

situational analysis
of illicit drug issues
and responses in the

Asia–Pacific
region

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A collaborative project conducted by the
Burnet Institute's Centre for Harm Reduction
and Turning Point Alcohol and Drug Centre

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A report prepared for the
Australian National Council on Drugs,
November 2004 – May 2005

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Published by the Australian National Council on Drugs
PO Box 1552, Canberra ACT 2601
Telephone: 02 6279 1650
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Email: ancd@ancd.org.au
Website: www.ancd.org.au

National Library of Australia Cataloguing-in-Publication data

Devaney, Madonna.

Situational analysis of illicit drug issues and responses in the Asia–Pacific region.

Bibliography.

ISBN 1 877018 14 7.

1. Drug abuse – Asia. 2. Drug abuse – Pacific Area. 3. Drug traffic – Asia.
4. Drug traffic – Pacific Area. 5. Drug control – Asia. 6. Drug control – Pacific Area.
7. Australia – Foreign relations – Asia. 8. Australia – Foreign relations – Pacific Area.
I. Reid, Gary. II. Baldwin, Simon. III. Macfarlane Burnet Centre for Medical Research.
Centre for Harm Reduction. IV. Turning Point Alcohol and Drug Centre (Vic.).
V. Australian National Council on Drugs. VI. Title. (Series: ANCD Research Paper; no. 12).

362.29095

Editor: Julie Stokes
Design: Starkis Design
Printer: New Millennium Print

Acknowledgement:

This work has been supported by funding from the Australian Government Department of Health and Ageing.

The opinions expressed in this publication are those of the authors and are not necessarily those of the ANCD or the Australian Government.

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Acknowledgements

The researchers wish to acknowledge the support and cooperation of all of the people who made valuable contributions to our understandings of drug use and responses in the countries reviewed. The team is grateful to all the colleagues who reviewed drafts of the country profiles and provided valuable comments:

Pacific: Professor Mac Marshall, Nic MacClellan, Judith Leveillee, Ruth Holland, Harley Stanton, Shaun Evans

Cambodia: Graham Shaw

China: Liu Zhimin

Hong Kong: Yuet Cheung

Indonesia: Elizabeth Pisani and Elizabeth Emrys

Laos: Damien Hoy

Macao: Celeste Vong

Malaysia: Adeeba bte Kamarulzaman

Myanmar: Willie DeMaere and Dr Myo Lwin

Philippines: Carmina A. Aquino, M.D., Lheng Matibag

Thailand: Nick Thompson

Vietnam: Khuat Thi Hai Oanh, Peter Higgs and Nick Walsh

The authors would like to acknowledge the advisory roles of Professor Nick Crofts, Associate Professor Alison Ritter and Dr David Jacka. The team is also very appreciative of the research assistance provided by Helena Faulkner.

Finally, the support of the ANCD's Asia–Pacific Drug Issues Committee is sincerely appreciated.

Executive summary

Context

In October 2003 the Prime Minister announced that the Australian National Council on Drugs (ANCD) had been asked to increase Australia's involvement throughout the Asia–Pacific region, specifically to promote the prevention and reduction of drug use, and treatment for those with drug problems. To provide appropriate advice to the Australian Government, the ANCD formed a committee of individuals with a broad range of experience and expertise in drug policy and in Asia and the Pacific. The mission of the Asia–Pacific Drug Issues Committee (APDIC) is to advise the ANCD and the Australian Government on ways to maximise Australia's response to and leadership and impact on Asia–Pacific regional illicit drug issues.

In order to provide a foundation for its work, in November 2004 APDIC contracted the Burnet Institute's Centre for Harm Reduction and Turning Point Alcohol and Drug Centre to undertake a situational analysis of illicit drug issues and responses in the Asia–Pacific region.

The project was desk-based; data sources included published and unpublished literature and information from key informants and regional institutions. For the purposes of this project the Asia–Pacific region was deemed to include the countries involved in the ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD), and those Pacific nations of interest to AusAID. The situational analysis focused on the unsanctioned use of all illicit drugs and directly related harms, with consideration of pharmaceutical drugs limited to their intentional misuse.

The body of this report provides a brief summary of the current illicit drug use situation, country responses to illicit drug issues, and Australian and international involvement in relation to illicit drugs for each country. More detailed analysis about each country, complete with referencing, is contained in Appendix A; and Australian and international project information, available at the time of the research, is outlined in Appendix B. The executive summary gives a broad overview of these data with findings for Asia and the Pacific presented separately.

The first thing to note about illicit drug production and use in Asia is its scale – the amount of illicit drugs produced, especially heroin and amphetamine-type substances (ATS), is measurable in many tonnes per year; numbers of people using and dependent on illicit drugs run into the millions across the region. Issues of such magnitude challenge the capacity of developed nations, let alone those that are attempting to hasten social and economic development, often from a low base.

Second, there is a profound impact on every level and sector of society of the illicit drug trade and use. Some aspects of this impact are especially iniquitous to the attainment of development goals, such as corruption, which are commonly linked with the drug trade and can be particularly destructive in regard to law enforcement.

Third, policy development concerning illicit drugs has not kept pace with the development of the drug trade or with changing patterns of drug consumption in the regions. Policy has generally been reactive, and on the whole uninformed by evidence or understanding of the phenomena involved. The policy approaches have commonly proved less than effective, to the detriment of approaches that promise more impact. This generally happens against a backdrop of inadequate public debate, around a subject that is politically contentious, domestically and internationally.

In terms of responses to illicit drug use, it is apparent that demand reduction approaches across the Asian region are in their infancy, not keeping pace with the rapid development of drug use trends and patterns, and not adequately building on evidence of effectiveness. Exploration of effective modes of drug treatment is just beginning across Asia, though pilot programs, often short-lived, have been in existence for many years. Much reliance is still placed on approaches for which there is little evidence of effectiveness, such as traditional medicines and ‘boot camp’-style rehabilitation centres, or even imprisonment. Reliance is also placed by national authorities on public awareness campaigns against the use of drugs, and by international bodies on campaigns such as ‘life skills education’ in schools.

For national agencies, there is little access to reliable and accurate information about illicit drugs, the antecedents of their use, and effective prevention and treatment approaches.

Lastly, there has been little linkage of agendas concerning illicit drugs with other major social and economic development in policy or programmatic terms.

Illicit drug issues and responses in Asia

Vulnerabilities to illicit drug production and use

Defining and identifying vulnerability of a particular population to involvement in illicit drug production, trafficking or use are not necessarily straightforward processes. However, there are a number of factors common to situations where there have been increases in illicit drug production or use. These include:

- rapid economic growth, with a burgeoning middle-class youth population, and with internal migration, and resultant cashed-up migrant labour populations away from their homes;
- inequitable distribution of the benefits of such growth, with increased gaps between rich and poor, and differential ability to participate in the formal economy;
- political upheaval, with resultant external migration, creating both human flows for drug trafficking and disenfranchised populations without access to the formal economy;
- inadvertent results of law enforcement and interdiction operations, moving drug trafficking routes, especially overland cross-border and coastal, to involve new populations;
- the impact of development programs, leading to all the above factors;
- corruption, and its role in the maintenance of power among ruling political elites;
- poverty and political disenfranchisement, operating through the above processes or on their own.

All these factors are variably present and often growing in Asia and the Pacific. The Asian region has been undergoing massive change over the last few decades: socially, economically and often politically. In almost all nations reviewed in this report there have been sizeable external migrations and/or the continuous influx of individuals – often men as labourers and women as sex workers – and families from rural areas to the cities. The extent of rapid urbanisation and resultant internal migration varies, but where they occur, such changes often lead to increased inequitable access to new wealth, and substantial strains on urban services.

Human development indices have improved on average for many in the Asian and Pacific regions, but with economic growth the gaps between the rich and poor have widened significantly over the years, and some sectors in society are more vulnerable than others. The most afflicted are the urban poor: a rise in the number of individuals and families living in urban slums with impoverished lives is often the inevitable outcome. This is fertile ground for involvement in illicit drugs: trafficking and dealing are ways of accessing the informal economy when access to the formal economy is barred; as well as using drugs to ease the experience of impoverishment.

Ethnic minority communities in border regions of China, Thailand, Myanmar and Vietnam and elsewhere (e.g. West Papua) carry many of these factors enhancing vulnerability. They are most often effectively disenfranchised, marginalised, living precariously and with the potential to slip into absolute poverty, if not in this state already. In China, for example, ethnic minorities make up only 7 per cent of

the total population, but represent 40 per cent of China’s poor. The lack of sustainable alternative development for these minority populations has often led to dependence on the cultivation and use of opium, evolving over time to the production and consumption of heroin. Such consumption has most often been via high-risk injecting practices: as a result, many ethnic communities in Asia have been among the hardest hit by the HIV/AIDS and subsequent tuberculosis epidemics from the 1990s.

This review found a population age structure throughout all countries in the region that is heavily weighted towards young people, while at the same time youth unemployment and under-employment are high: with rapid economic development, two youth populations at risk of illicit drug use are thereby created – those with money, and those with nothing.

In terms of availability of illicit drugs, most countries of Asia are either producing countries or on major transit or trafficking routes from producers to consumer nations. Many of those countries reviewed have a close geographical proximity to the Golden Triangle area, the major producing area for opiates and, since 1996–97, of amphetamine-type substances (ATS). The remainder are generally on trafficking routes for these drugs to the consuming populations – increasingly these are within the region, though much is still exported. The increased production of ATS in Golden Triangle countries has latterly been matched by a reduction in the production and supply of opiates; increasingly, transit countries for ATS are becoming producers.

Historical and cultural interactions with drugs

Opium has been reported in China since the 8th century. However, it was not until the 16th century that European merchants discovered the commercial appeal of opium with its production, export, import and use expanding exponentially. Opium became important socially, culturally and economically in much of Asia, and was also the mainstay of the therapeutic pharmacopoeia in many communities. From the mid-19th century until the early 20th century opium dens were found throughout Asia, catering to the millions of opium smokers, many of whom were dependent. Registration of opium users developed in a variety of Asian countries from the late 19th century, and opium was obtained through a rationing system. The colonial exploitation of this trade to redress trade imbalances by the British and French into China, and by the Dutch into Indonesia, among others, was the cause of enormous conflict and hardship, the memory and effects of which linger to the present day in many countries in the region.

The ban on the production, trade and use of opium began in the late 19th century in some Asian nations, but was not regionally complete until the late 1940s. From the mid-1950s and through the 1960s heroin use was present throughout Asia, but was generally a minor phenomenon. From the 1960s onwards the use of a variety of drugs – heroin, morphine, cannabis, amphetamines, barbiturates, tranquillisers, cough syrups, inhalants – increased in many of the principal urban centres of Asia. The American War in Vietnam through the 1960s and 1970s opened routes to western markets from the Golden Triangle region, and stimulated production of opiates enormously. China maintained a relatively firm control of drug use from the 1950s onwards but free market economic policies introduced increasingly from 1979, and the ‘Open Door’ policy of 1982, led to a major resurgence of drug use. Since then, increasingly ‘open door’ policies for international trade within the region have contributed dramatically to the increase in the availability and use of illicit drugs.

Current situation: prevalence of drug use

As with much of the rest of the world, reliable estimates of the numbers of people using illicit drugs are rare in Asia and the Pacific. Various official and unofficial estimates of the numbers of users of particular drugs exist, but few have been derived by any reasonable systematic and data-driven process. There is general agreement, however, that the numbers of people using illicit drugs in Asia have been climbing over the past decades – at times, and in some places, exponentially; at other times, and elsewhere, less rapidly. As well, there is a generally acknowledged flux of different drugs into different markets, often displacing previous illicit drugs from market dominance, and not confined to major urban centres.

A common phenomenon in many Asian countries is the registration of apprehended or disclosed illicit drug users; not uncommonly, the cumulative number of such people, from whenever registration began, is taken as an estimate of the numbers of such drug users in the country (or even as the exact number). Such figures have often been relied upon by government authorities, but have also often been made even less reliable by a failure to discriminate between different types of illicit drugs – all being bundled into the word ‘narcotics’, or for example *dada* in Malaysia, simply meaning ‘drugs’.

Behind such use of registration data there is a lack of understanding of the phenomenon of illicit drug use which characterises the ‘first wave’ of responses in these countries to the burgeoning use of illicit drugs. More sophisticated approaches to the estimation of population sizes of users of particular drugs are now gradually being introduced in many Asian countries.

