/AIDS cases (Ministry of Health 2001). As of the end of 1999 an estimated 52,000 adults and children were living with HIV/AIDS in Indonesia (UNAIDS 2000). However, recently it has been reported that the country may have around 80,000-120,000 HIV infections by mid-2001 and that the number of AIDS deaths in 2000 was about 3,000 (Suyudi 2001; WHO 2001; MAP 2001).

Government responses to illicit drug problems

In 1999, the Indonesian Parliament outlawed psychotropic drugs including ecstasy, and imposed penalties of up to seven years imprisonment for marijuana possession and a maximum of 20 years for marijuana trafficking (Narcotics 2001). Convicted heroin traffickers are receiving 8-17 years, but considering the low salaries of police officers it is easy for bribery and corruption to allow traffickers to be freed (Narcotics 1999). While the death penalty was imposed in 1983 upon traffickers it has rarely been used (La Depeche 1995). In 2000, a Frenchman was sentenced to death for smuggling 3.85 kilograms of hashish into Bali (an act that violates Article 82 of the 1997 law on psychotropic substances). Up to 10 people in 2000 already had been sentenced to death for possession and smuggling drugs but currently none have been executed (Russell 2000).

In the provisions of the law only the maximum penalty is specified, which may be up to the death penalty. Consequently, the minimum penalty could be very lenient. Many people believe that those caught trafficking drugs usually receive a minimum penalty that may result in days or months of imprisonment and a minor fine (Irawanto I, personal communication 2001).

Government response to drug use and HIV

There are virtually no information, education and communication (IEC) materials made available to IDUs by government; there is at least one prevention brochure issued by the National AIDS Commission/AusAID. There are no needle and syringe programs (NSP) in the country sanctioned by government officials and there are no known organisations supported by the government implementing peer education programs for IDUs. Consideration of harm reduction concepts by the government is difficult but there has been, in recent years, a series of introductory courses on the topic attended by government officials from various sectors. In 1999, the Ministry of Health with the National Narcotics Board provided informed support for a group of international donor agencies in Indonesia to conduct a RSA among drug users to assist the government in identifying the extent of the drug use problem in relation to HIV/AIDS (Burrows 2000).

A reported pilot study of methadone substitution therapy is currently in the planning stages for a Jakarta hospital. An application has also been put forward to use buprenorphine for substitution therapy and, if approved, will be implemented at the RSKO treatment centre in Jakarta (Health Department 2001; C. Green personal communication 2001).

In 1972 the Drug Dependency Hospital (RSKO) was established in Jakarta and remains the one and only specialised hospital of its kind in the country (30 regular and three VIP beds). The Department of Health has announced that mental hospitals and psychiatric departments of general hospitals throughout the country are to provide beds for those with drug dependency problems (Yatim *et al.* 1999). The number of beds currently available has not been able to be determined but it has been estimated that around 2,000-3,000 patients are admitted annually to various public hospitals for which fees are charged.

The Department of Social Affairs through its residential home approach implements what is termed *Panti Sosial Bina Remaja* (probably best translated as 'Juvenile Social Rehabilitation Institution') in several provincial cities for young drug users. The police have rehabilitation centres for juvenile delinquents and young drug users but details of how many and how they operate have not been able to be determined (Yatim *et al.* 1999).

National AIDS Policy

The Indonesian National AIDS strategy was developed in 1994. While still referenced in a number of government documents it has not been updated, and is likely to be now out of date in relation to addressing the changing situation of drug use and HIV/AIDS vulnerability. While it does mention IDUs as a primary group needing to be reached through the implementation of IEC prevention activities, there is no evidence to show this has happened. In no part of the document is there any specific mention of any policy on drug use and HIV (Ministry of Health 1994; Tantoro and Fidiansjah 1999).

Non-government responses to drug use and HIV

Coordination of community activities for the government is undertaken by the non-government organisation (NGO) called BERSAMA. While it is considered to be the

umbrella NGO for all activities related to drug using issues, no NGO is compelled to acknowledge BERSAMA in this role (Irwanto 2001a). The organisation *Yayasan Hati-hati*, founded in Bali in 1998, undertakes a broad harm reduction approach addressing the many needs of all drug users. The organisation conducts outreach using the peer education model (employing both users and ex-users), basic primary health care, a small-scale detoxification program and vocational training for its clients. Currently discussions are occurring with government and public health authorities to implement a NSP (Reid 2001).

In recent years private rehabilitation centres have grown in great number, particularly in Jakarta, while other cities have seen a few being developed. Many centres *claim* to be detoxification centres, recovery centres, therapeutic communities and behaviour modification institutions. While it is appropriate to have a diversity of approaches it is likely many involved in such operations have little understanding of the complexity of addiction nor are many focused towards HIV prevention (Gordon and Gordon 1999; Gordon *et al.* 2000). In 1999, in the Greater Jakarta area there were 10 private institutions caring for drug users; this increased to 40 in 2000 (Irwanto 2001a). With an economic crisis impacting upon the country, and drug using problems on the rise, the anticipated profits associated with running such institutions cannot be ignored as a motive for their establishment. The costs of seeking treatment from the majority of private centres is generally well beyond the means of most drug users in the country (D. Gordon personal communication 2001).

There are also several religious institutes that provide therapy and rehabilitation for drug users. The best known, established since the 1980s, is called *Pesantren Suryalaya* located in West Java. In East Java there is *Pesantren Tebu Ireng*. Both use an Islamic approach. There are also several Christian organisations implementing similar approaches. In recent years private community foundations have been forming collaborations with government mental hospitals (Yatim *et al.* 1999). Currently there are more than 30 mental hospitals throughout the country being mobilised to form links with community groups to respond to the drug using and potential HIV problems (Green 2000a).

Estimated number of drug users	1.3 million to 2 million
Estimated number of IDUs	Over one million
Drugs that are used	Heroin, methamphetamine, marijuana, ecstasy, cocaine, benzodiazepines, glue as inhalant.
Drugs that are injected	Heroin, methamphetamine, benzodiazepines
Estimated number of HIV infections among IDUs	In 2001, 19% of total HIV infections associated with IDU.

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Iran (Islamic Republic of)

History

Opium use has existed in Iran since the 17th century and for centuries the country was an important opium producing and distributing centre (Moharreri 1978; Spencer and Agaho 1990-91). Royal orders for the restriction of drug use are documented as far back as 400 years ago (Razzaghi *et al.* 1999). By the 1920s the size of illegal opium sales inside Iran, together with its contraband trafficking to other countries, amounted to about 100 tons a year (Kerimi 2000). It was not until the mid 20th century that opium addiction became a serious concern with an opium using population believed to be second only to China. In 1949 it was estimated that 11% of Iranian adults were drug users, that is 1.3 million opium addicts. During this period, Tehran had an estimated 500 opium dens (McCoy 1991). In 1955, Iran introduced its first laws against the cultivation and use of opium and consequently production and exports of opium dropped sharply (Spencer and Agahi 1990-91). This ban remained in place until 1969 by which time opium users numbered 350,000 and consumed an average of 240 tons of opium each year (McCoy 1991). In 1969 the government permitted limited and supervised cultivation of opium. At the same time they initiated a nationwide opium maintenance program for people 60 years and older for whom detoxification was not advisable due to various chronic diseases. By 1972, Iran's drug addicted population had grown to 400,000 of whom 105,000 were registered opium smokers. In 1975 it was reported there were 30,000 heroin users (Moharreri 1978; McCoy 1991).

From 1974 to 1977 a major detoxification program operated throughout Iran. Its emphasis was on out-patient treatment and it served around 30,000 out-patients (Spencer and Agaho 1990-91). To reduce a drug user's habit, coupons for opium tablets for two to three months were provided or methadone treatment was made available (Razzaghi *et al.* 1999). In 1978, a survey from the National Iranian Society for the rehabilitation of the Disabled showed 94% of registered addicts used opium while 50% of non-registered drug users mentioned heroin (Dalvand *et al.* 1984). Soon after the Islamic Revolution in 1979, there was an upsurge of drug use, with official sources suggesting 5% of the population was drug-addicted, possibly as many as two million people. At the same time, public health services for treatment were closed for the next few years (Razzaghi *et al.* 1999). By early 1980, a severe anti-drug campaign was introduced which involved the extensive use of the death penalty for drug trafficking (Dalvand *et al.* 1984; McCoy 1991). A survey conducted among Iranian adolescents during the early 1980s showed opium was the drug of choice followed by cannabis and heroin (Spencer 1985). Throughout the 1980s and 1990s the courts were sending drug users to mandatory treatment and rehabilitation centres or to prisons. In 1994, Iran developed out-patient treatment centres in all 28 provinces and supported the development of Narcotic Anonymous (NA) and other self-help groups. Since the late 1990s the law has allowed treatment-seeking drug users to be exempted from penal punishments (Razzaghi *et al.* 1999).

Current Situation

Iran, which borders the largest opium producing country in world, Afghanistan, has become a major bridge linking the drug production zone to the lucrative consumer

markets of the Persian Gulf, Turkey, Russia and Europe. (Narcotics 1998; Narcotics 2001; Drug Control Headquarters (DCHQ) 2001). Before the Islamic Revolution in 1979, Iran had up to 33,000 hectares of opium under cultivation but by 1993 it was estimated at 3,500 hectares (Narcotics 2001) although such a large amount is hotly disputed by Iranian authorities (Mehryar, A. personal communication 2001). Following an examination of over one million acres in traditional poppy growing areas in 1998/1999 the amount of opium cultivation is negligible, although in the more remote parts of the country it still may occur (Narcotics 2001). Currently the major trafficking routes into Iran can be found in the provinces of Khorassan, Sistan and Baluchestan, areas with harsh climatic conditions and rugged mountainous terrain. In these areas there are numerous border skirmishes with drug smugglers and in 2000 a total of 1,532-armed confrontations occurred. In the last two decades more than 3,000 law enforcement officials have been killed and 10,000 disabled. In 2000, 142 law enforcement personnel and 904 drug traffickers have been killed in armed clashes (UNDCP 2000; NDCR 2001).

According to UNDCP, 90% of the worldwide morphine and opium seizures occur in Iran. In 2000 a total of 254,271 kilograms (kg) of different types of narcotics were seized throughout the country. This included heroin (6,189 kg), morphine (20,275 kg), opium (179,053 kg), hashish (31,581 kg), Acetic (15,678 kg) and others (1,495 kg). Over the past 10 years drug seizures have increased with each passing year (NDCR 2001). It is believed that opium stocks in Afghanistan in the past two years have reached record levels so a continuation of large amounts of narcotics flowing into the country is likely. Recent studies have shown that the average revenue gained from opium cultivation in Afghanistan is 15 times higher than for wheat and as a result of poverty, political instability and warring factions the growing of opium will continue to be attractive (Narcotics 1998; Drug Control Headquarter 2000a; Narcotics 2001).

In 1998/1999 a rapid situation assessment (RSA) at ten major urban sites where 1,472 illicit drug users were interviewed was undertaken. It showed the most commonly used drugs during the last month of the interview was opium (73.3%), followed by opium residue (21.9%), heroin (39.4%) and hashish (12.6%). The life time use of heroin among drug users is high in places such as Kermanshah (70%), Khoransan (62.7% and Tehran (60%). The use of codeine containing syrups and analgesics purchased from pharmacies has also been reported (Razzaghi *et al.* 1999). Drug use is on the rise in Iran and the country is increasingly vulnerable. Iran is the most populous country in the region with 45% of its population under the age of 14 and 26% aged between 15 and 30 years old. Unemployment levels are estimated to be 14% (about 6 million people) and the per capital income has dropped sharply. In recent years there have also been increases in internal migration, urbanisation, crime and social problems: ingredients that can foster vulnerability to the risk of drug use (Razzaghi *et al.* 1999; UNDCP 2000; Iran News Daily 2001).

Drug taking practices and risk factors

The traditional practice is that opium (*thariac*), opium residue (*shire and sukhte*) and cannabis (hashish) are smoked in opium pipes. Opium is also swallowed and commonly dissolved in tea and coffee. From the 1930s to the 1950s drinking opium in tea and coffee shops was common but these practices are now heavily penalised, ensuring this is no longer the case. A small proportion of drug users have been known to dissolve opium or the opium residue (blackwater opium) for injecting (UNDCP

2001). Heroin is smoked, snorted and injected. In Iran the heroin is usually dissolved with citric acid or drops of lemon juice to form an injectable solution. When opium, or opium residue, is injected an aqueous solution is prepared by heating the substance in a cooker and then drawing it into the syringe using cotton wool as a filter. The RSA study found that most injecting is intravenous, using the veins of the arms and legs and the deep veins of the groin. Inside the prisons the injecting equipment consists of frequently used needles, hand-made needles (pumps) and droppers. The study found injecting is much higher than previously believed and that IDU was prevalent, to varying extents, in all urban sites under review. Drugs are commonly bought from street dealers and ethnographic studies show that deserted buildings, gardens or parks in the suburban areas of cities are common sites for using drugs. Opium tends to be used in the privacy of people's homes and hashish is commonly used at parties, rolled as a cigarette and smoked (Razzaghi *et al.* 1999).

During the past two decades, partly as a result of serious law enforcement policies after the revolution, the drug culture has changed. Illegal alcohol use was attacked with more fervour than drug use and government authorities were often reluctant to talk frankly about the emerging drug taking patterns and practices among some sectors of society (York 2000; Narcotics 2001). Polydrug use occurs and the RSA study showed 60% of the respondents used one drug while the rest used more than one substance. The majority (96.2%) used drugs more than once a day. The reasons given for switching to injecting was that the opium was not giving the desired high, that opium was becoming too expensive and unavailable and that heroin was cheaper and easier to get on the streets (Razzaghi *et al.* 1999). In 2000 it was reported that a gram of heroin could be bought for about US\$3-4 (York 2000).

Pharmacies are the most common places to buy needles and syringes (Razzaghi *et al.* 1999) and can be purchased without a prescription. Needles and syringes (particularly those for injecting insulin) are easily accessible at a relatively cheap price. Locally produced needles and syringes cost about 160 Rials (US\$0.9 cents). The average daily wage for a manual labourer is about 32000 Rials (about US\$4.00) (A. Mehryar personal communication 2001). In 1998 an RSA showed that of the respondents injecting drugs (N= 323) nearly half reported sharing their syringes and needles. Seventy per cent of those recruited from the streets were sharing needles. Among all the respondents injecting, up to 88% claimed to use some sort of cleaning technique: the methods included wiping with fingers or cloth, using saliva, plain water and hot water. Overwhelmingly the techniques were inappropriate to protect users from viruses such as HIV/AIDS (Razzaghi *et al.* 1999). Inside the prisons sharing is extremely common and the head of the Welfare Organisation reports that the cost of a syringe, which has been used perhaps more than 30-40 times, is 2,000 to 3,000 tomans (around US\$2.50) (Iran News Daily 2000).

Prevalence and profile

In 2000, there were over 269,259 drug offenders including 121,742 drug smugglers, 144,478 drug addicts and 2,939 foreign national arrested for drug law violations. Seventy-five per cent of those arrested were for opium related crimes; among these 3% were women. In 2000 there was an 18% growth in the total number of drug related detainees (compared to 1999). The highest rate of arrests of the 28 provinces occurred in Tehran (29%) (DCHQ 2001). Over the past 20 years up to 1,700,000 people have been imprisoned due to drug charges (State Welfare Organisation 2000).

Estimates of the number of drug users come from various sources. Mandatory drug screening occurs before marriage, government jobs and obtaining driving licences. In 1998, 1.3% of all people tested for drug use under the category of marriage and government jobs (n = 768,525) were found to be positive for opium use. Many who are screened by this method are aware of the implications of a positive test so the chances of under estimation are high (Razzaghi *et al.* 1999).

The government of Iran estimates the number of drug addicts at over 1.2 million with an additional 600,000 drug users. However, National AIDS experts have estimated there are up to 3.3 million drug addicts (defined as repeated and continuing drug use over a nine month period) (Wodak 1997; Narcotics 2001). Estimates suggest 200,000 people inject drugs daily with an additional 300,000 injecting weekly or fortnightly (Wodak 1997). In 2001 the estimated number of IDUs in the country ranged from 200,000 to 300,000 and this figure is rising as result of shifting drug trafficking patterns and the increased availability of heroin (Iran News 2001; MAP 2001). In some cities along major drug trafficking routes it has been estimated that 10% of the population are drug users (Moore 2001). In Tehran, with a population of 12 million, it is estimated there are about 240,000 drug users but this figure is considered far too low. Estimates as to the quantity of drugs consumed in Iran are difficult to gather but in 2000 experts in drug control suggested it was likely that 730 tons of opium was consumed annually although others have suggested it is much greater (Hamshahri 2000).

The RSA study of 1998/1999 showed that most drug users were aged between 20 and 40 years (68%) and of these 20% were aged between 25-29 years. Most are male (93.4%) although many experts believe drug use among women is rising dramatically and is under-estimated. Over half are married (56.7%) and most live with their families (94%). The respondents who were in prison were distinctly younger and their unemployment rate was higher. Most respondents (80%) are employed, mainly as labourers. The average cost of a drug habit for a user is about half of his average monthly earnings of about RI 400,000. Similar characteristics have also been found in another study among users at an out-patient treatment facility (Razzaghi *et al.* 1999; Ahmadi and Ghanizadeh 2000; Moore 2001).

In 2000, drug users constituted more than half of the prison population and the number of inmates incarcerated for drug related crimes was 80,415 (DCHQ 2001). Eighty per cent of prison authorities acknowledged that drug use took place inside prisons although not at a great rate (Razzaghi *et al.* 1999). Among the IDUs participating in the RSA study, 72.7% had a history of imprisonment compared to 36.3% among the non IDUs. The mean age of initiation into drugs among IDUs was 20 years and the mean age for starting IDU was 26 years. As a general rule, IDUs in Iran do not seem to be as young as IDUs in other countries. Just fewer than 50% of IDUs were found to have a history of drug use in the family, only slightly more than that found among non-IDUs (Razzaghi 2001).

Deaths as a result of drug use have been on the rise in recent years. In 1996 it was 717 people, and in 1997 it was 788 (DCHQ 1998). By 2000, this figure had risen to 1000 people throughout the country (State Welfare Organisation 2000).

The first AIDS case was identified in 1986. The cumulative total to late 1997 was 1,297 cases of HIV infection and 192 cases of AIDS (Wodak 1997). The Iranian

National Committee on AIDS has reported a cumulative total of 1,953 HIV/AIDS cases by April 2000 (Prevention Department 2000). As of July 2001 there were 2,458 reported HIV infections and 357 AIDS cases (MAP 2001). However, in 1999 it was estimated 25,000 people in Iran were HIV positive (Khah 1999) while in the same year the Ministry of Health estimated there were 60,000 people infected with HIV or AIDS (Prevention Department 2000). In 2001 of those people infected with HIV, 1,841 were identified as drug users with IDU the source of transmission (74.8%) (MAP 2001). Many of those people who had HIV were identified in prisons or had been to prison. HIV infections were detected among IDUs in two prisons in 1996; at this time 29% of injectors were found to be HIV infected. By 2001, HIV infection was found in IDUs in 10 prisons and at one prison the prevalence reached 63%. At the treatment centres the prevalence of HIV among IDUs was found to be 12% (MAP 2001). Identified cases of HIV/AIDS in low risk groups is as low as 1/160,000 but among IDUs it is reported to be as high as 1/81 (Prevention Department 2000). This prevalence rate among IDUs is high and as this group remain underground caution is required in accepting this figure (Mehryar A., personal communication 2001).

Government response to illicit drug problems

The Anti-Narcotics Law of 1988 covers all aspects of drug control including cultivation, production, consumption, sales and distribution. In 1997 this law was amended in order to be more responsive to the internal drug problem. The age of criminal responsibility is 16 years (UNDCP 2000). The possession of smuggling of opium and cannabis of up to 50 grams can result in a fine of 4 million rials and up to 50 lashes. The penalties become harsher according to the amount that is found on the person. The death penalty may be commuted to life imprisonment and 74 lashes if the quantity does not exceed 20 kg and the perpetrator did not succeed in smuggling/distributing/selling (DCHQ 1997). The execution of drug offenders is usually limited to drug lords, organised drug criminals and armed drug traffickers (DCHQ 2001). Anyone who deals in, puts on sale or carries heroin or morphine is sentenced to various punishments, for example for more than five centigrams to one gram the fine is two to six million rials in cash plus 30 to 70 lashes (DCHQ 1997).

Drug addiction is considered a crime but the authorities are ready to consider drug use as a medical problem. Drug users who are undergoing treatment are not meant to be persecuted, nor are the specialists offering treatment. The costs of diagnoses, treatment, medicines and rehabilitation are to be paid by the addicts according to the approved tariffs but the government will finance the costs for those unable to pay (DCHQ 1997). It is up to the judge to distinguish whether the person is an addict or a trafficker; a positive test to opium shows the person was an addict while possession was interpreted as being a trafficker (Razzaghi *et al.* 1999).

The State Welfare Organisation, affiliated to the Ministry of Health is in charge of treatment and rehabilitation of drug users. Up until recently there were 12 treatment and rehabilitation centres in the country with one centre for women. Until 1998/1999 an estimated 25,000 to 30,000 people were referred to these centres and 90% of these admissions were a result of court orders. The average duration of stay is two to six months. The centres were described as having the infrastructure of an overcrowded prison. These centres have now been closed and the new approach is the introduction of outpatient treatment centres (Razzaghi *et al.* 1999). In 2000, the number of outpatients centres in provincial capitals was 100 compared to 65 centres in 1999 and 40

in 1998. During 2000 it was anticipated that the treatment centres could offer services to over 100,000 volunteer addicts per annum. Treatment is generally modelled on medical detoxification using clonidine, phentiazines or other tranquillisers. The duration of treatment varies between three and six months and includes individual counselling, group therapy and family therapy. In addition the therapeutic community program model is currently being endorsed and preparations are under way for the establishment of nine such centres to offer these services. Duration of treatment may be from three months to two years. There has also been the development of self-referring and Narcotic Anonymous centres with an estimated 5,000 members throughout the country (Razzaghi *et al.* 1999; DCHQ 2001; Moore 2001). Relapse rates are believed to be between 60% and 80% depending on the site and duration of follow up but hard data is lacking (Razzaghi *et al.* 1999).

Government response to drug use and HIV

The majority of people who have become HIV infected are IDUs: this is due to widespread sharing of contaminated needles and syringes. In the 1998 RSA, up to 20% of the respondents had not heard of HIV/AIDS and over 20% to 30% of the respondents who had heard of AIDS did not know it could be transmitted through the sharing of injecting equipment. It appears there are scant HIV prevention programs in place among drug users or drug injectors in Iran and what is available is unlikely to be specific and/or explicit about the ways to avoid becoming HIV infected. It has been reported that there are no printed materials on HIV/AIDS for drug users (Razzaghi *et al.* 1999) and drug users are a hidden population and difficult to gain access to. Efforts to distribute needles and syringes to imprisoned drug users has met with strong objections (Mehryar A. personal communication 2001).

In recent times however, harm reduction pilot programs have been introduced in the three provinces most affected by injecting drug use (Kermanshah, Shiraz and Tehran) and the Ministry of Health has initiated these. The programs occur at outpatient clinics and also incorporate services for HIV infected patients (counselling, clinical management, antiretrovirals, laboratory tests and social support). There are no fees for such services. For IDUs there is counselling, methadone treatment and needle exchange. The clinic in Kermanshah attends to 700 clients per month and of these 150 are on methadone and about 50 use the needle exchange service. This pilot program presented its findings to the cabinet and the president in mid 2001 and has been warmly received. As a result of the findings the program is to continue and be expanded. Plans are now under way to extend the harm reduction program to 15 more clinics in 2002 (MAP 2001). Information on how long a client is maintained on methadone treatment is unavailable.

National AIDS Policy

Although a policy does exist, and HIV infections are highest among IDUs, the coordination of activities between the NAP and the National Drug Control Headquarters is generally lacking. Brochures have been prepared for schools and families on the issues of HIV/AIDS but none have specifically been produced for drug users. The main focus of the policy appears to be to control the nation's blood supply and the prevention of HIV transmission through medical injections (Mehryar A. personal communication 2001). Specific mention and/or activities aimed at drug users has been omitted.

Non government responses to drug use and HIV

In recent years a number of treatment facilities have been established by the private sector and are openly advertising in the press. The qualifications of the people running these clinics, and the outcomes of their activities, still remains largely untested (Mehryar A. personal communication 2001). There are three leading NGOs in the country involved in drug prevention, treatment, counselling, support for families and public awareness raising: the Drug Control Community, Aftab Society and POD International. NGOs dealing in drug prevention, treatment and rehabilitation are new to Iran and it is likely it will take some time before they can build up the capacity to effectively deliver the broad based services needed (Razzaghi *et al.* 1999). There are no known NGOs involved in harm reduction activities.

Estimated number of drug users	1.8 million to 3.3 million
Estimated number of IDUs	200,000 to 300,000
Drugs used	opium, opium residue, heroin, hashish, codeine
Drugs injected	blackwater opium, heroin
Estimated number of HIV infections among IDUs	1,841 IDUs infected with HIV, or 74.8% of all HIV infections are IDUs

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Japan

Comparisons: 1997 Versus 2001

Japan remains one of Asia's largest consumer of methamphetamines which is its most popular illicit drug. Alcohol is still the most frequently used drug. In 1997 the methamphetamines came from China and Taiwan, in 2001 Hong Kong and the Philippines have joined the list. Drug users tend to inject the methamphetamines and some use foil paper vapour, heroin and diazepam are also injected. The most commonly used drug by teenagers is organic solvents. In 2001, IDUs are generally still unable to purchase needles and syringes from pharmacies and studies continue to report high levels of needle and syringe sharing, little cleaning of injecting equipment and, where this does take place, inadequate methods are used.

In 1997 arrest statistics suggested there were 400,000 to 600,000 methamphetamine users in Japan with 150,000 to 500,000 being IDUs. In 2001 the figures are similar with the addition of estimates of 2.18 million casual users of methamphetamines. The prevalence of HIV among drug users in Japan in 1998 was 0.1% and remains about the same in 2001. In 1997 the cumulative total of HIV positive people was 4,200 (14 of whom were IDUs); as of the end of 2000 it was 5,313 (23 of whom were IDUs). Forty one per cent of HIV positive people are haemophiliacs who became infected through contaminated imported blood supplies.

The IDU community has not yet been exposed to HIV but Hepatitis C is significant due to the high rate of needle and syringe sharing. This suggests a high potential for HIV spread once the virus enters the IDU community. The government concentrates on supply and demand reduction with no harm reduction programs in place. There are strict penalties for drug possession and trafficking but few drug treatment programmes, no needle and syringe or methadone programmes and HIV prevention campaigns have minimal focus on drug users.

History

The use of drugs in Japan can be traced to the fifteenth century and was restricted to opium-based narcotics. Official drug policy began to form during this period because many Japanese knew that opium addiction was used to undermine China's economic, political and social infrastructure. By the seventeenth century the government prohibited opium smoking and its non-medical use. The nineteenth century saw a strengthening of anti-drug policy: for example the 1897 opium law made the sale and manufacture of opium a government monopoly and punished violators with seven years imprisonment (Vaughn M. *et al.* 1995).

Before the second world war Japan had a fairly insignificant drug dependence problem due to its isolation, the strict anti-drug laws and negative public opinion about drug use (Vaughn M. *et al.* 1995). However, at the same time, Japan became deeply involved in the opium trade in China and Japanese pharmaceutical firms manufactured large quantities of heroin and cocaine for distribution in occupied China. Japan's double policy of forbidding illegal drugs at home while promoting them abroad changed during WW11 when the imperial government started to produce stimulants for Japanese soldiers and factory workers involved in the war effort (Spencer and Navaratnam 1981; Vaughn *et al.* 1995).

After the war, methamphetamine use became common. At its peak, in 1954, between 550,000 (Tamura M 1989; Suwaki H *et al.* 1997) to 2,000,000 (Brill H. *et al.* 1969) people were estimated to be using methamphetamines. The precipitating factor was

the sudden dumping of large stocks of war-surplus methamphetamines on the market at a time when civil control was disrupted by the events following the close of WW11. In 1949 the Ministry of Health prohibited the production of stimulants in tablet or powder form but stimulants in liquid form, used for injection, were not covered by the prohibition. Consequently, injecting, which had been uncommon, became a major method of stimulant use (Tamura M. 1989). The methamphetamines, known as 'Philocon' came mainly in ampoule form, were taken by injection and were available without a prescription. They were aggressively marketed with the slogan "fight sleepiness and enhance vitality" (Suwaki H. *et al.* 1997). As the drug laws were strengthened (the Stimulant Control Law 1951/1954) and massive public education campaigns initiated, the use of the drugs declined. By 1957 there were relatively few drug cases. However, Japan did not return to its previous virtually drug free status: as amphetamine use declined there was a sharp rise in heroin dependence. In the 1960s it was noted that a large proportion (40%) of heroin cases had previously been using methamphetamines (Brill H. *et al.* 1969). In 1961 there was an estimated 40,000 heroin addicts (Spencer and Navaratnam 1981).

In the late 1960s the abuse of solvents reached epidemic proportions: it continues today in the form of sniffing glue, paint thinner and gasoline (Vaughn M. *et al.* 1995). Since the early 1970s a second epidemic of methamphetamine use has developed on a large scale (Nakatani Y. 1989). Cannabis use has also increased. Stimulants, both legal and illegal, are much in demand although it appears Japan did not experience the narcotic epidemic that swept most of Europe in the 1980s (Vaughn M *et al.* 1995).

Current Situation

Although Japan is not a major producer of drugs, it has one of the largest methamphetamine markets in Asia with 10 to 20 metric tons of imported methamphetamine consumed in 2000 (Narcotics 2001). Most of the methamphetamine smuggled into Japan is believed to have been refined in China, Taiwan, Hong Kong and the Philippines. Illegal methamphetamine arrives through a scattering of seaports from Hokkaido to Yakushima Island (Suwaki H.1991; Narcotics 2001). Japanese law enforcement officials have made record seizures in the last couple of years: to November 2000, 713 kilograms of methamphetamines were seized and also 50,000 dosage units of MDMA 'ecstasy' and 40,000 tablets of LSD (Narcotics 2001). Methamphetamines are the major item smuggled into Japan: in spite of the availability of heroin from South-East Asia the demand is not very large (Tamura M. 1989). Japan is regarded as a major money-laundering centre and narcotics-related money laundering is of concern. Approximately 90% of all drug arrests in 2000 were for methamphetamines (Narcotics 2001).

Japan does not cultivate or manufacture controlled substances but it is a major producer of 60 types of precursor chemicals that have legitimate industrial uses, for example ephedrine. Ephedrine is strictly controlled under Japanese law and the penalties for importation are almost as severe as for methamphetamines (Narcotics 2001). Methamphetamines can be prescribed for the treatment of narcolepsy, depression and hyperactivity but physicians are obliged to report their use of the drug in detail (WHO 1996). While methamphetamines are by far the most popular illicit drug, alcohol is the most frequently used drug in Japan (Wada K. *et al.* 1999).

Most drug users buy their drugs on the street, at a park or near railway stations: mobile phones are often used to set up transactions at designated public places. The drugs are usually taken at home or at a friend's apartment. One report suggests the dealers are often foreigners (Hayashi M, personal communication 2001).

Drug taking practices and risk factors

Studies show that the drugs most often used by teenagers in Japan are organic solvents, which can lead to other drug use: a recent survey found that 33% of methamphetamine users had inhaled solvents before embarking on methamphetamines. While solvents are generally inhaled, injecting is the preferred route for taking methamphetamines (Wada K. *et al.* 1999). A 1999 study of drug dependent patients admitted to medical care institutions reported very high injecting drug use and needle/syringe sharing rates; over 86% had shared needles and syringes and up to 71.1% had injected in the past twelve months. In the same year, a study amongst non-hospitalised IDUs reported 88.6% had been injecting drugs (Wada K. *et al.* 2000). A 1996 survey of a similar group reported that 70% used no cleaning technique for their needles and syringes. Of those who did most methods proved inadequate. Up to 26% had trusted water to effectively clean the needle before sharing and less than 4% used alcohol or boiling water. The use of bleach appears to be non-existent. Many found locating clean injecting equipment difficult (26%) or the desire to inject immediately was so strong that there was not time to find clean injecting equipment (23%). Less than 4% of the IDUs in the survey found that injecting equipment was too expensive (Wada 1997).

In Japanese law needles and syringes cannot be purchased from pharmacies and/or from hospitals. The exceptions are for those who can prove that they are either an insulin-dependent diabetic or a haemophiliac requiring a specific blood product and a prescription is usually required. Most of these people obtain their injecting equipment from doctors or other health staff. Drug users usually obtain their injecting equipment freely when they purchase drugs. A needle and syringe costs approximately 6-7 Japanese yen (approximately US\$0.07- 0.08 cents). The figure of 6-7 yen is the cost to hospitals when purchased in bulk at wholesale prices. It has been reported that there are no paraphernalia laws dealing with possession of needles and syringes (Hayashi, M., personal communication 2001; S. Yasushi, personal communications 2001).

Prevalence and profile

Japan is an industrialised country with an estimated population of 127 million with 58 million in the 15-49 year old age group (WHO 2001). Authorities believe there are an estimated 600,000 addicts and 2.18 million casual users of methamphetamines in Japan (Narcotics 2001). Of the 600,000 addicts, 150,000 to 500,000 are estimated to be injecting drug users (Sankary *et al.* 1997). A 1991 survey of HIV/AIDS risk behaviours among Japanese found that 0.9% of adults residing in five major cities in Japan had used stimulant drugs, cocaine, heroin or some other drugs. This calculates to roughly one in every 100 adults having used drugs with four in every 1,000 having used injections (Munakata T. *et al.* 1996). The first national general population survey on drug use in Japan found that life-time prevalence of solvent use, cannabis use, methamphetamine use cocaine use and heroin use in 1995 were estimated as 1.4%, 0.4%, 0.3%, 0.07% and almost 0% respectively (Wada K. *et al.* 1999).

A Ministry of Health profile of stimulant users reports that 50% are unemployed, 15% construction workers and 4% professional drivers. Nearly 50% of users are in their teens and twenties, 26.8% are in their thirties and 15.6% are in their forties. The ratio of male to female users is 5 to 1 (ATS workshop 1998). Forensic autopsy data in the southern part of Osaka found methamphetamine was detected in 646 people over a five year period between 1994 and 1998. The majority died not from overdose but from accidental traumas (Zhu B.L. *et al.* 2000).

HIV prevalence among drug users in Japan appears to be low at just 0.1% (Wada K. *et al.* 1999; Kihara K. *et al.* 1999). The first HIV positive injecting drug user (IDU) was reported in 1989 (Miyazaki M. *et al.* 1994). Since 1993 IDUs have been sampled nationwide on a voluntary basis from those arrested and inpatients at drug treatment hospitals: this is estimated to cover 20% of IDUs.

Some reports suggest that the number of people with HIV in Japan has continued to increase but the number of AIDS cases is slowing (Matsuyama Y. *et al.* 1999). HIV/AIDS surveillance has been operating since 1984. While HIV testing is available throughout the country, and is largely free, the detection rate of HIV is generally believed to be low (Inoue K. *et al.* 2000). The first case of AIDS in Japan was reported in 1985: the estimated deaths from AIDS in 1999 was 150 people (UNAIDS 2000). The estimated number of adults and children living with HIV/AIDS at the end of 1999 was 10,000 people. Japan continues to report HIV prevalence rates below 1% for most population groups except among female sex workers of foreign nationality (2.7%). Most reported cases in the early phases of the epidemic were due to HIV-infected blood products that had been imported for the treatment of haemophilia patients (WHO 2001). The high percentage of haemophiliacs (just under 41.6%) is still the distinctive characteristic of HIV in Japan which is not observed in other countries. A third of the AIDS cases (33.3%) reported in 1998 were haemophilia patients (WHO 2001).