Asian countries such as China, Malaysia, Myanmar and Vietnam maintain registration systems for drug users, supported by legislation and enforced by sanction. Even when such registrations are officially promoted as representing the number of drug users in the country, there is now usually unofficial agreement and acknowledgement that the real numbers are much higher. China has witnessed a 15-fold increase in the number of *registered* drug users from 70,000 in 1990 to 1,050,000 in 2003; whereas before 2000 these numbers were seen to reflect the *actual* number of illicit drug users. There is now official acknowledgement of estimates in the range of 6–12 million drug users. Four other Asian nations have estimated drug user populations of two million or more – Indonesia, Thailand, Laos and the Philippines; and three acknowledge estimates from 200,000 to less than one million – Malaysia, Vietnam and Myanmar. Brunei is the one country reviewed in the Asia region that has no official or unofficial numbers of drug users.

Injecting drug use

Injecting as a mode of administration of illicit drugs has usually followed the transition from opium to heroin use, and most often along and spreading from changing trafficking routes of heroin from the Golden Triangle, and more recently from the Golden Crescent countries. Injecting of drugs other than heroin is not common in Asia, and where it occurs is usually a secondary phenomenon to injecting of heroin; in some localities, the injecting of ATS is beginning to grow as these drugs replace heroin as the most popular illicit drugs in use. There have been many examples of extremely rapid spread of injecting as the preferred mode of administration across the region, and this rapid spread continues to evolve in many parts of the region (especially in Cambodia and Laos).

China has by far the most injecting drug users (IDUs), with a high estimate of 3,500,000; other Southeast Asian nations with IDU populations over 100,000 include Indonesia, Malaysia, Vietnam and Myanmar. In Cambodia and Laos the prevalence of IDU is low, but with a growing influx of heroin and ATS, signs are emerging of a rise in this mode of drug administration. A study of university students in East Timor, the world's newest nation, reported a prevalence of IDU of 3 per cent.

There is little data on IDU in the Pacific, and no indication of numbers who are injecting drugs, but the behaviour does exist (Guam had a short-lived needle exchange program), and it is highly unlikely that it is not growing.

Illicit drugs used

The use of heroin occurs throughout Asia; its popularity remains firm. Heroin remains the drug of choice among entrants to drug treatment centres in China, Hong Kong, Macao, Indonesia, Malaysia and Vietnam; this is biased to some extent by the nature of the services offered. Opium is still used in most of Asia, but its popularity and consumption have diminished largely as a result of decreased availability and accessibility; for a variety of reasons, heroin is a more 'marketable' drug than opium. Opium is still the main opiate used in Myanmar and Laos, but it is rapidly giving way to heroin (and of non-opiates, to ATS).

Beginning in 1996–97, and spreading from the Golden Triangle epicentre, a flood of ATS has meant that their use is now well entrenched throughout Asia. Methamphetamine is found throughout Asia, but its use is particularly prominent in Thailand, the Philippines, Myanmar, Indonesia, Brunei and increasingly in China. Ecstasy (MDMA) use continues to increase throughout Asia, but its retail cost generally appears to make it more confined to urban centres among youth at dance parties and other gatherings. The use of ketamine has been identified in some Asian countries, in particular China, Hong Kong, Macao and Malaysia. Cannabis use is generally widespread in Asia, often as the most or second most frequently consumed illicit drug – as in the Philippines, Indonesia, Brunei and Malaysia. Cocaine use overall is minor in Asia, largely due to its distance from the source countries and therefore the cost, but it is found in many major urban centres. Use of solvents and glue is common among street children and homeless youth in many parts of Asia.

Profile of drug users

Historically, opium smoking was a male phenomenon; it is still the case that the majority of drug users throughout the Asia-Pacific region are male. There has however been a rise in the number of female drug users in Asia in recent years, an increase that has been particularly recognised in association with female sex work in parts of China and in Vietnam. While drug use is stigmatised in all countries under review, use among women is even more highly stigmatised, and thus gender-specific data from drug treatment services do not accurately mirror the gender distribution of drug use in the overall society.

Illicit drug use is most common among young people, between the ages of 20 and 35 years, but there are indications in some parts of Asia that drug users are increasingly becoming younger. Studies of illicit drug use among school students report rising levels of drug use and falling ages of initiation in some countries.

Again, these increases in illicit drug use involve all elements of the socio-economic strata of many societies, often concentrated at the highest and the lowest levels. On the one hand, a substantial proportion of illicit drug users are unemployed or under-employed, and, while educational standards vary, large proportions have achieved lower secondary education at best. On the other hand, ATS is making substantial inroads into rapidly growing and economically powerful youth cultures in many countries; this is especially the case among the children of political leadership in some countries. Alienated communities of drug users exist in many Asian cities, but many young illicit drug users are still living in a family environment – illicit drug use, in many Asian communities, despite its stigmatisation, has not yet led to complete disruption of social connectedness. Cambodia, Laos and Vietnam all have substantial populations of street children, increasingly consuming drugs, living precariously with little or no family support or guardians.

Data collection systems in place

There is much variation in the nature and quality of data collection and surveillance systems for illicit drug use across the Asian and Pacific regions. Essentially, in the Pacific, there are no such formal systems. In Asia, there are substantial gaps in the data largely because coverage of data sources is neither comprehensive nor systematic, and more often than not, limited to detection through law enforcement activities. China, Hong Kong, Macau, Indonesia, the Philippines and Malaysia currently have mechanisms in place to better coordinate and integrate data collection, examining data provided by a range of sources, from health and/or drug treatment-related institutions to law enforcement and anti-narcotics institutions and processes. Generally, however, especially with the larger and less developed countries, these data collection systems are underdeveloped, with manual recording, inadequate validation and triangulation, and poor analysis.

A growing body of expertise in Asia has experience, variably, with data collection and analysis from rapid situation assessments, household surveys, school surveys, specific studies on drug users, drug policy assessment, arrest assessments and residential drug treatment assessments. This developing expertise is most often still supported by external expertise, with linkages with foreign universities, funded often by multilaterals (especially the United Nations Office on Drugs and Crime), and only gradually adapting methodologies appropriate to the culture and socio-political context.

A major shortcoming of such data collection, nationally and regionally, is the institutionalised failure of data sharing and analysis between different sectors – in other words, there is often little attempt to bring together nationally collated data from health, education, law enforcement and other sectors at the national level.

Drug supply, production, cost, availability and trade

Myanmar is the main producer of opium, heroin and ATS in the Asian region: while its production of opium has diminished in recent years, it remains the second-largest producer globally, surpassed only by Afghanistan. Laos is the second-largest producer of opium in the region, though, like Myanmar, its opium production has decreased considerably in recent years. Most heroin produced in Myanmar is now trafficked through China, rather than through Thailand to the peninsula as previously; China is now the most important transshipment route for the international market. Routes from Myanmar through China have been joined by new routes from Afghanistan into western China, particularly into and through Xinjiang Uyghur Autonomous Region.

Myanmar is one of the world's largest producers of ATS, up to 700 million tablets per year, with China being the major source of precursor chemicals. In recent years China has also become a major source of methamphetamine for many Asian and Pacific Rim nations, with the discovery of methamphetamine laboratories in provinces along the eastern and south-eastern coastal areas. The Pacific Islands region is developing into a significant transit and potential consumption area for heroin and especially for methamphetamines: the geographic location of these countries facilitates the drug trade, both eastbound and westbound throughout the region, with an estimated 5000 vessels transiting the Pacific on any given day – an attractive alternative for those shipping drugs as more traditional routes become increasingly policed.

Closure of drug trafficking routes in Asia has consistently proven to be a challenge for law enforcement agencies: many nations have borders that are porous, remote, inaccessible or mountainous, some with

extensive waterways and coastlines, and often undermanned customs services to monitor the heavy volume of people crossing certain land boundaries. Many countries in the region have multiple links to drug production zones, with trafficking routes often taking varied paths to reach a final destination: heroin from Myanmar transiting Thailand may be transported to Singapore before reaching Jakarta, or may cross the south of China to Hong Kong and onwards; or heroin may pass from Afghanistan onwards to Karachi (Pakistan), New Delhi (India) or Kathmandu (Nepal) and then onto Jakarta. From Vietnam, heroin often passes along the Mekong River from Laos through Cambodia; the Thai and Vietnamese fishing fleets transport illicit drugs, among other commodities, to every country around the Gulf of Thailand and the South China Sea.

While cannabis is produced in virtually all Asian nations, the major producers are Cambodia, the Philippines and some regions of Indonesia.

Methamphetamines and heroin require precursor chemicals for their production and the review found China, along with India, is currently the world's largest producer of these chemicals; China also produces potassium permanganate, which is shipped to Latin America in order to refine cocaine production.

As a result of the diversification of drug production, the availability of drugs throughout the Asia-Pacific region continues unabated. Costs of illicit drugs on the market depend on location, proximity to the drug production zone, and occasionally domestic events such as drug seizures. The review found that ecstasy tablets in China can be produced for as little as US\$0.06 per tablet, but in the cities of Beijing and Shanghai a single tablet in 2003 could retail for as much as US\$27–36.

Arrest and seizure data

As illicit drug production and consumption have increased, and as perception of illicit drugs as major social problems has grown, national drug law enforcement agencies at all levels have launched increasingly intensive campaigns against illicit drug use and related crimes. The rising trend in the number of narcotic-related arrests in most countries in Asia therefore is the result of a spiralling nexus of increased production, increased consumption, increased public and political perceptions, and increasing law enforcement responses.

Arrests for drug-related crime in Indonesia have increased by 58 per cent per annum over the past five years, while in Vietnam the number of drug arrests has increased from 6651 in 1996 to 23,199 in 2002. Thailand is the exception to this escalation: following its intensive 'War on Drugs', Thailand witnessed a sudden decline in drug-related arrests from an average of 220,000 people per annum from the late 1990s to 2002, to 104,588 in 2003; a suggested explanation for the decline is the massive diversion of drug users into treatment away from prosecution, and the collapse of drug cartels.

Along with a general rise in arrests for drug-related crime, there has been a continuing increase in frequency and amounts of drug seizures, fluctuating depending on the type of drug. Chinese authorities seized around 20 per cent of the world's heroin supplies in 2002. Indonesian drug seizures have been reaching record levels, indicating not only the large amount entering the country but also the amount being consumed. There has also been a substantial rise in the seizures of ATS throughout the Asia-Pacific region: in 2004 a methamphetamine factory was identified in Fiji, resulting in the seizure of 700 litres of liquid methamphetamine and enough precursor chemicals to produce an additional 1000 kilograms of methamphetamine.

Crop sizes and crop eradication

All the countries of the Golden Triangle region – Myanmar, Laos and Thailand – have witnessed a substantial decline in opium poppy cultivation, resulting in part from successful eradication efforts. Myanmar had an overall reduction of opium output, linked with a severe drought and the crop eradication of 2820 hectares in 2004, down 342 per cent from 2003. Farmers in northern Thailand are still planting opium illegally, often amongst legitimate crops to avoid detection, but overall the opium surveys reflect recent trends – that opium farming in the region has decreased significantly. Myanmar, Laos, Thailand and Vietnam have supported ongoing efforts to find socio-economically viable alternatives to opium cultivation, to alleviate some of the issues of poverty among opium growers and to sustain the eventual demise of opium production. These programs have often suffered from unforeseen and untoward deleterious social effects, and challenges remain for sustainable solutions.

Drug-taking practices, risk factors and trends

Historically, opium has been consumed by smoking. Transitions to the production of heroin initially encourage the smoking or ‘chasing’ of heroin, but underlie subsequent moves towards its injection – driven more by economic factors than anything else. Injecting predates heroin availability, in places such as the north of Vietnam where injection of ‘black water opium’ – the opium residue after it has been smoked – has been common. Where heroin is the drug of choice in Asia, the favoured method of administration is injecting. The rate of heroin

injecting does, however, vary from place to place and in different cultural and social settings: once the initial phase of smoking and inhalation of heroin has generally passed, the data suggest around 50–60 per cent of heroin users inject. This trend towards injecting heroin is established in all Asian nations. While there are some common injecting practices, there are also cultural variations: while professional injectors are still commonly found in Myanmar, and less commonly in Malaysia, this practice is decreasing. ATS are generally ingested or smoked, but injecting of ATS, albeit in smaller numbers, has begun to be identified in Thailand, China, Laos, Indonesia and Cambodia.

Sharing of injecting equipment is widespread, accompanied by unhygienic preparation and disposal practices. Pooling of money to purchase drugs and sharing of needles are common practices: economic necessity drives the social organisation of drug use, a major reason for the formation or joining of groups of injectors. Common reasons for the high rates of sharing needles include ‘situational’ reasons (e.g. incarceration), poor accessibility of clean injecting equipment, the urgency to inject, peer pressures and insufficient knowledge of the associated health risks. The use of cleaning techniques for injecting equipment is often crude, often incomplete and consequently inadequate to prevent the transmission of blood-borne viruses. While an increasing number of IDUs are aware of being at risk of HIV infection through the sharing of contaminated needles, studies generally show this knowledge does not extend to all other drug injecting paraphernalia: sharing of communal water to dilute the drug and/or using a common receptacle to draw up the drug solution are often observed.