Heterosexual transmission now seems to be the main cause of transmission of HIV. In 2000, 78% of newly diagnosed HIV infections appear to have been acquired through sexual contact (WHO 2001). Studies show low condom use among sex workers (UNAIDS & WHO 2000). Until recently the ban on oral contraceptives meant many Japanese used condoms to prevent pregnancy but there is concern about the spread of STDs, including HIV, if the pill becomes the favoured method of birth control (Inoue K. *et al.* 2000). Cases from intravenous drug use or vertical transmission are very small (Kamakura M. 1997). The largest number of HIV/AIDS cases are in Tokyo. By 2003 it is estimated that the number of HIV infected people in Japan will be 15,400 and 3,300 will have AIDS.

The methamphetamine user community has not been exposed to HIV because of its closeness and the low prevalence of HIV in the general population in Japan (Wada *et al.* 1999). However, Hepatitis C appears to be a significant problem among methamphetamine users in Japan due to the high rate of needle and /or syringe sharing and this suggests a high potential for the spread of HIV/AIDS once the virus invades this population (Ministry of Health and Welfare 2001). A study conducted at a drug and alcohol treatment centre in Chiba, an area which borders Tokyo, found the seroprevalence of Hepatitis C was 53.8% for methamphetamine-dependent patients, 18.4% for solvent-dependent patients and 5.6% for alcohol-dependent patients. A history of syringe sharing was reported by 87.2% of methamphetamine-dependent

patients (Wada K. *et al.*1999). A high percentage of Hepatitis C has been found among people with tattoos which are popular among drug users. The presence of a tattoo suggests a current or past close relationship with an organised gang, or “Yakuza”, in Japan. In Yakuza society those breaking the rules of the gang are also often punished by self-amputation of their own finger joints. In the above study 20.5% of methamphetamine-dependent patients reported self-amputation of finger joints (Wada K. *et al.*1999).

Government responses to illicit drug problems

Law enforcement agencies continue to combat the importation and distribution of methamphetamine by imposing strict sentences for drug violations (Suwaki H. 1997). In 1982 the Toxic Substance Law was revised and using and carrying organic solvents without legal permission became punishable (Baasher T. 1990). In 1997, 19,722 people were arrested for methamphetamine use (Oohashi H. 1998).

Government responses to drug use and HIV

HIV prevention and control programmes have been directed at the Japanese population at large but there has been little development of specific programmes for the populations at risk (Kihara M *et al.* 1997). Drug treatment programmes are small and generally run by private organisations. The Japanese government provides narcotics-related counselling designed to prevent drug use and supports the rehabilitation of addicts at health centres and mental health centres (Narcotics 2001).

The harm reduction approach has not been implemented in Japan. The Drug Abuse Prevention Centre, established in 1987, has been involved in publishing educational materials and organising a drug awareness raising campaign (ATS workshop 1998). The government runs drug education programs in schools, national publicity campaigns on televisions and radio and some drug education programmes at a community level including one which organises talks between students and former drug users (Narcotics 2001).

National AIDS Policy

The Japanese government implemented a ‘Seven Year Stop AIDS Plan’ in 1994 to be completed in 2000 which outlined broad measures for controlling the spread of AIDS.

These measures include presentation and dissemination of accurate information, establishment of a medical care system to deal with HIV/AIDS, improvement of testing and promotion of research and international cooperation (National Health Administration in Japan 1994). There is no mention of intervention with drug users and, given the small numbers of drug users infected with HIV, this is not surprising.

Non-government responses to drug use and HIV

There are a few self-help groups such as NA (Narcotics Anonymous) and DARC (Drug Abuse Rehabilitation Centre) for methamphetamine and other drug users in Japan but few out-patient treatment centres (Suwaki H. *et al.*1997).

Estimated number of drug users	400,000 – 600,000 drug dependent, 2.18 million casual users
Estimated number of IDUs	150,000 – 500,000
Drugs used	methamphetamines, alcohol, heroin, diazepam, solvents
Drugs injected	methamphetamines, heroin, diazepam
Estimated number of HIV infections among IDUs	HIV prevalence among IDUs is 0.1%

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The Lao People's Democratic Republic

Comparisons: 1997 Versus 2001

In 1998 it was estimated that 63,000 Laotians, 1.6% of the population, were daily consumers of opium. In 2000, nearly 5% of the population is estimated to be addicted to opium in the northern regions of the country, climbing to 10% among ethnic minorities. Laos is the third largest producer of opium, which remains by far the most popular drug, with only a small rise in the use of heroin. The late 1990s saw a rapid increase in the number of opium dens in the north due largely to the rise in western tourism. There has been a marked rise in the use of amphetamines in both urban and rural areas, unknown in 1997; one report on school children using amphetamines found that 12% were injecting the drug. Drugs still tend to be smoked or ingested, but there are reports of amphetamine injecting and, like Cambodia, great familiarity with the use of needles and syringes in health care and domestic settings. There is no doubt the transition from inhaling or swallowing to injecting drugs has begun. The prevalence of HIV remains low (0% of reported infections in 1997 gave histories of IDU) but is slowly increasing, with 2% of HIV infections identified as IDUs in 2001.

Opium was officially prohibited in 1996. In 1997 the government acknowledged harm reduction as an appropriate approach for drug dependent people but there was a lack of any services or treatment for drug users. In 2001 the need to address drug use has become an emerging priority, but information and services are grossly inadequate. For those people able to gain access to a treatment program the relapse rate is 90%. Harm reduction remains part of the National AIDS Plan but no programs have as yet been implemented.

History

Opium has been known in Laos for a long time, but trading and consumption expanded with the arrival of Chinese traders, workers, and immigrants of Hmong ethnicity, coupled with the emergence of French colonial rule during the 19th century. In 1899, French colonialism in Indo-China witnessed opium trafficking, processing and sales being consolidated into a single opium monopoly in addition to supplying refined opium for smoking to Government owned opium dens. In 1918, there were 1,512 opium dens, over 3,000 opium retail shops and an estimated 100,000 opium addicts in Indo-China. At the same time 115 tonnes of opium was sold annually plus an additional 60 tonnes was imported into Indo-China as a result of widespread domestic demand (McCoy 1991; Segar 1996; UNDCP 1999).

The Royal Lao Government prohibited opium production, use and sale in 1971, although ethnic minority addicts could still obtain a permit to cultivate the opium poppy. Following opium prohibition, heroin was available for the first time and subsequently a heroin epidemic occurred in Vientiane. In the early 1970s there were an estimated 50,000 opium addicts, mostly found in the rural areas (Segar 1996). In 1992, a comprehensive study of the drug situation suggested that opium poppies were grown in all provinces of northern Laos and only 11 out of 69 districts were completely poppy free. At the same time in northern Laos it was estimated there were 42,000 opium addicts; opium was ingested or smoked but not reported to be injected. Heroin use was not reported but an upward trend in glue sniffing, first detected in 1988 among school children, escalated by the mid-1990s (Segar 1996; Oppenheimer 1996).

Current Situation

In the northern region of Laos opium plays an important economic role with 32% of the villages in this region cultivating opium mostly to generate or supplement cash income. In the southern provinces there are no reports or evidence of opium cultivation. Opium cultivation is found in the north-western part of the country particularly in Pongsaly, Luang Namtha, Oudomxay, Houphan and Xieng Khouang (UNDCP 1999; UNDCP 2000a; UNDCP 2000b). Laos has for some years remained the world's third largest producer of illicit opium, behind Afghanistan and Myanmar. In 2000, there was an increase in opium cultivation rising to 167 metric tons (mt) compared to 140 mt in 1996 and 124 mt in 1999 (UNDCP 2000b; Narcotics 2001). In 1999, opium was produced in 10 out of the 17 provinces and the domestic consumption had been estimated to be 70 tonnes (UNDCP 1999). Domestic production of heroin remains limited and laboratories are believed to be located in the northwest of the country. In 1998, a major heroin laboratory was discovered in the Bokeo province, which borders Myanmar (UNDCP 1999).

In 2000 seizures of heroin and methamphetamine tablets increased from 1999, by 39% and 86% respectively; over 1.5 million methamphetamine tablets were reportedly seized (Narcotics 2001). It is believed methamphetamine, albeit in small amounts, is produced in Laos (UNDCP 1999). Cannabis production is to be found in many regions of the country and despite eradication efforts production is on a large scale (UNDCP 1999). Throughout the 1990s ongoing economic reform and the opening of borders have encouraged regional trade. One adverse effect is the potential for increased drug trafficking and compared to the size of the population it has been recognised drug seizures in Laos are relatively large. In recent years there has been a clear rise (although still relatively modest) in the trafficking of heroin which mostly originates from Thailand and Myanmar (UNDCP 1999). The potential for drug users to move from opium to heroin and for a subsequent injecting of heroin or other substances and the risk of associated HIV epidemic, as is occurring in neighbouring countries, still remains strong.

The most commonly consumed drug remains opium, particularly in the northern regions of the country where it is used for medicinal, ceremonial and social purposes. Addiction to opium is significantly higher in the north than the national level as the north remains the area where the opium poppy is cultivated. A 1998 survey in Laos showed, while the overall domestic consumption of opium amounted to approximately 70 tonnes, 20 tonnes is consumed by households for medical and ceremonial purposes (UNDCP 1999). It has been reported that in Luang Prabang it is probable that 'blackwater opium' was being injected but the cases were few (Oppenheimer 1996). In the late 1990s, the rise of western tourism has seen the rapid opening of a number of opium dens, either as rooms in guest houses or in unfurnished wooden shacks, in the northern region of the country. The venues catering for foreigners are concentrated in a small number of towns and opium consumption is still relatively small (Crampton 1999).

Heroin use is not widely reported although throughout the 1990s there has been a small incremental rise; in 1992 it was found only one of 80 opium users used heroin and in 1996 in Vientiane it was found one out of 16 patients treated for drug problems used heroin (UNDCP 1999). In 1996, a survey showed heroin use was reported (apparently for the first time) among refugees settled in the north-eastern parts of the

country, bordering Thailand and Myanmar (UNDCP 1999). Cannabis use is common but less widespread than opium consumption. The amount of cannabis cultivated has not been estimated but regular seizures do indicate cannabis production remains important to Laos (UNDCP 1999; Narcotics 2001). Methamphetamine use is markedly on the rise in the urban centres and spreading to outlying villages (local methamphetamine use was almost unknown four years ago) and the use of volatile substances (particularly glue sniffing), which are cheap, readily available and raise little attention when purchased, is relatively widespread. A study conducted among over 2,000 students aged between 12 to 21 years, specifically in Vientiane, found among respondents that 5.4% used solvents, 4.8% used amphetamines and 4.7% misused prescribed medications. The signs are that overall drug use is on the rise in schools (UNDCP 1999; UNDCP 2000c; Narcotics 2001). The use of ecstasy is found in urban centres but as of yet there are no reports of use in the rural communities (Narcotics 2001).

Drug taking practices and risk factors

Opium is usually smoked or sometimes ingested although it has been reported that 'blackwater opium' has been injected, albeit by very small numbers, in a rural district (Segar 1996, UNDCP 1999; Oppenheimer 1996). Solvents such as glue are inhaled and are now reported to have reached epidemic levels, particularly in the Vientiane municipality (Oppenheimer 1996; UNDCP 2000c). Cannabis is smoked (UNDCP 1999).

The use of amphetamine type substances (commonly referred to as *Ya-Baa*) is on the rise and mostly ingested and/or smoked using the 'chasing the dragon' method (Oppenheimer 1996; UNDCP 1999). However, in a recent school survey among youth in Vientiane injecting *Ya-Baa* was discovered: of the 191 current users of *Ya-Baa*, of whom 164 responded, 12% injected the drug. For those injecting amphetamines, information was not collected about the sharing of needles or the cleaning techniques implemented but it can only be assumed high risk behaviour is occurring (UNDCP 2000c). Culturally, there is much familiarity with needles and syringes and with the injecting of a wide range of drugs. In primary health care settings, the practice is unregulated and delivery is often associated with unsterile circumstances (Oppenheimer 1996).

It is anticipated that an increasing number of drug users currently inhaling solvents or smoking amphetamines will make the transition to injecting, depending on a variety of circumstances ranging from peer pressure to economic factors. Studies on the behaviours of injecting drug users are not known to have taken place. There are no reports as of yet of Laos having a culture of professional injectors as occurs in some neighbouring countries. A needle and syringe costs approximately 2,800 Kip (approximately US\$0.25 – 0.30). This price varies on quantity and place of purchase. As half the population live below the poverty line of US\$16 (Kip 127,050) per capita per month (NCCA Bureau 2001a), it could be anticipated for people at the lower end of the income scale that the potential risk of re-using a needle and syringe is high. There is no need to provide a prescription to purchase injecting equipment. Needles and syringes are generally accessible from pharmacies in both urban and rural areas although in some rural villages availability can be restricted due to a lack of pharmacies.

Polydrug use is common and among youth the use of *Ya-baa* and solvents is the most common combination; some also used prescribed medications and other illicit drugs as well (UNDCP 2000c). In villages it has been reported that former glue sniffers switched to heavy consumption of alcohol (Oppenheimer 1996).

Prevalence and profile

The overall number of drug users has not been estimated but attempts have been made to estimate the number of those consuming opium. In 1992, there were an estimated 42,000 people addicted to opium, equivalent to about 1.1% of the population of those aged 15 years and above (UNDCP 1999). In 1998, the figure reported was an estimated 63,000 people addicted to opium, equivalent to 1.6% of the population of those aged 15 years and above. However, it has been suggested that the prevalence rate could even exceed 2% of the population making it the either the world's largest consumer of opiates in per capita terms or second to Iran (UNDCP 1999; Narcotics 2001). In the northern region of the country the opium addiction rate is estimated at nearly 5% of the population above 15 years old (Narcotics 2001) and among some ethnic groups, the Muxeu Dam and the Akha, it is 10% and 9% respectively (UNDCP 1999). Most west European countries have significantly lower addiction rates for opiates which generally fluctuate between 0.2% to 0.3% of the population aged 15 years and above (UNDCP 1999). In 1998, a national opium survey found opium consumption was generally found among those aged 50 years and above; only 5% of the opium addicts were reported to be below the age of 20 years. The use of opium still remains a largely male phenomenon; females account for 19% of the total (UNDCP 1999).

The number of heroin users is considered to be small and reports of any estimates have not been found. Cannabis consumption is greater than heroin use but still appears to be relatively minor compared to the use of opium (UNDCP 1999). The use of volatile substances is believed to be widespread and particularly associated with youth. In a 1996 school survey it was found that of those under 20 years of age glue sniffing was the most common form of drug use, used by 1,100 of the participants, compared to 27 participants who used cannabis. Another school survey in 1999 found 17% of youths (aged 12 – 21 years) had tried some form of drug at some point in their lives and 7% had been using marijuana, hashish, inhalants or amphetamines. Most (90%) student drug users are male. For those aged 12-14 years old the most popular drug were solvents (6%) and for those aged 15-19 years it was *Ya-Baa*. The average age of first drug use is between 15-16 years old and the potential for widespread amphetamine use among school children is strong (UNDCP 2000c). The discovery of 12% of *Ya-Baa* users injecting in this survey and the likelihood of risky behaviours suggests the potential for HIV transmission is cause for serious concern. Studies on the risk behaviours of drug injectors are yet to be assessed but it is likely there is needle sharing and inadequate cleaning of injecting equipment. The overall number of IDUs is considered low but studies have yet to be conducted to confirm this widespread perception (WHO 2001).

The prevalence of HIV/AIDS still remains low but there are signs that the rate is slowly increasing. The first HIV case was identified in 1990 and the first officially identified AIDS case was in 1992. The cumulative number of HIV diagnoses from 1990 to 1997 was 204 cases of which only one identified as having a history of IDU. In the same period 51 people were diagnosed with AIDS, none of whom identified as

an IDU (NCCA Bureau 1997a). As of December 2000, the cumulative number of people identified with HIV stands at 717, of whom 12 (2%) identified as IDU. The cumulative number of reported AIDS cases in the same period stood at 190; it has not been determined who identified as IDUs (NCCA Bureau 2001a). The number of drug injectors is relatively small but there can be no doubt a transition from inhaling or swallowing drugs to injecting has commenced and requires serious monitoring. It is generally assumed that the current figures under report the true extent of HIV/AIDS in the country; at the end of 1999 it was estimated 1,400 adults and children were living with HIV/AIDS (UNAIDS and WHO 2000). With a low HIV prevalence the number of AIDS cases is projected to be relatively small with fewer than 100 annual AIDS deaths in 2000, rising to over 200 in 2005 (WHO 2001).

It is anticipated that an upward trend in HIV/AIDS detection will continue and injecting drugs as a mode of transmission will rise given the historical trends shown in neighbouring countries. There is significant population mobility to neighbouring countries with high HIV/AIDS prevalence rates (Thailand, Cambodia, Vietnam and Myanmar) as well as problems inherent with increasing internal population mobility. Long standing sexual behavioural tendencies and opportunities through formal and informal relationships with sex workers and opportunities for casual relationships (perhaps with other injecting drug using communities) add to the vulnerability for those on the move (Dalaloy 2001).

Government responses to illicit drug problems

In 1996, the Lao government revised its drug control plan and officially prohibited the production of opium. The possession of up to 2 grams of heroin for personal use is liable to incur a prison sentence of 1-5 years or a re-education program without loss of freedom. Possession of up to 3 grams of amphetamines or other stimulants for personal use is liable to a prison sentence of between 3 months and 3 years or to a program of re-education with no loss of freedom. Those who smoke marijuana will receive a behavioural correction sentence without being deprived of freedom. Providing services for opium smoking results in imprisonment for 3-10 years with a fine of 500,000 kip (US\$68.80) to 5 million kip (US\$688). Currently there are no penalties for inhalant use. Penalties for illicit drug trafficking (although the types of drugs trafficked has not been able to be determined) have been increased to life imprisonment (Oppenheimer 1996; UNDCP 1999).

Government response to drug use and HIV

It is acknowledged that there has been a significant rise in the use of recreational drugs among urban Lao youth although the amount of injecting drugs is considered minor. Even so, the effects of recreational drugs and associated behaviour are acknowledged to be significant vulnerability factors for HIV transmission. Addressing the drug using situation has become an emerging priority for the government but there is still little capacity for implementation of programs. In the next five years there is to be continuing HIV/AIDS prevention education among youth with specific attention to peer education, life skills and drug abuse. A new area of concern is the development of a prevention and support program for those with drug using problems (NCCA Bureau 2001b).

The National Committee for the Control of AIDS (NCCA Bureau) has produced a National HIV/AIDS/STD Plan for 1997-2001. During its development it was acknowledged that an insufficient amount of attention was given to problems of injecting drug use, and as a result a long-term activity would be to collaborate with agencies in other countries which focus on harm reduction. The Lao National Commission for Drug Control and Supervision (LCDC) is reported to be considering that where drug use cannot be eradicated it is best to encourage drug users to use methods other than injecting, as well as attempts to reduce the supply of drugs that can be injected such as heroin and amphetamines. While a primary objective is to enhance people's ability to reduce HIV transmissions among drug users through specifically designed programs, such programs have not been established. Currently there is no needle and syringe program (NCCA Bureau 1997b).

Currently there is no inventory of treatment and rehabilitation programmes in the country and record keeping systems in treatment centres are not standardized. However, even without this information, it is unlikely there are sufficient treatment services to deal with the substantial opium-addicted population let alone the increasing number of drug users consuming other drugs such as heroin, methamphetamines and glue. A 1998 survey found relapse rates from drug treatment generally to be as high as 90%, which is unsurprising considering the little training or expertise that exists to promote successful drug treatment. The types of treatment programs reported include detoxification, maintenance, self-help groups, support for families of drug dependent persons and emergency aid centres. Treatment programs are of three weeks duration followed by a reported one month maintenance therapy for opium dependent persons. Details of the maintenance therapy are not specifically explained but it is reported in the villages that in-patients addicts are provided with opium tincture that is gradually replaced with a placebo over the course of three weeks. Most detoxifications throughout the country are focused on the 'cold turkey' approach with some providing herbal or traditional medicines (UNDCP 1999). Implementation of detoxification programs is often left to provincial administrators. With many drug addicts residing in remote, often inaccessible rural areas, accompanied by the financial costs (about which no details have been obtained), difficulty of treatment and follow up simply act as barriers to successful treatment (Narcotics 2001).

National AIDS Policy

It is reported injecting drug use is uncommon in Laos but it is acknowledged this behaviour is a common source of HIV infection in most neighbouring countries. It is accepted the use of illicit drugs by non-injecting methods is on the rise and therefore targeting this group for HIV/AIDS/STD awareness will be a high priority. Periodical monitoring of the drug using situation will be undertaken and if it is found injecting of drugs is becoming a problem, measures will be taken to minimise the risk of HIV/AIDS infection; a harm minimisation approach has been suggested but the details are not yet clear (NCCA Bureau 1997b; Ministry of Health 2001).

Non-government responses to drug use and HIV

There are no national NGOs or community based organizations in Laos but there is participatory planning and implementation supported by mass organizations reaching from the central to village level. Currently there are nearly 70 international NGOs

working in Lao; one working exclusively on national condom social marketing and three others on programs for prevention of vertical transmission of HIV. Two NGOs run an integrated HIV/AIDS education for prevention program. Several other agencies are becoming more involved in HIV/AIDS work (NCCA Bureau 2000a). Donor agencies such UNDCP, AusAID and some embassies fund demand reduction programs such as the provision of educational materials and awareness raising of the consequence of drugs, particularly amphetamines. Currently there is no documentation of harm reduction programs targeting IDUs in Laos. The German NGO, GTZ, and the NGO, Norwegian Church AIDS (NCA) is currently supporting detoxification programs but details of these operations have not been able to be accessed.

Estimated number of drug users	In 1998, 63,000 people addicted to opium. Prevalence rate of drug users could exceed 2% of the population
Estimated number of IDUs	Unknown but considered low
Drugs that are used	Opium, 'blackwater' opium, heroin, amphetamines, cannabis, ecstasy, prescribed drugs, solvents such as glue
Drugs that are injected	'Blackwater' opium, amphetamines, some heroin
Estimated number of HIV infections among IDUs	2% of total HIV infections identified in IDUs

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Malaysia

Comparisons: 1997 Versus 2001

The Malaysian government's strong anti-drugs stance has, if anything, hardened since 1997. The government aims to have a drug free society by 2023 and will therefore not support harm reduction programmes which they see as encouraging drug use. Meanwhile, HIV prevalence among IDUs (the HIV epidemic in Malaysia primarily affects IDUs) remains about the same. To June 1997 the cumulative rate of known HIV infected people was 21,863 of whom 76.4% were IDUs. In April 2001 the figures were 40,049 HIV infected of whom 76.3% were IDUs. In 1997 it was estimated that there were 180,000 to 400,000 drug users in Malaysia: in 2001 the estimated number of IDUs is 200,000. No state in Malaysia is free of HIV/AIDS or IDU.

By 1997 there had been a significant rise in the use of illicit drugs with heroin the most popular drug. Amphetamine use had been reported in Kuala Lumpur. In 2001 heroin is still the drug of choice followed by morphine and cannabis. Studies in 1997 showed that injecting was the preferred method of taking heroin and a substantial number of IDUs shared their injecting equipment. This is still the case in 2001 with professional injectors injecting multiple customers with un-sterile equipment. Although needles and syringes can be bought on the black market (and by prescription) many IDUs are fearful of being found with equipment and identified as a drug user. IDUs can in fact be detained for 14 days by police for urine testing even if they have no equipment or drugs on them. If they are found to be positive for drugs they are automatically admitted to a rehabilitation centre for 18 months to two years. These 27 centres have a military style approach and a relapse rate of 70 to 75%. The government is concerned about this high rate and has recently announced it is considering detaining recidivist relapsers for 13 years, as recently announced in Singapore.

The National AIDS policy does link IDU and HIV/AIDS but the government does not support harm reduction and provides minimal support to NGOs. The few NGOs operating in Malaysia are small scale and have little chance of greatly affecting the HIV/AIDS epidemic. The umbrella group for NGOs is the Malaysian AIDS Council and they are working to remove the stigma from those living with AIDS.

History

Malaya (as it was then known) was never an opium producing country, opium was always an imported drug. The country has however, had a long history of opium use commencing in the early 19th century with the importation of migrant labour from China and South India. The smoking of opium was closely associated with the Chinese community, although not exclusively, while cannabis was considered to be used mainly by the Malay and Indian communities (Spencer and Navaratnam 1981; McCoy 1991). In 1929, there were 52,313 registered opium smokers in the Federated Malay States, all of whom were reported to be Chinese. In 1930, following a League of Nations report on opium smoking in the Far East, international pressure mounted upon Malay to curb the availability and use of opium. By 1936, the number of registered opium smokers was over 32,000 in Malay States, but it is likely that many more were obtaining their drug illicitly (Spencer and Navaratnam 1981; McCoy 1991).

In 1957, Malaysia became independent and a new trend in opium use emerged: opium had previously been confined to the elderly population but now a younger generation of men increasingly turned their attention towards heroin use. Heroin was believed to

be mainly imported from the Golden Triangle (McCoy 1991; UNAIDS and UNDCP 2000). In 1952, Malayan authorities launched an anti-drug strategy largely as a result of what was considered a rising tide of drug related crime. In the late 1960s the 'hippie' culture from the West made its impact upon Malaysia and it is believed this escalated the drug problem. Drug rehabilitation centres were established and more draconian punishments against drug use became enshrined in law. Even so, from the early 1970s onwards the drug using problem has been considered a grave concern and is referred to as 'public enemy number one' (McCoy 1991; How 1996; UNAIDS and UNDCP 2000; National Narcotics Agency 2001).

Current Situation

While Malaysia is not a producer of significant amounts of illicit drugs, domestic drug use is significant and believed to be growing. The geographical proximity of Malaysia to the heroin producing Golden Triangle provides a variety of smuggling routes across the Malaysian borders. The country shares an extensive land border with Thailand and the sea-borne traffic between the two countries is extensive (Narcotics 2000). It is believed fishing boats from neighbouring countries in the north, land at Pulau Langkawi, Penang and Kuala Perlis to trade but also to traffic in drugs (National Narcotics Agency 2001). Clandestine laboratory activities are mainly confined to the conversion of heroin base to the hydrochloride salt form. In 2000, 109 kilograms of heroin was seized. Heroin has been the most commonly used drug for many years followed by morphine and cannabis. In 2000, around 1,600 kilograms of cannabis was seized, down from 2,000 kilograms in 1999 (UNAIDS and UNDCP 2000; National Narcotics Agency 2001; Narcotics 2001).

There has been an increasing market for methamphetamine in the form of 'ice' or commonly called 'shabu'. Shabu is believed to have been introduced to the country by illegal immigrants from the Philippines: its use was mainly confined to eastern Malaysia. In the past two years methamphetamine use has spread to the western region of the country and in northern Malaysia, particularly among the fishing community. In 2000, 208 kilograms of *shabu* was confiscated, while in 1999 it was just over 5 kilograms (Narcotics 2001; National Narcotics Agency 2001). Psychotropics and ecstasy tablets (MDMA) are commonly seized by the authorities; the first seizures of ecstasy took place in 1996 (20,276 tablets) and by 2000, it was nearly 50,000 tablets. Ecstasy use is commonly associated with the more affluent youth at nightclubs and the quality varies; it appears most ecstasy is smuggled in from other countries (Reynolds 1999; National Narcotics Agency 2001). There has been a sharp increase in the existence of methamphetamine related clandestine laboratories with 26 amphetamine type substance laboratories seized from 1997 to 2000 (UNDCP 2000). Other drugs used include amphetamine, cocaine, codeine, cough mixtures and inhalants (Hanjeet *et al.* 1997; National Narcotics Agency 2001).

Drug taking practices and risk factors

In 1995, 24,230 drug users were surveyed and 24% were injecting drugs, 50% were inhaling the fumes of heroin 'chasing the dragon' and 24% were smoking cannabis (UNAIDS and UNDCP 2000). An earlier study in Penang among IDUs had shown the progression from 'spiking' cigarettes to 'chasing the dragon' and finally to injecting. Among this study group the process commonly took about seven years (Kin 1996). Contemporary reports examining the transition period from the smoking of heroin to

injecting have not been available. According to the Malaysian Drug Information System in the past three years there has been a modest increase in the trend towards smoking heroin; 14.7% in 1998 and 19.4% in 2000. It is a matter of speculation whether these patterns reflect the behaviour of unidentified drug users (UNDCP 2001).

Professional injectors are known to exist, injecting multiple customers with the same un-sterile injecting equipment. Heroin, in pre-prepared syringes, is reported to be sold in villages and this, it is believed, resolves any problems associated with the need to find a needle and syringe, which can be difficult. An additional benefit for drug users is that it can also assist in avoiding the draconian penalties associated with being caught with drug using paraphernalia (Bolton; 1996; Narayanan 1997; UNAIDS and UNDCP 2000). Heroin is usually placed into a tablespoon containing a mixture of water and lime juice, the drug is dissolved in this solution and heated over a flame. Once the solution has boiled, the preparation is drawn into a syringe and injected into a vein (Navaratnam and Foong 1996).

High risk behaviour among IDUs is common as a result of the widespread sharing of needles and syringes and other paraphernalia. Widespread sharing is not only a result of drug using etiquette but also because getting injecting equipment is not always that easy. Drug users can also be fearful of being identified by law enforcement authorities and do not wish to be seen either buying needles and syringes from the pharmacies or being in possession of such equipment. (Wai *et al.* 1996; Narayanan 1997; Reynolds 1999; UNAIDS and UNDCP 2000). The possession of needles and syringes does appear to constitute an offence under section 37 of the Dangerous Drugs Act 1952 (UNAIDS and UNDCP 2000).

In an early study of IDUs it was found that 77% of the participants admitted to sharing their needles and syringes with 10 other users and 23% had shared with more than 11 peers (Ismail 1998). In the mid 1990s another study showed that 70% had shared needles in their lifetime and more than half shared sometimes (Navaratnam and Foong 1996). A study of drug users with HIV infection showed that 88% of the participants had a history of sharing and another study which focused on female drug users showed the rate of current sharing was nearly 50% (Wai *et al.* 1996; Yoong and Cheong 1997). The cleaning of injecting equipment, is in most circumstances, either not done or totally inadequate to protect against blood borne diseases as a result of using water rinses alone (Wai *et al.* 1996; UNAIDS and UNDCP 2000).

There has only been one known outreach program based in Kuala Lumpur finding IDUs and introducing them to the concept of using household bleach for cleaning injecting equipment. The resources for this program are limited and it cannot be expected this method of cleaning with household bleach (which is widely available throughout the country) has been adopted by many IDUs in the capital, let alone the rest of the country (Crofts *et al.* 1998; Reynolds 1999). Reports of injecting and non-injecting drug use in prisons and rehabilitation centres exist. Injecting equipment is smuggled in, and as a result of the scarcity of such equipment, it is likely to be shared widely among many drug using residents or prisoners (UNAIDS and UNDCP 2000). Correctional authorities and rehabilitation centres are aware of the high risk of HIV transmission in these environments and have made attempts to ensure drug use is minimised but it is highly unlikely such behaviours can be eliminated altogether (UNAIDS and UNDCP 2000).

Under Section 37 of the *Dangerous Drugs Act 1952*, the possession of a needle and syringe constitutes an offence. A needle and syringe is purchased from a legal pharmacy and requires a prescription; the current average price is 1 to 2 Malaysian Ringget (US\$0.26 – US\$0.52). However, a needle and syringe can be purchased from an illegal pharmacy without a prescription at a higher price. It is plausible that both the legal and cost factors would discourage the purchase and encourage the sharing of injecting equipment (Reynolds 1999). While punishments for drug use are harsh, addiction has led some drug users to be brazen in their behaviour and in Kuala Lumpur some IDUs have no qualms about injecting in public spaces or in the various laneways of the city (Bidin *et al.* 2001).

Prevalence and profile

There are various estimates of the number of illicit drug users in Malaysia ranging from 180,000 to 400,000. It is reported that the lower figure represents those who have been identified by the authorities since registration commenced in 1970. Of these it has been estimated that between 170,000 to 200,000 are opioid users (Narayanan 1997; UNAIDS and UNDCP 2000). During the mid 1990s an estimate of 20,000 to 50,000 IDUs was made (Navaratnam and Foong 1996). At the same time the estimates of IDUs in the country were reported to be too low and a conservative figure of 90,000 was considered more realistic (Peak 1995). Currently, it is estimated the total number of IDUs is 200,000. (WHO and Ministry of Health 1999). The National Drug Information System between 1988 and 1996 identified a total of 127,000, non-duplicated drug user cases. These figures comprised 65,000 new cases and 62,000 repeat cases. In 1996, the number of new cases was 13,846 and relapses cases were 16,752. As a result of these rising figures the government announced it would intensify its primary prevention efforts (UNAIDS and UNDCP 2000).

In 2000, the total number of drug users identified was 30,593; new cases numbered 14,850, an average of 1,238 per month, and the number of relapse cases was 15,743, an average of 1,312 an average per month (National Narcotics Agency 2001b). From 1990 to December 2000, 141,22 drug users were identified by the authorities throughout the country but a breakdown of new and relapse cases has not been accessed (National Narcotics Agency 2001). The urban centres of Malaysia, such as Kuala Lumpur and Penang, are believed to have the largest populations of IDUs and a substantial number are HIV infected. The non-government organisation, IKHLAS, (a part of the Pink Triangle Foundation and a member of the Malaysian AIDS Council) operating in Kuala Lumpur since the late 1990s, estimated there were about 800 IDUs living in their local district (Reynolds 1999; UNAIDS and UNDCP 2000).

The injecting drug user population of Malaysia is extremely mobile and follow up for those found to be HIV infected has often been unsuccessful. It is likely the spread of HIV in Malaysia commenced from the north among IDUs and had been occurring for some time (Singh and Crofts 1993). The opportunities for HIV infections to spread to other parts of the country have been considerable; currently no state in Malaysia is free from injecting drug use or HIV infection (Singh *et al.* 1994; UNAIDS and UNDCP 2000).

In 1996, the National Drug Agency, Ministry of Home Affairs, showed in its annual report that most drug users were male (99%), the majority were aged between 20 and 39 years (80%) and of these 89% were part of the workforce; only 11% were

unemployed. Most drug users took heroin (65%) while 15% used morphine (Ismail 1998). In 2000, a profile of drug users compiled by the National Narcotics Agency, Ministry of Home Affairs showed most are male (94%) but of the 30,593 cases, females represented 509 cases (362 and 147 new and recurrent cases respectively). The breakdown according to race is as follows; Malay (65.8%), Indigenous Sabah/Sarawak (4.3%), Chinese (17.8%), Indian (10.8%), and others and foreigners amounted to 9.2%. The majority of drug users are still aged between 20 – 39 years old (73.4%) but those aged 19 years and under made up 7.6% (N= 2,323) of the total number. Heroin remained popular (44.4%), followed by morphine (27.9%) and cannabis (19.3%). Information has not been available about the ways of taking heroin and morphine. The drug user profile, according to profession, is diverse and includes construction, sales, service industry, general labour, transport, agriculture, production and factory work; only 9% identified as unemployed. A lower certificate of education is achieved by 34.5% and a substantial number (18%) had only achieved primary school or had no schooling (National Narcotics Agency 2001).

In 1996, there were 48,216 drug users receiving rehabilitation. Of these, 14,264 were placed in government rehabilitation centres; 9,107 inside correction facilities and 24,845 in community programs run privately, by NGOs or by religious organisations (Ismail 1998). In 2001, the number of drug users undergoing rehabilitation had grown to 54,058. Most had entered community programs (36,242) followed by prisons (8,688), government rehabilitation centres (8,178) and private centres (950) (National Narcotics Agency 2001).

The first AIDS case was reported in 1986 and since then the numbers have continued to rise. As of December 1998, the number of newly diagnosed HIV cases was 4,624 and the cumulative total number of HIV cases was 28,541. In 2000, the number of newly diagnosed HIV infections increased to 5,107. As of the end of April 2001, the cumulative total of known HIV infected persons was 40,049, of whom 30,575 (76.3%) were injecting drug users. A cumulative total of 5,103 were reported to have AIDS of whom 3,065 (60.1%) were injecting drug users. The number of deaths related to HIV/AIDS since 1986 to April 2001 is 3,881. The majority of HIV infections are found in males (94.6%) but there has been a slight increase among females; in 1998 it was 4.4% and as of April 2001 it was 5.4%. (UNAIDS and UNDCP 2000; WHO and Ministry of Health 2001; WHO 2001).

Malaysia is a country with an HIV epidemic primarily affecting the IDU community and the prevalence appears to be rising. It has been reported that the HIV prevalence among commercial sex workers is beginning to exceed 5% (WHO and Ministry of Health 2001). It is also projected that the number of people living with HIV will rise to between 72,000 to 103,710 by the year 2003 (WHO 1999; UNAIDS and UNDCP 2000). Other researchers believe the estimated figure could be nearly 200,000 HIV infections in 2000 (Malaysian AIDS Council 1998). HIV prevalence within the 28 drug treatment centres ranges from 10 to 27% and the current overall sero-prevalence among IDUs is thought to range from 30 to 40%. As drug users are subjected to routine testing before entry to a rehabilitation centre, and when they are detained by the police, it is believed the current figures are an over-estimate of the types of transmission based on risk factor (UNAIDS and UNDCP 2000). As of August 2001 the number of HIV infected inmates in the Malaysian Prisons is 1,834 and the main mode of transmission has been contaminated needle and syringe sharing (94%)

(Prison Department of Malaysia 2001). In the early 1990s the prevalence of hepatitis C among a group of IDUs was 85% (Sinniah and Ooi 1993).

Government responses to illicit drug problems

The government views illicit drug use as one of the most serious problems facing Malaysia and as a result they aim to eliminate drug dependency by providing treatment and rehabilitation to drug users, either by rehabilitation in an institution or under supervision in the community. Suspected drug users can be detained for a period of 14 days for urine testing and medical examination to ascertain their status. If the person is certified as a drug user, a magistrate will be guided by a social report of the person and then determine where to commit the drug user (How 1996; National Narcotics Agency 2001).

In Malaysia, a person can be defined as a drug user if they have tested positive through a urine testing, even without being in possession of any drugs or drug using paraphernalia. The penalty for having a positive urine toxicology is an automatic admission to a rehabilitation centre for 18 months to two years: in theory a person's drug use ranging from experimental and non-dependant to regular and dependent does not alter the involuntary treatment response (UNAIDS and UNDCP 2000; National Narcotics Agency 2001). The *Dangerous Drugs Act 1952*, covers various aspects of offences, procedures and evidence including providing for mandatory death sentences for drug trafficking offences (National Narcotics Agency 2001). The possession of 5 to 15 grams of heroin can result in a life sentence, while having more than 15 grams can result in the death penalty (Reid and AHRN 1997). A person in possession of prepared opium shall receive a fine not exceeding 25,000 ringgit (US\$6,583) or imprisonment for no more than five years or both (Dangerous Drugs Act 1952). The Dangerous Drugs (Special Preventative Measure) Act 1985 empowers the government to detain anyone suspected of being a trafficker without having to bring the suspect to any court of law. In 2000, 1,614 persons were detained under this act (National Narcotics Agency 2001).

The government has established and funded 27 drug rehabilitation centres and their focus is on work therapy, religious instruction or a multi-disciplinary approach. Within these centres the rehabilitation team consists of social workers, counsellors medical officers, religious teachers, education and military personal, vocational instructors and security officers. Training and rehabilitation of residents is orientated towards a military style approach (National Narcotics Agency 2001; Narcotics 2001). The average occupancy inside government rehabilitation centres is between 600 and 1500. It is believed that treatment centres are to start targeting specific drug using populations, including women and youth.

Between 1988 and 1996 the relapse was estimated to be 51%. Currently the relapse rate is estimated at 70 to 75%. Overwhelmingly, there is agreement the success rate is low and it is estimated that at least 40,000 to 50,000 drug users have undergone rehabilitation once. The government is concerned about the consistently high relapse rate and recently announced they are considering detaining recidivists for 13 years as has recently been announced by Singapore. The government funded treatment centres are full and cost the government around RM 60 million a year in upkeep (approximately US\$15.8 million or US\$1,200 for each drug user (Narcotics 2001; UNAIDS and UNDCP 2000; Hong 2001). It has been estimated that 40% of prisoners

in Malaysia are there for drug related offences although others have suggested the figure is much greater; in 2001, 26,900 inmates were cramped into 36 prisons nationwide exceeding their capacity by 3,000. It has to be said however that this is a problem common to many nations throughout the world (Vijian 2001).

In addition to the government treatment centres there are an estimated 55 private drug rehabilitation centres registered with the National Drug Agency. The Ministry of Home Affairs has approved 129 private clinics to provide services for those with drug related problems. There are also open community surveillance programs where drug users do not need to be admitted to a centre but are supervised by a drug program officer in the district. After care day centres focus on ex-drug users leaving the rehabilitation centres: the concept is to provide a space allowing an opportunity for counselling and other related activities. There are also after care centres offering a six month residential program; in 1996 there were seven such centres offering a maximum of 50 treatment time slots. All recovering drug users are required to attend a two year after care program upon their release from rehabilitation centres; the number of these centres has not been able to be accessed (Ismail 1998; UNAIDS and UNDCP 2000; National Narcotics Agency 2001).

Government response to drug use and HIV

The Malaysian government is strongly aware of the link between HIV/AIDS and drug use yet its general drug policy of promoting a drug free society by the year 2023 makes public health interventions such as substitution therapies or needle syringe programs difficult to implement. The Ministry of Home Affairs does not support needle syringe programs, as it is believed this would promote drug use. A pilot naltrexone relapse prevention program was implemented within drug rehabilitation centres but its success was limited and it is believed this was because of inadequate counselling and support services. Currently methadone use is not supported by government policy and it is likely this is so because it contradicts the goal of attaining a drug free society by 2023 (Kroll *et al.* 1999; UNAIDS and UNDCP 2000).

The government has, however, allowed an NGO (IKHLAS), based in Kuala Lumpur, to distribute bleach for the cleaning of needles and a small-scale distribution of needles and syringes to IDUs in their area (Narayanan 1997; Reynolds 1999). The small scale of its operations means it is unlikely to have a major impact upon the wider drug using community. All new inmates at treatment centres are tested for HIV and the majority of those who test positive are placed in separate living quarters but are still part of the overall program. According to the National Drug Agency there are 600 inmates in DRC who are HIV infected and the government is planning to build a separate DRC in the near future for these people (Sayuthi 2001).

National AIDS Policy

The National AIDS Policy was developed and approved in 1998, a process in which ministries, government agencies and NGOs affiliated with the Malaysian AIDS Council participated. The policy acknowledges that the use of contaminated needles and sharing of needles among injecting drug users (IDUs) is the main mode of HIV transmission in the country and that the majority of the HIV infected individuals are IDUs. Nevertheless, the objectives, guiding principles and strategies of the policy do not address issues of harm reduction nor of reaching out to drug users as a specific

issue. Generally the focus is on changing behaviour, practicing healthy lifestyles and awareness raising on the issue of HIV/AIDS. According to the “Strategic Prevention Activities to reduce the risk of HIV transmission”, emphasis should be put on messages such as ‘do not take drugs’, ‘do not inject drugs’ and ‘do not share needles or syringes’. The policy states that implementation of these activities must be carried out by the agencies and organisations involved in HIV prevention and the prevention of drug abuse.

Non-government responses to drug use and HIV

There are very few NGOs who focus their efforts on IDUs. The NGO IKHLAS in Kuala Lumpur has been able to achieve some success with Malaysian officials by not challenging the boundaries of the laws already set down. As mentioned previously IKHLAS distribute bleach to IDUs. The NGO Pengasih has adopted a peer outreach education program in working with drug users in the community. Currently the government provides very limited support for NGOs to undertake outreach work and this may be because it is not considered a part of the government’s HIV prevention strategy (Narayan 1997; UNAIDS and UNDCP 2000).

In 2001, the NGO, Malaysian Care organised referrals for 20 Chinese speaking drug users and 15 English speaking drug users to language appropriate DRCs. It also established a drop in centre and an accommodation house where they provided short term residential care for HIV positive discharged prisoners, the majority of whom are recovering drug users (Lew 2001). The DRCs are receiving increasing requests to undertake rehabilitation, in particular for users of ecstasy and amphetamines, but staff are ill prepared for this role as their focus has been the treatment of heroin use. In addition to the government DRC there are an estimated 55 private drug rehabilitation centres registered with the National Drug Agency throughout the country (National Drugs Agency 2001). The Malaysian AIDS Council is the umbrella organisation for all NGO working on AIDS issues and it receives its funds from the government. Since its establishment it has been very active in working to reduce the stigma against AIDS victims and their families (UNAIDS and UNDCP 2000). It is likely that NGOs who work with current drug users have many difficulties, particularly in a society who views drug users as criminals to be rejected rather than people with health problems (Low *et al.* 1995; UNAIDS and UNDCP 2000).

Estimated number of drug users	180,000 to 400,000
Estimated number of IDUs	200,000
Drugs that are used	heroin, amphetamines, morphine, cannabis, ecstasy, cocaine, codeine, inhalants
Drugs that are injected	heroin
The number of HIV infections among IDUs	HIV prevalence among IDUs is 76.3%

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Mongolia

Comparisons: 1997 Versus 2001

From the little information available about Mongolia it appears that while drug use and injecting are not widespread they are on the rise. In 1997 there were no reports of IDU, in 2001 there are 10 known IDUs and a Rapid Situation Assessment of drug users has just been completed. The highest prevalence of drug use in Russia is to be found in regions that are close to Mongolia. Alcoholism is of great concern to the government and since 1997 there has been an increase in the availability of marijuana, heroin, morphine, amphetamines and over the counter drugs. The injecting of pharmaceuticals at home, such as antibiotics, has increased in recent years. Needles and syringes are available without prescription from pharmacies but are too expensive for most Mongolians. There are reports of needle and syringe sharing. One case of HIV infection was reported in 1997, this has risen to two in 2001 but unofficial estimates suggest there are 100 HIV positive people in Mongolia. No specific policy on drug use and HIV exists.

History

Information not able to be accessed

Current Situation

Drug trafficking and use are not believed to be widespread in Mongolia but according to government and non-government organisations it is on the rise. It has been reported that the country only has about two to three years to develop a National Drug Strategy to prevent drug availability and use from becoming a problem. The border Russian region of Irkutsk, has however experienced an epidemic of injecting drugs in the last two years and it has been suggested there is a sense of urgency to quickly develop a drug strategy. Mongolia shares a border with China and Russia and the illegal trade of prostitution, migrants and traffic in drugs does occur. Drug use in Russia has grown rapidly and in 1997 it was estimated there were as many as 1.5 million drug users and substantial numbers were HIV infected. The highest prevalence of drug use in Russia is to be found in regions that are closest to Mongolia, which include Tomsk, Tyumeny, and Irkutsk (the main railway trunk line through Mongolia into China comes through Irkutsk). There are five to six cross border points between Russia and Mongolia and a number of provinces in Mongolia have their own cross route to Russia (Batsukh 2000; Narcotics 2001; National AIDS Foundation (NAF) 2001; T. Voolmann personal communication 2001). China also has a large drug using community estimated at six to seven million half of whom are likely to inject (UNDCP 2000; China Ministry of Health 2001). Traders in the region report there are 12 cross border points between China and Mongolia (Batsukh 2000).

Reports show that the availability and use of marijuana, heroin, amphetamines and over the counter psychotropic drugs (such as diazepam) have increased in recent years. While there is no special production of drugs in the country there are known to be small fields of opium and cannabis cultivation (Ministry of Health (MOH) 2000; Narcotics 2001). Since 1990, the use of alcohol has increased substantially, the problem is nationwide and greatest in major cities and towns. The vulnerability of the population to drug use is exacerbated by age (66% of the population are 0 to 29 years) and high levels of unemployment. According to the 1998 Living Standards

Measurement Survey, 36% of the population are classified as poor (Government of Mongolia 2000; D. Sukhjargalmaa, personal communication 2001). In recent years severe social and economic upheavals have created an environment where the potential for the introduction and widespread use of illicit drugs is a reality. Other substances used include glue, solvents, shoe polish and morphine (MOH 2000).

Fourteen narcotic drugs are listed by the government for medical treatment only, including morphine, codeine and diazepam. Mongolia has two pharmaceutical companies permitted by the Ministry of Health (MOH) to import such drugs. The MOH does not allow these two companies to sell to smaller pharmacies but only to hospitals and large pharmaceutical facilities in rural areas. It is much harder however to control transactions and it is likely that prescription tracking of narcotic drugs is poor. Officially a doctor must only prescribe narcotics after taking a person's medical history in a hospital (NAF 2001; D. Sukhjargalmaa, personal communication 2001). An increase in doctors prescribing morphine has been noted and cases exist where hospitals and service providers are receiving morphine supplies directly from Russia, by-passing the legal regulations established by the MOH (NAF 2001).

Drug taking practices and risk factors

Narcotics are known to be injected and injecting equipment is shared among other injecting drug users (IDUs) (NAF 2001). Reports suggest that syringes are often used many times by the same person (MOH 2000) and this may be a result of their cost. Needles and syringes are reported to be relatively easy to buy from pharmacies without a prescription. A syringe cost about Tugrics 100 – 200 (US\$ 0.1 - 0.2). While they are not considered expensive by authorities it has not been determined if such questions on accessibility and cost has been asked of IDUs. Reports say that IDUs inject by themselves and do not get the assistance of outsiders such as 'professional' injectors or health professionals (NAF 2001). Information about the cleaning techniques of injecting equipment by IDUs has not been determined. It is unlikely the procedures are of a standard to protect against blood born viruses. Cannabis is believed to be smoked (NAF 2001). Substances such as glue, petrol and shoe polish are sniffed. The main drugs of interest to street children are glue sniffing and swallowing of diazepam. Diazepam is sometimes taken with vodka in order to enhance the effect (NAF 2001).

Prevalence and profile

Official and unofficial estimates of how many drug users there are in Mongolia have not been made. In 2000 according the Centre of Mental Health and Narcology in Ulaanbaatar, there were 10 known IDUs who received regular medical checks in the centre (Batsukh 2000). Another study showed that, according to the centre's data, there were only five IDUs registered and all were addicted to morphine due to serious injuries or operations. Overall the number of IDUs is believed to be low (NAF 2001). Unofficially there are more people known to be using drugs in the capital Ulaanbaatar and in the northern and western provinces of the country (Batsukh 2000). In 2001 Mongolia conducted its first rapid situation assessment (RSA) of drug use in the context of HIV/AIDS in three main areas of the country, including two border points and the capital Ulaanbaatar. Approximately 650 people were interviewed. The study showed that the main drugs in use were cannabis (30%), psychotropic drugs such as diazepam (40%), morphine (25%) and glue (5%). During the RSA eight IDUs were

contacted with but all were reluctant to be interviewed (NAF 2001) A recent inspection of the detoxification unit by the MOH in the capital found 27 people had been admitted for diazepam misuse and 12 for barbiturate misuse (NAF 2001). The RSA study shows that drug users are mainly male, aged between 17 and 25, and have had limited educations (NAF 2001).

In 1999, a study conducted by the NGO *Association to Protect Population from Drug and Opium* (APPDO) found that of the nearly 1000 participants aged 15 to 25 years, 45 people used drugs: four used often and 13 would sometimes use drugs. In a voluntary follow up by the Centre of Mental Health and Narcology, seven of the 10 participants used morphine intravenously. In 2001 another survey was conducted by APPDO involving 5000 participants and it showed 140 people used drugs: three were found to be injecting and the drugs used included morphine, cannabis, glue, petrol, shoe polish and cocaine (APPDO 2001).

The first HIV infection was reported in 1992. Mongolia has remained relatively free from HIV infection: only three cases have been reported, two of whom have since died of AIDS. The last death was quite recent and it is believed HIV was sexually acquired in China where the person travelled frequently (NAF 2001; WHO 2001). HIV surveillance surveys are conducted among various population groups (sex workers, blood donors, those attending STD or peri natal clinics) but drug users are not checked. At the end of 1999, the estimated number of people living with HIV/AIDS was 100 (UNAIDS 2000).

Government responses to illicit drug problems

In 2000, there were 17 offences concerning drug abuse, sales and production investigated. Up to June 2001, there were 32 offences involving 90 people connected to drug use, sales and production (Sh. Lkhagvasuren, personal communication 2001). Penalties for trafficking and the use of drugs have not been available.

There is only one drug treatment/rehabilitation centre in Mongolia located in the capital Ulaanbaatar. It is managed by the government and mainly treats chronic alcoholics and drug users. The treatment centre provides detoxification and if necessary uses morphine. While the service is free the facilities are in a poor state and the counselling services made available are regarded as inadequate and poor. The patients stay for 14 to 21 days for detoxification and recovery: this period is usually for alcoholics. The treatment that is available is usually voluntary. Drug users are reported to be able to access and seek support from the traditional 12 step programs in mixed alcoholic anonymous (AA) and narcotic anonymous (NA) meetings in Ulaanbaatar and in other parts of the country (MOH 2000; NAF 2001). The treatment period for drug users is not clear or accessible. Figures on recidivism are not available but it is anticipated the rate is high.

Government response to drug use and HIV

In March 2000 the government established a National Council and approved the National Program against drug use. Appropriate responses to drug use and HIV have yet to emerge. Currently the program emphasises the need for non-government organisation and community involvement. Although the national committee at the sub provincial level (involving 21 provinces) has been formed, the majority of committee

members have very little understanding about drug issues. The media provides most of the information about drug using issues and drug users, often in a negative and judgemental fashion. A harm reduction approach is not being considered (NAF 2001).

National AIDS Policy

There is no specific policy on the prevention of HIV infection for drug users.

Non-government responses to drug use and HIV

There are four local NGOs involved in the area of drug issues and one such organisation is the *Association to Protect Population from Drugs and Opium*. A lack of knowledge and information activities among the NGO sector has resulted in the focus being on supply and demand reduction. The information, education and communication materials that are disseminated to the general community focus on the dangers of drug use. Recently the *National AIDS Foundation* (NAF), through its support of another NGO, has started a program among drug users, which is based in particular bars in Ulaanbaatar. The NAF has also recently commenced disseminating information, education and communication materials about drug issues to a target population that includes current drug users.

Estimated number of drug users	Unknown
Estimated number of IDUs	10 known
Drugs that are used	marijuana, heroin, amphetamines, psychotropic drugs, morphine, solvents
Drugs that are injected	unknown
Number of HIV infections among IDUs	100 HIV positive among all groups

Country Reference List – Mongolia

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Myanmar

Comparisons: 1997 Versus 2001

Myanmar is considered to have one of the most severe HIV epidemics in Asia due to the high prevalence of injecting drug use and HIV among drug users. Reports suggest there are approximately 150,000 to 250,000 IDUs in Myanmar. In 1997 HIV prevalence among IDUs was 54%, in 2000 this had risen to 63% and in some states was among the highest rate in the world, at up to 96%. National surveillance data shows that IDUs in Myanmar often become infected with HIV early in their injecting careers which is rarely seen elsewhere in the world.

Afghanistan has overtaken Myanmar as the world largest producer and supplier of opium and heroin but Myanmar is still in second place. Throughout the 1990s the drug of choice in Myanmar shifted from the traditional smoking of opium, sometimes through a water pipe, to the smoking and injecting of heroin. In 2001 there was increasing production of methamphetamines which are easy to get on the streets of Yangon and Mandalay. In 1997 injecting began to be seen, not only in the cities, but also in rural areas where shooting galleries were popular. In 2001 this was still the case and usually there was only one set of injecting equipment (often homemade) which was shared. Needles and syringes can be purchased without a prescription, although they are often in short supply, and they are illegal to carry: possession of a needle and syringe may result in a fine and/or six months in prison.

The penalties for drug use in Myanmar are strict as the government has criminalized addiction. An addict must register with the authorities and undertake inpatient drug treatment. Failure to register, or being unsuccessful in treatment, can result in a three to five year prison sentence. It is estimated that drug offenders make up 70% of the prison population where transmission of HIV contributes significantly to the epidemic. The government in Myanmar has been well aware of the link between HIV and IDU since the late 1980s. However, it is only recently that there have been significant changes in the government's attitude. In 2001 the government announced that HIV was of national concern with discussion of a multi-sectoral task force to be established to implement a range of activities aimed at IDUs and their families. But scant resources, the legal constraints of narcotic laws and a focus on abstinence-based treatment options are constraining factors.

History

The earliest recorded evidence of opium being transported and used in Burma is in the late 16th century. By the early 17th century the Dutch East India Company were documenting the profitability of opium in Burma. The cultivation of opium in the north-eastern part of the country is believed to have been introduced by Chinese traders from the Yunnan province where its own common cultivation of opium poppy was documented in 1736. Burmese kings discouraged the use of opium and before colonisation by the British in 1852 opium use was not widespread (Khant and Ne Win 1978; UNODCCP 2001). After the annexation of lower Burma, British administrators began importing large quantities of opium from India, establishing a government controlled opium monopoly. In 1878, the Opium Act made it illegal for any Burmese to smoke opium, which could only be sold to registered addicts, most of whom were Chinese. Before the ban, opium use was widespread and viewed as a scourge on the country. By 1906, the trading of opium was declared illegal but this had minimal impact (Spencer and Navaratnam 1981; McCoy 1991; UNODCCP 2001).

In 1921, the sale of prepared opium from government opium shops ceased, but at no stage was the cultivation of opium poppies eradicated; the Shan State territories, which included the Wa States in the northern part of the country, continued cultivation (Khant and Ne Win 1978). In 1930, there was still an estimated 100,000 opium addicts in the country. In 1948, after independence, the government planned to eradicate opium cultivation within five years but without success. In 1950, and for the next 10 years, the Chinese Nationalists settled into the Burmese Shan states and expanded opium production and trade. From the early 1960s until the mid 1970s U.S. troops in Vietnam, and a growing demand in the West, accelerated the heroin and opium trade. In 1973 it was estimated that 34% of all U.S. troops in Vietnam commonly used heroin. As a consequence of the prospering trade in illicit trade the local population became affected and epidemics of heroin use was found in the large cities of Burma (Khant and Ne Win 1978; McCoy 1991; Lintner 1993; UNODCCP 2001).

In 1977, there were 20, 269 drug users registered with the health department of Burma and 10 years later this figure had more than doubled (UN 1991). The ruling Burmese Socialist People's Party collapsed in the second half of the 1980s. In 1988 the State Law and Order Restoration Council (SLORC) came to power and from that time heroin use became widespread among youth. In the late 1980s the number of heroin users was estimated at 30,000 and by the early 1990s this figure had increased to 160,000 (McCoy 1991; Lintner 1993).

Current Situation

Myanmar is the second largest producer of illicit opium and heroin, despite a sharp (40%) decline in production since 1996. In the past four years cultivation of opium has declined by nearly a third and in 2000 the potential yield was 1,085 compared to 1,750 in 1997 (Narcotics 1998; Narcotics 2001). In 2001 however, the United States opium yield survey reported that Myanmar currently represented 68% of the world's opium production (80% is produced in South East Asia) and that Afghanistan only produced 6% (US Department of Agriculture 2001). This information contradicts other current literature where it is acknowledged that Afghanistan is the world's largest opium producer accounting for 72% of the world's illicit opium supply. (Narcotics 2001; UNODCCP 2001). Although the Taliban imposed a complete ban on opium cultivation in 2000, and the current conflict will no doubt destabilise opium production for some time, the UNDCP estimated recently that Afghanistan may have stockpiled as much as 60% of its opium production each year since 1996 (Bach 2001) and so is likely to remain the major supplier of opium for the world.

The decline in opium production in Myanmar is not solely the result of government efforts to eradicate the crops but is linked to recent adverse weather conditions affecting the areas during the planting season (UNDCP 2000; Beyrer *et al.* 2000; Narcotics 2001). The majority of opium poppy is found in the mountainous Shan plateau, which extends the entire length of the Shan State from the Chinese to the Thai border. It is frequently tended on a small scale by peasant farmers belonging to the various ethnic hill tribes (nearly half the population of Myanmar is believed to have an ethnic minority background). It is estimated that up to 300,000 of these people depend on opium poppy cultivation as a cash crop to supplement their subsistence existence (Department of Foreign Affairs 2001; UNODCCP 2001; Beyrer

2001). Recently western Myanmar has also become an important area for opium cultivation (Beyrer *et al.* 2000).

Armed groups are often found controlling the opium growing areas and what is not consumed by the locals is transported to various refineries located near the border of China and Thailand and transformed into heroin. For many indigenous people living in this area opium has been used for medicinal and ceremonial reasons and has become an integral part of the culture. Over time heroin use has become increasingly common in these areas. Most heroin is produced in small mobile laboratories, it is then largely trafficked through the porous Chinese and Thai borders. In 1999/2000 the Myanmar government destroyed 21 heroin refineries (Morineau and Prazuck 2000; UNDCP 2000; UNODCCP 2001).

The Central Committee for Drug Abuse Control (CCDAC) has found that heroin and opium are the main drugs of choice. It is reported that heroin tends to dominate in the Kachin State, in the Northern Shan State and in most of the large cities. For example in 1997, in the capital Yangon, 98% of those at the treatment centre used heroin. In the City of Myitkyina another study showed that in 1991 heroin use represented 0.7% of the total and by 1997, 95% were using heroin. Opium use is believed to dominate in the Eastern and Southern Shan State and in Kayah State. The pattern of drug use has tended to follow the drug trafficking routes and the availability, affordability and accessibility of the drugs (Porter 1994; UNAIDS and UNDCP 2000; Dorabjee 2001).

An increasing amount of methamphetamine production is taking place mainly in the Wa region and southern Shan State and most is trafficked to Thailand across the land border. There are also increasing discoveries of methamphetamine tablets being trafficked through to China, Laos, Cambodia, India and Vietnam. The current high rate of seizures show the use of methamphetamine may also become a serious problem and is spreading inland from the border areas; in 1999/2000 56 million methamphetamine tablets were seized by government authorities (UNAIDS and UNDCP 2000; UNDCP 2000; Narcotics 2001; UNODCCP 2001). Laboratories in the Wa territory are believed to be producing hundreds of thousands of these tablets each day. Each methamphetamine tablet costs about (U.S\$ 0.08) to produce and sells in Bangkok for around U.S\$3.00 (Cooke 2000). Stories are told of occupational amphetamine use among miners and seafarers, and of the easy availability of amphetamines on the streets of Yangon and Mandalay. With both heroin and methamphetamine precursors, chemicals are required and acetic anhydride and ephedrine respectively are sourced from China and India (Narcotics 2001). Other drugs used in Myanmar include, morphine, pethidine, cough mixtures containing codeine, marijuana, ephedrine, phensedyl, opium oil, stimulants and tranquillisers (UNAIDS and UNDCP 2000; UNODCCP 2001; Ministry of Home Affairs 2001).

Drug taking practices and risk factors

Throughout the 1990s the drug preference has gradually shifted from the traditional smoking of opium sometimes through a water pipe to the smoking and injecting of heroin. This transition has occurred either as result of cost or the desire for an instant effect. Opium use still remains popular as shown from the national data of 1998; among the registered drug users; 60% used opium and 30% used heroin (UNAIDS and UNDCP 2000; UNODCCP 2001). However, in some areas of the country such as Kachin State, in northern Myanmar, figures from a detoxification centre show 96%

used heroin. Among this group 40% inhaled, 47% injected and the rest used both methods. The study showed a tendency for drug users to smoke/inhale heroin for the first year and then move onto injecting. For those injecting, 14% used the blow pipe method in which a rubber hose is fitted to a needle, blood is then drawn into the hose, mixed with heroin and then blown back into the vein. The blowpipe is then systematically passed around to other drug users in attendance (Morineau and Prazuck 2000). Other methods have included using eyedroppers with an attached needle. Most of this equipment is impossible to sterilise and consequently the risk of HIV infection is great (UNAIDS and UNDCP 2000).

In the mid 1990s it was reported that many drug injectors had their first injection from a professional injector and that these injectors were used by drug users when they were away from their home area. Many professional injectors work in a drug injecting tea shop or 'shooting gallery' where for a fee, a drug user is administered with heroin. In some 'shooting galleries' heroin is only sold on the condition that it will be consumed on the premises, which presumably reduces the risk of police activity. The risk of HIV in such environments remains great as sterilisation of the various injecting paraphernalia items is rarely a consideration. Recent reports indicate that little has changed with high risk behaviours in 'shooting galleries' still widespread and access to such sites to implement HIV prevention activities still proving to be both sensitive and a challenge (Stimson 1994; Prazuck 1997; Morineau and Prazuck 2000; UNODCCP 2001).

The sharing of needles and syringes remains widespread and a recent study showed that 61% of IDUs using heroin shared their equipment. The same study showed that the rate of sharing could relate to occupation; among the farmers it was 91% compared to non-farmers, which was 46%. The results of the survey also showed that for those with experience of more than one detoxication treatment the rate of sharing was 69% and for those in treatment for the first time it was 55% (Morineau and Prazuck 2000). Earlier studies have shown similar sharing practices with many using the same needle for several weeks until it became blocked or blunt. For those cleaning their injecting equipment the results are nearly always inadequate to prevent HIV transmission (UNDCP 1994; Southeast Asian Information Network (SAIN) 1995; SAIN 1998). The modification of HIV risk taking among IDUs has, however, been achieved at the Yangon Drug Dependency Treatment and Research Unit. In 1992 it was found 95.7% had ever shared drugs and injecting equipment and by 1996 this level had been reduced to 70.6% (Doe 2001).

How freely available needle and syringes are to buy probably depends on the area of the country. Some reports show that in the markets of large towns needle and syringes are on open sale along with a variety of injectable preparations but some drug users considered them expensive (Stimson 1994; UNAIDS and UNDCP 2000). Other reports suggest an extreme shortage of such equipment (SAIN 1995; SAIN 1998) and in remote parts of the country this is likely to be the case. A major factor compounding the high rate of sharing is that it is illegal to possess a needle and syringe: it is punishable by six months in prison or a fine or both. Such regulations are likely to make it difficult to keep injecting equipment in the home for fear of discovery by family members (Stimson 1994; UNAIDS and UNDCP 2000). The current cost of a needle and syringe is around 25 Kyats for a 3cc and a 5cc and 65

kyats for a 20cc (US\$ dollar = around 600 to 700 kyats: US\$ 0.05 to 0.10 per units, retail price) (G. Le Hegarat, personal communication 2001).

Prevalence and profile

In 1998, the number of registered drug users was 66,076 and by 1999, it was officially 86,537 (UNAIDS and UNDCP 2000; Narcotics 2001). However, with an escalation of drug use throughout the country, the overall level of opiate use is likely to be significantly higher than reflected in the drug registry. UNDCP and various NGOs have estimated as many as 300,000 to 500,000 drug users are in the country (Chelala and Beyrer 1999; UNAIDS and UNDCP 2000; UNODCCP 2001). It has been difficult to determine how many of these are IDUs but in 1996 an estimate of around 300,000 nationwide out of total population of 40 million was made (Prazuck 1997). Recently it has been suggested by UNDCP that conservatively up to 50% of all drug users in the country are injecting (Department of Foreign Affairs 2001). Consequently a conservative figure of 150,000 to 250,000 are likely to be IDUs.

In the mid 1990s, the areas identified as having a high prevalence of drug use were Yangon, Mandalay, the Sagaing Divisions, the Shan and Kachin States (all include the main urban centres), the mining areas and the north-eastern border areas. The use of drugs is mainly found among young men in the cities, seasonal workers in the mining sector and the youth in the north-eastern drug producing areas (UNODCCP 2001). In the mid 1990s an estimated 3,000 IDUs resided in the city of Myitkyeena and a further 5,000 IDUs could be found in the city of Lashio (Prazuck 1997). In the same area an estimated 20-25% of the truck drivers occasionally injected drugs in the mining towns such as Phakhant in Kachin State (UNDCP 2001). It has been suggested many youth are vulnerable to drug use as a result of either being unemployed or under-employed; many universities have been closed for three to four years obstructing their education (UNAIDS and UNDCP 2000).

A particularly vulnerable group is the rural seasonal migrant workers visiting the nearby jade and ruby mining areas of Lashio in the Northern Shan State. Many frequently travel between their homes and these sites of employment. Up to 500,000 may visit these areas each year where heroin use, attendance at the numerous 'shooting galleries' and a thriving commercial sex work scene is widespread (Prazuck 1997; UNAIDS and UNDCP 2000). Drug users arrested in recent years have included government servants, students, traders, and farmers. In 2000, of those arrested under the Narcotic Drugs Law, 18% were female, a figure that has changed little in recent years (Ministry of Home Affairs 2001).

HIV was first introduced to Myanmar in the mid 1980s and in 1988 the first HIV/AIDS case was recorded. Within a year an emerging epidemic of HIV among IDUs was identified; in 1989 a survey in Bhamo, Kachin State found that the HIV prevalence among IDUs was 96%. The appearance of HIV infection among IDUs in Yangon closely paralleled the 'epidemic' of intravenous heroin use which commenced in the late 1980s (Doe 2001). Since that time HIV prevalence among IDUs at drug dependence treatment units still remains among the highest in the world (Wrigley 2001; WHO 2001). Myanmar has one of the most severe HIV epidemics in Asia, largely as a result of the high risk behaviour among the nation's IDUs. Myanmar has been conducting small scale HIV testing since 1985 but it was not until 1992 that the country commenced conducting bi-annual sentinel surveillance of

HIV/AIDS (UNAIDS and UNDCP 2000). The HIV epidemic among IDUs is believed to have resulted from the removal of various barriers to drug use, these were as follows: the lack of restriction of trafficking, the sale and use of drugs; the widespread mixing of drug users from different townships; the cheap availability of drugs; and the difficulty of finding clean injecting equipment (Doe 2001).

In 1997, it was estimated 440,000 adults and children had HIV/AIDS and that 86,000 people had already died from AIDS; as a result an estimated 14,000 children had been orphaned (UNAIDS and UNDCP 2000). At the end of 1999, it was estimated 530,000 adults and children have HIV/AIDS and the cumulative number of orphans as a result of losing their mother or both parents to AIDS is 48,000 (UNAIDS and WHO 2000). The annual number of adult AIDS cases has been calculated by UNAIDS to be 46,000 in 2000 and is projected to reach 55,000 in 2005 (WHO 2001). During the period 1988 to March 2001 a cumulative total of 33,553 HIV infected cases and 4,598 AIDS cases were recorded. A total of 1,973 AIDS deaths were reported to various hospitals in different regions of the country. Most people were aged between 20 and 40 years and the male to female ratio was six to one (Ministry of Health 2001a).

Reports suggest that IDUs in Myanmar often become infected early in their injecting career, as shown in the national surveillance data, a pattern that is rarely seen anywhere else in world (UNAIDS and UNDCP 2000). Data from the national surveillance over recent years show HIV prevalence among IDUs in 1997 at 54%, 56% in 1998 and in 1999 at 51%. In 2000, the HIV prevalence rate among IDUs had increased to 63% (Department of Health (DOH), 1997; DOH 1998; DOH 1999; DOH 2000; WHO 2001). Commercial sex workers (CSW) are another group increasingly at risk of HIV infection. In 1992, HIV among CSW was 4.3%, rising to 26% in 1997 and in 2000 the figure was 38%. Information about drug use among CSW is scant but has been documented and the link between IDUs visiting CSW and being involved in unsafe sexual practices is acknowledged (UNAIDS and UNDCP 2000; DOH 2000; Wrigley 2001). In 2000, at the sentinel sites (drug users are only routinely tested on average at 4 to 6 of the 21 selected sites) the HIV prevalence rate of IDUs in the various major urban centres were as follows: Yangon (37%), Mandalaly (58%), Lashio (76%) and Myitkyeena (90%). The figures in the various sites have fluctuated over the past five years but overall remain consistently high (DOH 2000).