There has been a marked increase in poly-drug use, for several reasons: when particular commonly used drugs are more difficult to access, often because drug seizures result in price increases, it is common for drug users to seek and use a range of alternatives to achieve the desired effect. In China, for example, there are currently 15 opiates other than heroin and 28 non-opiate substances such as ATS and alcohol that are commonly mixed and consumed. A consequence of poly-drug consumption or of increased purity of heroin is overdose; however, such data are rarely collected in Asia. For instance, drug overdoses are reported to be common in Indonesia, but medical treatment is not available as a result of fear of law enforcers and/or parents: a recent study in Bali found 44 per cent of 81 respondents had experienced a drug overdose at least once.

There is extensive mobility of drug users both within a nation’s borders and across those borders in many areas, especially around the Golden Triangle region, where ethnic minority groups live on either side of the border. These groups often have special travel privileges and family connections cross-border, and are often involved in drug trafficking. Such travel is being promoted by the extensive infrastructure development occurring across Asia, especially regional ring roads and rail connections. Since reunification, there has been extensive travel between Hong Kong and mainland China: a recent survey of over 6000 participants from Hong Kong aged 18–30 years found 20 per cent had used drugs inside mainland China: the most frequently used drugs were ecstasy, ketamine, cannabis and heroin.

Drug users in Asia have high rates of multiple sexual partners and low rates of condom use. High proportions in Asia buy sex from sex workers, the vast majority seldom or never

using condoms. A recent survey among IDUs in Yunnan Province, China, found 88 per cent had unprotected sex with a regular partner, while 64 per cent never used a condom with a sex worker. Increasing numbers of female IDUs exchange sex for drugs or money to purchase drugs, often the only way open to them to raise the funds to purchase drugs.

HIV infection and AIDS are epidemic in almost all Asian countries, associated with injecting drug use; in some places, HIV has become endemic. Among countries with high prevalences of HIV infection among IDUs, those with the highest prevalences include China, Myanmar, Indonesia, Malaysia, Thailand and Vietnam. In China, the proportion of all notified HIV infections in IDUs has dropped from 70 per cent in 2001 to 44 per cent in 2003, but drug injecting is still the main transmission route. This exemplifies a general trend of the virus moving from the initial core group to the wider community, transmitted sexually from IDU – especially where female sex workers are also IDUs.

A few countries in the region have yet to experience major epidemics of injecting drug use, and subsequent associated HIV epidemics. However, there are indications that these epidemics are now happening: in Cambodia, for instance, the first survey of homeless young IDUs found 45 per cent infected with HIV, while in Macao IDUs represented 60 per cent of the total number of notified HIV infections in 2004, an increase from 5 per cent in 2001. The prevalence of hepatitis C virus infection among IDUs is commonly 60 per cent or more across the region – up to 90–100 per cent in many places.

Agreements and treaties

All those Asian countries reviewed are parties to the 1961 United Nations Single Convention on Narcotics, the 1971 United Nations Convention on Psychotropic Substances, and the 1988 United Nations Convention against Illicit Trafficking of Narcotics and Psycho-tropic Substances. Some Asian countries in the region had previously set goals to be 'drug-free' by dates between 2010 and 2025; in recent years members of the Association of Southeast Asian Nations (ASEAN) (this includes all Asian nations under review, except China which is not a full member of ASEAN) have become signatories to the ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD) for a 'drug-free ASEAN by 2015'. All Asian countries reviewed participate in joint drug control programs with other countries to enhance information sharing and coordination efforts.

Policy responses

There is a general awareness among all countries in the Asia-Pacific region of the wide range of negative effects that illicit drug trafficking and use can have on social welfare, and of their implications for the social, economic, political and security structures of a nation. Most countries have a lead agency, often at least nominally multisectoral, to manage drug supply and demand reduction efforts, such as the Narcotics Division of the Security Board in Hong Kong, the National Narcotics Board in Indonesia, the Dangerous Drugs Board in the Philippines, the National Authority for Combating Drugs in Cambodia, and the Central Committee for Drug Abuse Control in Myanmar. There is general reported collaboration with other related agencies and/or ministries when developing policy responses (e.g. Ministries of Health and Education, the judiciary, non-government organisations).

Each country surveyed has as a major policy goal the reduction, often to zero, of drug use, trafficking of drugs, cultivation of illicit crops and/or manufacturing of drugs. Strategies to achieve this goal involve the implementation of a range of supply and demand approaches: from the ongoing and often increasingly intensive enforcement of laws against those using and trafficking drugs, to community-based prevention approaches such as school-based education, to the provision of treatment and rehabilitation for drug users. The emphasis and intensity of these approaches vary in different countries; there are few measures of the efficacy of any individual approach, or indeed of the combined approaches, in any country.

Law enforcement responses

Penalties for trafficking, producing, importing and exporting illicit drugs in Asia are generally harsh by Western standards. The death penalty for production or trafficking is in place in China, Vietnam, Malaysia, Brunei Darussalam, Myanmar, Indonesia, the Philippines and Thailand, but not in any of the nations of the Pacific region. In some countries, the 'war on drugs' has escalated in recent years: in China, for instance, during the International Anti-Drugs Day of 2004, more than 50 people were executed on drug-related crimes in eight of the 30 provinces over a one-week period. The 'War on Drugs Policy' introduced in Thailand in 2003 saw the deaths of over 2500 alleged drug criminals over a three-month period. In Vietnam, from 1996 through 2001, the courts handed down 288 death sentences to drug offenders.

Penalties associated with 'narcotic' crimes do not at times distinguish between different illicit drugs, nor often do they distinguish drug *users* and drug *dealers*, and consequently those in possession of drugs can receive a similar penalty to that

of a lower level trafficker, a relatively long prison sentence and a hefty fine. However, this review found a widely held belief that drug users should be coaxed and assisted but more commonly forced into detoxification and rehabilitation programs: for example, drug users in Myanmar are obliged by law to register for treatment or they face five years in prison; again, Prime Minister Hun Sen of Cambodia has publicly distinguished between drug dealers (as criminals) and drug users (as victims).

Health and drug treatment responses

While the focus of law enforcement approaches has historically been oriented to the reduction of supply and demand, in some places there has been a slow emergence of harm reduction approaches to tackle the dual epidemic of injecting drug use and HIV/AIDS. In China, harm reduction has recently been added to national policy as a third component, of equal priority with supply reduction and demand reduction, during a conference organised by the Ministry of Public Security.

There are treatment approaches for drug-dependent people in all countries in Asia, including medical detoxification, therapeutic communities, substitution programs, residential dependency programs and, in some countries, the introduction of drug treatment programs into correctional and detention centres. Generally, data collection around these approaches is poor or non-existent, so it is difficult to draw conclusions about their efficacy, but what evidence there is suggests relapse rates for dependent opiate users released from residential treatment approach 90 per cent or more. In some cases, it is difficult to determine if those incarcerated in residential drug treatment facilities are necessarily dependent; many such institutions mimic prisons.

Although drug treatment options are available, there are vastly insufficient numbers of treatment and rehabilitation centres in most countries to cater for the number of drug users: overall it is likely that 10 per cent (at best) of all drug users would access treatment, voluntary or mandatory. Most governments in Asia are aware of the shortage of treatment beds available, and are expanding the number of drug treatment programs available: in China, the country has been forced to quadruple its bed capacity due to a massive surge in the number of registered drug users, while in Vietnam the number of treatment and rehabilitation centres increased from 56 in 2000 to 74 in 2003.

Even with this expansion of such facilities, serious overcrowding is a major problem, contributing to a lowering of the outcome effectiveness. Many treatment facilities make an attempt to provide skills and/or vocational training, but the sheer number of drug users makes it difficult for many to get access to such programs; the lack of opportunities after release decreases their desired impact. Treatment approaches in most Asian countries to date mainly consist of traditional medicines and military 'boot camp' approaches, with little innovation: psychological and behavioural counselling is rare, as is assisting drug users to reintegrate into the community following treatment. It is generally agreed that recidivism rates are high – quoted as 80 per cent, but very likely much higher.

Increasingly the outcomes of current treatment approaches have frustrated some government policy makers, leading to increases in the length of detention in treatment or rehabilitation centres, and increases in the penalties linked to relapse: in Vietnam, the average duration of treatment in 2001 was 12 months but currently it is two years, with up to five years for chronic relapsers.

Treatment services in some places are free or subsidised, but generally fees are payable by those detained, to be paid by the detainee or by families and friends; for those unable to pay, it is difficult to discover what arrangements are in place. Certainly in some places, incarceration in prison is the only option. Private voluntary treatment and rehabilitation centres appear to be flourishing in some Asian countries, but the fees required are beyond the reach of the ordinary drug user and their family; there is a belief that many private treatment centres lack understanding of the complexities of addiction. From the data gathered it appears that there are few, if any, youth-specific drug services in Asia; as a result, young drug users are integrated with adults.

Substitution therapy programs are expanding in some Asian countries, while in others such approaches are under consideration. Hong Kong is currently the only Asian state with methadone maintenance treatment (MMT) programs that are considered by international opinion to be of a high quality and with wide coverage. MMT programs, implemented in a variety of ways – often pilots, more recently in private practice – can be found in mainland China, Indonesia, Malaysia and Thailand. Following the successful piloting of MMT programs in China, the current strategic plan is to have 1500 MMT programs in operation by the end of 2007.

In 2004, the Indonesian Narcotics Control Board signed a Memorandum of Understanding with the National AIDS Commission, paving the way for the introduction of harm reduction measures such as needle and syringe programs and methadone programs, including those to be prison-based. The Central Committee for Drug Abuse Control in Myanmar has increasingly become an important player in health policies such as harm reduction within Myanmar but the impact of such involvement is too recent to measure.

Other responses

School-based educational programs targeting students ranging from primary to university level are common in Southeast Asian countries: the focus is to promote anti-narcotics education, often by promoting a life skills curriculum through lectures, seminars and workshops on the dangers of drugs; in some nations this also includes a HIV/AIDS component.

Community development approaches are also common, using a range of government agencies and NGOs to mobilise and heighten the level of awareness among society of anti-drug campaigns through events, exhibitions, and radio and television advertisements, among others.

In Myanmar, Thailand, Laos and Vietnam there have been several long-term alternative development projects to diminish the need among impoverished communities to grow opium, with varying degrees of success. Indonesia, Malaysia, Thailand, China and Vietnam have all witnessed the emergence of harm reduction working groups with representatives of government and NGOs advocating innovative and alternative ways of addressing problems experienced by drug users: fundamentally the focus has been to control the further spread of HIV and other public health consequences associated with unsafe drug use and sex practices.

Illicit drug issues and responses in the Pacific

Vulnerabilities to drug use

The geographical proximity of the Pacific to illicit drug-producing countries, such as in East Asia, only serves to facilitate the illicit drug trade. Additionally, the isolation of the coastal regions offers useful transit points for drugs. Moreover, the terrain of the Pacific makes it very difficult for effective government administration of all territories and creates challenges for effective law enforcement.

The region has developed as a world tourist destination. Subsequently, expansion of transportation links with Asia and North and South America has produced fears that the islands will be used as transshipment routes for trafficking.

Social indicators for the Pacific region, such as increased youth population, urban migration, unemployment and low literacy rates (in some countries), are reported to increase the vulnerability of people to licit and illicit drug use and abuse and its concomitant social and economic consequences.

Current illicit drug situation

Pacific societies have a tradition of drug use incorporated into their culture. A range of psychoactive substances, including betel nut and kava, have traditionally been used across the Pacific region. Rapid socio-economic changes have led to changing patterns of consumption of these and other licit and illicit substances and the potential for abuse.

According to key informants, the prevalence of drug use varies between the six countries reviewed, but cannabis is by far the most common and widespread illicit drug used. It is reported that cannabis is the drug of choice due mainly to its availability and low cost. Key

informants and published reports indicate that cannabis is generally consumed with alcohol. Regionally, cannabis is mainly smoked but it is also chewed and sometimes baked with flour. All data sources agreed that cannabis use is strongly gender-linked, with significantly more male than female users. The majority of cannabis users are young, aged approximately 15–20 years. Cannabis is also used in the expatriate community and by tourists.

Key informants offered that drugs such as heroin, methamphetamines and cocaine are not commonly used in the six countries reviewed due to their high cost compared to the average income. It is concerning to authorities that methamphetamine abuse could become an issue for other Pacific Island countries in the near future. Injecting drug use is believed to be very small. A number of anecdotal reports from key informants indicated inhalant use in these countries was under investigation. The most widely used inhalant is petrol.

Drug supply and trade

Limited options and market opportunities in the agricultural sector have resulted in illicit cultivation of cannabis, predominantly for domestic consumption. The Pacific environment provides ideal growing conditions for cannabis and allows for continuous year-round growing cultivation. Wild growth occurs in all of the countries listed for this review. According to key informants, cannabis cultivation is most significant in Papua New Guinea and Fiji.