Government responses to illicit drug problems

In 1974, the government enacted the Narcotic and Dangerous Law to provide a broad legal framework. In 1993 it was replaced by the Narcotic Drugs and Psychotropic Substance Law. This law not only provides for the destruction of narcotic crops and confiscation of equipment but also prescribes a series of penalties which can include the death penalty to be imposed upon drug violators under certain circumstances (MOH 2001b). Even so it has been suggested that both policy and judicial officials have been slow to implement the law, targeting few if any, major traffickers and their drug related assets (Narcotics 2001).

The law follows a series of guidelines for registered drug users whereby they attend a place designated by the Ministry of Health or a government recognised medical centre. Those that don't register are punished with imprisonment for a minimum of three years to a maximum of five years. Drug users are obliged to appear with their parents when registering for treatment and are issued with a card which they must

carry with them to confirm registration. Determining how long the drug user is registered has not been confirmed (UNAIDS and UNDCP 2000; MOH 2001b).

On first admission, drug users are kept within the drug treatment centre for five to six weeks, the first 2 weeks centres on detoxification using opium tincture followed by various prescribed medications (*diazepam*, analgesics). It has been estimated the relapse rate is 60 to 70%. Upon a second or third visit, drug treatment is usually for two to three months and the program is much the same as for the first visit. It has been reported that treatment is free but it has also been suggested the drug user or their family pay for the fees. A mixture of the types of methods used, and the many unqualified staff, or lack of staff available to deal with the complexities of drug users lives has probably had the effect of driving many drug users underground (UNAIDS and UNDCP 2000). The many drug users who have not sought treatment and are then caught, are sent to prison (UNAIDS and UNDCP 2000). It is difficult to assess how many prisoners are there as a result of drug use (data is not available) but it can be anticipated that the figure would be great. It is likely the transmission of HIV in prisons through injecting, both medical and non-medical, contributes disproportionately to the Myanmar HIV epidemic. In the mid 1990s prisoners were not allowed reading materials about HIV transmission (UNDCP 1994), but the current situation on this issue is uncertain.

Since 1997, 30 drug treatment centres have been established and the locations of six major drug treatment centres (DTC) are found in Yangon, Mandalay, Myitkyeena, Taungyi, Lashio and Kyaing Tung. There are also 22 subsidiary centres which are to be found in Kachin State (4), Sagaining Divisions (10), Shan State (5), Mandala Division (2) and Mon State (1). There are also what are called two comprehensive centres. The township hospitals are also to provide drug treatment services in those townships without DTC. Currently the six major DTC have 250 beds in total and the yearly capacity has been estimated at 2000. (Ministry of Health 2001b). While attempts will be made to increase the number of beds and facilities to serve this population it is clear the current capacity to assist drug users is totally inadequate. The Ministry of Social Welfare is responsible for providing rehabilitation and after care for those leaving the DTC. Currently there is only one rehabilitation centre in the country offering social and practical skills training (UNAIDS and UNDCP 2000).

Government response to drug use and HIV

The government, and its polices, have been responsive towards the HIV epidemic but the sustained activities over the years have been more orientated towards the bio-medical sphere. At the senior policy level there has been a real reticence or ambivalence towards dealing with the underlying issues of HIV/AIDS. In 2001 however, there were significant changes in the government's attitudes towards the HIV epidemic. At the recent United Nations General Assembly Session on HIV/AIDS in New York, the Deputy Minister of Health stated: 'we are fully aware of the tremendous toll it could exact, not only on the victim alone but also to society as a whole. Consequently, HIV/AIDS has been designated as a disease of national concern and Myanmar is committed to fighting this disease by all its available resources' (The Myanmar Times 2001). How this will manifest in dealing with the high HIV prevalence among IDUs remains unknown.

The Burma Excise Act of 1905 which prohibits the making, selling, possessing or use of a hypodermic needle without a licence is still being implemented and as a consequence high risk behaviour among IDUs remains (UNAIDS and UNDCP 2000). However, in April 2001 the Myanmar Police Force commander issued instructions not to enforce these stipulations, but it is not yet clear how this new instruction will be followed (G. Le Hegarat, personal communication 2001). Disseminating these new instructions may take time and therefore the law as it stands is likely to remain a major obstacle for early prevention and effective peer education approaches for reaching out to active drug users. This is reflected in areas where high risk injecting behaviour inside 'shooting galleries' remains obvious. Access to these establishments by NGOs willing to offer HIV preventative measures (such as supplying bleach to clean needles) is still regarded as highly sensitive by government authorities (Morineau and Prazuck 2000; UNAIDS and UNDCP 2000). Drug treatment is orientated completely towards total abstinence and substitution therapy has only recently been considered on a pilot basis (G. Le Hegarat, personal communication 2001). Information and HIV preventative programs using a peer education approach inside DTC have been operating on a low scale but it has been difficult to gauge how specific and explicit the information is.

National AIDS Policy

The National AIDS Program (NAP) is within the Ministry of Health and its policy was established by the National AIDS Committee. The issue of HIV/AIDS in Myanmar is of national concern and has been recognised by the Ministry of Health (MOH) as one of the three priority communicable diseases. The National Health Plan ranks drug abuse as priority number seven. Among the various specific objectives to address the HIV epidemic the NAP has stated the need to prevent HIV transmission among IDUs. Recently the response of the UN Theme Group for HIV/AIDS in Myanmar, in coordination with the MOH, has been to focus on seven priority areas including reducing the harmful consequences of IDU.

Appropriate information, education, counselling, care and support will need to be made available to IDUs and their families and communities affected by HIV/AIDS. A multi-sectoral task force will be established to implement a range of activities. Currently, various activities have yet to be implemented and it is not known how they will work considering the various constraining factors for preventative interventions to occur. These include; scant resources to deal with the many social and health issues, the legal constraints of narcotics laws and the regulations focusing on abstinence oriented treatment objectives (UNAIDS and UNDCP 2000; UNAIDS 2001; MOH 2001a).

Non-government responses to drug use and HIV

In 2001 there are 16 National NGOs working in Myanmar on issues related to HIV/AIDS including six international NGOs. Several of these have very small programs and have restricted themselves to single issues or geographic locations. Those that work specifically on drug use and HIV vulnerability are more limited. *World Concern* has a peer education program for IDUs in Kachin State with the aim of preventative education and raising awareness of the risk associated with injecting while also discouraging IDU among high risk groups. *Medecin du Monde* has been working in Kachin State with IDU since 1996. Much of their work is closely linked

with local treatment centres, providing preventative education about HIV/AIDS and the safe use of injecting equipment. Currently they are attempting to link up with a small number of shooting galleries, to provide preventative education and a bleach program for IDUs. *Population Services International* has been operating since 1997 and running successful programs in the social marketing of condoms. They have not worked with drug users but it is likely they will soon adopt a policy of applying social marketing to drug use and HIV vulnerability (UNAIDS and UNDCP 2000; World Concern 2000; Morineau and Prazuck 2000; UNAIDS 2001).

Of all the national NGOs the most prominent is the *Myanmar Anti-Narcotics Association*. Their main role is to assist the national program in suppressing the use of drugs, to educate the community about drugs and improve rehabilitation services which they believe prevent the spread of HIV among IDUs. They attempt to address behaviour change in the community and at school and are also involved in conducting surveys on drug use attitudes, knowledge and behaviours. Essentially their role is to promote a demand reduction approach and to encourage abstinence from drugs. All the NGOs are extremely aware of the political sensitivities of their activities in this area and consequently do not openly acknowledge the exact nature of their work or their activities (UNAIDS and UNDCP 2000).

Estimated number of drug users	300,000 to 500,000
Estimated number of IDU	150,000 to 250,000
Drugs that are used	heroin, opium, methamphetamines, morphine, pethidine, codeine, marijuana, ephedrine, phenseydl, opium oil, stimulants, tranquilizers
Drugs that are injected	heroin
Estimated number of HIV infections among IDUs	HIV prevalence among IDUs is 63%, in some states as high as 90%

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Nepal

History

Cannabis has been used in Nepal for centuries and was traditionally associated with religious festivals. In the 1960s the ease of availability of cannabis, and a tolerant attitude to drug use, led to an image abroad of Nepal as a Shangri-La which attracted foreign tourists: the so-called 'hippies'. By the mid 1970s this image was beginning to fade as stricter drug legislation and controls were enforced (Jutkowitz *et al.* 1997). Heroin was introduced to Nepal in the mid-1960s and was mainly smoked or chased (UNAIDS and UNDCP 2000). The first case of heroin abuse was reported in 1976 and by 1985 it was estimated that there were 12,000 addicts in the Kathmandu valley (Ray 1998).

In 1990 the introduction of buprenorphine changed the drug use culture and by 1991 it had replaced heroin as the drug of choice among opioid-dependents and initiates. Buprenorphine has been increasingly administered by injection, given the availability of the injectable form. The majority of Nepal's drug users are in the Kathmandu and Pokhara valleys (UNAIDS and UNDCP 2000; Bharadwaj *et al.* 2001). By the mid 1990s Nepal experienced an explosive HIV epidemic, which impacted substantially upon the injecting drug using population (WHO 2001).

Current Situation

While Nepal is not a significant producer or a major transit point for narcotics the local use of heroin (number three) is reported to be increasing although this may be a moot point (Narcotics 2001). The cultivation of cannabis, particularly in the lowland areas is well established. It has been suggested that there may be some small scale opium cultivations, but it is widely believed all heroin used in the country has its origins from elsewhere. It is believed Nepal produces a considerable amount of cannabis and most of this is diverted to the Indian market. Patterns of seizures, and the arrests of those linked with heroin and opium, have remained relatively similar over the years and most drug seizures occur at the Tribhuvan international airport in Kathmandu (Narcotics 2001).

The number of injecting drug users (IDUs) is increasing all over Nepal. They have a high prevalence of HIV/AIDS and in addition to their unsafe injecting behaviour, their high-risk sexual behaviour has contributed to an overall increase in HIV among them (MEH 2000). A Rapid Situation Assessment (RSA) in early 1999, covering most of the urban area of the southern part of the country, found that the majority of drug users interviewed (36.5%) had education up to year 9 to 10, that almost 7% of drug users were illiterate and that most respondents felt peer pressure and unemployment were the main determinants of drug use (UNAIDS and UNDCP 2000). The government's Situation Analysis (NCASC 2000) says that illicit drug users come from all family backgrounds, caste, socio-economic and educational status (Burrows *et al.* 2001).

The official government view is that there are 50,000 illicit drug users in Nepal of whom 20,000 are IDUs but it is likely that the number of IDUs is substantially higher. The most commonly used drug is buprenorphine (commonly known as Tidigesic)

which is injected. The number of women IDUs appears to be low: in the 1998 RSA there were only four women among 1108 illicit drug users interviewed (Karki 1999). However, the stigma of being a woman IDU in the Kathmandu Valley is extreme so women IDUs are much more carefully hidden than male IDUs. (Burrows *et al.* 2001). A recent survey of 300 female sex workers in Kathmandu found that 5% had injected drugs and 11 of these 15 were HIV positive (Burrows *et al.* 2001).

The NGO Richmond Fellowship Women's programme has identified 20 to 25 sites in Kathmandu where women are injecting drugs: they reported that the women were living in very depressed conditions often without access to clean water and sanitation. Most of the women had children, many of whom were illegitimate which is problematic in Nepali society (Burrows *et al.* 2001). Commercial sex work is not illegal per se in Nepal but female sex workers may be arrested for causing social disturbance; sex between consenting adults for cash or kind is not strictly illegal (J. Ross, personal communication 2001). It is estimated that as many as 50% of the women returning from India, where they have worked in the sex industry, are HIV positive (UNAIDs and UNDCP 2000).

Drug taking practices and risk factors

Injecting drug use is a relatively recent phenomenon among Nepalese people in Kathmandu. Injecting drug users in Nepal were initially believed to share injecting equipment in relatively small and isolated networks but since the mid 1990s an explosive increase in HIV infection has occurred in IDUs throughout the country (Chin 1999). The ritual of injecting heroin is fairly standard in Nepal. Water and a vitamin C tablet (or lemon juice) are added to assist in the dissolving process, a match or a lighter is used to heat the drug solution and then a cigarette filter is used to draw up the drug before injecting. Tidegesic is usually mixed with other pharmaceutical drugs such as avil or phenergen. It is common to inject in the arms although there are increasing reports of injecting into the veins in the neck when traditional injecting sites no longer prove feasible (Peak *et al.* 2001).

Poly drug use is common and may include marijuana, tidigesic, phensydryl, alcohol, codeine, nitrazepam, 'brown sugar' heroin cooked with vitamin C and diazepam. The usual price of brown sugar is NRs 600 (US\$8.30) a gram with a half a gram used in each injection. Tidigesic costs NRs 60 – 100 (US\$0.83 – 1.30) for one ampoule bought on the black market (it is no longer for sale in Nepali pharmacies) (Burrows *et al.* 2001). A popular myth in Nepal is that injecting 'brown sugar' is safer than injecting Tidigesic: the theory is that the time taken to prepare a shot of a 'brown sugar', including heating the liquid, kills HIV whereas the breaking open of a Tidigesic ampoule, drawing up and injecting is so fast that HIV stays alive (Burrows *et al.* 2001). One survey found that a few respondents reported collecting cottons (used for filtering cooked 'brown sugar') from friends and injected the water squeezed out of those cotton balls: generally these are free but are occasionally sold (Burrows *et al.* 2001). There are no formal reports of the use of amphetamine-type stimulants in Nepal, however there are some isolated anecdotal reports of its introduction (Burrows *et al.* 2001).

Heroin is usually injected two to three times per day while Tidegesic is injected two to four times a day (Peak *et al.* 2001). A 1998 assessment found that Kathmandu IDUs were injecting, on average, 16 times a week. (Burrows *et al.* 2001). Needles and

syringes are available but it is point of contention as to whether they are always easy to get. It has been shown that IDUs who do not have a doctor's prescription may be charged a higher price or refused service depending on the proprietor (J. Ross, personal communication 2001). Most drug users tend to buy their injecting equipment from a pharmacy for around NRs 5-10 (US\$0.07 – 0.14), ranging in size from a 1ml to 5ml. Tidigesic is purchased from various sites. In Birantagar, many IDUs will cross the border into India (just 10 kilometres away, IDUs often use public transport to get there) to buy Tidigesic at 'teashops'. At these sites the drug users buy the drug and use on site; for an additional fee of NRs 5 (US\$0.07) the proprietor of the establishment will also administer the drug (Peak *et al.* 2001). It is not known how widespread the practice of using a 'professional' injector is in Nepal but the practice of helping other IDU friends to inject is common (Peak *et al.* 2001).

A survey of 200 drug users in 1997 by the NGO LALS found the average age respondents first injected was 20 years. The average time gap between the age of first drug use and first injection was three years (Maharjan *et al.* 1997). Needle and syringe sharing remains common risk behaviour for IDUs throughout the country. A 1999 survey of 92 methadone clients found that 36% had shared injecting equipment (Burrows *et al.* 2001). It is common for IDUs to inject one another and as a general rule there is little time or preparedness to sterilise injecting equipment between use (Karki 1999; UNAIDS and UNDCP 2000; Peak *et al.* 2001).

The cleaning of injecting equipment is generally inadequate. Commonly saliva, urine, cold and hot water are used and some drug users use bleach (Karki 1999; Peak *et al.* 2001). Pharmacies sell needles and syringes but will often raise the price if they suspect the buyer is a drug user. A survey of a methadone treatment seeking population in Kathmandu found that 82% were injecting in 1994, increasing to 96% in 1996 (UNAIDS and UNDCP 2000).

Prevalence and profile

The National Centre for STD and AIDS Prevention estimates that there may be between 40,000–50,000 drug users from a population of about 20.9 million people in Nepal (UNAIDS and UNDCP 2000). A recent study into injecting drug use in selected sites of the terai (outside of the Kathmandu Valley) of Nepal was undertaken. Eight sites were selected and the estimated number of drug users and percentage of IDUs are as follows: Biratnagar (5,000 to 7,000 drug users of which an estimated >75% are IDUs); Birgunj (800 to 2,000 drug users of which an estimated 40-50% are IDUs); Damak (500 drug users of which an estimated 40% are IDUs); Dharan (4,000 to 5,000 drug users of which an estimated 80% are IDUs); Hetauda (1,000 to 1,5000 of which 10-15% are IDUs); Kakarbhitta (200 drug users of which 40-50% are IDUs); Nepalgunj (2,500 of which are estimated 50% are IDUs); and Pokhara (5,000 to 10,000 of which an estimated 60-70% are IDUs) (Peak *et al.* 2001).

In Kathmandu, 1.6 % of IDUs tested in 1991 were HIV positive (Karki 1999). In 1993 and 1994, no evidence of the virus was found among IDUs tested at that time. However, by 1997, 50 % of IDUs tested in Kathmandu were HIV positive (UNAIDS 2000, Oelrichs *et al.* 2000, Furber *et al.* 2001, Burrows *et al.* 2001; Karki 2001).

The increase in HIV prevalence is believed to be due primarily to changes in the type of drug used, that is the significant shift to the use of injectable buprenorphine (Chin

1999). High risk injecting behaviour is also reflected in the hepatitis C prevalence in Nepal: about 72% of drug users were found to be injecting and 94% of IDUs were hepatitis C positive (Oelrichs *et al.* 2000). The first case of AIDS in Nepal was reported in 1988 (MEH 2000). Government statistics to the end of 2000 show cumulative totals of 1,807 people infected with HIV of whom 455 have developed AIDS and 142 AIDS related deaths (Furber *et al.* 2001). The estimated HIV prevalence at the end of 2000 is 34,000 and the number of those living with AIDS is 3,000; the number is expected to double by the year 2005 (UNAIDS 2000; WHO 2001). HIV prevalence among blood donors in Kathmandu has almost doubled from 1997 to 1998 from 0.28% to 0.48%. Prisoners are not routinely screened for HIV.

Figures from the Minister for Health suggest that nearly 75% of HIV positive people are youths aged between 15 and 29 years. The estimated HIV prevalence in Nepal is currently less than 0.5% of the total 15 to 49 year old population. In the absence of effective public health interventions HIV prevalence in Nepal may, over the next decade, increase to 1 to 2% of the 15 to 49 year old population. This would mean that 100,000 to 200,000 young adults would become infected with HIV (Chin 1999).

Government responses to illicit drug problems

Drug use is itself illegal in Nepal and the government's aim is to achieve 'zero drug use'. The Narcotics Drugs (Control) Act, 2033 (1976) states that cultivation, production, preparation, manufacture, export, import, purchase, possession, sale or consumption of most commonly abused drugs is illegal (Narcotics 1998; Narcotics 2001). The maximum penalty for drug trafficking is 33 years imprisonment (UNAIDS and UNDCP 2000).

There are no laws which specifically prohibit the use of methadone or other opioid substitution treatment (UNAIDS and UNDCP 2000). Needle and Syringe Programmes (NSP) are not unlawful since there are neither paraphernalia laws prohibiting possession of needle and syringes nor any laws to suggest selling them breaches any legal provisions. But, there seems to be confusion about this among the bureaucracy and the police. The public health rationale behind NSP is not accepted by many senior officers in the government and instead is seen as counterproductive (UNAIDS and UNDCP 2000). The main focus in the Ministry of Home Affairs is on demand reduction and they do not agree with the implementation of NSP. However, the Ministry of Health has advocated for this strategy to be implemented (UNAIDS and UNDCP 2000). The specialised HIV/AIDS sector is not involved at any level in drug policy in Nepal and *visa versa*.

Government responses to drug use and HIV

There is no specialised drug treatment sector in Nepal. Treatment and rehabilitation are almost exclusively provided by NGOs who receive no financial support from the government. However, there are a small number of beds reserved for in-patient detoxification in two government hospitals in Kathmandu. Since 1994 a methadone maintenance programme has been operating at the Mental Hospital in Lalitpur: the program has 270 registered clients of whom 135 attend the hospital every day for dosing. The program costs NRs 20 (US\$0.27) for a 40mg dose: the average dose is 40 – 60mg with no upper limit. The World Health Organisation provides the methadone tablets for the program. The HIV sero-conversion rate among clients has been 2% per

year, much lower than the general population of IDUs in the Valley (Burrows *et al.* 2001). There is great demand for the program to expand but currently the government will not allow this. The majority of drug users are placed in custody at police stations or are confined in jails; often they have been referred by their families (UNAIDS and UNDCP 2000). In some treatment and rehabilitation settings HIV infected or Hepatitis B positive users are not admitted (UNAIDS and UNDCP 2000).

A government detoxification centre at a Kathmandu teaching hospital provides medicated detoxification for 15-20 days. Clients must pay for all medications and must bring a family member to stay with them. Assra Sudhar Kendra Drug Rehabilitation Centre (Assra) is a secured camp in Kathmandu for drug dependent people. Clients must pay for the programme which lasts for three months. It is run by the police and all inmates are tested for HIV. The relapse rate, after drug treatment is very high (Burrows *et al.* 2001).

National AIDS Policy

The government adopted a national policy on AIDS and STD prevention in 1995 (National AIDS Programme of Nepal) and the strategic Plan for HIV and AIDS in Nepal 1997 – 2001 is the current policy. This plan proposes the strengthening of access to drug treatment and rehabilitation, the provision of sterile needles and syringes to drug users through NGOs and a review of the legal context of illicit drug use in relation to HIV prevention activities (UNAIDS and UNDCP 2000). The processes of policy development and implementation for control of illicit drug use and for control of AIDS are entirely separate. A clear cut national strategy is still lacking in Nepal (MEH 2000). The annual government budget (development) for AIDS control is limited to NRs 1.5 million (US\$20,575) which looks more like symbolism than serious commitment (MEH 2000).

Non-government responses to drug use and HIV

Existing drugs or HIV/AIDS services are not reaching the overwhelming majority of IDUs in Kathmandu: harm reduction outreach services are reaching fewer than 10% of IDUs and less than three per cent are being provided with drug treatment and rehabilitation (Burrows *et al.* 2001). It is estimated that the current reach of all NGO residential drug rehabilitation services for male IDUs in Kathmandu was 350 in the past 12 months, to January 2001 (Burrows *et al.* 2001). Little evidence-based drug education is targeted to the general community and there is community and police misunderstanding and opposition to drugs and HIV/AIDS services.

Non-Government Organisations are very active in Nepal: one estimate suggests that there are at least 10 International NGOs, 13 central NGOs, a large number of district level NGOs and five UN agencies including UNAIDS which have developed programs for the prevention and control of HIV/AIDS in Nepal (MEH 2000). But, there are only a small number of NGOs working in the drug-related HIV prevention area. Two NSPs operate in Nepal: at the Life Giving and Life Saving Society (LALS) in Kathmandu and out of International Nepal Fellowships (INF) in Pokhara; it is believed NSP in Pokhara is not officially recognised (UNAIDS and UNDCP 2000; Burrows *et al.* 2001).

Since 1991, LALS, Kathmandu has been working with drug users providing harm reduction outreach and introduced a NSP, the first in a developing country. Between 1993 and 1997 the number of clients visiting, or visited by, LALS increased from 450 to 1,025. In 1997 an HIV sero-prevalence was undertaken in Kathmandu of 200 drug users found on the streets, in shooting galleries, hotels and temples. The results suggested that those people who had attended LALS had experienced a degree of protection from HIV, that is, LALS had a discernable public health impact (Wodak 2000; UNAIDS & UNDCP 2000). However, in 1997 LALS also underwent a 50% cut in funding which massively reduced their services at a time when HIV among IDUs was estimated to be 45%. Other NGOs focusing on drug users include: Punarjiwan Kendra, Kirat Yakthung Chumlung (KYC) Revival Centre which provides a drug detoxification, treatment and rehabilitation programme over six months in Dharan. The NGO HELP provides vocational skills training and focuses on understanding drug use patterns and risk behaviours of IDUs in Biratnagar in the Morang district (Peak *et al.* 2001).

In the Kathmandu Valley there are three-drug rehabilitation centres. The Freedom House (FH), established in the early 1980s by a Jesuit mission, offers a non-medicated detoxification service. It also offers a residential rehabilitation service for a minimum of three months taking about 65 residents a year (Burrows *et al.* 2001). Youth Vision was started in 1984 and provides a medicated detoxification (30 beds) for seven days followed by residential rehabilitation (160 to 175 per year) for a minimum of three months. It also offers a wide range of other programs including a drop-in centre, support group for ex-residents (using NA steps), halfway house, outreach and limited vocational training. All staff, except the coordinator are ex-drug users. The Richmond Fellowship (RF) runs a rehabilitation service for male drug users, a drop-in centre and a women's program. It offers a non-medicated detoxification service. The program runs for a minimum of three months with approximately 100 residents a year (Burrows *et al.* 2001).

Estimated number of drug users	40,000 to 50,000 (official figures)
Estimated number of IDUs	20,000
Drugs that are used	buprenorphine, heroin, marijuana, phensydril, alcohol, codeine, nitrazepam, diazepam
Drugs that are injected	heroin, buprenorphine, drug cocktails
Estimated number of HIV infections among IDUs	0.5% of total 15-49 population HIV +, but in Kathmandu 50% of IDUs tested were HIV positive

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Pakistan

History

Pakistan has a long history of the cultivation and use of opium and cannabis, as is the case in many countries in the region. During the time of British colonial rule, when Pakistan was a part of the Indian subcontinent, the taxes and levies raised from opium poppy proved an important source of revenue for the authorities. While opium production flourished in various parts of India (such as Bengal and Kashmir) it was not so widespread in the Pakistan region, except in limited quantities in the tribal areas. In the late 19th century opium was often referred to as 'Afghan Opium' and amounted to around 40 tons annually (Haq 1996; Narcotics Control Division, Government of Pakistan (NCD) 1998). At that time, and for years later, most opium used for addicts was imported from India and retailed through Government licences shops under regulation (NCD 1998). Traditionally, opium has been used for the relief of body aches and pains, diarrhoea and various other ailments (UNDCP 1998).

Soon after Pakistan achieved independence in 1947, commercial domestic farming of opium began with selling taking place through legal opium vendors. Opium production was encouraged throughout the 1950s to replace the opium imported from India (Seccombe 1995). Between 1955 and 1975, the annual licit production of opium was about 7.2 metric tons (NCD 1998). By 1979 an exceptional opium poppy crop produced about 800 metric tons (UNDCP 1998). At this time 80,000 to 100,000 hard core opium users were estimated (Seccombe 1995; UNDCP 1998). Heroin use was virtually unknown although some researchers have suggested there may have been about 5,000 heroin users throughout the country (Sadeque 1992). In the late 1970s, the use of cheap licit drugs became more evident and increasing numbers of people became dependent upon barbiturates, stimulants, hallucinogens or tranquillisers (Spencer and Navaratnam 1981).

In 1979 the Prohibition Order was introduced by government authorities and ended the lawful production, sale and consumption of opium, alcohol and cannabis. Although at the time there were thousands of chronic opium users regularly receiving their drug from government licensed opium vendors, there were virtually no support service available to accompany the new law and many drug users went in search of other substitutes (NCB 1998; UNDCP 1998). In 1980 the number of heroin users was negligible but by 1983 it was estimated at around 100,000 and by 1993 it had increased to around 1.5 million (NCD 1998; UNDCP 1998). In the early 1990s estimates suggested there were another million people consuming opium, marijuana and hashish (Sadeque 1992). In 1993 Pakistan conducted its one and only National Survey of drug use. The findings showed there were an estimated 3.01 million chronic drug users and the drug of choice was heroin (51%), followed by cannabis (29.5%) (UNDCP 1998).

Current Situation

Poppy cultivation and opium production in Pakistan has dropped substantially over the years. In 1996/1997 opium production was about 24 metric tonnes and by 2000 it was approximately 11 metric tonnes (NCD 1998; Narcotics 2001). Most opium is cultivated in Pakistan's North West Frontier Province in the Bara River Valley which

borders Afghanistan's Nangarhar province (Narcotics 2001). Ironically, while opium production has diminished in Pakistan, its neighbour Afghanistan has tripled its poppy cultivation since 1993. A consequence of this is large amounts of raw opium and heroin being transported across the mountains of the Afghanistan/Pakistan border which are generally unpoliced. In the late 1990s it was estimated that about 800 tonnes of the opium trafficked from Afghanistan into Pakistan was consumed annually (NCD 1998; Narcotics 2001). In late 2000, illicit drug seizures had increased significantly in comparison to 1999: 7.4 metric tons of heroin; 7.8 metric tons of opium and 108 metric tons of hashish (Narcotics 2001).

While Pakistan is now considered a minor producer of opium it has become a large importer of opiates and a major transit country for the precursor chemical acetic anhydride trafficked to Afghanistan's heroin laboratories. The number of laboratories destroyed in Pakistan diminishes each year and in 2000 none were destroyed. Most of the heroin smuggled out of South-West Asia through Pakistan goes to the European market, including Russia and Eastern Europe (Narcotics 2001).

Drug taking practices and risk factors

Opium and cannabis '*bhang*' is traditionally consumed orally either by swallowing or smoking. *Bhang* is also commonly ground and added to a liquid concoction of spices and milk (UNDCP 1998; NCD 1998). This concoction is also called '*serdai*' (a cooling drink) and is typically used by the care takers at Sufi shrines (T. Zafar, personal communication 2001). From the early 1980s opium was generally processed into heroin and smoked or, increasingly, the 'chasing the dragon' method of inhaling the fumes emitted by the heated heroin through a small pipe was used (UNDCP 1998; NCD 1998). Heroin is also smoked as '*madak*' where it is mixed with barley husk, which are then formed into pellets or as '*chandu*' where it is boiled and converted into a paste (NCD 1998). Heroin is increasingly being injected: this has been detected in the urban centres in particular (Khawaja *et al.* 1997; UNDCP 1998; NCD 1998; Ministry of Health (MOH) and UNAIDS 2000).

Studies which focus on IDUs in Pakistan are scant. In January 2000, a study in Lahore found that half of the 200 respondents injected drugs less than one year after beginning to smoke or 'chase' heroin and it has been suggested injecting has become increasingly popular in the early stages of drug dependency. Further, the study found that an increasing number of drug users are injecting a combination of legally procured injectable drugs. They included sedatives (*diazepam*), antihistamines (*avil*), anti-vomiting drugs and morphine. A popular drug purchased over the counter is *Temgesic* (a preparation buprenorphine), it was used by 59% of the participants (UNDCP and UNAIDS 1999).

The major reasons for the change in shifting from heroin to legally procured substances is that they were cheaper, the 'high' proved more satisfying, peer pressure, the easy availability and the assurance that the quality would be better. Among the respondents 82% injected between one and three times a day and all used disposable syringes and needles (UNDCP and UNAIDS 1999). Poly drug use is generally recognised as widespread among many drug users in Pakistan (UNDCP 1998; UNDCP and UNAIDS 1999; Nai Zindagi 2000). The progress to injecting is viewed as relatively easy as the enforcement of the laws governing the sale of legal drugs is poor and many pharmaceutical drugs do not require a prescription. Needles and

syringes are easy to obtain over the counter without a prescription (MOH and UNAIDS 2000). The cost of an average needle and syringe is currently Rs 4-5 (US\$0.06 – 0.08).

Hashish and marijuana are commonly smoked either with tobacco or by inhaling the fumes through a straw as if 'chasing' (NCB 1998). Another common way of smoking marijuana is mixing it with the pharmaceutical *mandrax* tablets and burning it on coal. The fumes are inhaled and this concoction is referred to as '*Ganga Jumuna*' and is common among Afghan refugee drug users on the streets of Pakistan (T. Zafar, personal communication 2001).

The risk behaviours among IDUs are high and the Lahore survey showed that only 12% of the respondents used a new needle and syringe each time they injected and that the use of non-sterilised and contaminated needles is widespread. This is despite the fact that 91% of the Lahore drug users knew that sharing contaminated needles could lead to the transmission of disease and infections. Among the 200 respondents, 42.5% admitted to cleaning their needles but of these 83% rinsed their injecting equipment in water; 15% claimed they sterilised the equipment in boiling water (UNDCP and UNAIDS 1999). In 2001 a study conducted in Quetta showed that among those people injecting drugs, 52% shared their needles with others and 64% of them cleaned their syringes with water before reuse. Of those injecting, only 28% changed their syringes after a single injection (Nai Zindagi 2001).

Prevalence and profile

In 1993 the National Drug Use Survey concluded there were an estimated 3.01 million chronic drug users in Pakistan. Throughout the 1980s the average annual increase in drug users number was about 12% and between 1988 and 1993 it was believed to be 7% (NCB 1998). In 1999, in a population of 131 million people, it was estimated that 1.7% of the population aged 15 years and above used opiates and in 1998 it was estimated that 1.2% of the population, 15 years and above, used cannabis (UNODCCP 2000). In 2000 those using charas (hashish) totalled 0.9 million, while opium was used by 170,000 persons (UNODCCP 2000).

In 2000, it was estimated there were 4 to 4.8 million drug users overall, growing by 7% a year (MOH and UNAIDS 2000: UNODCCP 2000) and that half were likely to be heroin users (UNODCCP 2000; Narcotics 2001). Since 1993 there have been no reliable surveys to verify these figures. Pakistan is a resource poor country and increasing social, economic and political instability means the potential for the drug using population to swell in size cannot be discounted. The number of IDUs is estimated at 180,000 (Deany 2000) but this figure is likely to increase. Surveys in Karachi among drugs users have found 1.8% of drug users admitting to IDU in 1993 but in 1994 another survey found the figure had increased to 29% (McCormick 1995; Khawaja 1997). More current surveys for this city have not been available.

A major survey on IDUs in Lahore found that *Temgesic* was the most popular drug in use: other surveys have indicated heroin is still the major drug of choice overall. The earlier National Study of 1993 showed 51% favoured heroin followed by cannabis (29.5%). Another study in the mid 1990s in Sindh, showed that among a group of male drug users heroin was the predominant drug identified (98%) (Baqi *et al.* 1998).

In the late 1990s a study in a treatment centre in Rawalpindi/Islamabad showed heroin as the drug choice (98%) (Nai Zindagi 2000).

The 1993 National Drug Users Survey found the highest proportion of users were aged 26 to 30 years, all were male, 60% were employed and many were involved in unskilled occupations (NCD 1998). Illiteracy was at about 40%, similar to a study in Sindh (NCD 1998; Baqi *et al.* 1998). A recent study in Lahore among IDUs found 63% were not formally educated, could not read or write, 25% were between the ages of 15 and 25 years, 38% were married and 56.5% were unemployed. Half of the respondents reported having physical problems associated with their drug use including localised swelling, collapsing of veins, miscellaneous infections and adverse reactions as result of extended unhygienic drug use (UNDCP and UNAIDS 1999). It has been reported that a significant number of heroin addicts are street dwellers and that it is likely that about 10% of street heroin addicts are children (Mustikhan 1999). In 2001 a survey in Peshawar found that 49% of drug users begged, 41% were involved in labour, and for others it was theft (4%) and drug pushing (3%) (Nai Zindagi 2001).

While surveys do not generally pick up on female drug users, it has been suggested that 8% of heroin addicts are women (Mustikhan 1999). In Lahore a primary health care service for drug users, with an attached needle syringe program (NSP) is used by female drug users who are also commercial sex workers and their numbers are increasing (Nai Zindagi 2000). A recent study among female drug users in Lahore and Karachi found that among the 98 participants the median age of initiation into drug use was 23 years. Heroin (34%) and tranquillisers (43%) are the two most popular drugs and 28% reported poly drug use. Injecting was not reported among the heroin users but it was found among a few users of tranquillisers. The smoking of heroin in cigarettes is more popular among the men than inhaling the fumes (UNODCCP 2000).