The development and greater organisation of the cannabis industry in recent times have resulted in an oversupply of cannabis to local markets. As such, cannabis has been exported to other markets in the region, for example, from Samoa to American Samoa and from Fiji to Tonga. The only documented international trading of drugs from the Pacific is cannabis, coming from Papua New Guinea, trafficked mainly to Australia.

A concern of Pacific Island authorities is that the development of the cannabis industry may allow for profits to be invested in other commodities such as the production of methamphetamines. The Pacific Islands region is developing into a significant transit and potential consumption area for crystal methamphetamine. For example, there was a large seizure of a crystal methamphetamine 'super laboratory' in Fiji on 9 June 2004.

The major form of trafficking, for the six countries reviewed, is transshipment: drugs produced elsewhere transit Pacific Islands for the destination market. The geographic position of countries in the Pacific region facilitates the drug trade, both eastbound and westbound throughout the region. South American cocaine is transported into Southeast Asia and Australia, while South-east Asian heroin and methamphetamine are transported by couriers into Canada, and to a lesser extent into the United States. There have been reports of a number of large seizures in the region. Since the drug market in the region is small, shipments of large quantities are reported to indicate that the drugs are destined for larger markets. Availability and demand for cocaine remain limited in Oceania, with the exception of Australia. Seizures at the Australian border in 2001 doubled from the preceding year. Seizures have been made in recent years in Tonga and Fiji, and seizures in Australia have also indicated that the drugs transited some Pacific Islands. Large seizures of heroin have been made in Vanuatu and Fiji, destined for other markets.

The concern for the Pacific region is, if large amounts of illicit drugs are moving through local communities, then seepage of the drugs into those communities will result and the social impacts of drug dependency will be experienced.

Drug-related crime

Official law enforcement figures could not be obtained for this review. Information about drug-related crime for the region was derived from various sources including newspapers, case studies and regional reviews. Concerns include:

- violence against women and family, particularly in Melanesian countries (Papua New Guinea, Solomon Islands, Fiji), after abuse of cannabis and home-brewed alcohol;
- significant association between alcohol consumption and cannabis smoking with crimes committed by youth;
- in Papua New Guinea serious law and order issues prevail – murders, armed robberies, rape and car jacking are daily occurrences;
- corruption and white collar crimes are written about constantly in the newspapers;
- there are particular concerns regarding the association between cannabis cultivation and the trade for illegal guns;
- money laundering of proceeds of illicit drug trafficking.

Agreements and treaties

Fiji and Tonga are party to all three international drug conventions, the 1961 Convention on Narcotics Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. Samoa and Vanuatu are not party to any of the Conventions. The Solomon Islands have ratified only the 1961 Convention on Narcotics Drugs. Papua New Guinea has ratified the 1961 and 1971 Conventions and adherence to the 1988 Convention is under discussion.

Regional/country illicit drug control policy and legislation

Presently, there is no overall regional or country-based illicit drug policy in the Pacific. Moreover, the inability of current illicit drug legislation within the region to provide a common base for law enforcement agencies to operate from both a national and a regional basis has been noted with some concern at the Forum Regional Security Committee (FRSC) meeting. In 2002, a joint working group was established to address this complexity and to begin to devise a common approach to illicit drug control across the Pacific. The working group has developed new legislation for illicit drug control. The purpose of the Illicit Drug Control Bill is to repeal existing laws and put in place laws addressing aspects of illicit drugs trade that have not otherwise been addressed under current laws, or that require strengthening to allow for more effective investigation and enforcement.

The Forum Secretariat leaders have signed off on the Bill and endorsed its adaptation to local environments. The Bill calls for illicit drug legislation to be consistent in the region with respect to offences, penalties, classes of illicit drugs, and investigation and enforcement (search, seizure and forfeiture). The Illicit Drug Control Bill has been used as the basis of legislation in Tonga and Fiji (as well as in the Northern Mariana Islands).

Law enforcement response to illicit drugs

In general, the principal law enforcement agencies in the region are the Police and Customs and Excise Departments, and Immigration. However, more recently the region

has taken a whole-of-government approach to transnational crime issues and is working closely with the Navy, Defence, Police and Customs.

Due to a lack of resources and training and the constraints of ineffective legislation, the police and customs administrations have difficulty fulfilling their extended role as drug enforcement agents and generally cooperate with other countries on illicit drugs enforcement as needed.

Treatment responses and services

There is limited publicly available documented information on prevention and treatment interventions for drug users in the Pacific. Discussions with key informants point to the same conclusion: with the exception of the northern Pacific, programs or interventions do not specifically address drug users. Drug use/abuse issues are generally incorporated as part of life counselling or other programs undertaken by NGOs and churches: topics include employment, family conflict, sexually transmitted infections, marijuana use/abuse, alcohol (particularly home-brew), unplanned pregnancies and domestic violence.

In Papua New Guinea the psychiatric units in Port Moresby General Hospital and some other hospitals in the provinces, and the National Psychiatric Hospital located at Laloki (on the outskirts of Port Moresby) treat some patients whose condition is linked to drug use (mainly alcohol and cannabis). Like Papua New Guinea, treatment of drug use issues in Fiji and the Solomon Islands is conducted by general or psychiatric hospitals. For example, St Giles in Fiji treats people who experience cannabis-induced psychoses.

Australian and international efforts at a regional level

Australian and international contribution to responses to illicit drug issues in Asia and the Pacific is varied – individual and institutional; government and non-government; direct (bilateral) and indirect (multilateral); focused on illicit drug issues, or addressing them tangentially or consequentially (e.g. economic development aid); and across multiple sectors. This project was incapable of identifying or accessing every such individual or organisation, especially where illicit drugs were not the sole or main focus of the activity or involvement. A detailed list of activities appears in Appendix B.

Australia's efforts at a regional level

Australian organisational involvement in the region, in relation to illicit drug issues, derives mainly from Australian Customs, Australian Federal Police and AusAID activities.

Customs

Australian Customs contributes to the World Customs Organisation (WCO), to support its initiatives in countering traffic in illicit drugs and precursors. Information generated by Customs activities is shared with the Regional Intelligence Liaison Office for Asia and the Pacific of the WCO, currently based in Beijing.

Australia is also an active member of the Oceania Customs Organisation (OCO) and works very closely with the OCO Secretariat. Australia is a member of the current OCO Advisory Committee and is contributing to the development of the Regional Trade Facilitation Program, funded by AusAID and NZAID. As a member of the OCO, Australia delivers capacity-building assistance to fellow members as necessary.

Customs has taken a strong role in promoting cooperation among law enforcement agencies in the Pacific region. This cooperation encompasses the range of customs activities including those that relate to illicit drugs and precursors. Australian Customs has longstanding agreements in place with its counterpart agencies in Hong Kong, New Zealand, Korea and Papua New Guinea. More recently, agreements have been signed with: Indonesia (March 2003); Japan (June 2003); Fiji (October 2003); Thailand (December 2003); and China (April 2004). Customs has Senior Australian Customs Representatives in six locations – Bangkok, Beijing, Brussels, Jakarta, Tokyo and Washington. Their duties include representing Customs at a wide range of illicit drug-related meetings, seminars, conferences and working groups.

Australian Customs was recently appointed as the Central National Authority (CNA) for Australia's involvement in the International Narcotic Control Board's Project PRISM (Precursors Required In Synthetic Manufacture). Customs also works to foster international initiatives with illicit drug-related applications. Australian Customs vessels have continued to support joint cross-border patrols by law enforcement officials from Australia and Papua New Guinea.

AusAID

In relation to direct involvement with illicit drug issues, through its international development aid agency, AusAID, Australia is committed to support the United Nations Office on Drugs and Crime (UNODC) as a critical partner in the global fight against illicit drugs; AusAID contributes to UNODC for its regional work in south Asia and Southeast Asia.

In relation to drug-related harm, Australia has taken a leadership role, again through AusAID, in the Asia-Pacific region on HIV/AIDS issues, a role recognised by the Develop-

ment Assistance Committee and Executive Directors of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and by the United Nations Joint Programme on AIDS (UNAIDS). Australia continues to contribute to and actively engage with the Global Fund both at the headquarters and country levels.

Australia is a key donor in the Asia-Pacific region, with programs drawing on Australian expertise to work in countries with increasing HIV prevalences. The two major national bilateral involvements are currently Papua New Guinea (current contribution \$60 million over five years) and Indonesia (currently \$35 million over five years).

The HIV epidemic in Asia is in many if not most places driven by injecting drug use. In recognition of this, one of the five priorities identified within Australia's International HIV/AIDS Strategy, *Meeting the Challenge* (July 2004), is 'Addressing HIV Transmission Associated with Injecting Drug Use'. As well, Australia views the Asia-Pacific Leadership Forum on HIV/AIDS and Development (APLF) as an important mechanism to promote high-level leadership for effective regional and national action on HIV/AIDS. Australia has made a three-year, \$3 million commitment to the APLF.

Australian Federal Police

The Australian Federal Police (AFP) has strong cooperative operational and intelligence relationships with overseas law enforcement agencies through the AFP International Network. At 31 January 2005, the AFP International Network was made up of 65 people located in 26 countries. The network comprises 47 liaison officers, five analysts, three attachments to Interpol, and one short-term attachment in Fiji.

The AFP's international capability is further augmented through the International Deployment Group and Law Enforcement Cooperation Program (LECP), which seeks to build capacity and enhance cooperation with overseas law enforcement agencies. Major activities include the missions into Papua New Guinea, the Solomon Islands, Nauru and Timor-Leste.

Other

There are a number of Australian non-government organisations undertaking work in the Asia-Pacific region in relation to illicit drugs. The major ones include:

- the Centre for Harm Reduction at the Burnet Institute
- Program of International Research and Training at the National Drug and Alcohol Research Centre
- Drug and Alcohol Services Council of South Australia.

International efforts at a regional level

International organisational involvement in the region, in relation to illicit drug issues, derives mainly from UNODC, the World Health Organization (WHO) and international non-government organisations (INGOs).

UNODC has the global and regional functions of leading the development of demand reduction and supply reduction coordination efforts. As well, through its sponsorship of UNAIDS, UNODC is the lead co-sponsor on harm reduction as it relates to prevention of HIV among injecting drug users.

The UNODC Regional Office for Southeast Asia and the Pacific, in Bangkok, is carrying out a number of cross-border, sub-regional and regional projects covering demand reduction and law enforcement involvement in illicit drug issues. Much of this work is capacity building, working with and through national multisectoral task forces or other bodies, providing training and management capacity building. In relation to illicit drug issues, this work links with UNODC's regional role in providing capacity building for law enforcement through training in police academies.

UNODC is also engaged in supporting a number of projects to improve regional collaboration and data sharing, and in developing and improving data collection and surveillance systems.

WHO is mandated to provide technical support and assistance in the fight against HIV/AIDS among and from injecting drug users, and carries out this function by coordination meetings and production and dissemination of technical and training materials.

The United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) has supported projects in primary prevention and community development and strengthening.

A number of INGOs have supported and are carrying out harm reduction and demand reduction work in the region, among them Family Health International and Population Services International.

1. Situational analysis of illicit drug issues and responses in the Asia–Pacific region

1.1 Introduction

In October 2003 the Prime Minister announced that the Australian National Council on Drugs (ANCD) had been asked to increase Australia's involvement throughout the Asia–Pacific region, specifically to promote the prevention and reduction of drug use, and treatment for those with drug problems. The Australian Government provided \$400,000 from existing Tough on Drugs and related funds for this initiative. To provide appropriate advice to the Australian Government, the ANCD formed a committee of individuals with a broad range of experience and expertise in drug policy and especially in Asia and the Pacific. The mission of the Asia–Pacific Drug Issues Committee (APDIC) is to advise the ANCD and the Australian Government on ways to maximise Australia's response, leadership and impact on Asia–Pacific regional illicit drug issues.

Terms of reference for APDIC

The Asia–Pacific Drug Issues Committee will advise the ANCD by:

1. Surveying current illicit drug initiatives in the Asia–Pacific Region and building a knowledge base of national and international efforts within the Region.
2. Assessing the strategic directions, approaches and models required to coordinate Australian illicit drug and related activities in the Asia–Pacific Region.
3. Identifying potential structures and processes for addressing new and emerging issues in the Region.
4. Developing a comprehensive options paper on the models available to best address illicit drug issues in the Asia–Pacific Region and identifying Australia's potential contribution.

The goals of the committee are:

1. To develop a comprehensive options paper on the current initiatives and models available to best address illicit drug issues in the Asia–Pacific Region and identify Australia's potential contribution.
2. To develop and promote strong liaisons among international organisations, national governments, appropriate government agencies, community-based organisations and regional networks including UNODC, ASEAN, UNAIDS, UNICEF, World Bank, Asian Development Bank, UNESCAP, IFNGO and the Asian Harm Reduction Network.
3. To develop a comprehensive approach to addressing illicit drug issues in the Asia–Pacific Region, including supply, demand and harm reduction strategies.

A situational analysis of drug issues and responses

In order to provide a foundation for its work, APDIC identified an urgent need to map the current situation regarding illicit drugs and work currently being undertaken in the Asia–Pacific region, to identify gaps in responses, tailor responses to specific situations, and avoid duplication at the international level.

In November 2004, APDIC contracted the Burnet Institute's Centre for Harm Reduction and Turning Point Alcohol and Drug Centre to undertake a situational analysis of illicit drug issues and responses in the Asia–Pacific region.

While the Committee acknowledged the importance of engaging with all countries in the region, for the purposes of this project the Asia-Pacific region was deemed to include the countries involved in the ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD), and those Pacific nations of interest to AusAID.

- Myanmar
- Laos
- Thailand
- Cambodia
- Vietnam
- China
- Hong Kong
- Macau
- Brunei Darussalam
- Indonesia
- Malaysia
- Philippines
- Timor-Leste (East Timor)
- Fiji
- Papua New Guinea
- Samoa
- Solomon Islands
- Tonga
- Vanuatu

APDIC viewed the analysis as a three-part project:

1. a situation analysis and country profile for countries in the Asia-Pacific region, including an overview of drug policy, policy processes and partnerships as well as a review of the prevalence, epidemiology and harms of drug use in each country;
2. an audit of Australian involvement in responses to illicit drug issues in the Asia-Pacific region including government, non-government organisations and individual contributions; and
3. an audit of current illicit drug-related activities being undertaken by other national and international agencies and funders in the region.

Core areas of inquiry

The project focused on unsanctioned use of all illicit drugs and directly related harms, with consideration of pharmaceutical drugs limited to their intentional misuse.

The core areas of inquiry for each country in this project were:

- contextual information for each of the countries of interest
- historical (cultural or traditional) interactions with illicit drugs
- the current illicit drug use situation
- illicit drug production and trade

- illicit drug-taking practices, prevalence, risk factors, trends
- policy around illicit drugs in each of the countries
- country responses to illicit drug issues (including health, law enforcement, education)
- international involvement in the countries of interest in relation to illicit drugs
- Australia's involvement in the countries of interest in relation to illicit drugs.

1.2 Method

The project was desk-based; data sources for the three components of the study – country profiles, Australian involvement, and international involvement – included published and unpublished literature and information from key informants and regional institutions. The approach taken for this project reflects the importance of local involvement and ownership of the method, process and outcome. Given that the methodology relied on participation from key informants and regional institutions, the quality, accuracy and verification of the information collected were dependent upon the cooperation of those in the field.

The two major methods for accessing information were literature review and key informants.

Literature review

The literature was searched for information relevant to the core areas of the project. The review included:

- peer-reviewed articles using PubMed, Medline and PsychInfo
- existing literature such as:
 - The Hidden Epidemic Series – 1997, 2002
 - UNODC's 2004 regional study of amphetamine-type substances (ATS)
 - UNODC's 2004 report on *Drugs and HIV/AIDS in Southeast Asia*
 - UNODC's *World Drug Report, 2004*
 - US State Department's 2003 Narcotics Control Report
- 'grey' literature – unpublished and in-house reports
- website searches – for example, CIA, US State Department, UNODC, INCB
- internet lists – SEA-AIDS and the Association for Social Anthropology in Oceania email discussion group
- key informant suggestions for sources of relevant information.

Key informants

A Microsoft Access database of key informants was developed for the project. An introductory email was sent to all relevant key informants (approximately 350 contacts) to introduce the project and invite contributions. A post on SEA-AIDS was also made to introduce the project. Responses to the initial email were very low (approximately 5%). A follow-up email was sent two weeks later to non-responders resulting in a further 5% reply. Contact was made with the individuals who responded to the initial information requests. Contact was also made with new contacts as they were identified throughout the project and with people who were known to the researchers (either through experience or as identified in the literature review) as having relevant information.

Relevant key informants, including representatives from funding bodies, regional institutions and program implementers, were sent an email requesting information regarding Australian and international involvement in responding to drug issues in the Asia-Pacific region. They were asked to provide information in a Word/Excel format or to complete the online survey.

The online survey was hosted on the Turning Point website. The survey was designed to collect information on the involvement both of Australian and of international organisations.

There were eight steps required for successful completion of the survey.

1. Click on the link <http://survey.turningpoint.org.au/masurvey/login.php>

2. Log-in

Type in user name and password.

Individuals were given a unique username and password in order to secure the information.

3. Introduction

Read the introduction and note project team contact details.

4. Update agency details

To reduce data entry time on the respondent's behalf, available agency information was entered by the research team.

5. Add program information

6. Add funding sources

Prior to entering funding information for programs the relevant funding sources should be added.

7. Add funding information

Add new funding	Funding Source	Funding Amount	Resurring
Edit Delete	USAID - Family Health International	49930.00	1

Records 1 to 1 of 1

8. Log-out

Once all information is entered, click on 'log out' in the menu. If necessary, it is also possible to log back in to add or edit information at a later stage.

People were followed up at least twice to try to encourage a response. Responses received regarding Australia's involvement were reasonably comprehensive; however, the response for international involvement was poor. Information on projects known to the researchers was followed up with the project implementers, in literature or on websites.

Methodology for the Pacific

There is very little documented information regarding illicit drug use in the Pacific. Additionally, there is no established network of people knowledgeable about illicit drug use in the region. With the exception of the literature review, a different approach was undertaken for data collection in Pacific countries. A contact network of people working in the Pacific who could provide information on the illicit drug use situation was established. Following this, information on the core areas of interest was collected through telephone interviews and, to a lesser degree, via email correspondence.

In order to validate information obtained from regional reports and initial interviews, a focus group (based in Melbourne) was conducted with eight people working in the Pacific. Participants represented the Centre for International Health, Burnet Institute; the Centre for Harm Reduction, Burnet Institute; World Vision; and the International Women's Development Association. One participant was a journalist in the Pacific while another was a consultant who had undertaken international aid work in the Pacific. Participants were provided with a document outlining the core areas of the situation assessment and information collected to date on each area. The group worked through the document and made comments regarding accuracy of the information. The group also provided suggestions for other relevant contacts.

In-country review of profiles

A draft of the country profiles was sent to at least two in-country representatives for validation of information.

Human Development Index (HDI)

The HDI rank was used in the country profiles to give a broad view of each country's development. The HDI is a composite index measuring average achievement in three basic dimensions of human development – a long and healthy life, knowledge and a decent standard of living. A lower rank indicates better development.

Definition of drug treatment

The contemporary model of drug treatment (according to the United Nations Office on Drugs and Crime (UNODC)) focuses on detoxification, stabilisation, rehabilitation and continuing care. Incarceration and education *alone* are not regarded as treatment. This report presents information about drug treatment as conceived by the country in which the data were collected. It is acknowledged that the Asian model of treatment may be different from that of UNODC.

2. Country summaries

2.1 Brunei Darussalam

Population: 365,251

2.1.1 Overview of recent drug trends

The main drugs in use appear to be methamphetamine and cannabis. There have been no known seizures of heroin since 2002; potential heroin use is likely but cannot be confirmed. Use of ecstasy appears to be minor. The Government of Brunei considers drug problems a concern, but does not consider consumption to be widespread; in particular, there is little acknowledgement of the existence of injecting drug use.

2.1.2 Prevalence of drug use

There are no estimates, official or unofficial, of the number of drug users in Brunei; there have been no surveys of drug use among the general population or the student/youth population.

2.1.3 Drug supply

No cultivation or production of any form of narcotics has been reported from Brunei as of 2003. Despite the dense jungles and rivers along the borders and coastline of Brunei – ideal for drug trafficking – the size of the country allows government authorities to closely monitor the country. The amount of drugs entering or transiting through Brunei is minor; what drugs are smuggled into the territory are usually from Malaysia.

2.1.4 Drug-taking practices, risk factors and trends

Most drug consumption would seem to be oral, and not by inhalation or injection. Information about drug-taking practices and associated risk factors was not able to be accessed. By the end of 2004 there was a cumulative total of 609 HIV infections (males 89%) and 23 AIDS cases. Mode of transmission was reported for 542 of these cases, of which only one was injecting drug use. However, it needs to be noted that this figure conflicts with previous HIV/AIDS notification figures (from 2002–03) in which apparently 3.8 per cent of diagnosed HIV infections were linked to the sharing of needles.

2.1.5 Summary table

Estimated number of current drug users	Unknown
Main drugs used	Methamphetamine, cannabis
Drugs injected	Unknown
Estimated prevalence of HIV infection among IDUs	Unknown; conflicting information

2.1.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to the ASEAN declaration for a drug-free ASEAN by 2015.
National drug control policy	National policy is based on supply and demand reduction. The name of this policy is not known.
Main drug control legislation	<i>The Misuse of Drugs Act 1984 (MDA)</i> , Chapter 27
Drug control policy lead agency	The Narcotics Control Board is under the Prime Minister's Office (PMO), and as a result most policies are formulated by the PMO.
Law enforcement bodies	The Narcotics Control Board is the lead agency in dealing with drug-related issues with assistance from the Royal Brunei Police Force.
Drug use addressed in last National HIV/AIDS Plan	Unknown
Possession of N&S unlawful	Unknown
Harm reduction	
Needle and syringe programs (NSPs)	No
Peer-based approaches	No
Supply reduction	
Crop eradication	The supply reduction approach is to enhance enforcement activities and to harmonise drug laws with other legislation in the region. There is a specific <i>Drugs Laws and Poisons Act</i> that governs import, export and misuse of licit drugs.

Demand reduction	The demand reduction approach is to focus on public awareness by promoting anti-drugs messages through media to all community members. Mandatory drug rehabilitation takes place at the sole drug rehabilitation facility in the country.
Treatment	After detoxification, inmates undertake an orientation program for one week. The rehabilitation program includes physical, psychological, social, moral and civic rehabilitation. The duration of drug supervision post-discharge is 6–24 months.
Voluntary or self-referral	Unknown
Compulsory	Yes
Methadone for detoxification	No
Substitution therapy	No
Most common type of treatment provided	Therapeutic community model with a likely military approach
Primary prevention	Yes. Mainly based on 'say no to drugs'.
School-based education	Yes
Community education	Yes

2.1.7 Australia's involvement – NA

2.1.8 International involvement – NA

2.2 Cambodia

Population: 13,363,421

2.2.1 Overview of recent drug trends

The majority of situation assessments undertaken in the past few years point to the same conclusions with respect to type of drugs used in Cambodia: *yama* is the most frequently used drug; cannabis, heroin, opium and ecstasy are also prevalent. The most common method for using illicit drugs was by smoking. The study undertaken by Mith Samlanh–Friends in 2002 showed the most common drugs reportedly used by the street-based youth interviewed in the capital, Phnom Penh, were glue (71%) and *yama* (65%). Glue is preferred mainly by younger (less than 15 years) and poorer youth, including girls. Heroin injecting was evident among male street children aged 14+ years in Phnom Penh.

2.2.2 Prevalence of drug use

There are no national population estimates for drug use in Cambodia. The UNODC estimates a population prevalence of 4 per cent, which suggests there are about 520,000 substance users in Cambodia (population of 13 million). Data are obtained monthly from up to four sources: law enforcement, local authorities, social affairs, and schools using simple reports. In the August 2005 reports (June 2004 – December 2004) the total number of illicit drug users across the nine provinces was estimated to be 5044 people, equivalent to 0.08 per cent of the population in the nine provinces (or 0.15% of the population aged 15–64 years of age).

2.2.3 Drug supply

Cambodia shares borders with the world's major producers of opium and heroin. Based on seizures, street price and availability indicators, authorities report large quantities of illicit drugs are entering Cambodia for domestic consumption as well as transiting en route to other countries. Law enforcement authorities in Cambodia, Thailand and Vietnam believe that the Mekong River, flowing from Southern China through Thailand, Laos, Cambodia and Vietnam, together with the road network, is being used to traffic illicit drugs.

According to the UNODC, drug trafficking of amphetamine-type substances (ATS) into Cambodia in 2004 increased ten times compared to 2003. Since the mid-1990s Cambodia has been used for transiting heroin and cannabis. Cambodia has become one of the largest sources of cannabis for the world market. Cannabis is cultivated within Cambodia on an organised basis for export. Indicators suggest methamphetamine may be increasingly manufactured in Cambodia.