In Sindh province, a study of drug users and prisoners found injecting behaviour with a high number who had donated blood for cash. In Pakistan many blood banks buy blood. In the mid 1990s paid commercial donors provided almost 25% of the blood supply; in recent years this has dropped below 5% as a result of media campaigns and a reported improvement in blood transfusion services. At the same time few blood banks screen for HIV, hepatitis B and C (Baqi *et al.* 1998; Kazi *et al.* 2000; MOH and UNAIDS 2000). The government is aware and concerned about the decentralised, fragmented blood collection services and the lack of national guidelines on safe blood transfusion. Recently some provinces have taken the initiative of introducing legislation to ensure safe blood transfusion practices (MOH and UNAIDS 2000).

HIV/AIDS was first discovered in Pakistan in 1987. The country is still regarded as having low HIV prevalence but its South-Asian location, and its subgroups with recognised lifestyle risk factors, suggests Pakistan will experience an expanded HIV epidemic (Shah *et al.* 1999; Kazi *et al.* 2000). Pakistan experienced a rapid increase of HIV notifications in the mid 1990s largely as result of an influx of HIV expatriates deported from other countries: in the late 1990s the figures stabilised (Kazi *et al.* 2000). HIV has been reported in all the provinces of the country, mainly in the major urban centres. The levels of HIV will surely rise however as there is much migration between the rural and urban areas of the country (MOH and UNAIDS 2000).

As of January 2000 there was a total of 1,436 HIV infections and 187 AIDS cases. Heterosexual transmission accounts for the majority (37%) followed by contaminated blood and blood products (18%), homosexual/bisexual sex (6%), injecting drug use (4%) and lastly mother to child transmission (1.3%). The reported number of unknown transmission modes is a high 35%. The widespread under reporting of cases, due to an inadequate surveillance system and the fact the epidemic may be in the early stages, are the major factors for the low level of HIV (MOH and UNAIDS 2000; MOH 2000). The current estimated number of HIV infections ranges from 74,000 to 100,000 (Hyder and Khan 1998; MOH and UNAIDS 2000; Save the Children 2000; UNAIDS 2000). It has been estimated that the annual AIDS deaths are 3,500 for 2000 and will be 11,000 for 2005 (WHO 2001). Hepatitis C levels among drug users are rarely monitored but one study among IDUs has shown the prevalence rate at 89% in comparison with the estimated rate among the general population of 7% (UNDCP and UNAIDS 1999).

Government response to illicit drug problems

Until February 1979 drug control laws from Britain were still in force, these were replaced by the Prohibition Order of 1979. Under British laws the penalties had often resulted in fines and imprisonment for up to two years. Under the Prohibition Order 1979 the penalties became much more severe and have remained that way. A person who violates the regulations of import, export, manufacture or processing of any intoxicant is punished with imprisonment for a term extending to five years, a whipping not exceeding thirty and a fine. Intoxicants included cannabis, opium, and its derivatives such as heroin and coca leaf and its derivatives. Amendments followed in 1983 and further penal measures were imposed.

People found in possession of heroin, in excess of 10 grams or raw opium in excess of one kilogram or traffickers or financing trafficking of heroin, are punished with imprisonment for life (25years) or with imprisonment which is no less than two years and an accompanied fine (Husain 1984). In 2000, some of the penalties issues have included a life imprisonment and a fine of Rs 250,000 (US\$4,053) for a person in possession of 40 kg of opium; a four year imprisonment and a fine of Rs 50,000 (US\$810) for a person possessing 500 grams of heroin and three years imprisonment and a fine of Rs10, 000 (US\$162) to a person in possession of one kilogram of hashish (Anti Narcotic Force 2000). The penalties imposed upon drug users have not been able to be accessed.

There are approximately 200 detoxification centres in the country with most operating on commercial lines. The majority exists in the urban centres and the detoxification process usually lasts from 7 to 10 days. Rehabilitation is rarely attempted and consequently the relapse rate is usually between 80% and 90%. There are currently about 80 Government drug treatment centres: these comprise about 1000 beds and the fees are about Rs 25,000 (US\$405) per person, generally paid for by the government. The number of treatment centres is totally inadequate considering the vast number of drug users addicted to various substances, particularly heroin. In recent years all district headquarters hospitals in the country had to set aside a ward for the treatment of drug users. In the NGO sector there are around 200 beds available. Drug users are normally charged a fee to cover food costs when they can afford to do so. The totally monthly cost in such facilities is usually Rs2, 000 (US\$32) to 3,000 (US\$48) per patient. It has been reported that the government is going to assist NGOs in

establishing at least one such treatment centre in every district of the country (NCD 1998).

Government response to drug use and HIV

There is an acknowledgment by the Ministry of Health that IDUs are at a high risk of acquiring HIV and other blood born viruses, largely as a result of the widespread sharing of injecting equipment. They are also aware the risks are not just associated with injecting, that IDUs can pose a risk to others through sexual transmission. Yet, at this stage, the government and the NGO sector have a limited capacity to respond. The focus is upon supply and demand reduction and the government is fully aware that a full range of services for drug users remains severely limited. Harm reduction has been considered as a way to address the current problems but it will require substantial financial support both from international and federal bodies and a strong political will (NCD 1998). There are currently no plans to introduce government funded needle syringe programs (NSP) although the government has permitted a NSP to operate in Lahore by the NGO *Nai Zindagi*. As a result of the NSP in Lahore, other such programs have now been initiated by the same NGO in collaboration with partner NGOs in Quetta, Rawalpindi, Karachi and Peshawar. The focus of these programs is to provide street outreach services to reduce HIV transmission and to provide referral for drug treatment (T. Zafar personal communication 2001). There are currently no substitution therapy programs in the country.

National AIDS Policy

In 1987 the government established the Federal Committee on AIDS and in 1988 the National AIDS Control Programme (NACP) was launched. The NAP plays an important role in increasing awareness about HIV/AIDS issues in Pakistan but many of its efforts have been thwarted as a result of inconsistent political resolve and a scarcity of financial resources (MOH and UNAIDS 2000). At end of 1999, NACP with various other bodies both government and non-government, expanded the National HIV/AIDS Strategic Framework for 2001 to 2006. In this new framework nine priority areas are the focus including vulnerable and high-risk groups such as IDUs. One of the goals is to implement effective peer education programs and to initiate innovative comprehensive harm reduction programs for IDUs, which would also include income-generating initiatives (MOH 2000).

There are no specific details available about these harm reduction initiatives or how they should operate. With the ongoing social, economic and political difficulties in Pakistan it is difficult to determine how much of an impact these new approaches will have upon the very large drug using community of Pakistan.

Non government responses to drug use and HIV

It is acknowledged that the HIV epidemic cannot be addressed by the government alone and that NGOs have special access to groups at higher risk of HIV infection. Currently there are least 72 NGOs involved in HIV/AIDS related activities but very few are directly involved with working with drug users (MOH and UNAIDS 2000).

The NGO *Nai Zindagi* based in Lahore, is a key agency working directly with drug users and IDUs with funds received from UNAIDS. Founded in 1990, they not only

provide primary health care services, but drug treatment services, outreach, counselling, social services (bathing facility and drop in site) and in late 2000 a NSP commenced. In March 2001, 628 IDUs registered with the program. Since the NSP has been in operation, the daily average of IDUs using the service has been increasing. At the beginning of 2001 the daily average of IDU for the NSP was 70, two months later it increased to 95 clients. Even though it is permitted to operate the program is still the target of police raids, harassment of clients and arrests at least monthly. Nearby neighbours complain of those clients queuing up for the various services that are on offer, indicating a number of issues still need to be resolved (Nai Zindagi 2000; Nai Zindagi 2001). Currently there are over 4,000 drug users registered with Nai Zindagi's programs in five cities and data and information related to the street drug using scene is becoming more available (T. Zafar, personal communication 2001).

Estimated number of drug users	4 to 4.8 million
Estimated number of IDUs	180,000 (conservative)
Drugs that are used	opium, heroin, sedatives, antihistamines, morphine, hashish, marijuana, temgesic
Drugs that are injected	heroin
Estimated number of HIV infections among IDUs	4% of HIV infections are among IDUs

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Philippines

Comparisons: 1997 Versus 2001

Although injecting drug use in the Philippines appears to be limited, the Philippines Health department estimate there are 10,000 IDUs while other sources suggest the figure may be as high as 400,000 IDUs. Except for Cebu, in the southern part of the country, sentinel surveillance has stopped monitoring IDUs as none of the sites were able to come up with the requisite sample size of 100 per site. In 1997 the cumulative total for HIV was 958 (five of these were IDU), in 2001 HIV prevalence among IDUs was estimated at 1% (the cumulative total was 1,503: six cases were IDU). But the WHO estimates the figures to be more like 28,000 people infected with HIV.

The drug of choice in the Philippines is crystal methamphetamine, called 'shabu', which is usually smoked or inhaled. The use of this drug has grown substantially since 1997 and whereas in 1997 it was imported from China, Hong Kong and Taiwan it is now also being produced locally. The Philippines is a major producer and exporter of marijuana and it is a popular drug. Cebu city has an identified community of IDUs and the most popular drug for injecting is the pharmaceutical analgesic Nubain. Needles and syringes can be bought from drugstores without a prescription but needle and syringe sharing rates are high. One study in the early 1990s in Cebu showed 100% of IDUs were sharing. A harm reduction program in Cebu has been making inroads against this since 1996 and continues today. It offers a needle and syringe programme, information on safer injecting, cleaning methods and disposal.

Illicit drug use remains a crime in the Philippines and drug trafficking can result in the death penalty. The government is well aware of the link between HIV and injecting drug use but, because of the low HIV prevalence in this group, has done little about it. Treatment and rehabilitation programmes are run by government and NGOs; if drug users submit to the programme voluntarily criminal prosecution against them will be dropped, if not they are forced to undergo the programme and when it is completed face the courts.

History

Opium use was first reported in the Philippines in the 17th century. The use of opium increased in the latter part of the 19th century as Chinese immigrants took to the habit, something which was tolerated by the authorities. Opium dens were established throughout the country and in 1903, in Manila alone, there were an estimated 190 dens selling a total of 130 tons of opium. By 1906, after the United States banned opium use, there were no legal opium dens, although this did not stop the smuggling operations from China. Opium provided about 4% of colonial revenue and in the end the United States regime decided to restrict the sales to Chinese males and registered 12,700 opium smokers. Over time drug use declined through a mixture of prohibitions and high prices, more so than other countries in the region (Spencer and Navaratnam 1981; McCoy 1991).

By the 1960s, in Manila, heroin laboratories began operation producing small amounts of heroin for the local market. During the early 1970s, production of heroin increased but local demand remained small with consumption of heroin estimated to be only 9 to 10 kilograms per month in Manila. However, increasing addiction was detected in the student population and alarmed government authorities. With the American War in Vietnam, a steady flow of marijuana, anti-depressants, amphetamines and heroin arrived at the U.S. military bases in the Philippines (Mc

Coy 1991). Intelligence reports at the time estimated there were 150,000 young drug users. By the late 1970s this dropped to around 12,000 and a period of extreme drug suppression followed; heroin and opiates became scarce but the use of sedatives, tranquillisers, cough syrup and inhalants increased substantially (Ponce 1978). In the late 1980s, methamphetamines and ephedrine hydrochloride entered the country, mainly via Hong Kong, and became known as *Shabu*. It is mainly smoked although reports of injecting *Shabu* mixed with analgesic solutions have been reported (Poshyachinda 1993; Aquino 1995).

Current Situation

The Philippines is a major producer and exporter of marijuana and has been for many years. It is grown throughout the country but the largest areas of cultivation are found primarily in the mountain areas of northern Luzon, central Visayas and central, southern and western Mindanao; part of the cultivated marijuana in this last region is transported to Malaysia and Taiwan. Most marijuana is either consumed domestically or exported to Australia, Japan, United States and Europe. Currently marijuana is the most available and affordable drug in the country. Seizures of heroin have dropped dramatically. In 1997, 3,000 grams were seized, dropping to 21 grams in 1999. As a result its use is reported to be minimal. On the other hand, the use of methamphetamines has grown substantially and it is now the favoured drug. While methamphetamine continues to be smuggled by ship from China, it is reported that the domestic production of this drug is also a growing problem. In 1998, 312 kilograms of methamphetamines was seized and by 1999 this had increased to 943,000 kilograms (Dangerous Drug Board (DDB) 1998; DDB 2000a; Narcotics 2001).

As a result of its strategic location, close to the Golden Triangle and major illegal drug markets such as Japan, Australia, United States and Taiwan, the Philippines is still a likely place for drug smuggling operations and a transshipment point for illicit drug trafficking (DDB 1998; DDB2000a; Narcotics 2001). Throughout the late 1990s the Philippines continued to be a transit point for heroin trafficked mainly from Thailand and Pakistan and destined for various countries. In 1999, heroin cost, on average, US\$109 per gram, with purity reported to be 90% (UNODCCP 2001). Cocaine, from Brazil, destined for the Philippines and other countries in Southeast Asia, was also seized (Narcotics 1998; DDB 2000a; Narcotics 2001). In 1999 the drugs used included various types of narcotics/analgesics (heroin, codeine, nubain), cannabis, hallucinogens (LSD, mescaline), stimulants (cocaine, methamphetamine, ecstasy), sedatives (luminol, anoral), benzodiazapines (diazepam, midazolam, flurazepam), cough/cold preparation (corex-D, corex plain) and inhalants (*rugby*, solvents) (DDB 1998; DDB 2000a).

Drug taking practices and risk factors

The preferred way of taking methamphetamines is by inhaling the fumes. Generally it is accepted that injecting of this drug is not widespread but it has been reported in the City of Cebu (Aquino 1995). In 2000 a study in Cebu showed that the drug of choice for injecting was the pharmaceutical analgesic *Nubain* (University of Southern Philippines Foundation (USPF) 2000a). In the early 1990s a study in Cebu found that the sharing of needles and syringes was widespread even among IDUs who understood that the practice was risky (Department of Health 1992; Tan 1994). In a later study it was reported that IDUs tended to share in groups of 3 to 13 people and

the primary reasons for sharing were a lack of money for buying clean equipment, inability to get clean equipment and to enhance camaraderie among friends. The cleaning of needles was generally inadequate with cold water often used to flush the equipment. After use, injecting equipment was generally not disposed of carefully, was thrown away, sold at a reduced price, rented to others or kept for reuse. Poly drug use was common (Aquino 1995).

In 2000 a new study in Cebu showed that poly drug use still occurred but appeared less common overall (23%). The study showed that among IDUs, 35% injected 3 to 4 times a day, with 18% injecting 5 to 6 times per day. While 60% of the IDUs in the study disposed of their needles appropriately, the rest either threw them into a garbage container or threw them elsewhere. The study showed that a little over half of the IDUs bought their needles and syringes from somewhere other than drug stores and tended to borrow from their IDU friends or from a variety of shooting galleries in the city (USPF 2000b). The common price for the preferred 1ml tuberculin 'orange cap' syringe is approximately Philippine Peso 15.00 (US\$0.29) and can be bought from a drug store without a prescription. In Cebu, the organisation USPF currently conducts a small-scale needle syringe program (NSP) through their community health outreach workers. They promote the cleaning of needles and syringe with bleach and water. The program is unable to access many IDUs in Cebu so crude ways of cleaning needles and syringe remains widespread (USPF 2000b). Studies on the drug using practices in metropolitan Manila are unavailable and there are no current programs in the capital specifically targeting drug users.

Prevalence and profile

In 1999, 92% of all clients in treatment were suffering from methamphetamine related problems. In the same year, the number of people officially registered for methamphetamine misuse was 4,531 persons: a rise of 13% since 1998 and three times higher than in 1994. It has been suggested that the increased use in methamphetamine is related to the rising levels of unemployment but there is also an increase use in the workplace (UNODCCP 2001). In 1995, the estimated prevalence of methamphetamine use was 900,000, by 1997 this had risen to 1,530,00 (2.1% of the population). In the late 1990s this figure had risen to 1.7 million. By 2000, the Philippine drug law enforcement community revised the figures and estimated the total number of drug users is closer to 1 million nationwide. Determining the number of drug users in each drug category has yet to be undertaken (Vidal 1998; Narcotics 2001; UNDCP 2000). In 1999, a total of 5,455 clients were reported by the residential treatment centres and out-patients centres throughout the country. Fifty nine per cent of those recorded are resident in the National Capital Region (DDB 2000b).

In the late 1990s it was estimated that the rise of methamphetamine continued with a 20% increase in numbers each year. In 1999 statistics showed that up to 10% of the population was drug dependant, mostly on methamphetamines but a breakdown of the drug category was not supplied (UNDCP 2000; Narcotics 2001). It has been acknowledged that there is limited data on IDUs in the Philippines and what data is available shows a wide range of figures. For example one survey (Trends – MBL) showed that 5% of males injected drugs while another survey (Young Adult Fertility Survey II) report 2% for males and slightly less than 2% for females (information as to where and how many people were surveyed was unavailable). The HIV sentinel surveillance system has discontinued monitoring IDUs as a sentinel, except in Cebu,

as none of the sentinel sites were able to come up with the required sample size of 100 per site (WHO and DoH 2000). Estimating the number of IDUs in the country remains elusive as studies on a national scale have yet to be undertaken. While it appears that the figure of 10,000 IDUs is more likely (B Reyes, personal communication 2001) others have documented it at 400,000 which does seem too high for the Philippines (WHO and DoH 2000).

Constructing a profile of drug users has mainly come from data from treatment centres. The mean age among drug users was 26 years and 27 years in 1997 and 1999, respectively. In 1999, most drug users were aged between 20 and 34 years (66%), of those aged between 14 to 19 years 16% were drug users: these figures are similar to 1997. In 1999, many people in the centres had started using drugs between the ages of 15 and 19 years (43%) but a substantial number commenced between 9 and 14 years (14%) (DDB 1998; DDB 2000b). In the 15 to 19 age group in the centres, 20% were girls and 15% were boys (DDB 1999b). The ratio of male to female drug use is 12: 1. With the estimated 1.5 million street children expected to increase by 64,000 every year, and an estimated 60,000 forced into prostitution, the issue of drug use and vulnerability among this sector of the society will need to be monitored (Save the Children 2000). In 1999, the duration of drug use was usually for more than two years. Fifty seven per cent of drug users were single, 26% had been to high school and 28% had been to college. In 1999, an increasing number of students were using drugs (9%) compared to 1997 (4%) (DDB 1998; DDB 2000b).

In 2000, a study in Cebu showed that among a group of IDUs, 99% injected nubain, 84% inhaled shabu, 23% drank cough syrup and 18% smoked marijuana. In the area where the study was focused there were more than 900 IDUs and eight shooting galleries. Of the 26 female IDUs identified, 27% were commercial sex workers (CSW). Six of the seven females diagnosed with HIV infection were CSWs. In recent years there has been an increasing trend of CSWs becoming IDUs (USPF 2000a). A recent behavioural surveillance study in Iloilo City showed registered and freelance CSW were using various drugs and injecting drug use was identified in freelance CSWs. The same study also showed some men having sex with men were also IDUs (Kabalaka *et al.* 2000).

In 1998, a three-year study on drug use among secondary and college students conducted in 13 regions and involving over 13,000 respondents showed that 6% had tried drugs and 4% were still taking drugs. Marijuana was the drug of choice (71%) followed by cough preparations (16%) and shabu (9%) (DDB 2000a).

The first documented cases of HIV infection occurred in 1984 among men and CSW (Tan and Dayrit 1994). The prevalence of HIV infection still remains relatively low despite the substantial commercial sex industry (Mastro *et al.* 1998). It has been estimated the Philippines has 500,000 sex workers with an HIV prevalence rate of 1% (WHO and DoH 2000). From January 1984 to May 2001, there were 1,503 HIV infected people, 503 of whom had AIDS. The main mode of transmission is through sex (83%). Six HIV infected cases have been related to IDU (National Epidemiology Centre 2001). The estimates of HIV infection have varied widely over the years: in 1993 estimates suggested there would be 100,000 cases of HIV by 2000, in 1996, 38,000 cases by 2000 was suggested and a recent estimate suggests HIV infections range from 5,000 to 13,000 people (WHO and DoH 2000; WHO 2001). If the

estimate of 400,000 IDUs is accepted, the HIV prevalence among IDUs is 1% which calculates to 4,000 HIV infected IDUs (WHO and DoH 2000).

Government responses illicit drug problems

In 1999, it was reported that the Philippines lacked the resources, finances and the training to mount large scale investigations and actions into dismantling and eradicating local drug networks. The possession of illicit drugs remains a crime and penalties for drug trafficking can include the death sentence. The Dangerous Drug Act (DDA) of 1972 covers a broad range of drugs including narcotics, stimulants, hallucinogens, barbiturates, hypnotics and volatile substances. Illegal possession or use of prohibited drugs can lead to a death sentence, a fine of Ps 500,000 (US\$9,624) to Ps 10,000,000 (US\$192,493) or imprisonment. However, no criminal liability will be imposed if a drug user voluntarily attends treatment and rehabilitation. The current Act also provides for compulsory submission to treatment and rehabilitation and, following discharge, prosecution for the criminal offence (Vidal 1998; DDB 2000a; Narcotics 2001).

Amendments to the DDA by Presidential Decrees have outlawed the maintenance of, or visit to, a drug den, unauthorised possession of any drug paraphernalia and the confiscation of instruments of the crime such as needles and syringes. At some point in time the possession of bleach and water in special containers was also considered drug paraphernalia. This has changed recently but much depends on the current chief of police (C. Aquino, personal communication 2001). However, this contradicts the Philippines AIDS Law, RA 8504, which attempts to prevent the spread of HIV/AIDS by employing scientifically proven methods to stop infection among drug users: this may be used to justify needle and syringe programs (NSP) (Rodriguez A 1999).

The Philippine Government continues to promote its demand reduction approach of the 'Citizens Against Drugs' throughout the country. There has been encouragement for both government and non-government organisations (NGO) to establish treatment and rehabilitation centres for all types of drug dependant people. In 1999, there were 35 to 38 residential treatment centres and 16 out-patient centres. In the same year there were 2,300 beds in the rehabilitation centres including both those run by the government and the NGO sector (DDB 1999). Clearly this number is inadequate to service the number of drug users in the community. In 1998, there were 28 rehabilitation centres, 10 of which were run by the government and 18 by NGOs. The government-owned facilities are believed to be over-utilised while the non-government facilities are under-utilised. It is unclear why this is the case but it may have something to do with costs of admission into NGO centres. It is believed the treatment centres are inequitably distributed in six regions of the country (the country is divided into 16 regions) but this may be because these regions are more urbanised and where drug use is more concentrated (Reynolds 1998; DDB 2000a).

In 1999, 90% of cases are new admissions with the rest as re-admissions. Up to 87% of the drug users have been located in residential centres and the rest are seen as out-patient referrals. In 1999 there was a 16% increase in new cases and a 28% drop in re-admitted cases. It is difficult to determine how many facilities are established for women only but one has been identified in Manila (DDB 2000a; DDB 2000b).

Government response to drug use and HIV

Since the Government has not recognized the linkage between drug use and HIV infection as a priority, little is done to service this group. The provision of information, education and communication (IEC) materials specifically targeting drug users on ways to reduce the harmful consequences of drug use does not appear to have been produced. The government has provided and promoted information about drug use and HIV but the focus is general and orientated towards a demand reduction approach. There are no known substitution therapy programs in operation and there are no government funded NSP in the country. The relapse rate of people who have attended rehabilitation centres is 10%: others have suggested the rate may actually be as high as 90% (Peak 1996).

National AIDS Policy

Concerns have been raised regarding the issue of drug use and the risk of HIV infection but there are apparently no sections focusing specifically on this issue in the policy. This may be explained by the fact that there has been no rapid increase in HIV infections detected throughout the country and the main route of transmission is sexual.

Non-government responses to drug use and HIV

There are up to 40 NGOs concerned with HIV/AIDS issues but few focus on the IDU community. An estimated 20 to 23 NGOs operate treatment centres but the costs of entering these facilities has not been determined. In Cebu, the NGO USPF-HRP Chek-AP (Community Health and Education in Kamagayan for AIDS/STD Prevention - Kamagayan is a barangay (village) known for its illegal drug activities) focuses on the local IDUs community and distribute a harm reduction kit which includes bleach, water, condoms, antiseptic creams, cotton balls and IEC materials on safe sex. They also demonstrate how to clean needles and syringes to individuals and groups inside shooting galleries. They have a referral and networking system with various service providers in the vicinity in an attempt to keep IDUs healthy and to prevent the spread of HIV/AIDS and STDs. Community health outreach workers are instrumental in the delivery of IEC materials specifically targeting this population. This program is carried out in collaboration with a health project which allows the IDU community to receive regular medical examinations by health professionals (USPF 2000b; C. Aquino, personal communication 2001).

In General Santos, in Mindanao, the NGO, Social Health Environment and Development, Inc (SHED), is being funded by *the Philippine HIV/AIDS NGO Support Program* (PHANSUP). They are currently undertaking assessments in the area and it is hoped harm reduction activities will be introduced in 2002, or earlier, once funding comes through from the international NGO *Alliance*. There has been a previous harm reduction program in Metro Manila implemented by *Kabalikat ng Pamilyang Filipino Foundation* supported by *ASEP* in 1996. The activities were focused in Tondo, Cubao and the Marikina area. These activities finished in 1997 and most of the trained workers, who were either recovered or recovering drug users, reverted to their previous drug habits (C. Aquino, personal communication 2001).

Currently in Manila, the AIDS Society of the Philippines in partnership with a Catholic NGO called *Parokia ng San Juan Bosco* is preparing to undertake work in an urban poor area of Tondo which is notorious for widespread drug use (Melgar I. Personal communication 2001).

PATH is hoping to explore the possibility of developing a harm reduction advocacy project on national, provincial, city and barangay levels. It is believed that there are many myths surrounding NSP. It is hoped that strategies will be developed to inform and persuade stakeholders on the health and economic benefits of harm reduction (Linsangan and Hernandez 1998).

Estimated number of drug users	1 million
Estimated number of IDUs	10,000
Drugs that are used	heroin, codeine, nubain, cannabis, LSD, mescaline, cocaine, methamphetamine, ecstasy, luminol, noral, benzodiazapines cough/cold preparations and inhalants
Drugs that are injected	Nubain, drug cocktails
Estimated number of HIV infections among IDUs	4,000 HIV + IDUs or prevalence of 1%

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Comparisons: 1997 Versus 2001

Methamphetamine remains the drug of choice and since 1997 its popularity has increased. Of the 10,500 drug offenders arrested in 1999, 69% were methamphetamine users. Between 1996 and 1999 there was a six-fold increase in the number of arrests for methamphetamine use. No estimates of the number of drug users exist. Previously doctors needed to report drug addicts to government authorities or face imprisonment or fines and as a result doctors rarely made primary diagnoses of drug use to avoid government investigations. Currently doctors are under no obligation to notify the government of drug users in their care. Injecting remains the preferred method of taking methamphetamine. In 1997, heroin was not believed to be in use but in 2001, the amount of heroin trafficked into the country appears to be increasing and most is for local consumption.

The government remains repressive towards drug users and as a consequence they are difficult to access and little is known about their behavioural risks. Behavioural studies among drug users are scarce. The Republic of Korea (ROK) is recognised as a low HIV prevalence country, however, the number of recent HIV infections show HIV is spreading quicker than previously. The annual number of reported new HIV infections has more than doubled since 1998. Before the year 2000, there were no known HIV infections among IDUs. Currently there are two reported cases.

History

Opiate use increased in Korea after the Opium War in 1884, when it was no longer possible to stop the flow of opium entering from China. From that time, until World War II (WWII), poppy cultivation and the selling of opium was encouraged as a source of revenue. The number of opium addicts was unknown but opium use was considered a social problem. During WWII methamphetamine was being synthesised by people who were returning from Japan where it is likely the manufacturing skill was learnt. After 1945, drug use became a serious social problem and with the commencement of the Korean War in 1950, the demand for opium increased. By 1954, opium use was widespread and the south of the country had an estimated 50,000 opium addicts. In an attempt to address the problem the government enacted the Narcotic Control Law in 1957 and a few years later narcotic use was to be one of the five social evils. Soon after, a sharp decline in opium use was detected but it was replaced by widespread cannabis use (Cho 1991; Reynolds 1998).

In the early 1970s the manufacturing of methamphetamines increased and local production wholly supplied the domestic market (Cho 1991). By the 1980s cheaper methamphetamine was being smuggled into the country from China, the Philippines, Taiwan and Thailand and domestic manufacturing declined. In the mid 1970s fewer than 100 people were arrested for methamphetamine use per year, by 1988 annual arrests exceeded 3,300. During this period no part of the country was free from methamphetamine use. To combat the problem in the late 1980s law enforcement was strengthened, large seizures of methamphetamines took place and with a massive increase in price, methamphetamines became rare. By early 1992 the annual number of arrests for methamphetamine use had declined by a third. Among the young the main drugs of choice had become organic inhalants, butane gas and glue sniffing (Cho 1991; WHO 1997; Reynolds 1998; Criminal Prosecution System (CPS) 2000).

Current Situation

Methamphetamine, called 'ice', 'philopon' or 'shabu' is the most commonly used drug in ROK and by the late 1990s its use increased. Although ROK has been known to produce methamphetamine, for both domestic and international markets, current evidence shows that most of the country's methamphetamine is cheaply made imports smuggled in from Taiwan, the Philippines and in particular China. Domestic manufacturing still occurs but in small amounts: in 1999 only two methamphetamine factories were detected. In 2000 just over 10,000 grams of methamphetamine was seized compared to 5,396 grams in 1997. In 2000, the street price for one dose (0.03 g) of methamphetamine was 110,000 Korean won (exchange rate at the time equalled US\$95) while the wholesale price was 80,000 Korean won (CPS 2000).

Heroin trafficking was rare in the 1990s but in recent years ROK became a transit route for heroin from the Golden Triangle. In 2000, authorities seized 227 grams, most of it apparently destined for local consumption (CPS 2000; Narcotics 2001; Korean Customs Service (KCS) 2001).

While illegal cultivation of opium poppies still occurs, mainly in the mountainous and secluded parts of the country, it is only cultivated on a small scale and there have been no detected cases of opium poppies being turned into opiates. The government is keen to eradicate the cultivation of opium poppies and in 1999, 779 people were charged with such practices. Small amounts of opium are smuggled from China and in 2000 customs seized 2,211 grams of raw opium. Authorities report opium being used for medicinal purposes where medical facilities are unavailable (CPS 2000; KCS 2001). Cocaine is not a popular drug as a result of its high price and limited accessibility but in 2000, was still used, albeit in small amounts. Marijuana is the second most popular drug and there are conflicting reports as to whether most is grown domestically or is imported. Other drugs used include ecstasy, inhalants, hypnotics, LSD, *Yaba* tablets and psychotropic drugs (CPS 2000; Narcotics 2001; KCS 2001).

Drug taking practices and risk factors

In the late 1980s the rates of injecting methamphetamine, among drug users who were surveyed, was high. Figures of above 60% to 80% were reported (Cho 1991; WHO 1996). Throughout the 1990s intravenous injection was still believed to be the preferred method (Reynolds 1998). In 2001 injecting remains the most popular method with up to 80% of methamphetamine users preferring to inject (D. Oh, personal communication 2001). Other ways of taking methamphetamine are by smoking and sniffing. Most people starting to use methamphetamines prefer to smoke it. For many years the government has taken a repressive approach towards drug crime and use and as a consequence information about this target group is often lacking. There are still no behavioural studies of drug users. Information about the sharing and cleaning of injecting equipment is scarce, but needles and syringes are easy to get from pharmacies throughout the country. A prescription is not required and the current price for one needle and syringe is US\$ 0.25 cents (D. Oh, personal communication 2001).

Prevalence and profile

The number of methamphetamine offenders has increased substantially in recent years. In 2000 of the 10,304 drug offenders, 7,066 (69%) were for methamphetamine use compared to 1,272 in 1996 (Kim 1997; CPS 2000; Narcotics Department 2001). These are used as the official figures for the number of drug users, unofficial estimates are 10 times higher (D. Oh, personal communication 2001). Information about how many drug users inject is not available.

In 2000, 40% of people arrested on drug offences were unemployed, 9% were in the entertainment industry, 7% were merchants and 5% were farmers. In recent years drug use has spread rapidly into areas of society where it was previously undetected, such as at home and in the workplace. Most drug offenders are aged between 20 and 40 years (83%) and reports of the arrests of those aged 15 years and under are unavailable (Narcotics Department 2001; KCS 2001).

The ROK's first HIV infection case was reported in 1985 and the first AIDS case in 1987. As of June 2001, the cumulative total of HIV infected individuals was 1,439 and 220 AIDS cases have been recorded. The main route of HIV transmission was sexual contact (81%), 7% were unspecified and two had IDU as their probable transmission route (0.1%). Until 1999 there were no known IDUs infected with HIV. It is estimated there are about 3,800 HIV infected people in the country (Oh and Choe 1999; National Institute of Health 2001; WHO 2001). While the ROK is recognised as a low HIV prevalence country, the annual number of new HIV infections shows that HIV is spreading more quickly: 159 new HIV infections were recorded in the first six months of 2001 compared to 110 in 2000 and 64 in 1998 (Chi-dong 2001; Korea Herald 2001).

Government responses to illicit drug problems

The laws and regulations covering narcotics and psychotropic drugs took shape after the introduction of the Narcotics Control Law 1957, with further amendments in 1961, 1967 and 1973. These amendments included strengthening the penalty of life imprisonment for illicit trafficking in narcotics. In 1993 the law was further amended to ensure that 22 kinds of precursors and essential chemicals were not diverted to the illegal manufacturing of drugs (WHO 1997; Oh 1997; Reynolds 1998). People found guilty of trafficking in narcotics (opium, heroin and cocaine) receive penalties ranging from fines of 50 to 100 million Korean won (US\$38,583 – 77,000), to life imprisonment or capital punishment. For a first time drug user a penalty of 50 hours of community work and enrolment into an educational programme focusing on the dangers of drug use may be issued. If relapse occurs the person may be forced to attend compulsory hospitalisation for detoxification and rehabilitation and may receive a fine depending on the seriousness of the drug offence. However, under Article 39 (Prohibition of Use of Narcotics) a person using narcotics for the first time can also be placed under medical treatment and protection for a period of six months or less (Narcotics Department 2001). Alternatively, an individual found in possession of narcotic drugs, as a result of a drug habit, may receive a prison sentence of three years or more. For those with a psychotropic substance habit, the penalty may be imprisonment of no more than five years or a fine not exceeding 50 million Korean won (US\$38,583) (KCS 2001).

Currently there are 22 national or public hospitals acting as treatment and rehabilitation centres for drug users. Rehabilitation is based on traditional medical models accompanied by intensive psychological, psychiatric and social counselling. The average time spent in rehabilitation is unknown. It is not known if there are voluntary centres for drug users. The Ministry of Health and Social Affairs is responsible for treatment costs. The major treatment setting is in hospitals (Oh 1997). Patients admitted to compulsory drug treatment may attend follow-up once a month for a year after discharge (D. Oh, personal communication 2001).

Until the Narcotic Act 2000 was introduced, drug addiction was a notifiable condition and doctors had to report such cases to the Ministry of Health or face imprisonment or a fine. However, it has been suggested doctors rarely made primary diagnoses of drug use in order to avoid the patient being investigated by the authorities. Since the changes to the Act, doctors are under no obligation to notify the government of drug users in their care and subsequently have observed a 10% to 20% increase in the number of voluntary drug users seeking treatment (D. Oh, personal communication 2001).

Government response to drug use and HIV

As a result of HIV infections among IDU being rare, little is done to specifically target information to them. It appears that the information, education and communication materials produced are targeted to the general community and the approach is one of zero tolerance to drug use and the promotion of supply and demand reduction. There is a widely held belief that the cheap injecting equipment available from pharmacies has contributed to the low rate of HIV infections among IDUs. Peer outreach programs targeting current drug users are not known to exist and the establishment of a needle and syringe program is not on the government agenda. There are no known methadone maintenance programs in operation or any other harm reduction programs.