2.2.4 Drug-taking practices, risk factors and trends

Due to the lack of surveillance data, the true nature and extent of drug-related HIV prevalence and risk in Cambodia remain unclear. From the limited data available, there is evidence to suggest an increase in injecting drug use in major urban centres, and there is a strong suggestion that factors for HIV transmission through injecting drug use (IDU) already exist in Cambodia. The I-RARE

study reported that every injecting drug user they interviewed in their study said they reused needles and syringes. The methods of administration of glue and amphetamines do not pose a risk of HIV transmission; however, the behaviours associated with their use do increase HIV vulnerability through high-risk sexual behaviour (non-use of condoms). However, over the past year there is evidence of injecting methamphetamine in Phnom Penh.

2.2.5 Summary table

Estimated number of current drug users	520,000
Main drugs used	<i>Yama</i> (amphetamine)
Drugs injected	Heroin and methamphetamine
Estimated prevalence of HIV infection among IDUs	37% amongst IDU street-based youth in Phnom Penh

2.2.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions
National drug control policy	National Drug Control Master Plan (2006–10)
Main drug control legislation	Law on the Control of Drugs 1997 as amended in 2005
Drug control policy lead agency	National Authority for Combating Drugs (NACD)
Law enforcement bodies	National police of the Ministry of Interior; Military Police of the Royal Cambodian Armed Forces (RCAF)
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	No
Harm reduction	Yes. Stated as an intervention in the Drug Control Master Plan.
Needle and syringe programs (NSPs)	A pilot NSP, as part of a broad harm reduction program, is operating in Phnom Penh under authorisation from NACD (2004–06 inclusive); a second NGO has received similar authorisation from NACD to commence NSP in 2005 as part of a broader harm reduction program.
Peer-based approaches	No
Supply reduction	The Royal Government of Cambodia has adopted various strategies for responding to illicit drug issues in the country including supply reduction.
Crop eradication	Yes

Demand reduction	The demand reduction approach is limited. Currently there are no treatment and rehabilitation services available for the general population.
Treatment	Five-year Master Plan outlines establishing policies and services for drug treatment. Street children/youth in Phnom Penh and Poipet have access to limited counselling, treatment, rehabilitation and reintegration activities run by several NGOs. One mental health unit at one hospital in Phnom Penh provides drug abuse counselling and limited symptomatic treatment. One private clinic in Phnom Penh provides symptomatic medications for opiate treatment but at high cost.
Voluntary or self-referral	Drug control law 1997 provides for voluntary referral for users.
Compulsory	Yes, being planned by the Cambodian Government to be based in Phnom Penh.
Methadone for detoxification	No
Substitution therapy	No
Most common type of treatment provided	Symptomatic medications and mental health treatment
Primary prevention	Yes, but limited
School-based education	Yes
Community education	Yes, but limited

2.2.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Two AFP liaison officers and an adviser	AFP						Phnom Penh
Establishment of a Transnational Crime Coordination Centre	AFP			Intelligence sharing and investigation capacity in region			
Strengthening the Secretariat of the National Authority for Combating Drugs (NACD) and National Drugs Control Program of Cambodia	AusAID core contribution to UNODC in 2002 (approx. US\$50,000); Sweden (approx. US\$1.5m.); USA (approx. US\$0.25m.)	UNODC Project AD/CMB/01/F14		Law enforcement, demand reduction, capacity building, legislation, coordination, management	April 2001 – September 2005		

2.2.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Reducing HIV vulnerability from drug abuse	UNAIDS/UK Luxembourg	UNODC		HIV/AIDS	April 2002 – March 2004	\$1.4 million	Greater Mekong sub-region (Thailand, Laos, Cambodia, Vietnam, China, Myanmar)
Nationwide assessment of high-risk behaviour and institutional opportunities for intervention and intervention design among selected sub-populations	United States Centers for Disease Control and Prevention through UNAIDS	UNODC		To strengthen national capacity for monitoring, evaluation and research	December 2002 (1.5 years); final report June 2005	\$65,000	Phnom Penh, Poipet, Koh Kong (casino workers, beer promotion girls and garment factory workers)
Drug abuse data collection network	UNODC national project (CMD/F14) in collaboration with ATS data and information systems (RAS/F97) and ACCORD monitoring project in Cambodia (RAS/F73)	NACD through UNODC assistance		Establishment of a monthly data collection network	2004 ongoing		Currently 11 provinces/municipalities; due to be expanded (if additional funds become available) to national scale in 2005

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Community-based drug abuse counselling, treatment and rehabilitation services	UN Trust Fund for Human Security – through funding from the Government of Japan	UNODC	3.5 years	Establishment of community-based drug abuse counselling, treatment, rehabilitation and reintegration services in three selected locations	mid-2005 to end of 2008	\$1.1 million	Phnom Penh (2 centres) Battambang (1 centre) + 1 other centre (to be decided)
Injecting drug use and related HIV/AIDS risk in Phnom Penh and Poipet using I-RARE	United States Centers for Disease Control and Prevention through UNAIDS	WHO		To strengthen national capacity to conduct rapid assessments relating to risk behaviour for HIV/AIDS	January 2003; final report June 2005	\$65,000	Phnom Penh and Poipet
Integrated expert to help support the activities of the NACD	German Centre for International Migration and Development (CIM)		2 years (with possible extension for an additional 2 years)	Demand reduction	late 2003		
Development of the drug control sector	Government of Sweden	UNODC project (AD/CMB/01/F14)	since 2001			over \$1 million	
[see entry 3 above re this project]	United States Centers for Disease Control and Prevention (CDC)	CDC to NACD, UNODC, National AIDS Authority and the expanded UN Theme Group on HIV/AIDS, throughout 2003				\$20,000	
Program Acceleration Fund	CDC and UNAIDS	UNAIDS WHO			Information is not available for the UNAIDS aspect of the project. The WHO component is Oct 2003 – June 2005; UNODC component is 2003 – June 2005.	\$65,000 + \$65,000	

2.3 China

Population: 1,298,847,624

2.3.1 Overview of recent drug trends

The drug of choice for drug users in China is heroin, followed by benzodiazepines (including triazolam, diazepam, clonazepam and nitrazepam), other opiates such as morphine and opium, cannabis, ketamine and amphetamine-type substances (ATS), such as 'ice' and 'ecstasy'. In China's growing urban centres, use of MDMA ('ecstasy') has become increasingly popular while cannabis use is widespread in Xinjiang. The use of ATS was rare until 1995 but is currently expanding rapidly: there is a perception that ecstasy and methamphetamine are the most popular drugs consumed.

2.3.2 Prevalence of drug use

The Government of China acknowledges that the number of drug users is much higher than those who are registered. As of late 2003, the number of registered drug users was 1,050,000, a 15-fold increase, accounting for 0.081 per cent of China's total population. Officially, some suggest the number of drug users ranges from an estimated 6–8 million; unofficially, estimates are as high as 12 million. However, it must be stated this is not based on scientific or epidemiological studies. The estimated number of injecting drug users (IDUs) ranges from a low of 356,000 to 3,500,000 with a mid-range figure of 1,928,000.

2.3.3 Drug supply

The growing of illicit opium is minor, and manufacturing of heroin within China's national borders has not yet been identified. Most heroin produced in Myanmar is reportedly trafficked through China, which has become an important transshipment route for the international market. This proliferation of drug trafficking in China largely emerged as a result of new routes from Afghanistan into western China, particularly Xinjiang Province. Cannabis is grown mainly in Xinjiang and Yunnan, primarily for domestic use.

The ephedrine plant grows wild in many parts of north-east China and the chemical extracted from the plant is processed for pharmaceutical purposes. Methamphetamine laboratories are located in various provinces along the eastern and south-eastern coastal areas. China in recent years has become a major source of methamphetamine for many Southeast Asian and Pacific rim nations.

Chinese law authorities also note a surge in the production of MDMA, mostly for the domestic market in Beijing, Shanghai, Nanjing, Guangzhou and Shenzhen. China also produces the chemical potassium permanganate, known to be sold to Latin America to refine cocaine.

2.3.4 Drug-taking practices, risk factors and trends

Smoking of heroin is still popular but the trend towards injecting is well established. Ecstasy is generally taken orally or by smoking, while 'ice' is usually inhaled or smoked: there are reports of injecting methamphetamine, sometimes mixing it with heroin, but it is difficult to gauge how widespread the practice is. Reports show that unsafe injecting is widespread among drug users, the greatest risk factor being the sharing of syringes.

Sexual risk behaviours among drug users are alarming, with multiple sexual partners common and the rate of condom use in sex being low. By 2002, HIV was found among drug users in all 31 provinces, autonomous regions and municipalities. In 2001, 70 per cent of all HIV cases were found among IDUs, but as of 2003 the proportion of reported HIV among IDUs had dropped to 44 per cent: IDU remains the main HIV transmission route in China. The prevalence of hepatitis C among IDUs was mostly above 70 per cent.

2.3.5 Summary table

Estimated number of current drug users	1,050,000 registered but an estimated 6–12 million in total. Estimated number of injecting drug users ranges from 356,000 to 3,500,000
Main drugs used	Heroin, benzodiazepines, amphetamine-type substances (methamphetamines, ecstasy), cannabis, opium, ketamine
Drugs injected	Heroin, methamphetamine, diazepam, pethidine, morphine
Estimated prevalence of HIV infection among IDUs	As of 2003 the proportion of reported HIV among IDUs was 44%. In some areas the prevalence rises above 80%.

2.3.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. While China is not a full member of ASEAN, it has become a signatory to the ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD) for a 'drug-free ASEAN by 2015'.
National drug control policy	Focused on prohibiting drug trade, drug consumption, crop cultivation and manufacturing of drugs, drug eradication programs and closure of drug trafficking routes.
Main drug control legislation	The State Council of China promulgated the Procedures for Narcotic Drugs Control (1987) and the Procedures for Psychotropic Substances Control (1988). The Prohibition Against Narcotic Drugs adopted in 1990 sets out penalties for drug trafficking, possession and use.
Drug control policy lead agency	National Narcotics Control Commission (NNCC)
Law enforcement bodies	Ministry of Public Security, Ministry of Public Health (regulates pharmaceutical industry) and the Customs General Administration. Within the Ministry of Public Security, the Narcotics Control Bureau is responsible for all criminal investigations and the anti-trafficking of illicit drugs.
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	No
Harm reduction	
	NSPs, outreach and peer education programs appear to be expanding but still have limited scope. Substitution therapy programs are expanding. Harm reduction appears to be gaining a gradual acceptance among the authorities but serious operational difficulties are encountered.
Needle and syringe programs (NSPs)	Yes (limited)
Peer-based approaches	Yes (limited)
Supply reduction	
	The overall position of Chinese law enforcement is zero tolerance. According to Chinese law, drug users must be rehabilitated, and consequently the country has adopted compulsory treatment as its main principle. The smuggling, trafficking or manufacturing of illicit drugs can result in either death or a life sentence.
Crop eradication	Statistics on eradication of illicit opium are not available.

Demand reduction	Anti-drug campaigns and education prevention programs for schools and the wider community are in place. The government's policy is to actively rehabilitate drug users, first by admission into either voluntary or compulsory rehabilitation centres; and, if unsuccessful, drug users are sent to re-education through labour centres. Substitution therapy programs are currently gaining much wider acceptance.
Treatment	Arrested drug users are first sent to a compulsory rehabilitation centre (CRC) for 3–6 months. There are 583 CRCs in the country. If relapse occurs, the user is sent to re-education through a 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. There are 165 RELCs in the country.
Voluntary or self-referral	Yes
Compulsory	Yes
Methadone for detoxification	Unknown
Substitution therapy	Yes. At the end of 2005 it is anticipated there will be 100 methadone maintenance treatment programs operating in various parts of China.
Most common type of treatment provided	Rehabilitation includes medical and psychological treatment, legal education and 'moral education'. The moral and psychological education entails exercises such as rote repetition of slogans, marching, exercises and shouting of numbers.
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.3.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Five AFP liaison officers	AFP						Beijing (2), Hong Kong (3)
Xingjang HIV/AIDS Prevention and Care Project	AusAID			HIV in China	2004–2007	\$15 million	
China Integrated Development Program	AusAID			HIV in China	Sept 2004 – Aug 2005	\$87,000	

2.3.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
HIV Prevention Trials Network (HPTN)	Johns Hopkins University (via NIH)	Guangxi Center for HIV/AIDS Prevention and Control	4 years	Research			
Peer Driven Intervention among IDU project	ABT Associates (via NIDA)	Guangxi Center for HIV/AIDS Prevention and Control	2 years	Intervention, research			Guigang City
Cohort development	Johns Hopkins University (via NIH)	Guangxi Center for HIV/AIDS Prevention and Control	5 years	Research			

2.4 Hong Kong

Population: 6,855,125

2.4.1 Overview of recent drug trends

In 2003, heroin was still the drug of choice but there has been a decline in its popularity. Hong Kong has witnessed a rise in the use of psychotropic substances over the last decade with ketamine, triazolam/midazolam, cannabis, 'ecstasy' and methamphetamine commonly used. The proportion of polydrug use has been on the increase. The use of tranquillisers was common among drug users; among heroin users, they were commonly consumed to prolong the effects of the narcotics and to ease withdrawal symptoms.