National AIDS Policy

There is no specific policy on drug use and HIV.

Non-government responses to drug use and HIV

It does not appear that there are any NGOs involved in introducing harm reduction methods for drug users. There is one NGO called the Korean Anti-Drug Campaign Centre but, as its name implies, its approach is one of demand reduction. The educational information on drug issues is oriented more towards the wider community than to meet the specific needs of current drug users.

Estimated number of drug users	10,304 drug users arrested in 2000
Estimated number of IDUs	Unknown
Drugs that are used	methamphetamines, heroin, cocaine, marijuana, ecstasy, LSD, hypnotics, psychotropic drugs
Drugs that are injected	methamphetamines
Estimated number of HIV infection among IDUs	2 known cases

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Singapore

Comparisons: 1997 Versus 2001

Singapore continues its vigorous combination of punishment and rehabilitation for drug users and traffickers. By 1997, 190 drug traffickers had been executed. In 1996, 9000 drug users were forced to attend rehabilitation centres from six to 18 months which was followed by community-based rehabilitation, routine urine tests and one to two years probation. The relapse rates were 70%. In 2001 the regime is even more stringent with ex-users monitored by an electronic device worn around their ankles for six months and then they are supervised for another two years. The relapse rate hovers around 60% and if a person relapses or refuse to give a urine sample, he/she will be imprisoned for seven to thirteen years. Naltraxone has been available since 1995 and since then has been expanded and incorporated into mainstream treatment and rehabilitation with medical practitioners and designated clinics prescribing: it is unclear whether it is used as a maintenance therapy.

There are no official figures on IDUs in Singapore but they are believed to be limited. However, the highest number of IDUs seem to be situated near the border with Malaysia, a country with a significant number of HIV infected IDUs. Since the 1970s the drug of choice in Singapore has been heroin with chasing the dragon the favoured method of ingesting. In the past few years the seizures and use of amphetamine, known as Yaba, have increased substantially.

In 1997 the total cumulative number of people infected with HIV was 631, with 14 identified as IDU. In December 2000 the numbers were 1,362 people HIV positive: 96.5% sexually transmitted with 1.9% IDU.

History

From the early 19th century, Singapore, then part of Malaya under British colonial rule, became part of the opium trade. After Singapore's opening for settlement, opium was soon imported into the country and exported to other countries in the region. By 1819, the government earned more than half of its total revenue by leasing an opium franchise to the influential Chinese. By the 1850s, the Chinese merchants of Singapore were exporting opium to their labourers working in the jungle plantations to the north (McCoy 1991; Hing and Isralowitz 1996). As in other South- East Asian countries at the time, opium became popular among immigrant Chinese populations, both poor and rich, and quickly became a central part of the economy. In the period 1898 to 1906 the average annual revenue from opium was 49% of the total income of the Straits Settlements, which included Singapore (Hong and Isralowitz 1996).

By the beginning of the 20th century, as opium addiction became increasingly widespread, an anti-opium movement emerged yet prohibition was not deemed necessary. By 1925 licenses were introduced to allow people to smoke opium at home; four years later a rationing system was introduced to buy opium. In 1929, there were nearly 41,000 registered (requiring a medical certificate) opium users in the Straits Settlement most of whom were Chinese; in 1934 there were 31,000 registered and an estimated 90,000 unregistered opium users. Cannabis was also available but its use appeared to be more common among Indian immigrant workers and was not viewed as a social problem (Hong and Isralowitz 1996).

By 1946, a law was introduced to make all opium smoking illegal and while there were still thousands addicted to the substance there was no treatment on offer. A black market for opium emerged and morphine, which was less expensive, was soon used as a substitute (Spencer and Navaratnam 1981; McCoy 1991; Hong and Isralowitz 1996). Throughout the 1950s and 1960s, although opium and morphine use continued, demand waned and the number of drug offences diminished substantially. By the 1970s, opium users had shifted to heroin in epidemic proportions. In 1973, the number of arrests for heroin was 10, increasing to 2,263 in 1974 and by 1997 it was 7,372; in the late 1970s there were an estimated 13,000 to 20,000 heroin addicts (Chia-Chow 1979; Mc Coy 1991; Boon 1998). Government authorities, greatly alarmed by the increasing number of heroin users, introduced draconian punishments: the first execution of a drug trafficker took place in 1978 (Chia-Chow 1979). Death penalties became mandatory for anyone found trafficking up to 15 grams of heroin (Hing and Isralowitz 1996). Throughout the 1980s, and early 1990s, the number of drug offenders arrested had decreased but figures of around 6,000 on average still concerned authorities. Although heroin was the drug of choice, and mainly smoked, the use of solvents has been a concern since the late 1970s. In 1980, 24 inhalant users were identified, increasing to 1,112 in 1987 and by 1992 decreasing to around 300 (Teck-Hong 1986; Kin and Navaratnam 1995).

Current Situation

Singapore has not been known for the cultivation or production of narcotics or precursor chemicals. Most of the land in Singapore is taken up with dwellings, industries, parks and public areas thus making cultivation difficult. With 85% of the population residing in high rise apartments built in close proximity, manufacturing of heroin and amphetamines is considered a difficult clandestine undertaking (Lee 1998; Narcotics 1998; Narcotics 2001). However, it remains a major financial and transport centre and consequently its allure as a target for money laundering and drug transshipment continues. In 1999, authorities seized 56.7 kilograms of heroin and 98 kilograms of opium. By 2000, the amount of seized heroin was slightly less and the amount of opium was down to 4.5 kilograms. However, as has happened in other Asian countries, amphetamine type substance (ATS) seizures and use has increased substantially. In 2000, nearly 25,000 methamphetamine tablets, commonly termed *Yaba* were seized: an increase of 1,692% from 1999. In 2000, there have also been significant increases in the seizures of cannabis and *nimetazepam* with each seized substance rising by more than 200%, compared to 1999. Seizures of ecstasy and 'ice' decreased substantially in 2000 but ketamine rose by nearly 50%, compared to 1999 (Narcotics 2001; Central Narcotics Bureau (CNB) 2001a).

Since the late 1990s Thai trafficking organisations operating in Singapore have been responsible for the distribution of *Yaba*. However, recently it has been shown that Singaporeans are involved in distribution and supply maintenance for an increasing number of local drug users (Narcotics 2001; Central Narcotics 2001). Heroin still remains the main drug of choice, a pattern that has not changed since the 1970s (Chia-Chow 1979; Lee *et al.* 1998; CNB 2001a).

Drug taking practices and risk factors

The most common way of taking heroin in Singapore is by 'chasing the dragon'; this process involves heating the heroin on foil and then inhaling the fumes that are

emitted. While it is believed the administration of heroin by injection is not popular, it is difficult to accurately gauge any sense of the numbers of IDUs when the publication of such information is poor. It has been reported that the incidence of heroin injecting is minor and this may explain why heroin overdoses are uncommon (Lee *et al.* 1998). Information about needle and syringe sharing, or how injecting drug users clean their injecting equipment, remains unknown as there is no documentation available. However, it can be assumed that needle sharing does occur and that it is executed unsatisfactorily. Up until 1997, there were no known behavioural studies undertaken among drug users in Singapore and in 2001 this had not changed.

Needles and syringes can be widely purchased, without a prescription, for approximately \$3 Singapore (US\$1.65). It remains a moot point as to whether those from a lower socio-economic background find the cost of buying injecting equipment prohibitive. It is acknowledged that 'ice', a crystallised form of methamphetamine, can be injected or snorted. Ecstasy is usually swallowed while opium and cannabis are smoked (CNB 2001a). Benzodiazepines, such as *nimetazepam*, which are being seized in increasing amounts, are potentially used as a substitute for heroin when drug users are unable to get their usual supply (Lee *et al.* 1998). Whether they are swallowed and/or injected remains unknown. In 1997, the Central Narcotics Bureau reported that the purity of heroin had been decreasing and on average had dropped from 16% to about 4% (Boon 1998).

Prevalence and profile

By the end of 1998, 5,000 people were confined to drug rehabilitation centres (DRC) as a result of consuming drugs; in 1997 the figure was 6,160. This number has been decreasing since 1994 when it was then 8,695 (Boon 1998; Narcotics 1998; Narcotics 2001). As of October 2001, there were a total of 2,178 in Drug Rehabilitation Centres (DRC), a lower figure due to the long term imprisonment of frequently relapsing drug users who are now prosecuted in the courts. This change in drug policy results in a corresponding increase in the penal population (Central Narcotics Bureau, personal communication 2001). In 2000, most arrests were related to heroin use but there has been a downward trend from the previous years; 2,557 heroin users were arrested in 2000 compared to 3,142 in 1999. The number of methamphetamine users being arrested rose by 13% (N=175) in 2000, accounting for 6% of the drug using population. In 2000, 51% (N=341) of new drug users arrested consumed heroin and those consuming ecstasy formed the second largest proportion (N=138) of new drug users. As shown in previous statistics, arrested drug users are disproportionately of Malay ethnicity; in 2000, 1,575 were Malay while 1,096 were of Chinese ethnicity (CNB 2001a).

The first reported case of HIV/AIDS in Singapore was in 1985. As of December 2000, the total cumulative number of HIV/AIDS infections was 1,362: 767 of whom were AIDS cases. Sexual transmission was the main mode of transmission (96.5%) with a small proportion (1.9%) contracted through injecting drug use. The total cumulative number of HIV infections among IDUs was 26, of whom nine were diagnosed in the past two years (Ministry of Health 2000). Data on Hepatitis C remains scant. The Central Narcotics Bureau does not make estimates of the number of drug users arrested. According to law enforcement sources less than 5% of drug users inject their drugs (Central Narcotics Bureau, personal communication 2001). There are no official or unofficial numbers of drug users or IDUs available.

Government responses to illicit drug problems

The Government of Singapore uses a combination of punishment and rehabilitation, an approach that has been pursued vigorously for many years. The Central Narcotics Bureau is responsible for the enforcement of Singapore's anti-drug laws (Narcotics 2001). The death penalty exists for the import or export of more than 15 grams of heroin. By 1997, there had been 190 drug traffickers executed by hanging since the introduction of Misuse of Drugs Act in 1975 (Boon 1998). According to the Home Affairs Ministry there has been 340 hangings in the last decade for drug related offences. The death penalty, depending on how much is illegally trafficked, is also applicable for opium, morphine, cannabis and methamphetamine. Possession and consumption of heroin, opium, cannabis, ecstasy and methamphetamine may result in a fine of \$20,000 (Singapore dollars) (US\$10,950) or 10 years imprisonment or both (CNB 2000).

It has been reported that in an effort to curb drug consumption outside of Singapore, narcotic officers may require a urinalysis from every Singapore citizen and permanent resident returning from outside the country. If the urine test is positive the person would be treated as if they had consumed an illegal drug in Singapore (Narcotics 2001).

Government response to drug use and HIV

The number of officially known IDUs is reported to be small. A study done by Barrett and Ong (1994) reported that addicts in both male and female focus groups estimated the number of addicts who had "jabbed" (injected) drugs was about one in five. They also mentioned that the prevalence of injecting among drug addicts across the causeway in Malaysia was much higher. From all accounts information specifically targeting drug users is minimal. Most information provided is within a general context and there is a strong emphasis on zero tolerance towards all illicit drug use. General information on HIV/AIDS for the wider community does exist and includes mention of the risks associated with needle and syringe sharing among IDUs. However, there is no depth to the information. Needle and syringe programs do not exist. It is not known if any information about HIV prevention, specifically targeted for drug users, is available for those in rehabilitation centres but it is considered unlikely.

Naltrexone, for those using heroin, has been available since 1995 and has been incorporated into the mainstream treatment and rehabilitation programs. The Ministry of Home Affairs has expanded the program by allowing and encouraging private medical practitioners, and designated Government clinics, to treat addicts with this medication (Boon 1998). The cost of one naltrexone tablet is SG\$2.57 (US\$1.41). The government bears the cost of administering this drug: the inmates incur no charge. Due to the high cost of the community-based rehabilitation programs, selected inmates are allowed to spend their remaining year in the community with a compulsory prescription of naltrexone and they are tagged with an electronic device. Upon completion of the detention period, discharged inmates will be put under the supervision of the Singapore Central Narcotics Bureau. The person can then decide if they wish to continue with another year of naltrexone prescription with regular urine tests or stop the prescription and have more frequent urine tests. Naltrexone must be taken with a doctor's prescription (Singapore Prisons Department, personal

communication 2001). Studies or data on the relapse rate associated with naltrexone have not been accessed.

Following an arrest on drug possession or consumption it is compulsory for all drug users to attend a drug rehabilitation centre (DRC). Those classified as non-hardcore addicts are first put through an initial detoxification process at a specific DRC. They are then transported to a variety of DRCs, according to their drug records, and put through a 6-12 month community-based rehabilitation scheme. They are then admitted to a pre-release camp for one month to develop strategies for re-entering the wider community. Drug users who have gone through the initial rehabilitative treatment will either be released to a Half way House Scheme (HWH) or placed under a residential scheme (Boon 1998).

Those people placed into the HWH (as a result of inadequate family support) are there for six months; in 1997 there were approximately 17 HWH in Singapore. Following discharge they are monitored for another two years. Drug users with a conducive home environment are offered a residential scheme for six months. An electronic device worn around their ankles monitors their movements: this is removed after six months but they are still supervised for another two years. In 1997, the official relapse rate was 66% (Boon 1998). It is unlikely this figure would have changed much in recent years. As of 1998, drug users who have been in a DRC three or more times are given prison sentences for between five and seven years. If a person relapses after discharge, or fails to provide a urine sample upon request, he/she will be imprisoned for 7 to 13 years (CNB 2000).

The government has designated medical institutions for those drug users who wish to seek treatment voluntarily but they must pay their own costs. Upon detoxification they are referred to a HWH for six months (Boon 1998).

National AIDS Policy

The National AIDS Control Programme of Singapore was drawn up in 1985. The control and prevention of AIDS comes under the control of the Ministry of Health and is assisted by the AIDS Task Force. The main focus of the program is health education targeting the general population and those at risk of HIV infection. The current policy of zero tolerance towards drug use, coupled with the fact that HIV infection among drug users remains low, is possibly a reason for the lack of specific and/or explicit detailed information or programs targeting the drug using community of Singapore.

Non-government responses to drug use and HIV

As of 1997, there were 17 Halfway House Schemes established to meet the needs of drug users upon their discharge from the compulsory community-based rehabilitation centres. In order to sustain the HWH the government provides grants and subsidies. There are at least six voluntary welfare organisations offering information about drug using issues but the practice of offering voluntary detoxification and/or rehabilitation is now discouraged. In 2000, a large-scale evaluation study of halfway houses (Barrett *et al.* 2000) found that HWH performed the role of a residential treatment centre, but did not include professional counselling. Most HWHs offer work therapy, spiritual programmes and informal counselling. There is only one true therapeutic

community, *Pertapis*, which caters to Muslim addicts. Christian HWHs have evolved a relationship-building model, using ex-addicts to exert social pressure on the drug user to conform to the norms of the community: a kind of modified therapeutic community approach.

Estimated number of drug users	Unknown
Estimated number of IDUs	Unknown
Drugs that are used	heroin, methamphetamines, cannabis, benzodiazapines, ecstasy, ketamine
Drugs that are injected	heroin
Estimated number of HIV infections among IDUs	cumulative total of 26 known HIV infection among IDUs

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Sri Lanka

History

Sri Lanka has a long history of drug use. From the sixteenth century until the middle of the twentieth century, the colonial powers, first Portuguese, then Dutch, and finally British, regulated the use of opium as a revenue earning measure (Jayasuriya 1995). When the British arrived in 1796, they soon set up a license system for outlets to sell opium. The promotion of opium consumption to generate revenue has always been a controversial and sensitive issue in Sri Lanka. In 1893 a member of the Sri Lankan legislative assembly submitted a petition signed by 27,000 Sri Lankans to the British governor urging the colonial government to take action to prevent the abuse of opium in a predominantly Buddhist country (Jayasuriya 1995). During the British era, the East India Company imported commercial quantities of opium and distributed it through licensed opium shops in the island (Kandiah 1994).

Towards the beginning of the twentieth century, with public opinion turned firmly against the sale of opium, the government restricted the import of opium to the Civil Medical Officer and closed down all the opium shops, of which there were 65 registered until 1907 (Ray 1998). In the 1920s, it was believed there were about 60,000 to 68,000 opium users in Sri Lanka. Since independence was achieved in 1948, various measures have unsuccessfully attempted to scale down drug use in Sri Lanka. Until the middle of the twentieth century opium was distributed by government medical officers to registered opium users (Jayasuriya 1995).

In the late 1970s and early 1980s, with the escalation of ethnic violence and the demand for a separate state for the minority Tamils in the northeast of the country, evidence began to emerge of a close link between drug smuggling, arms smuggling and applications for asylum (Jayasuriya 1995). Many researchers believe that drug use became a real problem in the 1970s with 3,000 people reporting to various treatment facilities between 1975 and 1979. Traditionally, cannabis, opium and alcohol have been the drugs of choice: cannabis and opium were often part of medicinal preparations. The principal drugs used in the 1970s were cannabis and opium with the occasional use of morphine, cocaine and LSD (Ray 1998). In the mid-1970s patients treated for opium addiction were provided with methadone twice a day to address withdrawal symptoms; this procedure usually lasted 10 days (Satkunanayagam 1979). Methadone maintenance programs are not known to have been implemented in Sri Lanka at this time.

In the early 1980s, it was estimated there were between 10,000 to 15,000 opium users in Sri Lanka (Ray 1998) with reports of 40 opium divans (dens) operating in Colombo where clients consumed the opium through hookah pipes, in cigarettes or cigars or diluted in coffee or tea (Spencer and Navaratnam 1981). The use of heroin was virtually unknown in Sri Lanka before 1981 and was initially introduced through the 'hippie' tourists: it was expensive and mainly used by foreigners (Ray 1998; Alcohol and Drug Information Centre (ADIC) 2001).

Current Situation

The 'Afghan War' in the late 1970s prevented traditional land routes being used by heroin traffickers. Sri Lanka's strategic location, being situated between the 'golden triangle' and the 'golden crescent' made it a natural choice as a transit point (Kandiah 1994). The island's popularity as a trans-shipment point for narcotics from South Asia has been growing (Narcotics 2001). Heroin is the only known narcotic to transit Sri Lanka in significant quantities. Sri Lanka's 1,100 miles of coastline cannot be adequately patrolled, especially since Sri Lanka's naval forces are heavily involved in the ongoing conflict with the Tamils (Narcotics 1998). In June 2000 there was a record seizure of 38 kilograms of heroin after a small vessel was intercepted crossing over from India (Narcotics 2001). Officials believe much of the heroin seized in southern India each year (amounting to hundreds of kilograms) is bound for Sri Lanka. Large consignments of cannabis and heroin from Karachi and other cities in Pakistan are believed to reach coastal cities and the capital of Sri Lanka for shipment through Colombo international airport and seaport to destinations outside the region (UNDCP 2001).

Sri Lanka has a comparatively modest drug problem, but a number of recent heroin seizures in India bound for Sri Lanka, and in the gulf of Mannar between India and Sri Lanka, confirm the existence of a heroin trafficking pipeline in the area (Narcotics 2001). There has been a slight but steady increase in narcotics consumption, particularly of heroin. Cannabis is the only illicit drug cultivated and produced in Sri Lanka and its use is widespread (Kumar *et al.* 1997). In 1993 it was estimated that there were two million cannabis users on the island (Ray 1998). A study in the early 1990s found that most heroin users also took other drugs including tobacco, alcohol, cannabis, opium, hashish and cocaine, along with psychotherapeutic drugs such as diazepam, methadone, lorgactil, librium, phenobarbitone and amphetamines (Kandiah 1994).

Opium is an important substance used by Ayurvedic practitioners and the law permits a quota system to enable registered practitioners to use it (Jayasuriya 1995). Opium use is now insignificant. However, the use of benzodiazepines, methaqualone, codeine, methadone and amphetamines have been reported (UNDCP 2001). Alcohol is the oldest and most prevalent drug used in Sri Lanka. Betel chewing is also popular especially among male and female rural peasants (Kandiah 1994). There are reports that heroin has become the drug of choice to entice members of the minority ethnic group to become part of an international smuggling operation, the proceeds of which are being used to supply arms as well as to better their future prospects (Jayasuriya 1995).

To November 2000, 12,598 people were arrested on drug-related charges (10,463 of these were for heroin), down from 15,875 arrested in 1999 (Ratnayake and Senanayake 2000; Narcotics 2001). As a comparison, in 1981 there were only eight heroin-related arrests, by 1989 this had grown to 5,000 and by 1996 to 10,120 (Jayasuriya 1995). Nearly 40% of all prison admissions for men and women in 1999 were for narcotics, the largest single category (Ratnayake and Senanayake 2000). Street level prices of heroin between 1996 to 2000 have remained stable with the low price of Rs 1,000,000 (US\$10,761) to a high price of Rs 1,300,000 (US\$13,990) per kilogram. When sold to foreigners the price is often doubled (Ratnayake and Senanayake 2000).

Drug taking practices and risk factors

The most common way to take heroin in Sri Lanka is by 'chasing the dragon' known locally as the 'Chinese way'. Some cases of injecting have been detected but the number is too small to identify a trend (UNDCP 2001; ADIC 2001; K. Kumara de Silva, personal communication 2001). In 2000, treatment admissions by route of use were 25% for smoking, 0.3% for injecting and 67% for the 'Chinese' method (Ratnayake and Senanayake 2000). It has been suggested that the low prevalence of injecting may be a result of the high level purity of heroin that is available on the market and the desired effect by 'chasing' is achieved. However, during times when heroin is scarce, some drug users are reported to switch to injecting, and then mostly pharmaceutical drugs are used (D. Guniyangoda, personal communication 2001). The average purity of heroin in 1999-2000 was 44% (Ratnayake and Senanayake 2000).

A study among heroin users in the early 1990s found the prevalence of injecting had increased from 1% in 1988 to 13% in 1992 (Kandiah 1994). The rise in the injecting of drugs appears to have been sustained during the late 1990s, but of those in treatment in 2000, only 0.3% injected their drugs (Ratnayake and Senanayake 2000). A study conducted in the early 1990s specifically focused on heroin users found IDUs were having sex with multiple partners, that sharing needles and syringes was relatively common and that the IDUs of Sri Lanka were at high risk of an HIV epidemic (Kandiah 1994).

The same study showed that 76% of the IDUs had obtained their needles and syringes from a pharmacy while 18% had obtained them from another drug user and 40% of users shared their needles and syringes. The injecting paraphernalia was referred to as the 'kit' or the 'works': 28% had shared their kit at times and 29% often shared. Amongst the users, 68% had injected with a partner and 34% by themselves. Only 26% of the IDUs always cleaned their needles and syringes compared to 38% who never cleaned them. Hot water (46%) and soap (16%) were the common cleaning agents. The reasons for cleaning were to prevent diseases and clogging of the equipment (Kandiah 1994). No other more recent studies of drug using behaviour have been found.

Prevalence and profile

The population of Sri Lanka is 18.6 million people, with a literacy rate of 90% and an unemployment rate of 11.3% (UNAIDS/WHO 2000). Until recently there had been no large scale surveys or Rapid Situation Assessments of drug users conducted in Sri Lanka (Ray 1998). In 1998 WHO estimated there were 22,500 drug users. However, in 2000, the National Dangerous Drugs Control Board (NDDCB) carried out an island-wide outreach campaign and conducted individual counselling sessions with 25,000 drug users in urban areas. Based on this project they estimate that there are now about 40,000 to 50,000 heroin users in Sri Lanka (UNDCP 2001; Narcotics 2001) and about 200,000 cannabis users (ADIC 2001). The Police Narcotics Bureau says there are 300,000 drug users in Sri Lanka, with 100,000 of them using heroin and the rest using cannabis (Xinhua News Agency 1999). A World Bank update estimated 30,000 drug addicts, of whom 2% inject drugs (World Bank 2000).

The majority of heroin users are 20 to 35 years old, generally from urban areas and predominantly young men. High risk groups include manual labourers, street

vendors, taxi drivers, commercial sex workers and tourist industry workers in Colombo. Women are also using heroin and members of an outreach team in Negombo have started work with heroin using commercial sex workers (UNDCP 2001). Female commercial sex workers have been reported to be injecting drugs (D. Guniyangoda, personal communication 2001). A study of heroin users in the early 1990s found the majority (75%) were Sinhalese, male and unmarried (Kandiah 1994).

A considerable number of users were employed with a significant income and skills (nearly a third of the study group were unemployed). The study also found heroin users generally came from a higher socio-economic stratum than the poor of the society and most lived at home with their families. Ninety six per cent were using the 'Chinese' method and 0.3% were injecting. Most of the IDUs came from Colombo and had started using heroin in the 'Chinese' way and switched to injecting because of the increased 'high' and to reduce costs. Sixteen per cent of IDUs had had 'sex for money'. Condom use was high among IDUs and condoms were easily available and acceptable to the Sri Lankan population. Ninety per cent of the IDUs were aware that HIV/AIDS could be spread through unprotected sex while 48% believed they had a possibility of contracting HIV through injecting drugs. Heroin users were found to be as literate as the general population (about 90%) (Kandiah 1994).

In 2000, treatment admissions showed the following profile: the majority were heroin users (88%); the route of use was the 'Chinese' method (67%) and smoking (25%); many were aged between 20-29 years (39%); nearly all were male (98%); over half were single (52%); and educational levels were generally low, with 12% having below five years and 22% between five and eight years of schooling. In 1996 there were 1,816 people admitted for treatment as a result of heroin; by 2000 this had increased to 3,550 (Ratnayake and Senanayake 2000).

HIV testing was conducted among women at various antenatal clinics during the 1990s and no HIV was found. Sex workers were also tested and HIV infections were found at only one site, Kurunegala, in 1995 where 0.5% of sex workers were HIV positive. The prevalence among adults at the end of 1999 was 0.07% (UNAIDS and WHO 2000). As of April 2001, the cumulative total of HIV infections was 370, (of whom 232 were male) and the cumulative total AIDS cases was 123. The cumulative total of deaths from AIDS as of January 2001 was 91. The reported modes of transmission were 86% heterosexual, 12% homosexual/bisexual, 1% blood transfusion and 1% mother to child transmission. Transmission by injecting drug use has yet to be seen (National STD/AIDS Control Program 2001). As of 2001, it has been estimated the HIV prevalence is about 8,500, with the number of AIDS deaths in 2000 estimated to be 350, projected to increase to over 1,000 by 2005 (WHO 2001). Injecting drug users have not been selected as a population to test and this may explain why HIV infections have not been found in this group.

Government responses to illicit drug problems

The Ministry of Defence has overall responsibility for counter narcotics and demand reduction activities but the conflict with the Liberation Tigers of Tamil Eelam (LTTE) separatists drains the Ministry's resources, leaving it little time, personnel and funding to address the drug problem. The National Dangerous Drugs Control Board (NDDCB) is in charge of overseeing and coordinating all drug control activities of law enforcement and prevention, treatment and rehabilitation through a number of

agencies (UNDCP 2001). Again, most of its funds and law enforcement personnel are tied up with the ongoing conflict with the LTTE.

The penalties for drug offences range from fines to life imprisonment or death. The death penalty (not mandatory) relates to a minimum amount of (a) 500 grams of opium, (b) 3 grams of morphine, (c) 2 grams of cocaine or (d) 2 grams of heroin. Less serious offences receive fines or imprisonment (Ratnayake and Senanayake 2000).

Government response to drug use and HIV

The government of Sri Lanka became concerned about the growing drug problem in the 1970s. The first national seminar on the subject of drug abuse in Sri Lanka was held in 1973 and a National Narcotics Advisory Board was established (Jayasuriya 1995). In 1984, as drug use continued to increase, the government created the National Dangerous Drugs Control Board (NDDCB) under the Ministry of Defence. The Board is made up of representatives from the departments of education, health, police, customs, government analysts and experts on the ayurvedic system of medicine (Ray 1998).

Since then the National Dangerous Drugs Control Board (NDDCB) has continued a nationwide drug education campaign that features a weekly national radio programme, seminars for judicial officers, training courses for police, and drug awareness seminars for students, teachers and parents on 'drug abuse prevention' (Narcotics 2001). The in-school drug abuse education has apparently met with little success (Jayasuriya 1995). Accessing information and preventative and support services by drug addicts is difficult (World Bank 2000). A study of IDUs in the early 1990s found that two thirds of heroin users had been treated for heroin dependence and, on average, had been treated three times. Most had been treated by general practitioners and a considerable number had been treated through the intervention of NGOs (Kandiah 1994).

There are four government treatment centres in Sri Lanka with a total capacity of 143 beds and seven counselling/rehabilitation centres of 30 beds in total. These centres are dedicated to de-addiction. There are also three training institutions for demand reduction activities (Ray 1998). The prison department also provides a specific program for drug dependent people through an 'open prison' programme (Ray 1998). The absence of a comprehensive and well-designed treatment and rehabilitation program for drug users has been a major constraint in treating drug dependency in Sri Lanka. Attempts to provide treatment at hospitals meant primarily for patients with mental disorders have caused many problems, partly because of the social stigma attached to such patients (Jayasuriya 1995). In 2000, 74.7% of drug users admitted to treatment went to government run centres, 1.5% to NGO run centres and 21.2% to prison. Eighty-eight per cent of people in treatment were admitted for heroin addiction (Ratnayake and Senanayake 2000).

Since the late 1970s, methadone detoxification has been offered to heroin users: the programme offers methadone for 10 days, followed by eight days in hospital for the withdrawal symptoms (Spencer and Navaratnam 1981). It has not been determined if methadone detoxification is currently on offer to heroin users.

National AIDS Policy

The Government of Sri Lanka has considered its National Strategic Plan in the light of an external review of the National AIDS Programme. While the National HIV/AIDS Policy remains a draft as of 29 August 2001, it recognises that efforts should be concentrated among groups in society which are vulnerable to HIV infection, and this includes IDUs. However, Sri Lanka has decided to adopt as policy that HIV in the drug using population should be addressed by reducing the size of the drug using population rather than adopting harm reduction strategies. Currently Sri Lanka resists pressures by third parties who wish to introduce harm reduction programs as a means of responding to the envisaged problems of HIV infection among IDUs. The supply and demand reduction approach will be maintained as in the past (Government of Sri Lanka 2001).

Non-government responses to drug use and HIV

The role of NGOs has been encouraged and supported by the government, particularly in relation to demand reduction. In 1986 the Federation of Non-Government Organizations Against Drug Abuse (FONOADA) was born and is the umbrella group for NGOs. During the 1990s, NGOs began a highly systematic programme of counselling, treatment and rehabilitation of drug users. In 1993, five NGOs offered treatment at 120 sites (Ray 1998).

The NGO Mithuru-Mithuro Movement is involved in long term residential treatment and rehabilitation and operates five centres. Currently they have nearly 500 clients and over the years have seen more than 5,000 people. The approach that is implemented is based on the Therapeutic Community model. Education on HIV/AIDS and STDs is provided as part of the rehabilitation process (K. Kumara de Silva, personal communication 2001). As so few of their clients are known to be IDUs (0.5%), it is unlikely that the concepts of harm reduction are an integral part of the program.

Estimated number of drug users	240,000 - 300,000
Estimated number of IDUs	Of the 30,000 addicts (lowest figure), 2% are injecting
Drugs that are used	Heroin, opium, hashish, cannabis, various benzodiazepines (diazepam, flunitrazepam, rohypnol) codeine, methaqualone, amphetamines, methadone
Drugs that are injected	Heroin, pharmaceutical drugs
Estimated number of HIV infections among IDUs	Prevalence among adults is 0.07%. HIV has not been found among IDUs but as a group they are not tested.

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Taiwan

Comparisons: 1997 Versus 2001

The government of Taiwan does not regard drug use and HIV as a problem and therefore no direct policy exists, no IEC material, no NSP or methadone programmes. The government does acknowledge Hepatitis C as a concern and has implemented screening: a study in the mid 1990s showed Hepatitis C prevalence among drug users at 53 to 81% which suggested risky behaviour was taking place. While drug users are regarded as criminals, patients are sent to hospital for detoxification rather than prison and then on to a drug treatment centre. If they behave well they may be released early and put on probation for two years during which time they must submit to urine testing. The relapse rate in 1997 and 2001 remains the same at about 80%.

Methamphetamines and heroin remain the drugs of choice in Taiwan and there are indications of a rise in the use of ecstasy, benzodiazepams and cannabis and an unexpected reappearance of solvent sniffing. Methamphetamines are inhaled, snorted or swallowed, while heroin is inhaled, snorted and over time injected. Needles and syringes are cheap and easily available from pharmacies: an argument the government uses against the need for NSPs. There were minimal studies on IDU behaviours between 1997 to 2001. In 1997, the estimate of drug users was between 200,000 to 300,000, with 150,000 using heroin. A recent report suggests 1.4% of the population (or 294,000 people) use methamphetamines and that there are 60,000 IDUs in Taiwan.

In 1997, 3.3% of reported HIV infections were due to IDU: in 2001 just under 2% are related to IDU. In 1997, 1,331 people were HIV positive, although researchers think it more likely that 5,000 people have HIV. In 2001, 3044 cases of HIV infection were recorded but the real rate is estimated to be more like 9,000 to 15,000 HIV infected people. The main route of transmission is through sexual contact (92%).

History

The history of opium use in Taiwan is similar to China. Before Japanese colonisation, the smoking of opium was legal and had become a popular custom: it has been estimated that 10% of the population smoked opium. Opium imported to Taiwan between 1865 to 1894 was the largest import by value, accounting for an estimated 45% to 75% of total import (Liu *et al.* 1999). During the colonial period (1895 to 1945), the Japanese were hesitant to introduce an opium ban, as was the case in Japan, and founded the Opium Monopoly Bureau which had the exclusive right to produce and sell opium in Taiwan. The use of opium without a license was strictly prohibited and punishable and by 1900 all opium addicts in the country were registered. In 1900, there were just over 160,000 addicts or approximately 6.3% of the population. It is likely there were more opium users because many people feared prosecution if they were registered (Lin 1995; Liu *et al.* 1999). Opium use was severely hampered through, the process of licensing its use, treating existing users, prohibiting sales to others and the selling of opium at substantially higher prices (Liu *et al.* 1999).

By the end of 1942, the number of registered opium users was 3,624 or just 0.056% of the population (Liu *et al.* 1999). In 1955, the Government of Taiwan introduced the "Narcotic Wipe Out Regulation". With this regulation, first time narcotic offenders would receive a 3 to 7 prison sentence, 5 to 10 years for a second time user and the death sentence for a third time offender. From the 1950s to the 1980s, the number of

people using narcotics was minor. In the 1960s, glue sniffing among the young was identified as a problem and throughout the 1970s, pentazocine (a synthetic opioid analgesic) became a popular choice among drug users. In the 1980s, the drugs of choice were barbiturates and methaqualone, largely because they could be bought from a pharmacy without a prescription. New regulations were eventually imposed which controlled this problem (Lin 1995; Li 1996; Chou *et al.* 1999). In 1990, a sharp increase in the use of methamphetamines was reported and it soon reached epidemic proportions as a result of its cheap price and its easy conversion from the raw material ephedrine (Li 1997; Chou *et al.* 1999; Chen *et al.* 1999). It is believed that heroin was introduced into Taiwan in the early 1990s and quickly became the principal illicit drug seized from the early to the mid 1990s (Lin 1995; Denq *et al.* 1996).

Current Situation

While Taiwan is not thought to be a cultivator of illicit drugs, it is believed to be a producer of methamphetamines, and in 2001, of ecstasy. The technique of manufacturing methamphetamine is believed to have originated from Japan and Korea (Shaw 1999; Narcotics 2001; Taipei Times 2001). In 2001, authorities discovered a large crop of 3,000 cannabis and opium plants in Miaoli, the largest haul in many years (Chi-ting 2001). It is believed that the country faces a serious problem of heroin and methamphetamine consumption. The primary source of most drugs smuggled into the country is China. In 2000, about 93% of methamphetamines and 53% of heroin identified in Taiwan had its origins in China; a small percentage of heroin is also trafficked from Thailand (Narcotics 2000; Narcotics 2001).

Drugs are usually brought into the country by fishing boats and cargo containers arriving from China. By the end of October 1999, authorities seized 70 kilograms of heroin and 1,139 kilograms of methamphetamines. In 2000, the seizure of heroin was 220 kilograms and 621 kilograms of methamphetamines. Methamphetamine seizures have a tendency to fluctuate; in 1997 over 2,500 kilograms were seized. Narcotic related convictions have increased and in 2000, there were 8,714 cases, a substantial increase from 5,925 cases the previous year. Methamphetamines and heroin are the drugs of choice but there are also indications that ecstasy, benzodiazepines and cannabis are becoming a problem. It is believed morphine and cocaine are rarely used (Shaw 1999; Narcotics 2000; Narcotics 2001; Prelypchan 2000). In 2000, the sniffing of glue and other solvents made an unexpected reappearance and this was attributed to government crackdowns on other drugs (Prelypchan 2001).

Drug taking practices and risk factors

The use of methamphetamines is generally by inhaling the fumes after they have been heated on foil. They are also snorted and, when supplied as pills, swallowed. Injecting methamphetamines has not been documented as a popular route of administration (Prelypchan 2001). Heroin is smoked (either mixed in with tobacco or inhaled in the form of 'chasing'), snorted, and over time injected. The current transition time between smoking and/or snorting to injecting has not been assessed but during the mid 1990s it was reported to be from weeks to a few months (Lin *et al.* 1995; Prelypchan 2001).

The Department of Health has placed no controls on syringes and needles, which can be bought without a prescription. There is a widespread perception that needles and

syringes are cheap and drug users should be able afford injecting equipment. However, reports of IDUs sharing their injecting equipment occur, and its possible they do not wish to identify themselves as drug users to pharmacies and/or it is a part of the cultural ritual among the IDU community. The price of a needle and syringe is less than TWD\$20 (US\$0.61).

Prevalence and profile

In 1992, there were 33,655 drug seizures and up to 42,000 people tested positive to illicit drug use. By 2000, up to 39,000 drug seizures occurred and 57,714 people tested positive for drug use (Prelypchan 2001). In the mid 1990s, the Ministry of Justice and Department of Health estimated that there were around 200,000 people using illicit drugs, although public health officials suggested the figure was closer to 300,000. A recently published report stated the rate of methamphetamine use alone is estimated to be 1.4% of the population. In a country with a population of 21 million people this would amount to 294,000 methamphetamine users (Shaw 1999). In an earlier report it was estimated there were 100,000 to 150,000 heroin addicts (Lin *et al.* 1995). Currently, it is estimated there are 60,000 IDUs in the country (Chen *et al.* 2001).

A study of 1,358 adolescent students aged 16 to 18 years was conducted to examine the prevalence of licit and illicit drug consumption. The prevalence of illicit drug use was 6.4% (6.6% for males: 5.6% for females) (Yang *et al.* 1998). In another study focused on junior high school students, illicit drug use was found in only a very small proportion (Chong *et al.* 1999). Periodic nationwide surveys of substance use among adolescent students are conducted. Published data has shown, throughout the early to mid 1990s, the prevalence of illicit drug use has remained relatively consistent; between 1991 to 1996 it ranged from 1.1% to 1.5%. In 1996 of those using illicit substances, 43% used amphetamines, 24% sniffed glue and 9% used a substance called flunitrazepam. Glue sniffing among students was on the rise (Chou *et al.* 1999).

Fatalities related to methamphetamine use have been recorded and a retrospective study between 1991 to 1996 showed there were 244 fatality cases out of a total of 3,958 forensic fatalities. Most of the fatalities were people aged between 20 and 40 years, with a mean age of 30 years, and most were males (73%). Most methamphetamine fatalities are related to accidental deaths (59%) (Shaw 1999). Current data on methamphetamine fatalities was not yet available.

The first AIDS case was identified in 1985. By July 2001, there were 3,044 officially recorded cases of HIV/AIDS. According to Taiwan's Centre for Disease Control there is one recorded person with HIV per 5,773 adults. The Centre suggests unconfirmed HIV infections are likely to be one person per 1,200 to 2,000. In 2001 it was estimated the number of HIV infections was between 9,000 to 15,000 people. The major route of HIV transmission is sex (92%) with IDUs less than 2%. The male to female ratio of HIV infections is currently 11:1 compared to 42: 1 in 1989 (Frazier 2001; Chen *et al.* 2001). The prevalence of HIV among Taiwan's IDUs has never been systematically studied (Chen *et al.* 2001).

As a result there being few restrictions on medical supplies and needles and syringes the sharing of injecting equipment is reported to be low (Chen *et al.* 2001). However, new evidence has suggested this is not the case. A recent study (including only those

who self reported heroin use) among female drug users (N=616), where participants were recruited from four female prisons, showed that over half had shared their needles with other people (55.5%). The study found heroin use to be popular (32.3%) and the use of heroin and other drugs was reported by 67.7% of the study participants (Szu-Hsien *et al.* 2001a).

In the late 1990s, a survey of drug users from rehabilitation centres and prisons was conducted to examine the prevalence of hepatitis C: it was found to be 67% (Chang *et al.* 1999). Other studies in Taiwan have shown the prevalence of hepatitis C to be between 53 and 81% (Wu *et al.* 1991). This clearly indicates that risky behaviours among the IDU community are taking place and consequently they are at risk of becoming HIV infected.

Government responses to illicit drug problems

The law for the ‘Eradication of Illicit Drugs’ was first enacted in 1995. There have been a series of revisions and currently drug users are regarded not only as criminals, as the law requires it, but also as patients. As a result of the new regulations, any illicit drug users caught by the police will be sent to a hospital for detoxification rather than detained in a prison. Following the acute phase of treatment, the patient is then sent to a compulsory therapeutic drug unit where the treatment can last for up to one year. While there they participate in a mandatory program which combines psychological counselling, vocational training, physical work, exercise and religious activities. If there are no problems, drug users may be released early. Once they have been discharged from the institution they will be supervised by a probation officer or they may choose to stay at a ‘halfway’ house. The probation period can also up to two years. During the probation period mandatory urine tests for illicit drug use will be conducted. If they relapse, the person is likely to receive a prison sentence of over six months but not more than 5 years (Ma 1996; Lin *et al.*; 1995; Li 1997).

However, it seems that even with such actions and strict law enforcement, the ongoing epidemic of drug use has not abated. In the mid 1990s the prison population was 39,840 and of these 24,737 (62%) were there as a result of drug use (Ma 1996). In a later assessment the National Department of Justice estimated that 20,000 people were incarcerated in jails as a result of drug use (mainly methamphetamines and heroin). It has been reported that repeat offenders may be punished with a life sentence. Concerns have been raised that the law deprives heroin users of the right to treatment if they also have a co-existing psychiatric disorder, a situation that is not uncommon (Bai *et al.* 1998; Chen *et al.* 1999; Chong *et al.* 1999).

To support the introduction of the policy, the Department of Health expanded the capacity of drug treatment facilities to take in more patients by designating 133 hospitals to accommodate drug users and assisting in the training of qualified personal. One the largest detoxification centres is the Taipei City Psychiatric Centre. Long term follow-up studies of people who have been discharged have not been undertaken but it is estimated that the relapse rate remains very high at 70 to 90%.

Government response to drug use and HIV

The Government does not currently regard drug use and HIV as a problem. This is possibly because HIV infections among IDUs remain low and consequently little is

done to service this group. The provision of IEC material specifically targeting drug users on ways to reduce the harmful consequences of drug use has not occurred. It appears that no knowledge, attitude, behaviours program among drug users has been undertaken by the government. The government has provided and promoted information about drug use and HIV but the focus is general and strictly orientated towards a supply and demand reduction approach.

Studies of hepatitis C among IDUs have shown a high prevalence and, as a result, it is believed the government has implemented hepatitis C screening of all known drug users. The results of such screenings have not been available.

There has been resistance by the government to the implementation of a methadone maintenance program and government authorities do not understand the issues associated with heroin addiction (Chen *et al.* 1999). It is believed naltrexone is more acceptable as an ‘antagonist’ rather than a drug substitute. In the mid 1990s a clinical voluntary trial of naltrexone took place among ex-users of heroin and it was believed this program may be introduced into compulsory treatment programs. It has not been determined if a policy change on naltrexone occurred. Needle and syringe programs are not an option and it is likely the government would argue that the availability and accessibility of injecting equipment from pharmacies means such programs are unnecessary.

National AIDS Policy

There have been no changes to the AIDS policy and specific details that focus on drug use and HIV do not exist.

Non-government responses to drug use and HIV

Currently, there are a few NGOs who target HIV/AIDS issues and provide care for those people living with HIV/AIDS. There do not appear to be NGOs targeting drug users. The number of NGOs involved in managing rehabilitation treatment centres has not been determined. One religious NGO focuses on drug intervention and the four centres under its operations are registered with the government. This approach uses religion to treat drug use. There are no financial costs involved but only those who become Christians are able to enter.

Estimated number of drug users	300,000 to 400,000
Estimated number of IDUs	60,000
Drugs that are used	methamphetamines, heroin, ecstasy, benzodiazapines, cannabis, solvents
Drugs that are injected	heroin
Number of HIV infections among IDUs	less than 2% of HIV infections are through IDU

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Thailand

Comparisons: 1997 Versus 2001

The most dramatic change to have occurred in Thailand since 1997 is the massive increase in the use of amphetamines (1,000% increase between 1993 and 2001). Amphetamines, called *yabaa*, have overtaken heroin as the prime drug of choice largely due to the surrender of the Burmese drug lord Khun Sa in 1996 and the subsequent decrease in availability and increase in the cost of heroin. Amphetamines on the other hand are easy to obtain, relatively cheap and available throughout the country. *Yabaa* is generally taken orally or a tablet is crushed, the foil lit underneath and the vapour inhaled: there are reports of injecting of *yabaa* but at this stage this is limited. Heroin is still commonly available in the hills of north Thailand and in the south, where it is largely injected.

Despite the change in preferred drug and method of administration there is still a high prevalence of HIV among IDUs due the frequency of injecting, the widespread sharing of needles and imprisonment of drug users. In the mid- to late 1990s the often quoted figure was 1.29 million drug users in Thailand. In 2001 the estimated figure is two to three million drug users, about five per cent of the population. In 1995, 32% of IDUs were believed to be infected with HIV: in 2001 this has risen to 50%.

In 1997 a pilot needle and syringe project was operating among the Akha people in the north of Thailand. A limited methadone programme had been introduced which allowed for 45 days decreasing methadone as part of a detoxification program. Generally, in 1997, the government acknowledged the high prevalence of HIV among IDUs and the need for prevention activities but did not lean towards harm reduction. In 2001 the Ministry of Public Health is attempting to implement reforms to narcotics regulations to allow HIV prevention activities, for example, to extend the methadone programme from 45 days to one to two years. The Akha NSP programme is still operational but the government is generally unsupportive of NSP. The Asian Harm Reduction Network continues to produce advocacy materials on HIV and drug use but basically there is limited HIV prevention activity with IDUs across the country.

History

In 1851, Thailand (then known as the independent kingdom of Siam) legalised opium. In 1905, Bangkok had up to 900 opium dens and by 1917 this had increased to 3,250. As a result of the much-needed tax that opium sales raised the government found it difficult to disengage with this commodity. In 1921 it was estimated there were 200,000 opium addicts in the country. As a result of international pressure the government went through the process of closing the opium dens and by 1930 had closed 2,000. For nearly 30 years opium use continued and the opium addicted population's dependence upon imported opium was undiminished. In 1959 the government banned opium smoking and selling and all opium users were required to be registered; within 6 months over 70,000 users registered. However, the supply of narcotics was not completely restricted as the tribal areas where opium was grown in the northern Thailand were not amenable to effective law enforcement (Westernmeyer 1976; Mc Coy 1991; UNAIDS and UNDCP 2000).

After the ban on opium, heroin and to a lesser extent morphine, imported from Hong Kong, appeared on the market and the first heroin epidemic in Thailand began; the method of administration was smoking. It is likely during this time Bangkok became

the region's and possibly the world's largest opium refining and distribution centre (Spencer and Navaratnam 1981; McCoy 1991; Treerat *et al.* 2000). By 1967 another heroin epidemic began with the availability of a higher quality of heroin spreading rapidly in Bangkok and then into the rural areas. By the mid-1970s the purity of the heroin increased and reports of injecting the drug among Thai adolescents emerged. In 1976, 24,429 heroin users received treatment; by 1988 this had increased to 35,000. By the mid-1980s the injecting of heroin was entrenched in many regions of the country (McCoy 1991). By the late 1990s after nearly 40 years of being the most popular drug on the market, heroin was replaced by the synthetic drug, amphetamine, which had first appeared in the early 1960s. By 1996, the amphetamine problem became so widespread the government imposed legal penalties upon amphetamine use, possession and sale at the same level as for heroin (Treerat *et al.* 2000; Poshyachinda *et al.* 2001).

Current Situation

Thailand's opium crop now accounts for less than 1% of the regional production of opium and is no longer a major source of opiates internationally. Opium cultivation mainly occurs in the northern border areas near Myanmar and Laos (Chiang Mai, Chaing Rai, Hong Son and the Tak Province) where it has historically been grown by many of the tribal/ethnic communities in the region for cultural and medicinal uses and as a source of cash. In 2000, 1,648 hectares of opium were cultivated of which over 50% was subsequently eradicated by the authorities. The recent trend by opium farmers is to cultivate smaller, more isolated fields and to engage in multiple cropping to avoid eradication (Gray 1998; Office of Narcotics Board (OONB) 2000; Narcotics 2001). It is however the problem of opium produced outside the country and imported into Thailand that is of major concern to authorities. In 1999 and 2000 opium smuggled from Laos and Myanmar into Thailand amounted to 1,890 tons annually. It is believed that heroin manufacturing does not now exist in Thailand, and that most heroin smuggled into Thailand has its origins in neighbouring countries. In 1999, 1.5 tons of heroin was seized by the Thai authorities (Treerat *et al.* 2000; OONB 2000).

A major change in the heroin market came in 1996 after a drop in supply and the surrender of Khun Sa to the government; Khun Sa was a Burmese drug lord and leader of the Shan State army, who controlled a vast heroin production empire and a trafficking network over many years (Treerat *et al.* 2000). A consequence of these events was a sharp increase in the price of heroin and the expansion of the amphetamine type substance (ATS) market. Currently most ATS is produced outside the country, with most originating from Myanmar. Domestic methamphetamine production factories have been found to be expanding and relocating from the north to the central regions of the country in order to avoid government suppression. Initially labourers and truck drivers wishing to work longer hours were the major consumers of ATS, but over time the market has expanded and is now dominant in youth and student culture. Methamphetamine, commonly called *yabaa*, is easy to obtain, the price has remained stable and it can now be found throughout the country. In 1999, the retail price of a methamphetamine tablet was about 120-150 baht (US\$2.70 – \$3.40). Currently, the Ministry of Public Health believes there are 301 different types of *yabaa* from 50 provinces on the market (WHO 1997; UN 1999; OONB 2000; Peak 2001; UNDCP 2000; UNODCCP 2001; Narcotics 2001). It is reported that heroin is

bought in three common measuring units; *tua* (50mg), *fa* (200-250 mg) and *bic* (1gram). Amphetamines are shipped usually in packages of 200 tablets which retailers then divide into 5-10 tablets placed into a straw for sale (Treerat *et al.* 2000).

In 1999, an estimated 300 million methamphetamine tablets were imported into Thailand, growing in 2000 to as high as 600 million tablets (OONB 2000; Narcotics 2001). As a consequence there are major increases in the size of methamphetamine seizures: in 1997 just under 2,000 kilograms was seized, doubling by 1999, and in the first eight months of 2000 authorities had already seized 4,752 kilograms. Methamphetamine indictments of the total number of drug related indictments rose from 1.8% to 67% from 1988 to 1998 (OONB 2000; Narcotics 2001). The use of ecstasy has also increased as is reflected in the increase in seizures: in 1998 nearly 6,000 tablets, in first eight months of 2000 25,000 tablets (OONB 2000; Narcotics 2001). Cultivation of marijuana has decreased over the years and mainly occurs in three provinces, Mookdaharn, Nakornpanom and Sakonakorn. Other drugs that are used in the country to a lesser degree include cocaine, ketamine, and volatile substances such as glue (OONB 2000; Narcotics 2001; UNODCCP 2001).

Drug taking practices and risk factors

The most preferred method of administering heroin according to treatment data is still by injecting, at around 70% to 80% of all heroin users (UNDCP 2000). The prevalence of injecting heroin has increased during the last five years from 52% of all heroin users in 1994 to nearly 70% in 1998. The heroin users administer the drug around 2-3 times per day (Treerat *et al.* 2000). Injecting heroin is still common among a variety of hill tribes in Northern Thailand. Heroin is still commonly available in southern Thailand where its use has not decreased. In places such as Yala heroin is reported to be easily purchased in teashops for around 100 baht (US\$2.26) (Peak 2001).

It is believed the injecting of heroin is common in Yala but that the sharing of needles is less so. Heroin is also smoked and administered by fume inhalation. It has been reported that that when a person switches from heroin to *yabaa* it is common that the person injects heroin in the morning and when the effect is wearing off then *yabaa* is used. It is believed the heroin dosage is gradually reduced by half using the same ritual procedure. Over time this process is maintained until *yabaa* becomes the only drug used (Peak 2001). The reason for the change from heroin to *yabaa* is largely to do with increased cost and general decreased availability of heroin.

The use of *yabaa* is either through oral ingestion of the tablet, or, commonly, by taking the foil off a gum wrapper, folding it lengthwise, adding the crushed tablet, putting a lighter underneath and inhaling the smoke through a tube as is commonly done when 'chasing' heroin (Peak 2001). Many participate in this activity as a group, commonly also drinking alcohol and then moving on to recreational activities. Currently, methamphetamine is mainly available as a tablet as opposed to 'crystal' and this may explain why it is not commonly injected, but such behaviour does occur (Poshyachinda *et al.* 1999; Thomson 2001). Currently, many users of methamphetamine have a positive attitude towards the drug, as they do not believe it is addictive and find it enhances both work performance and enjoyment (MOPH 1999).

Ecstasy and ketamine are orally ingested while marijuana is generally smoked but in rural communities it can be ingested. Opium is smoked and injected. 'Chasing' and ingesting *yabaa* are the dominant forms of administration and consequently their impact on the risk of HIV infection is difficult to quantify. Yet the *yabaa* epidemic may still have multiple effects on HIV transmission among drug users, in that it may facilitate increased sexual risk taking and thus a potential for HIV infection to occur. Qualitative sexual research in this area has yet to be undertaken (Peak 2001; Vanichseni *et al.* 2001).

Despite the relative ease and availability of needles and syringes from pharmacies throughout most of the country (except in remote rural communities where it can still remain a problem) and the introduction of education programs in some institutions on risk reduction practices, a high HIV prevalence among IDUs remain. This can be explained largely as a result to the frequency of heroin injecting and of the widespread sharing of needles. Before to HIV/AIDS risk education programs among IDUs in the early 1990s, it is likely frequent sharing of injecting equipment was universal. A later study in Bangkok showed that 96% of the participants obtained clean injecting equipment from pharmacies yet sharing of equipment still occurred and they became HIV infected. As well as the sharing of needles in the wider community the problems are compounded by the high incarceration rate of drug users where access to clean injecting equipment is severely limited, resulting in widespread sharing (Choopanya *et al.* 1991; World Bank 2000; Vanichseni *et al.* 2001).

Prevalence and profile

For a number of years the most frequently quoted estimate of drug users was compiled by the Thailand Development Research Institute in 1993; it was estimated then that there were 1.29 million drug users (approximately 2.2% of the population). In early 1994, it was estimated of these around 100,000 to 250,000 were IDUs (UNAIDS and UNDCP 2000; ESCAP, UNAIDS and UNDCP 2001). Currently the estimates of drug users range from two to three million or possibly nearly 5% of the population. From 1993 to 2001 there has been a 1,000% increase in the use of ATS and there are likely to be 300,000 ATS dependent persons (UNDCP 2000; Narcotics 2001; Chandrasekaren 2001). According to the Office of the Narcotics Control Board (ONCB), methamphetamines comprise 75% of the drugs in use in Thailand and heroin now only accounts for 10%. The other 15% includes opium, marijuana, solvents, ecstasy and ketamine (Peak 2001; Narcotics 2001). Current estimates for the number of IDUs in Thailand have not been found. It has been estimated there are 40,000 opiate users in Bangkok alone of whom 90% inject (ESCAP, UNAIDS and UNDCP 2001).

Data reported by 296 drug treatment centres to the ONCB in 1999 show heroin is the most commonly used drug during the 30 days preceding admission to treatment centres (58%). This was followed by methamphetamines (33%), opium (5%), volatile substances (2%) and marijuana and other drugs. Of these patients most preferred to take their drugs by injecting (48%), followed by smoking (46%), sniffing (2%) and the rest by eating or using more than one method. The patterns of drug use show 90% used only one kind of drug (ONCB 2000). Data from the Northeastern Drug Dependent Treatment Centre shows that while *yabaa* is the most popular drug many qualify as poly-drug users. If *yabaa* is not available young people will use heroin, glue or opium depending on availability and price. The use of particular drugs can

depend on the region of the country. Data from the Northern Drug Dependence Treatment Centre shows that among the patient admissions 39% from the lowlands use *yabaa* compared to 3% among the hill tribe residents where opium and heroin remain popular (Peak 2001).

In 1999 statistics from the Corrections Department showed that the number of prisoners charged with violation of narcotic control laws accounted for 53% of the total prisoners in the country. In Bangkok the proportion of drug related offenders in prisons has increased to 69% compared to 61% in 1996. In 1996-97 the figures for heroin offenders declined by 9% but since then the figures have been increasing (Treerat *et al.* 2000). The use of drugs among youth has more than doubled in the past five years throughout the country. In 1999, an estimated 12% of students used or associated with drugs compared to only 1% in 1998. The major drugs used are amphetamine (7%), marijuana (3%) and inhalants (2%) (Treerat *et al.* 2000; Peak 2001).

Most of those dependent on drugs are male (around 90%) and among those addicted to heroin most are aged between 20-24 years, while more than half of those dependent on methamphetamine are in the 14-19 year age group (Treerat *et al.* 2000). In 1999, of those registered in treatment centres, many were employed (50%) while 34% were unemployed. The rest were students or unidentified occupations (ONCB 2000).

HIV was first identified in Thailand in 1984, but it was not until the late 1980s that the first epidemic was experienced particularly among IDUs in Bangkok: in 1988 the HIV prevalence among IDUs increased from around 2% to 43% (Mastro *et al.* 1998; Kitayaporn *et al.* 1998; Celentano *et al.* 1998). Sentinel surveillance was introduced in 1987; since then nearly 300,000 people have died of AIDS and it is estimated that at the end of 1999, 755,000 adults and children were living with HIV/AIDS. In 2000, it was believed a further 55,000 people would develop AIDS and roughly the same number would die from it. It has been estimated that around 2% of Thai men and 1% of Thai women are living with HIV. According to Thai authorities, close to 30,000 new infections occur each year (UNAIDS and WHO 2000; World Bank 2000; WHO 2001).

In June 2001, the results of the national HIV sentinel seroprevalence showed injecting drug use as a major risk. As a population group the seroprevalence stood at 50% followed by prostitutes (16%) and male prostitutes (9.6%) (Epidemiology - Ministry of Public Health 2001). In 1999, the HIV prevalence among army conscripts, pregnant women and sex workers declined sharply. Over the years this decline has not been observed among IDUs, among whom HIV prevalence remains high and for whom the outlook is poor. In 1995, HIV prevalence nationally among IDUs was 32%, increasing to 51% in 1999 and in 2000 the national sentinel surveillance found it to be 54%. It has been estimated that 5-10% of drug users become HIV-infected each year (Phoolcharoen 1998; Tangcharoensathien *et al.* 2000; UNAIDS and UNDCP 2000; Peak 2001; WHO 2001). The riskiest behaviours amongst this group in Thailand have still not been addressed and stand out as major causes of continued HIV transmission (World Bank 2000).

Government responses to illicit drug problems

The Narcotics Act 1979 stipulates that for narcotics to be properly controlled, because of the different dangers and because some can be used for medicinal purposes, they have been classified into five categories. For those in possession of dangerous narcotics such as heroin, amphetamine, methamphetamine, ecstasy and LSD, and if they are of pure substance of no less than 20 grams, they will be imprisoned for 1-10 years and fined between 10,000 to 100,000 baht (US\$226 -\$2,267). Those discovered consuming dangerous drugs may receive imprisonment of six months to 10 years and a fine of 5,000-100,000 baht (US\$113 -\$2,267) (Legal Affairs Division 2000). The highest penalty for both heroin and/or methamphetamine trafficking is capital punishment. In 2001, 17 methamphetamine traffickers were sentenced to death in six separate drug cases but the outcome is not yet determined (Bangkok Post 2001).

Treatment and rehabilitation services are available to drug users through three treatment systems; voluntary, convicted and compulsory. For a first time user of dangerous drugs, it is likely they will be referred to a treatment centre. The Narcotic Addict Rehabilitation Act 1991 is aimed at enforcing the compulsory treatment of an alleged offender to recover from narcotic addiction. An official transfers the person to the rehabilitation centre within the territorial jurisdiction; the person will then be committed for rehabilitation for a period of no more than six months. An extension of this period may be made many times but each extension lasts not longer than six months, the total period not exceeding three years. If the result of rehabilitation is not deemed satisfactory a consideration shall be made as to whether or not it is expedient to institute criminal proceedings (Cheurprakobkit 2000; Legal Affairs Division 2000).

The Ministry of Public Health believes the best way to combat drug use is through the promotion of drug detoxification. Voluntary treatment is provided by 247 treatment centres (197 belong to the government and the rest to the private sector). Treatment is focused on both western and traditional Thai medical treatments (UNAIDS and UNDCP 2000). Nearly 39,000 patients were registered in such facilities in 1999 (MOH 1999). It has been reported that since some laws were amended all hospitals are now responsible for providing drug treatment. As a result there are 640 registered treatment centres in the country, of which 561 are public institutions and the rest are private facilities (Peak 2001). The number of beds available for drug treatment has been reported about 1,670 (Narcotics 2001). Treatment is based on four stages and while many complete the pre-admission and detoxification stages only a small number receive rehabilitation and after care to assist people to reintegrate back into the community. As a result the treatment outcomes are poor and relapse is at least 75% and probably higher (UNAIDS and UNDCP 2000).

Government response to drug use and HIV

Currently the Narcotics Control Legislation includes no consideration of HIV prevention among IDU. The Ministry of Public Health has been attempting to implement a public order reform to the narcotics regulations to allow certain activities to help prevent HIV infection among IDUs. The methadone program is one such activity which is operating nationally but a part constraint was that drug users were officially only permitted to stay on the program for 45 days. Clients could re-apply to go on methadone within a week of completing the previous course but most go to another clinic and immediately re-register. The Ministry of Public Health suggested

that methadone maintenance be made available for a period of one to two years and a change in policy in 2000 now allows for ongoing methadone maintenance (Vanichseni *et al.* 1991; Celentano *et al.* 1999; UNAIDS and UNDCP 2000).

Since 1989, several narcotic clinics in Bangkok have been providing free bleach in packets and providing instructions to IDUs as to how clean their injecting equipment appropriately. It is unlikely that such programs and services are widespread outside of the capital. The government is not supportive of needle and syringe programs (NSP) and although it is considered there are no major legal impediments to their implementation there is little interest in pursuing this approach. One needle and syringe program is however operational among the Akha people in the far north of the country, although on a small scale. While it is generally agreed that needles and syringes can be purchased without difficulty drug users are often reluctant to carry injecting equipment to avoid police scrutiny and arrest; possession of paraphernalia is not used in itself as evidence but it may be used as collaborative evidence (Pinitsuwan 1998; Yodavaudh *et al.* 1999; UNAIDS and UNDCP 2000; Vanichseni *et al.* 2001).

National AIDS Policy

The National AIDS Committee proposed the National Plan for Prevention of HIV/AIDS 1997-2001, with a focus on human resource development and creating enabling environments conducive to HIV/AIDS prevention. One of the major approaches adopted is to implement a variety of educational and behaviour modification interventions targeting high-risk groups and vulnerable sectors of society. While the government appears to have acknowledged the high prevalence of HIV infection among IDUs, which has not abated since the epidemic began, many obstacles still remain to the implementation of risk reduction policies and prevention activities - largely as a result of the constraints of the Narcotics Act 1979. There is acknowledgment of the need for strengthened intersectoral cooperation yet operational links between drug control policy and HIV prevention and intervention policies still appear remote. Needle syringe programs are too few to have any impact, and methadone therapy whilst available is so constrained as to be largely ineffective (UNAIDS and UNDCP 2000).

Non-government response to drug use and HIV

In Western Thailand there are both national and international NGOs working on HIV issues, but none is primarily working on HIV prevention among drug users, and availability of treatment for drug addiction is scant. In Northern Thailand there is a myriad of NGOs and community based organisation working on HIV issues. The *Asian Harm Reduction Network* mainly focuses on producing advocacy materials on HIV and drug using issues. The *HIV/AIDS prevention and Care for Hill tribes of Northern Thailand (HAHP)*, working with the Akha people of Chiang Rai, has been in operation since the mid-1990s. The project has been working in and around nine villages where there is a relatively large population of drug users. Needle and syringe programs and long term methadone maintenance are the main activities. This is still the only NSP in the country. The *Mae Chan Harm Reduction* project has been declining since external funding finished. Another organisation, *Dawn Projects*, targets hill tribe communities but it does not provide primary prevention on drug use. In Mae Sai there is one NGO program focused on HIV and drug use and in Fang there are none (Peak 2001).

In north-eastern Thailand there are limited number of NGOs working on HIV issues and there is only one (*AIDSNet*) that is working directly with potential, current or former drug users. In Bangkok, *Alden House* offers HIV-infected drug users a choice of outpatient care or the option of living in a therapeutic community setting; in the past its funding mainly came from the government but recently this has been dramatically reduced. It appears those working in the capital on HIV and drug use issues are few. Southern Thailand has very few HIV projects implemented by NGOs or funded by international donors. Drug rehabilitation and detoxification centres are in operation but it has been difficult to determine which are government and which are NGOs. However, it does not appear that there are any NGOs targeting or working directly with current drug users (Pinituwan 1998; Peak 2001).

Estimated number of drug users	Two to three million or possibly nearly 5% of the population
Estimated number of IDUs	Currently unknown (In 1994: 100,000 – 250,000).
Drugs that are used	Heroin, opium, methamphetamines, marijuana, cocaine, ketamine, ecstasy volatile substances such as glue.
Drugs that are injected	Heroin, opium, methamphetamines
Estimated number of HIV infections among IDUs	The 2001 national sentinel seroprevalence survey showed rates of 50% among IDUs

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Vietnam

Comparisons: 1997 Versus 2001

Vietnam's HIV epidemic is being fuelled by injecting drug use with at least 65% of notified HIV infections occurring in IDUs. A crossover in major risk activities is also beginning to occur with 25% of commercial sex workers in Hanoi and Ho Chi Minh City also injecting drugs. There has been a dramatic increase in IDU and in HIV infection in the north of the country, a region where, in 1997, HIV was extremely limited. In 1997, estimates suggested there were 135,000 opium smokers and 50,000 IDUs in Vietnam; in 2000 official figures state 100,293 drug addicts; unofficially estimates range from 128,000 to 183,000 but others claim it is even greater. Prevalence of IDU among sex workers (SW) ranges from 10-50%. Current overall IDU estimates are not available but HIV prevalence among IDUs ranges from 0% to 89% according to the province. The National AIDS Committee reported 6,700 cumulative HIV infections by September 1997, in August 2001 there were 38,000 people reported with HIV but in reality the numbers are more likely to be about 122,000.

There has been a modest increase in poppy cultivation since 1997 and in 2001 heroin and opium (especially 'blackwater opium') remain the most commonly used drugs. In 1997 opium was usually smoked with little evidence of injecting, since then there has been an increased transition from smoking to injecting with injecting becoming the most common way to take both heroin and opium. In 1997, IDUs commonly used shooting galleries to both buy and inject their drugs but many of these have closed down due to the "social evils eradication" campaign. In the cities drugs are widely available like 'vegetables in the market place'. Needles and syringes are still available from pharmacies and markets but price, and fear of being caught by the police, can stop users from purchasing injecting equipment.

Police and customs officials increased their efforts in the late 1990s: in 1996 13 drug traffickers were sentenced to death, and in 2000 86 people received the death penalty. In 1997 there were 43 rehabilitation camps where drug users were forced to attend for six weeks to six months. By 2001 these had increased to 55, with a stay of up to one year. In the early 1990s, the Vietnamese government was quick to recognise the seriousness of the HIV epidemic and implemented HIV surveillance and prevention programs. Harm reduction is well understood in Vietnam and programs such as pilot peer education, needle and syringe programs and a methadone maintenance trial were begun (the last has only been implemented on a very limited scale). In 2001 harm reduction is still supported and there are a range of ongoing projects but constraints, such as the social evils campaign, limited funding and confusion about drug laws continue to impede their spread and acceptance.

History

There is a long history of opium cultivation in Vietnam among some ethnic minorities in the mountainous areas of Vietnam (Westernmeyer *et al.* 1991). Opium was used not only medicinally but also as a means to alleviate hunger. In the early 19th century, British opium began flooding into southern China and then into Vietnam. The economic strains of opium addiction began to show and in 1820 the Vietnamese monarch outlawed opium. This restriction on opium smuggling from China was unsuccessful. Colonisation by the French led to the establishment of an opium franchise and the sale of opium reaped large profits for the colonisers. Opium dens were widespread throughout the country (McCoy 1991; Le Ngoc Yen 1999).

It has been estimated that two per cent of the entire population were dependent on opium by 1945, including almost 20 per cent of the Vietnamese elite. After

independence in 1945 the government made serious attempts to eradicate opium cultivation but by the early 1960s this had proven unsuccessful (Nguyen Tran Hien 1998; Le Ngoc Yen 1999). In the late 1950s there was a strong push to re-open opium dens in South Vietnam and recommence the distribution network for smuggled opium. By the early 1960s in Saigon's sister city of Cholon there were an estimated 2,500 opium dens in operation (McCoy 1991). The patterns of drug use changed during the American war in Vietnam when opium smoking and heroin injecting became a large problem among American and South Vietnamese soldiers. Most American soldiers smoked opium rather than injected heroin, most only started injecting when they returned to the United States. By mid-1971 it was estimated there were more American heroin users in South Vietnam (81,000) than in the entire United States (68,000) (McCoy 1994). In 1974 it was estimated that in Saigon alone there were 150,000 drug users. After the war heroin use largely disappeared when drug supplies became scarce: a small percentage of Vietnamese continued using opium (McCoy 1991; Nguyen Tran Hien 1998).

Before 1975 most drug users resided in south of Vietnam, particularly in Saigon (later re-named Ho Chi Minh City (HCMC) in 1976). In the 1980s drug use began to reappear. Some of those people who had been dependent before 1975 began appearing at treatment centres and there was also evidence of many new drug users. The number of drug users has continued to increase and they are now to be found in most provinces. Between 1970 and 1990 the main drug used in Vietnam was opium but since the mid-1990s heroin has become the drug of choice and the popularity of amphetamines has been increasing (UNAIDS/UNDCP 2000; Ministry of Health and UNDCP 2000). The injecting of drugs became increasingly popular, accompanied by widespread sharing of injecting equipment, and leading to the emergence of an HIV/AIDS epidemic. In 1993 among the total annual reported cases the proportion of HIV infection among injecting drug users (IDUs) was 87%. While this has been decreasing the levels of HIV infection among IDUs have remained high throughout the 1990s (National AIDS Committee 1998a; 1998b; Nguyen Tran Hien 1998; Ministry of Health & UNDCP 2000; Chung A 2000).