2.4.2 Prevalence of drug use

In 2004, the number of drug users registered with the Central Registry of Drug Abuse was 14,714, a 6.3 per cent fall from the 15,708 registered in 2003 – the lowest in the past decade.

In 2000, the estimated number of drug users was calculated, through the indicator dilution formula, to be 36,384. A study in 2004 reported the estimated number of injecting drug users ranged from 13,000 to 40,000 with a mid-range figure of 26,999.

2.4.3 Drug supply

Hong Kong's role as a transit and transshipment point for large consignments of drugs from Southeast Asia to the international market has diminished considerably over the years, largely as a result of its law enforcement efforts and because of alternative drug trafficking routes through Southern China. Heroin smuggled into Hong Kong is reported now to be mainly for the local market. Much of the heroin entering Hong Kong originates from the Golden Triangle, often transported through the provinces of Yunnan and Guangxi, with some drugs making their way towards Guangdong Province, where they are commonly stockpiled. Methamphetamines are similarly transported to Hong Kong following the same route as the heroin trade.

Air transport is the favoured route for the smuggling of drugs from distant countries, such as ecstasy from Europe and cocaine from South America. Bulky drugs such as cannabis (often transported from the Golden Triangle or Cambodia) are more likely to use sea routes, utilising the extensive maritime traffic in the waters surrounding Hong Kong.

2.4.4 Drug-taking practices, risk factors and trends

Data from the Central Registry of Drug Abuse in 2003 found, among the heroin users, that injection was the preferred method (54.9%), followed by fume inhalation (42.3%) and smoking (14.4%). Participants recruited from methadone clinics found that, of the 668 subjects, 51.2 per cent injected; of 351 clients, 14.8 per cent had shared injecting equipment at one stage, and of this percentage 20 per cent had done so in the past three months. Of the 686 participants, 78 (11.4%) had injected drugs in mainland

China; of this group, 23 clients had done so within the last three months. The rate of injecting equipment sharing over the years has declined and current sharing may be a result of complacency among IDUs towards the high risks associated with sharing and/or the continuing low incidence of HIV infections among IDUs. However, it is important to note the proportion of HIV infections among drug users has increased from not more than 3 per cent before 1998 to 10 per cent in 2003 and 2004. Testing for hepatitis C showed a prevalence of 46 per cent in 2001. Sexual risk behaviours of drug users were not identified in the research.

2.4.5 Summary table

Estimated number of current drug users	36,384 (2001) – updates not available
Main drugs used	Heroin, ecstasy, methamphetamine, ketamine, cocaine, cannabis, cough mixtures, solvents
Drugs injected	Heroin
Estimated prevalence of HIV infection among IDUs	Proportion of HIV infections among drug users has increased from 3% (1998) to 10% (2003–04)

2.4.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions
National drug control policy	The strategic approach to deal with drug problems is broad-ranging and includes legislation (involving law enforcement, police and customs); preventive education and publicity programs; treatment and rehabilitation services; research; and external cooperation and exchange of information with others involved in narcotic matters.
Main drug control legislation	Dangerous Drugs Ordinance (Chapter 134)
Drug control policy lead agency	Narcotics Division of the Security Bureau
Law enforcement bodies	Hong Kong Police, and Hong Kong Customs and Excise Department
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	No
Harm reduction	Harm reduction approaches are limited. However, Hong Kong has the most comprehensive methadone maintenance programs in Asia, operating since 1972.
Needle and syringe programs (NSPs)	No
Peer-based approaches	Yes (limited)
Supply reduction	The Hong Kong Government has gone to great efforts to suppress illegal drug supply for over 45 years by vigorously imposing sentences from the <i>Dangerous Drugs Ordinance</i> for those in possession of illicit drugs. A five-pronged strategy includes legislation by the Narcotics Division of the Security Bureau and law enforcement by the Police and the Customs and Excise Department.
Crop eradication	No

Demand reduction	The Government has a strong focus in the area of treatment and rehabilitation of drug users. There are various facilities for people who voluntarily seek treatment and rehabilitation, many operated by NGOs. The Narcotics Division works with various agencies and government bodies to reach out to young people with anti-drug messages. Annually there are also many anti-drug projects funded by government.
Treatment	Substance abuse clinics in six hospital authorities' agencies. The Society for the Rehabilitation and Aid for Drug Addicts operates four residential treatment centres, five halfway houses and post-discharge socio-medical care. There are at least 15 other NGOs offering treatment.
Voluntary or self-referral	Yes
Compulsory	Confined to the Correctional Services Department
Methadone for detoxification	Yes (for out-patients, and in some residential treatment programs)
Substitution therapy	Yes (there are no waiting lists to receive therapy)
Most common type of treatment provided	A hybrid of various approaches and activities, including work and socialising
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.4.7 Australia's involvement – NA

2.4.8 International involvement – NA

2.5 Indonesia

Population: 238,452,952

2.5.1 Overview of recent drug trends

Since the late 1990s there has been an increasing trend towards the use of heroin, methamphetamines and cannabis: heroin is the most common drug for which treatment is sought at treatment facilities. In recent years there has been some increase in the use of cocaine. The most consumed drug is cannabis, but in a recent study 10 per cent of high school students indicated they were using methamphetamines and 9 per cent were using ecstasy.

2.5.2 Prevalence of drug use

There has been an exponential increase nationwide in drug use, not just confined to the large urban centres. Estimates of the numbers of illicit drug users range from 1 to 3 per cent of the total population – between 1.3 million and 6 million people. Access to drugs has become increasingly easy, with drug use spreading to all sections of society. It is unclear from the data available as to what constitutes ‘drug use’, thus some drug use estimates are questionable. Reliable estimates of injecting drug users (IDUs) range from 124,000 to 196,000.

2.5.3 Drug supply

Illicit drugs can enter Indonesia through any of hundreds of points throughout the world’s largest archipelagic country with a coastline of more than 8500 kilometres. Indonesia has a relatively weak customs service, with poorly paid officials and unsophisticated law enforcement techniques, contributing to great difficulty in the control of smuggled illicit drugs.

Drugs come into Indonesia from a variety of regions and nations: most of the heroin entering Jakarta has its origins in Afghanistan, entering via Pakistan. Heroin can also transit from Thailand with a favoured route through Bangkok and Singapore into Jakarta. Methamphetamine pills can originate from Myanmar and Thailand. Ecstasy is smuggled into Jakarta from the Netherlands, Belgium and Germany, and increasingly from Ghuang Zhou in China. Cannabis is grown and harvested in North Sumatra, and especially in the province of Aceh.

2.5.4 Drug-taking practices, risk factors and trends

In 2004, the commonly used drugs were: cannabis, heroin, methamphetamine, ecstasy and solvents. Heroin is most commonly injected, with rates of injecting appearing to be increasing throughout the country. A large study found that while 98 per cent of the respondents knew that HIV could be transmitted by the sharing of needles and injecting equipment, 85 per cent reported using needles that had previously been used by another person within the past week.

Sexual behaviours of drug users are a concern. A recent study that examined the sexual risk behaviours of IDUs found 70 per cent had multiple partners over a 12-month period and that consistent condom use with wives, girlfriends and casual partners was below 10 per cent. There has been a dramatic rise in HIV prevalence among IDUs in recent years. In 2004, the Ministry of Health stated that 41 per cent of 5701 people notified as living with HIV/AIDS had been infected as a result of injecting drugs; in 2003, 80 per cent of new infections were linked to IDUs.

2.5.5 Summary table

Estimated number of current drug users	1.3–6 million. Of these, 124,000–196,000 are IDUs; it has been suggested this figure could rise to 1 million.
Main drugs used	Cannabis, heroin, methamphetamine, ecstasy, depressants, solvents, codeine, cocaine
Drugs injected	Heroin, methamphetamine, cocaine
Estimated prevalence of HIV infection among IDUs	As of 2003, 80% of new HIV infections were linked to IDU.

2.5.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to the ASEAN declaration for a drug-free ASEAN by 2015
National drug control policy	Controlling drug abuse and illicit drug trafficking includes: prevention (communication, information and education); community participation; law enforcement; treatment and rehabilitation; regional and international cooperation; control and supervision of legal drug market and precursors; and Enhance Human Resource Development
Main drug control legislation	<i>Narcotics Law</i> (No. 22 of 1997) and <i>Psychotropics Law</i> (No. 5 of 1997)
Drug control policy lead agency	National Narcotics Board
Law enforcement bodies	Indonesian National Police
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	Officially, injecting equipment related to illicit drug use is confiscated. Needles and syringes are to be provided or distributed only with a government permit.
Harm reduction	
	Has been gathering momentum in recent years but only 5–10% of all drug users in the country have access to any form of harm reduction.
Needle and syringe programs (NSPs)	Despite a small number of NSPs, effort for adequately scaled distribution of clean needles to IDUs is not yet sanctioned by national authorities.
Peer-based approaches	Yes (limited)
Supply reduction	
	The primary aim of the National Narcotics Board is to prevent and control drug use, particularly among Indonesian youth, and to protect the general public from the harmful consequences of drug use and illicit drug trafficking.
Crop eradication	Crop eradication (cannabis) has been undertaken periodically in Aceh; however, this has been postponed since the mid-1990s due to various security constraints in this region.

Demand reduction	School-based drug prevention education programs and government-sponsored programs to mobilise communities for drug prevention. Treatment and rehabilitation for drug users remain a focus for the government and NGO sector, but demand for assistance is vast: there is only one government hospital in the country that specialises in treatment for those with substance-related disorders.
Treatment	Various drug treatment approaches have been implemented including medical detoxification, therapeutic communities, substitution programs, residential chemical dependency programs, and recently the introduction of drug treatment into correctional and detention centres. All government mental hospitals, teaching and general hospitals need to provide 10% of their bed capacity for drug users. There has been a surge in the number of privately owned treatment centres.
Voluntary or self-referral	Yes
Compulsory	No
Methadone for detoxification	No
Substitution therapy	Yes (limited)
Most common type of treatment provided	Medical detoxification and therapeutic communities
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.5.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Five liaison officers	AFP						Bali (1), Jakarta (4)
MOU with Indonesian National Police	AFP				June 2002		
Transnational Crime Coordination Centre	AFP			Intelligence sharing and investigation capacity			
Indonesia Australia Specialised Training Project, Phase 2	AusAID			Training – to strengthen good governance	Oct 1999 – Dec 2004 (completed)	\$1,313,000	
Indonesia HIV/AIDS Prevention and Care Project, Phase 2	AusAID	CHR		HIV/AIDS	2002–2007	\$34,000,000	
HIV Prevention among Vulnerable Groups	AusAID			HIV	July 2004 – June 2005	\$46,000	

2.5.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Harm Reduction Advocacy in Indonesia	USAID – Family Health International	Centre for Harm Reduction/AHRN Indonesia	3 years	Advocacy and technical assistance			

2.6 Laos

Population: 6,068,117

2.6.1 Overview of recent drug trends

Opium remained the most commonly used drug in the Lao People's Democratic Republic (PDR) until recently. Patterns and numbers of opium use have remained similar over the past few years, with typical consumers being male farmers living in the north and north-west provinces of the Lao PDR.

Recent evidence points toward a rapid increase in the use of amphetamine-type substances (ATS) in the Lao PDR. Young people tend to prefer ATS over opium. Studies involving school-based youth reported an average age of initiation for ATS use being about 16 years of age. Other studies suggest that ATS is also commonly consumed by sex workers, clients at discos, and by unemployed youth in Vientiane. While cannabis is also used in the Lao PDR, the extent of its use is unclear.

2.6.2 Prevalence of drug use

The overall number of drug users in the Lao PDR has not been estimated. The Lao Government estimates that there are currently about 28,000 opium users. Studies involving school-based youth suggest that lifetime prevalence of drug use ranged from about 17 per cent in the capital to about 5 per cent in the provinces. The same study reported that 7 per cent of youth surveyed in Vientiane used an illicit drug at least monthly. Overall, use of ATS is thought to surpass opium use.

2.6.3 Drug supply

Despite continued efforts to eradicate the cultivation of opium poppies in the Lao PDR, it remains the third-largest producer of opium in the world. In 2004, cultivation was confirmed in 11 out of the 17 provinces in the Lao PDR. Cannabis is also thought to be widely produced in the Lao PDR, although, unlike opium, most is destined to markets in neighbouring countries or to supply international networks.