Current Situation

Vietnam is considered a relatively major opium producing country even though it grows less than one percent of opium grown in the Golden Triangle (Narcotics 2001). Mostly farmers experiencing poverty and ongoing hardship grow opium in the uplands and mountainous regions of some north-western provinces of Vietnam. In the year 2000 Vietnam saw a modest 10 per cent increase in poppy cultivation (Narcotics 2001). Due in part to its proximity to the Golden Triangle, Vietnam is also a drug transit country for opium, heroin and increasingly synthetic drugs, amphetamine type substances (ATS) and psychotropic drugs manufactured in China and Myanmar. The growing availability of drugs has led to a growth in domestic consumption, especially among urban youth (Narcotics 2001). There are a variety of trafficking routes through Vietnam. Much of the heroin from the Golden Triangle currently enters the country via the mountain borders of Lai Chau province before it is transported to Hanoi. Amphetamine type substances and other illicit substances are believed to enter Vietnam at various points along the China border and are then transported to northern areas. Much heroin crosses the border from Laos into Nghe An Province. Heroin also passes through various other points on the Lao/Vietnam

border and is then transported to HCMC (UNDCP 1998; Le Ngoc Yen 1999; Narcotics 2001). Drug seizures overall continue to rise although they are considered to be relatively small compared with what is entering the country. In 2000, 60 kilograms of heroin and 567 kilograms of opium were seized. Nearly 7,000 ATS tablets (including methamphetamine) were also seized in 2000, an increase of 27% from 1999 (Narcotics 2001).

Drug-related cases constitute a large proportion of all criminal prosecutions in Vietnam. According to press reports, Vietnamese courts tried 7,093 cases involving 10,242 drug offenders in 2000. Of those convicted, 86 people received a death sentence, 87 received life sentences and over 4,800 were sentenced to prison terms ranging from 7 to 20 years. Distribution of 600 grams of heroin or 5 kilograms of opium warrants the death penalty (Narcotics 2001). Under new legislation, in drug offence cases, capital punishment will only be meted out in cases where drug traffickers have transported 600 grams of heroin or more. This follows the Resolution N0 01/2001/NQ-HDTP, which was issued by the Supreme People's Court Jury in March 2001. This resolution relates to regulations laid down in articles 139, 193, 194, 278, 279 and 289 of the Criminal Code of 1999 (Nguyen Quoc Viet, 2001). Heroin and opium are the most commonly used drugs in Vietnam: opium is both smoked and injected in the form of blackwater opium (UNAIDS/UNDCP 2000). The phenomenon of using ATS called *hong phien* 'pink narcotics' has recently appeared in some localities such as Nghe An but also in all major urban centres (Khanh N T 1999; Vu Doan Trang, 2001). There is also widespread use of pethidine, morphine, promethazine and diazepam often together with either opium or heroin (UNAIDS/UNDCP 2000; Doussantousse *et al.* 2001). *Hong phien* is sold for between 170,000 to 270,000 Vietnamese dong (US\$11-18). The smallest amount of heroin is sold in small plastic packets for between 25,000 and 50,000 dong (US\$1.66-3.33) each. Opium is about one-third the price of heroin. In some areas drug sellers are also including clean needles and syringes in the price of the heroin they sell (Vu Doan Trang, 2001; Higgs, 2001).

Since 1995 pilot programs have operated to replace opium cultivation with other crops in the mountainous areas of north/central and northern Vietnam: it has been reported that opium cultivation has been reduced from 12,900 hectares in 1993 to 2,300 hectares in 2000 (Narcotics 2001). The most commonly injected drugs are opium and heroin but in the past few years heroin's popularity has increased substantially, particularly in the urban centres, but also in rural areas that previously saw very little use of this drug. Cocaine is in use, albeit in small amounts. A variety of pharmaceuticals including diazepam, promethazine, phenobarbital and pethidine are able to be purchased at pharmacies without prescription; most of these latter drugs are mixed with illicit drugs before injecting (Quan *et al.* 1997; Nguyen Tran Hien 1998; Doussantousse *et al.* 2001). Other drugs used include cannabis and cough mixtures containing codeine.

Drug taking practices and risk factors

The pattern, extent and mode of illicit drug use vary between urban and rural areas and between provinces and cities across Vietnam (Vu Doan Trang 2001). During the past decade heroin has emerged as one of the most commonly used drugs and the sharing of HIV infected injecting equipment remains the principle mode of HIV transmission in Vietnam (Quan V *et al.* 2000; Vu Doan Trang 2001). In 1999, police

first detected ecstasy and noted the increasing use of heroin, methamphetamine and other synthetic drugs. They also reported drug users drinking amphetamines and ecstasy in addition to smoking, inhaling and injecting them (Narcotics 1999).

Injecting is the common route of taking drugs including heroin, opium and other narcotics. In a recent study in Hanoi respondents interviewed injected on average 2.4 times per day and spent on average VN 91,300 (US\$6) per day. Over two-thirds of the sample interviewed had smoked heroin for at least two years before injecting (Doussantousse *et al.* 2001). The north of Vietnam has seen a major change from more traditional opium smoking to an explosion of heroin injecting. Reports of new injectors near the China border indicate the enormous scale of this increase: by 1999 over 1,500 drug users had been identified in Quang Ninh province north-east of Hanoi, all were young, nearly all were injectors and 90% were HIV positive (UNAIDS/UNDCP 2000).

Needles and syringes are available at pharmacies for 500 to 1000 dong each (US\$0.33-0.66) but as injecting is considered a crime IDUs are reluctant to go the pharmacies (Khanh N.T. 1999) and older opium users, who are usually extremely poor, find them too expensive (UNAIDS/UNDCP 2000). Users do not like to carry syringes and often throw them away where they were injecting (Khanh N.T. 1999). As a result needles and syringes can be found on beaches, parks, footpaths and city lanes. This practice may cause community backlash against existing needle and syringe programs (NSP) and drug users (Vu Doan Trang 2001).

The sharing of needles and syringes is widespread. A study in HCMC, Da Nang and Quang Ninh found the prevalence of sharing of a needle and syringe in the past six months was 14-50% among IDUs. While it is reported injecting equipment is widely available in many cities its accessibility where the drugs are used can be low. Many IDUs still inject in public areas or in a shooting gallery environment which are not supportive of safe use (Nguyen Tran Hien 2000; Nguyen Tran Hien *et al.* 2000). The various methods undertaken by IDUs to clean their injecting equipment ranges from the use of cold water, hot water, sometimes boiling hot water and the use of alcohol or bleach is generally negligible (Nguyen Tran Hien 1998; Nguyen Chi Phi 1999; Abdul-Quader *et al.* 1999; Nguyen Tran Hien *et al.* 2001).

Some reports from rural areas suggest that injecting equipment is not readily available, so injectors go to shooting galleries to be injected by 'professional' injectors (UNAIDS/UNDCP 2000). Data collected in 1997 showed that among IDUs recruited from the street in HCMC, 28.5% visited a shooting gallery to inject. In Da Nang, the figure is 20% and in Quang Ninh it is 8.2% but in this city 67% inject on the streets (Nguyen Tran Hien *et al.* 2000). Currently it is believed shooting galleries are rarely evident in Vietnam (Higgs 2001).

A study of IDUs in Hanoi found the use of disposable syringes increased from 27% in 1998 to 52% in 1999 and people using sterilised syringes increased from 62% to 85% (Khanh N.T. 1999). Condom use among IDUs varies but several studies show that the understanding of the importance of using condoms is low and many do not use them (Khanh N.T. 1999, Nguyen Tran Hien *et al.* 1999a; Nguyen Tran Hien *et al.* 2000; Nguyen *et al.* 2001). In Ha Long most of the drug users who are HIV-infected through needle sharing are still injecting after being made aware of their serostatus and many still share their equipment. However, there is a tendency for those users

who are aware of their HIV positive status to inject last in order to prevent passing the virus to other users (Doussantousse 2001).

Prevalence and profile

According to figures from provincial steering committees for drug control, Vietnam has 100,293 drug addicts, with 1,609 being students. Ho Chi Minh City is estimated to have the largest number of drug users. Local press reports in HCMC citing government figures reported that the number of addicts in HCMC had increased from 4,712 to 17,239 in 2000 (Narcotics 2000). Other research suggests the figure is more like 30,000 drug users (Vu Doan Trang 2001). There have been contradictions in the estimates of drug users in Vietnam. The lower figures are of 90,000 drug users, a claim made by the Vietnam Drug Control Committee. The Ministry of Labour, War Invalids and Social Affairs (MOLISA), who are responsible for drug treatment centres, on the other hand estimate 185,000 to 200,000 (UNAIDS and UNDCP 2000). In 1997, MOLISA estimated there were 69,000 IDUs (UNDCP and UNAIDS 2000) but this was likely to be a conservative figure. The actual numbers of users is elusive and unknown but it has been suggested that these may be higher than what is currently cited (Higgs, 2001).

A research project in 1999 among IDUs in five provinces of northern Vietnam gives a snapshot of drug users (Nguyen Chi Phi 1999). Of the 472 IDUs interviewed 396 (84%) were HIV positive. The majority of the IDUs were young men (average age 25) who were single, sexually active and lived with their families. More than half were unemployed while about 25% were self-employed, motorbike taxi drivers, porters, food sellers and so on. Virtually all the IDUs had heard about HIV/AIDS and 93.5% knew HIV could be transmitted by blood and sharing injecting equipment, but only 45.7% were aware of the need to use clean needles and syringes as a preventive measure. Most of the men had been using drugs for three to four years and had been injecting for about two years. They bought their drugs on the streets rather than at shooting galleries and injected once or twice a day. About 80% had tried drug treatment, mostly by detoxifying at home and nearly all returned to using (Nguyen Chi Phi 1999).

Recent data from various surveys show that drug users in urban areas are getting younger with three-quarters of them in the 18-35 age group. There have been reports of a high prevalence of drug injecting among sex workers (SW) in HCMC, Hanoi and Hai Phong (Vu Doan Trang 2001). Recent reports show the prevalence of injecting drugs among SW ranges from 10% in Ba Rai Vung Tau, 20% in Da Nang and 50% in HCMC (Hoang 1999; Le T.G. 2000; Reuters 2000). Generally IDUs can be categorised into three groups: pre-1975, younger IDUs and female IDUs who practice sex work. The pre-1975 IDUs come from the south and central Vietnam, are in their early 40s or older and tend to use opium. The younger IDUs can be found all over Vietnam, they begin using heroin by smoking and quite quickly switch to injecting. (Vu Doan Trang 2001). A major new trend is the injecting of heroin among 'street kids' in HCMC. There is limited research available on this phenomenon and HIV testing is not routine (Terre des Hommes 2000). Injecting has also been reported in 'street kids' in Hanoi and HIV infection rates similar to adults have been found (J. Uhrig, personal communication 2001).

The pattern of drug use and the profile of drug users in mountainous provinces in central and northern Vietnam where opium was traditionally cultivated are different to other regions: here the use of opium is considered a cultural habit (Vu Doan Trang 2001). The age of IDUs is getting younger. People in the 20-29 age group only accounted for one-quarter of cases in 1997: this had doubled by 2000. For the 13-19 year olds a similar increase was observed (Vu Doan Trang 2001). Condom use among IDUs is low. A recent study in HCMC found that of those having sex with female sex workers (15%), it was shown that only half had used condoms. Most of the IDUs did not use condoms when they were with their girlfriends (Nguyen Tran Hien *et al.* 2000). In Haiphong, a study among drug users under 30 years of age showed that of those reporting sexual relationship in the last six months, 57% never used condoms (Nguyen Tran Hien *et al.* 2001).

Younger IDUs from well-off families appear to have a much lower rate of infection than those from poor families. At the Nhi Xuan Treatment Centre in HCMC, 80% of IDUs from poor families are HIV positive whereas the rate is half this in fee-paying IDUs. This may be because they can afford disposable needles and other injecting equipment, can inject at home and are better educated (Vu Doan Trang 2001). However, the reason for this could simply be that those fee paying patients have been using for a short period of time and hence had less opportunity to be infected with HIV (Higgs 2001).

As of April 2000 there were a total of 18,326 HIV infections and 3,163 AIDS cases notified; of these 1,606 had died (Nguyen Tran Hien 2000). However, by April 2001 according to the Ministry of Health and a statement by the Deputy Prime Minister there are between 35,000 to 36,000 people with HIV infection (Khiem 2001). Recent estimates suggest the cumulative figure in 2000 may be more like 104,000 to 185,000 infected with HIV (Chung A 2000; Ministry of Health & UNDCP 2000; WHO 2001). By 2005 it has been estimated there will be more than 200,000 persons HIV infected and the AIDS cases will be over 11,000 (Khiem 2001; WHO 2001). Injecting drug use is the predominant mode of HIV transmission in Vietnam and the majority are among heterosexuals; (Ministry of Health and WHO 2000) but this is an assumption as sexual orientation is a question not asked. Injecting drug users (IDUs) represented 89% of all those for whom risk had been reported before 1997 and 88% from 1997 to 1998. HIV prevalence rates among IDUs in 1999 ranged by province from 0% to 89.4%. In 2000 HIV infections among IDUs accounted for 65% of the total reported HIV cases (Nguyen Tran Hien 2000).

Significantly increasing HIV trends among IDUs were found in 14 of the 21 sentinel provinces during 1996 to 1999. HIV prevalence among commercial sex workers in HCMC has increased from 3.1% in 1998 to 15.9% in 1999 and in Hanoi from 3.2% in 1998 to 6.5% in 1999 (Nguyen Tran Hien *et al.* 1999b; Nguyen Tran Hien 2000). HIV prevalence among pregnant women, blood donors and military recruits was 0.12%, 0.20% and 0.61% respectively (Nguyen Tran Hien *et al.* 1999b; Quan V *et al.* 2000).

The first case of HIV in Vietnam was detected in 1990 (National AIDS Committee 1998). HIV infections have been reported from 61 provinces and all major cities throughout the country (WHO 2001). Most of the dramatic recent increase in reported HIV infections has taken place in the north, a region where evidence of HIV was very limited even four to five years ago (Quan V *et al.* 2000). Examples of

provinces with high HIV infection rates among IDUs in 1999 include HCMC (26.9%), Vung Ta Ba Ria (37.5%), Dac Lac (41%), Binh Dinh (71%) and Hanoi (13.5%). Quang Ninh has emerged as the province with the second largest number and highest cumulative incidence rate of reported HIV infection in the country. Seroprevalence-surveys have shown an explosive increase among IDUs from 0% in 1996 to 62.4% in 1997, 65.9% in 1998 and 64.9% in 1999 (Nguyen Tran Hien *et al.*, 1999b). The median age of HIV-infected IDUs was 22 (Quan V *et al.* 2000).

Of those reported with HIV infection, 86.7% have been men, and infection is occurring increasingly in younger people especially in the 20 to 29 age group (Quan V *et al.* 2000). An important part of monitoring HIV in Vietnam is the sentinel serosurveillance program. In 1999 20 provinces and major cities conducted annual or semi-annual HIV surveys in sentinel populations: IDUs, sex workers, STD patients, tuberculosis patients, pregnant women and military recruits (UNAIDS 2001; Quan V *et al.* 2000). HIV among blood donors is uncommon in Vietnam (Quan V *et al.* 2000).

Government responses to illicit drug problems

In December 2000 the National Assembly passed Vietnam's first Law on Drug Control, which came into effect from June 2001. While it recognises that drug use is a social issue and that drug users are not criminals, the legislation contains what many believe to be harshly punitive measures for young drug users (between 12 and 18 years) who have no fixed address or who relapse following detoxification in their homes or community. The punishment includes one year of mandatory detention and labour (Vu Doan Trang 2001). Within the Ordinance on the prevention and control of HIV/AIDS, article 12 states that all acts of prostitution, intravenous drug use and other practices susceptible to HIV/AIDS transmission are strictly prohibited (Chung A 2000). Security regulations require police to detain those who are found in possession of or using drugs and to commit the person for a period of six months to a compulsory drug treatment centre or a drug re-education centre (Quan *et al.* 1998).

Additionally, criminal law decrees in 1999 and a decree on administrative treatment in 1995 are important legislative bases for the government's struggle 'against drugs'. At the same time the Vietnamese government believes that it is very important to reduce harm for the drug users in two ways: to prevent and stop the behaviours which lead to the illegal use of drugs and, secondly, to organise drug treatment for users themselves. There are specific administrative responses to drug use and or distribution. Users who have been educated several times and have been put in the centres but relapse will be put in prison from three months to two years. If they commit the crime again, they will be put in prison from two to five years (Article 199-Criminal Law). People who force and tempt others to use drugs illegally will be imprisoned from two to seven years. Those who commit crimes against children, pregnant women, and other users who are on the period of giving up using drugs are imprisoned for up to 15 years. Causing death and organising illegal drug use merits a life-sentence or the death penalty (Article 200 Criminal Law). Those who rent or let places for illegal drug use can be imprisoned for 15 years (Article 198 Criminal Law) (Nguyen Quoc Viet, 2001).

Government response to drug use and HIV

Vietnam was quick to establish sentinel surveillance and undertake prevention activities (Nguyen Tran Hien *et al.*, 1999b). Despite the political complexity of issues surrounding drug use, the government and the public sector have been open and pragmatic and have kept the public well informed regarding the HIV epidemic. The risks, the role of prostitution and drug use and discussion of condom use have been very public (Quan *et al.* 2000). Out of all of Vietnam's national health programs, HIV/AIDS has received the highest funding reflecting the seriousness with which the government is approaching the epidemic (Chung A 2000). The total current annual government allocation for HIV/AIDS control activities ranges from US \$4 to \$5 million. Additional support has been provided through international and non-governmental organizations (Quan V *et al.* 2000). AIDS-related activities, including surveillance, prevention and treatment are coordinated and funded nationally by the National Committee Against HIV/AIDS, Drugs and Prostitution, which is made up of several government ministries and mass organisations. At the provincial or city levels, AIDS activities are coordinated by the provincial or city AIDS committee (Quan *et al.* 2000). However, the smallest proportion of the national AIDS budget is spent on prevention activities among IDUs.

The concept of harm reduction is well understood in Vietnam and is advocated as a way to reduce the risks of HIV infection (National AIDS Standing Bureau, 1999; The Macfarlane Burnet Institute for Medical Research & Public Health, 2001). There is a range of ongoing harm reduction projects supported by the national and provincial AIDS authorities but it is still difficult to implement such projects in Vietnam. Some of the constraints include: competing interests for health finances; the direct conflict between harm reduction and the 'social evils' campaign which aims to eradicate all drug use; some cities/provinces being more in favour of harm reduction than others; the ambivalence to harm reduction in the countryside where support for the 'social evils' campaign is strong; confusion about drug laws; lack of human and financial resources and lack of long term sustainable funding (Vu Doan Trang 2001; UNAIDS/UNDCP 2000).

Although drug use is illegal (as defined by a government decree in May 1997) drug users are regarded as victims to be treated and rehabilitated rather than criminals to be punished. Very few drug users are convicted and sent to prison for drug use alone (UNAIDS/UNDCP 2000). The sharing of injecting equipment with other drug users can be considered as drug promotion and can result in punishment (Dousantousee, personal communication 2001). Vietnam has 55 drug centres nationwide offering a choice of institution or community based treatment. There is often a waiting list and the rate of relapse is high at 80-90 %. The Ministry of Labor, War Invalids and Social Affairs has ordered improvements in treatment centres including increasing the duration of detention from 6 months to one or two years, diversifying care, providing professional training for staff and vocational training and jobs for patients (Narcotics 2001).

The relapse rate is about 80% (Nguyen Chi Phi 1999; Khanh N.T 1999) and detoxing occurs at home, community detoxification and detention centres known as O6 centres. Studies show lack of support, the influence of friends and unemployment are factors which lure people back into drug taking (Khanh N.T 1999). Forced detoxification in centres (i.e. without the IDUs consent) usually results in 100% relapse (Khanh N.T.

1999). Home detoxification is increasing. Complex procedures for voluntary and paid admission of centres discourage IDUs: a written request has to be approved by the commune, then by the district and the province level through the O6 centre which takes about 55 days (Khanh N.T 1999).

Demand for drug rehabilitation is high. HCMC alone has 17 drug rehabilitation centres: 14 of these are private and have been established in the last two years. A Situation Assessment conducted in 2000 (Vu Doan Trang 2001) visited five-government centres and found that they offered similar programs. All centres apply a standard detoxification regime authorised by the Ministry of Health, test most detainees for HIV upon admission and provide vocational training if funding is available (Vu Doan Trang 2001). Between 40 and 80% of the detainees at these centres were HIV positive. Four out of five centres did not inform the detainees of their HIV status. The majority of detainees were admitted to the centres after police round-up campaigns. Compulsory treatment is free but IDUs are detained for six to twelve months. Voluntary treatment at centres or private clinics costs between one and two million dong a month (US\$66-133) and they are allowed to specify how long they want to stay (Vu Doan Trang 2001).

Harm reduction programmes have been piloted and expanded in Vietnam since 1993 and have resulted in measurable behaviour change. However, support for the harm reduction approach is not uniform, with some local governments more supportive than others. There is evidence that current drug control laws are in direct conflict with the harm reduction approach (Vu Doan Trang 2001). Harm reduction programs are usually of short duration (one to three years), pilot in nature and dependant on international funding: once the funding is withdrawn local resources are unlikely to sustain the programs in their entirety (Vu Doan Trang 2001).

The National Institute of Mental Health in Hanoi began Vietnam's first trial of methadone maintenance therapy in 1996-1997. Despite encouraging findings and the Institute's recommendation for its introduction, the Ministry of Health appears unconvinced by local and international evidence and the program remains extremely small scale (Vu Doan Trang 2001; The Macfarlane Burnet Institute for Medical Research & Public Health, 2001). People living with AIDS have little access to anti-retroviral drugs because of their high costs (Vu Doan Trang 2001; Higgs, 2001). Many provinces have established and oversee Friends Help Friends clubs which provide a variety of services such as home care, counselling and social support: some clubs have reportedly distributed needles and syringes and offered detoxification support for current HIV positive IDUs.

National AIDS Policy

Vietnamese health authorities were swift in responding to the spread of HIV among IDUs. In 1990 the government established the National AIDS Committee (NAC) within the Ministry of Health (Chung A 2000). Since 1993, the National AIDS Committee (abolished in May 2001), now the National AIDS Standing Bureau under the National Committee for AIDS Prevention and Drug and Prostitution Control has adopted a harm reduction approach in tackling HIV epidemics among IDUs (Vu Doan Trang 2001). The NCAPCPC is now under the direct control of a vice-Prime Minister who acts as chairman. It allocates financial resources and manages the national HIV/AIDS program. At the local level, 61 Provincial AIDS Committees

deliver AIDS services and HIV control often through the Ministry of Health, Centres of Preventative Medicine (Chung A 2000).

A draft National Harm Reduction Policy for Prevention of HIV/AIDS Transmission Among Drug Users was developed in October 2000, at a national meeting, but has been criticised by observers for failing to deal with, among other things, government financial commitment to harm reduction, contradictions between harm reduction philosophy and the anti-social evils approach and the sustainability of foreign-funded harm reduction projects when the international funding is withdrawn (Vu Doan Trang 2001). The Government has yet to approve the draft policy.

Non-government responses to drug use and HIV

Harm reduction programmes include peer education, needle exchange/distribution, drug treatment and care and support for people living with AIDS. Across Vietnam 49 groups of peer educators for IDUs have been formed sometimes funded through INGOs. The largest project has been by the UNDCP in five northern provinces (Vu Doan Trang 2001). Peer education is now a well-known concept and has received excellent support from the majority of stakeholders but there is concern about the sustainability of such programs given that the majority of the funding comes from international organisations (Vu Doan Trang 2001).

The Vietnam INGO Directory 2000-2001 lists 212 international NGOs currently operating in Vietnam. Of these only twenty-two have programs in HIV/AIDS. UNAIDS estimates that only 2% of the total funding for HIV/AIDS projects is spent on harm reduction for IDUs (often the distribution of syringes is not on the budget and the focus is on information, education and communication programs). Some of the organisations who provide funding for harm reduction programs for IDUs are Care International, Cooperation Internationale pour le Development et la Solidarité, Save the Children-UK, Family Health International, Huynh De Viet-Phap, Medicos del Mundo, Mediciens du Monde, Population Council, The Ford Foundation, British Columbia Centre for Disease Control, the Macfarlane Burnet Institute for Medical Research and Public Health and World Vision (UNAIDS 2001; Higgs 2001).

Local NGOs are also involved in harm reduction for IDUs. They are all located in Hanoi and rely on international funding. These include The Research and Training Centre for Community Development, STDs/HIV/AIDS Prevention Centre, Supporting Centre (SHAPC) for HIV/AIDS/STDs Control and the Vietnamese Community Mobilisation Centre for AIDS Control. Current drug laws make needle and syringe exchange difficult for both IDUs and peer educators because the possession of contaminated needles and syringes can be used as evidence of drug use and can result in arrest (Vu Doan Trang 2001). The majority of NSPs are internationally funded and when funds are withdrawn the projects are downgraded and/or cease. Da Nang is a case in point: this city distributes around 300 needles to about 200 IDUs per month (Vu Doan Trang 2001). Distribution of needles stopped in the city of Nha Trang in Khanh Hoa province when international funding stopped (J. Uhrig, personal communication 2001). The Ford Foundation have announced that they will continue funding the project though it is yet to be seen if needle and syringe distribution is a key part of the program. Prevention activities include: mass information, peer education and outreach among groups at increased risk, availability of low cost syringes and condoms (US\$0.02 – 0.05 cents) through pharmacies, needle

exchange pilot projects in Hanoi and HCMC, widely available treatment for STIs, HIV antibody screening of blood for transfusion and free medical treatment at government hospitals including AZT and ddI (Quan V *et al.* 2000).

From January 1999 the HCMC AIDS Committee, with the assistance of the Centre for Disease Control British Columbia, (Canada), developed a project entitled 'Consultation room and approach activities to STI, HIV/AIDS in Ho Chi Minh City'. The AIDS Committee of HCMC is responsible for implementing the activities. Consultation and treatment for STIs, (free of charge for sex workers), was started up in *Café Hy Vong* (Hope Coffee Bar) three afternoons a week. This then increased to five afternoons a week because of the increase of clients. The program has recently spread to Binh Thanh district (Le Truong Giang 2001).

The pilot program *HIV Drug Access Initiative* in four developing countries funded by UNAIDS has provided anti-retroviral therapy for approximately 400 PLWHA in Vietnam (Harrington, 2000). But it was reported at a recent (March, 2001) Merck Sharpe & Dohme sponsored workshop in Hanoi that PLWHA were only given access to two anti-retroviral drugs at a time and only when this fails (which international evidence says it will) is the person then be eligible for combination therapy. It was also reported that about 30 people are currently receiving combination treatment (Higgs, 2001). It is not known how many IDUs living with HIV/AIDS (ILWHAs) are among the group receiving the treatment.

Estimated number of drug users	185,000 to 200,000, possibly higher.
Estimated number of IDUs	In 1997, 69,000 (likely to be conservative)
Drugs that are used	Heroin, 'blackwater' opium, amphetamines, morphine, pethidine, promethazine, diazepam, cocaine, phenobarbital, cannabis, cough mixtures containing codeine
Drugs that are injected	Heroin, 'blackwater' opium, morphine, pethidine, promethazine, diazepam, phenobarbital.
Estimated number of HIV infections among IDUs	Prevalence of HIV infections among IDUs accounted for 65% of total reported HIV cases.

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Appendices

The Centre for Harm Reduction

Reducing the harms from drug use
in Australia, Asia and around the world

What can we do for you?

We can

- provide technical expertise and training in every aspect of harm reduction
- assist in every stage of developing and implementing harm reduction programs
- provide policy, assessment, research and training support and development for harm reduction.

The Centre for Harm Reduction (CHR) was set up at the *Macfarlane Burnet Institute* in 1998 to consolidate and build on all our experience and expertise in the prevention of drug-related harms, especially HIV infection among and from injecting drug users in Asia.

Comprising over 30 leading consultants and associates working across Asia and globally, the **Centre** is the *lead technical agency in the region for developing responses for the reduction of drug related harm.*

What do we do?

- **Research:** epidemiology of blood-borne viruses (HIV and Hepatitis C) and STD, including behavioural and ethnographic studies; epidemiology of illicit drug use; evaluation of programs. *The Hidden Epidemic* report, published in 1997, was the first regional rapid situation assessment on HIV and drug injecting. We have currently finished a second, updated and expanded edition.
- **Resource and training materials:** such as *The Manual on Reducing Drug-Related Harm in Asia*. The *Manual* has already been adapted for use in Indonesia and will be adapted into a variety of other country-specific versions

- **Program and policy development:** relating to blood-borne viruses, illicit drug use and harm reduction for community organisations and governments, including working with police and public security.
- **Advocacy:** through national, regional and global meetings; support to organisations on national-level dialogue and advocacy.
- **Teaching and training:** at universities, training and policy workshops on harm reduction in various Asian locations, including Nepal, Vietnam, Thailand, India, China, Philippines, Laos, Myanmar and Indonesia.
- **Consultancies** on HIV prevention and policy development in Asian countries for *WHO, UNDP, UNAIDS, UNDCP* and other multilateral agencies, and many bilateral agencies
- Development and support of the **Asian Harm Reduction Network (AHRN):** Originally based at CHR in 1996, then moved to Chiang Mai in 1998.
- **Technical assistance** to harm reduction programs across Asia.

Our staff

*Among its staff and associates, **CHR** now embodies an enormous amount of experience and expertise on every aspect of the prevention of HIV infection among injecting drug users, in Asia and elsewhere. Harm reduction is not solely about HIV prevention, however, and CHR has been developing expertise in many other facets of harm reduction.*

*Associated units at MBI include the International Health Unit and research centres into epidemiology, social research and virology. With all our experience, a multicultural staff, offices in Chiang Mai, Hanoi, Jakarta and Bali, associates in most Asian countries, and an understanding of every aspect of HIV prevention, **CHR** is able to respond to any need related to research, training, advocacy, program design and implementation, evaluation and policy development in this area.*

Centre Director, Dr Nick Crofts, has major research interests in the epidemiology and control of blood borne viruses among injecting drug users in Australia and Asia. A winner of the prestigious International Rolleston Award for Harm Reduction, Nick has been a long time campaigner and instigator for more widespread and compassionate harm reduction programs to respond to the global spread of HIV/AIDS, Hepatitis C and other infectious diseases.

Dave Burrows of Sydney, Australia works as an Associate of The Centre for Harm Reduction. He has worked in the fields of HIV prevention, care and support and drug use in 19 countries, mostly in Asia and Eastern Europe. He has provided consultancy and/or training for UNAIDS, UNDP, UNICEF, Open Society Institute, Department for International Development (UK), *Medecins Sans Frontieres*, Family Health International, Better World Advertising, Australian Business and International Family Health among others.

Jimmy Dorabjee has been program manager for Sharan, Society for Service to Urban Poverty, New Delhi, which co-ordinates a comprehensive treatment and care program for injection drug users and their sexual partners in five Indian cities. He has worked with Sharan since 1991, and in 1993 he began the first oral buprenorphine substitution program in India. This program has now been initiated in five Indian Cities. Mr. Dorabjee still manages this program and promotes harm reduction on a national and regional level. From 2002, he will be full-time with CHR.

CHR Visiting fellow, Samiran Panda MD, DTM&H is a tropical medicine specialist with varied interests in molecular biology and public health. He was awarded the Best Junior Scientist medal for 1996 by the Indian Council of Medical Research for his work on HIV/STDs in IDU. Dr Panda has helped drug abuse situation assessment & HIV/STD intervention programs in Nepal, Bangladesh, India and other countries as a consultant for UNAIDS, UNDCP, AusAID, DFID, FHI, Care-Bangladesh and PCI.

CHR Associate **Aaron Peak** has been working in the field of HIV prevention among IDUs since 1986. He initiated amendments to legislature in Hawaii to include needle exchange. In November 1990 he moved to Asia and began the first harm reduction program in Asia, the Life-Saving & Life-Giving Society. Since then he has worked in India, Nepal, Malaysia, Philippines, Vietnam and Myanmar. He is presently working on projects for UNDCP.

Paul Deany is Senior Project Officer at the Centre. He has been a program manager, researcher and trainer in the areas of HIV/AIDS, illicit drug use and community development for 15 years. Paul was co-founder and Executive Officer of the Asian Harm Reduction Network, and has since been a consultant or adviser to UNAIDS, UNDP, WHO and AusAID, working throughout Asia, in Brazil, Western and Central Eastern Europe and the US.

Gary Reid is a Senior Research Officer at CHR. He commenced working at MBC in 1996. In 1997, he wrote *'The Hidden Epidemic'* examining drug use and HIV in Asia. He co-authored the *Manual for Reducing Drug Related Harm in Asia* and has researched on drug use in ethnic communities and on primary health care for drug users. He is the principle author on Revisiting 'The Hidden Epidemic' A Situation Assessment of Drug Use in Asia in the context of HIV/AIDS.

Peter Higgs has worked since 1996 with the Centre on a variety of social research and community development projects with heroin users of Vietnamese ethnicity here in Australia. In Vietnam he is working on an AusAID funded project developing harm reduction interventions for local level health and law enforcement officials.

Other Staff and Associates

Dr. Lisa Maher is a Senior Lecturer in the School of Public Health and Community Medicine, University of NSW. Trained as an ethnographer, she has international experience in research, program development and service delivery to IDU, sex workers and marginalised youth, and in the social, cultural and environmental contexts of harm reduction. She coordinates the Indo-Chinese Outreach Network (ICON) in Cabramatta, Sydney.

Dr Campbell Aitken joined the Epidemiology & Social Research Unit of the Macfarlane Burnet Centre for Medical Research in 1995. He has worked on a broad spectrum of topics in the fields of illicit drugs and blood-borne virus epidemiology, but particularly on injecting drug use and hepatitis C. Dr Aitken is a Senior Research Officer at MBC, and has been the Deputy Director of MBC's Centre for Harm Reduction since April 1998.

Michael Kerger has been part of the Centre's Epidemiology & Social Research Unit for 10 years, working with IDUs, with the main focus on blood borne viruses. Part of the team which first documented the extent of the Hepatitis C epidemic among IDU in Australia, Michael has also worked and consulted on numerous peer research and education projects across Australia in the area of HIV/AIDS, Hepatitis C & injecting drug use. He is currently the Centre's street-based research facility in Footscray, Melbourne.

Jenny Kelsall has a background in the arts and an arts degree (B.A.) from Auckland University. JK has worked at the Macfarlane Burnet Centre for Medical Research for the past 10 years in the Epidemiology & Social Research Unit, with a focus on IDU issues & blood borne viruses. JK was also part of the multi-discipline research team, which documented the HCV epidemic amongst IDUs for the first time in Australia

For 10 years, **Jean Wyldbore** - CHR's Administration Officer - has been involved with public health in rural Victoria. Her interest was piqued by access and equity issues in relation to rural people and HIV/AIDS and Hep C. A co-founder of the Country AIDS Network, a former Victorian AIDS Council Board Member, and an enthusiastic researcher in her own right, Jean's particular interest is HR. Her passions? The Needle & Syringe Program and other safe living strategies.

Genevieve Costigan is a freelance journalist and editor with a particular interest in public health issues. She was the lead writer of the *Manual for Reducing Drug Related Harm in Asia*, published in 2000. Ms Costigan has a Bachelor of Arts (University of Melbourne) and a Graduate Diploma in Journalism (RMIT). She is the co-author on Revisiting 'The Hidden Epidemic', A Situation Assessment of Drug Use in Asia in the context of HIV/AIDS.

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