Laos is a transit country for heroin and ATS as well as equipment and precursor chemicals used in ATS production. The majority of these commodities enter from Myanmar and China. While local production of heroin or ATS has not been found in recent years, a growing domestic market and increased regional law enforcement control preventing drugs from entering the country suggest that local production is likely if not already occurring.

2.6.4 Drug-taking practices, risk factors and trends

As stated above, there is increasing use of ATS in the Lao PDR, especially among urban youth. The public health ramifications of increased ATS use are not totally clear; however, there has been an increase in the number of drug-related mental health hospital admissions in Vientiane recently. There is also speculation of increased HIV vulnerability associated with increased sexual risk and ATS use.

While injecting drug use is thought to be limited in the Lao PDR, there are increasing reports of blackwater opium and heroin injection, and evidence that some groups are injecting ATS. The most common route of administration for both opium and ATS is smoking, although many also report ingesting ATS.

2.6.5 Summary table

Estimated number of current drug users	Unknown (estimated 50,000–70,000)
Main drugs used	Opium, ATS, cannabis and prescription drugs
Drugs injected	Heroin, blackwater opium, ATS
Estimated prevalence of HIV infection among IDUs	Unknown

2.6.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to ACCORD 'drug-free ASEAN by 2015' strategy
National drug control policy	Based on the implementation of three strategies: prevention and rehabilitation of drug users, alternative options for illicit crop farmers, enforcement of adequate laws to fight against drug traffickers. Overall goal is to eliminate opium production by 2005.
Main drug control legislation	Article 135 of the Criminal Code on Drug Trafficking
Drug control policy lead agency	The Lao PDR National Commission for Drug Control and Supervision
Law enforcement bodies	Counter-Narcotics Office
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	Unclear
Harm reduction	
	Very few harm reduction services exist for drug users in the Lao PDR.
Needle and syringe programs (NSPs)	No
Peer-based approaches	Yes, but limited to Vientiane with abstinence-based focus.
Supply reduction	
	Crop eradication and alternative development are a major focus of supply reduction in the Lao PDR with the goal to eliminate opium cultivation by 2005 clearly stated.
Crop eradication	Yes

Demand reduction	Demand reduction in the Lao PDR is geared toward total abstinence from drugs. Methods include detoxification treatment, primary education and harsh penalties for drug use.
Treatment	
	Drug treatment is provided through government facilities (i.e. hospitals) as well as through private clinics. Detoxification of an opium user usually involves administration of tincture of opium and herbal medicine over a 15–42 day period at an in-patient detoxification centre.
Voluntary or self-referral	Yes
Compulsory	Yes
Methadone for detoxification	Yes
Substitution therapy	No
Most common type of treatment provided	Detoxification
Primary prevention	Yes. Life skill and drug education introduced to all primary schools
School-based education	Yes
Community education	Yes

2.6.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Health risks of ethnic groups along the Lao–Thai border: social and economic consequences of the National Road 3 construction	Rockefeller Foundation	Department of Anthropology, Macquarie University	2 years	Research the health risks of ethnic groups along the Lao–Thai border: social and economic consequences of the National Road 3 construction	2005–2007		

2.6.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Beng Alternative Development Micro-Project		UNODC Laos		Income generation Reduced opium cultivation Detoxification			Beng, northern Lao PDR
Drug control capacity building in the Lao PDR		UNODC Laos		Establishing national drug control regulation and data collection systems			National
Drug supply and demand reduction in border areas of the north-western Lao PDR		UNODC Laos		Reduce opium production and consumption among ethnic minorities in the highlands communities of Luang Namtha Province			Border areas of the north-western Lao PDR
United Nations Nonghet Alternative Development Project		UNODC Lao		Reduction of opium consumption through alternative development and treatment			
Lao–American Project		Multiple	Ongoing	Rural development Drug treatment Law enforcement		\$2 million (2004 financial year)	National
Drug Use and HIV Risk Reduction	UNODC	Burnet Institute, Laos	3 months	Assess extent of ATS use in three provinces. Assess extent of ATS use and HIV implications in three provinces. Assess the level of injecting drug use in three provinces.	2005		Phongsali Luang Namtha Bolikhamsay

2.7 Macao

Population: 425,286

2.7.1 Overview of recent drug trends

The dominant drug of choice is heroin. However, many drug users consume cannabis, methamphetamine, ketamine, cocaine and various other pills, usually amphetamine-type substances – mainly ecstasy, MDMA and a variety of sedatives. Statistics indicate that heroin use has been declining in recent years.

2.7.2 Prevalence of drug use

In 2003, 634 drug users were registered with the authorities, an increase of 18 per cent compared to 2002. No formal estimates exist of overall numbers of drug users, but a recent study suggested there were about 3700 heroin users, or 0.87 per cent of the population. There may be as many as 900 injecting drug users (IDUs), but this is likely to be an under-estimate considering that most heroin users are injectors.

2.7.5 Summary table

Estimated number of current drug users	Unknown, but an estimated 3700 heroin users and 500–900 injecting drug users
Main drugs used	Heroin, cannabis, 'ice', methamphetamine, ketamine, cocaine and various other pills usually of ATS quality, mainly ecstasy, MDMA and sedatives
Drugs injected	Heroin
Estimated prevalence of HIV infection among IDUs	Unknown. In 2004, there were 18 HIV cases among IDUs, comprising 60% of the total.

2.7.3 Drug supply

There is no evidence to indicate that Macao is a drug-producing country. Main sources of illegal drugs entering Macao are mainland China, Hong Kong and other parts of South-east Asia. Most narcotics originate from the Golden Triangle. Adolescent drug users are crossing into mainland China, particularly Guangdong Province, for drug trafficking and consumption.

2.7.4 Drug-taking practices, risk factors and trends

The favoured method of administering heroin is injecting, followed by fume inhalation. Ketamine and ecstasy are usually ingested and most drink alcohol with these drugs. The sharing of needles among IDUs is common practice: most have difficulty accessing injecting equipment at night when stores and pharmacies are closed. In 2001, there were 13 HIV cases among IDUs, 5 per cent of the total. In 2004, there were 18 HIV cases among IDUs, 60 per cent of the total. This significant proportion among this group of people has become a matter of concern for public health authorities. Hepatitis C prevalence among IDUs has been reported at 69 per cent and hepatitis B infection at 13 per cent. Information about sexual risk behaviours was not available.

2.7.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions
National drug control policy	Aimed at supply control and demand reduction. Includes legislative means and implementing the law to stop crimes associated with drugs; and to focus on prevention and treatment of drug dependence.
Main drug control legislation	Act 4/2001 governs 19 drugs and psychotropic substances.
Drug control policy lead agency	Implemented by public entities, under the supervision of the Under-Secretaries for Administration and Justice; Security (related departments include Public Security Police, Judicial Police, Marine Police and Macao Prison) and Social Affairs and Culture (related departments include Health Bureau and Social Welfare Institute).
Law enforcement bodies	Judicial and Security Police
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	Yes
Harm reduction	
	Harm reduction is not well accepted but recently limited substitution therapy has been implemented for HIV-positive drug users.
Needle and syringe programs (NSPs)	No
Peer-based approaches	Exist but limited
Supply reduction	
	The Narcotics Section of the Macao Judicial Police is responsible for issues of drug trafficking, drug use and also planning for the larger operations to prevent drug-related activities. Its missions are supported by other security agencies. The Judicial Police has its own anti-trafficking section and over the past 40 years they have played an important role in the suppression of drug trafficking and consumption.
Crop eradication	No
Demand reduction	
	The Department for Prevention and Treatment of Drug Dependence of the Social Welfare Institute is responsible for the planning and execution of anti-drug prevention and treatment work.

Treatment	In the Government's primary detoxification unit in-patient treatment usually lasts 14 days, in which clonidine and buprenorphine therapies are provided. NGOs follow the traditional 'spiritual' detoxification model of massage, hot baths and prayer.
Voluntary or self-referral	Yes
Compulsory	No (although if convicted of drug use, drug users can be sent to a prison where a special unit has been established).
Methadone for detoxification	No
Substitution therapy	Limited to HIV-positive drug users
Most common type of treatment provided	Traditional detoxification, often with medication in government facilities but often no medication in NGO system. Post-treatment rehabilitation provided.
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.7.7 Australia's involvement – NA

2.7.8 International involvement – NA

2.8 Malaysia

Population: 23,522,482

2.8.1 Overview of recent drug trends

Although amphetamine-type substances (ATS) (mainly in the form of crystalline methamphetamine) are increasingly popular and appearing to be more accessible in 2003, heroin followed by cannabis are the most common illicit drugs for which people sought and received treatment. Ecstasy use is established but widespread use is unclear.

2.8.2 Prevalence of drug use

There are varying estimates of the number of illicit drug users in Malaysia, none particularly methodologically sound; the current literature suggests an increasing number of people using illicit drugs. In 2002, the National Drug Agency estimated more than 350,000 drug users in the country, with the media in 2004 citing government sources reporting figures ranging from 400,000 to 500,000. In 2003, there were 36,996 registered drug users. From January to March 2004 there were 1931 new cases of drug users registered per month. In 2004, the UN Reference Group on drug injecting issues suggested 150,000 to 240,000 injecting drug users (IDUs) with a middle-range figure of 195,000.

2.8.3 Drug supply

Malaysia is not a major producer of illicit drugs. However, its close geographical proximity to the Golden Triangle and other Southeast Asian countries that produce heroin and ATS has ensured that the supply of illicit drugs entering the nation is substantial. Drug trafficking through Malaysia most often stems from Golden Triangle countries, with trafficking overland across the long border that Malaysia shares with Thailand, or through various and extensive sea routes between the two countries.

2.8.4 Drug-taking practices, risk factors and trends

On average, drug users progressed from smoking and 'chasing' to injecting over a period of two to five years. Generally the timeframe had shortened. When the quality of heroin decreases, the trend in Kuala Lumpur is to 'chase' and to mix the heroin with methamphetamine. There is widespread sharing of needles and syringes, often 60 per cent and greater, as well as of other injecting paraphernalia. Most drug users are aware of the dangers of being identified by law enforcement officers and are reluctant to be caught in possession of injecting equipment, or purchasing such equipment from a pharmacy. Drug users are frequently sexually active and at risk. One study found, among nearly 2000 respondents in 16 rehabilitation centres, 64 per cent were sexually active, of whom 90 per cent did not use condoms; 20 per cent of the respondents were HIV infected and, of these, 81 per cent shared needles and 28 per cent reported being sexually active. The HIV epidemic in Malaysia has for over 15 years primarily affected IDUs; from 1986 to 2002, 76 per cent of all HIV/AIDS cases were found among IDUs. Of the 6756 HIV infections reported in 2003, 75 per cent were among IDUs.

2.8.5 Summary table

Estimated number of current drug users	350,000–500,000; of these, there are 150,000–240,000 injecting drug users.
Main drugs used	Heroin, amphetamine-type substances, cannabis, ketamine
Drugs injected	Heroin, and possibly methamphetamine
Estimated prevalence of HIV infection among IDUs	In 2003, 75% of all HIV/AIDS notifications found among IDUs.

2.8.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to the ASEAN declaration for a drug-free ASEAN by 2015.
National drug control policy	Revised in 1996 with a series of new strategies and priority areas of prevention, enforcement, treatment and rehabilitation, and regional and international cooperation. The prevention strategy is focused on efforts to create an environment to protect individuals and the community from drug use.
Main drug control legislation	<i>Dangerous Drugs Act 1952</i>
Drug control policy lead agency	National Narcotics Agency
Law enforcement bodies	Royal Malaysian Police, Narcotics Department
Drug use addressed in last National HIV/AIDS Plan	Yes, but overall a poor response to implement programs
Possession of N&S unlawful	Yes
Harm reduction	
	Overall, harm reduction is not accepted. However, recently there has been an increased acceptance of substitution therapies.
Needle and syringe programs (NSPs)	No
Peer-based approaches	Yes (restricted and limited in scope)

Supply reduction	The focus is on striving to eliminate the supply of illicit drugs and create a drug-free Malaysia by 2015. The strategy is to strengthen law enforcement measures to curb illicit drugs entering the country. Another important approach is imposing severe penalties to possess, supply, traffic or use drugs.
Crop eradication	No
Demand reduction	In 2004, there were 28 government-funded drug rehabilitation centres (DRCs). In addition to the DRCs there were 60 private drug rehabilitation centres approved by the National Drug Agency, and 121 private clinics approved by the Ministry of Health to treat drug users. The goal is to eliminate drug dependency and prevent recidivism. Treatment overall tends to last for two years. There is a major movement to encourage people to reject use of drugs and mobilise the community towards drug abuse prevention programs.
Treatment	Since the early 1990s the DRCs have modelled themselves loosely on a therapeutic community. There have been calls since the early 1980s to develop more flexible and individualised programs for those confined to an institutional setting but this has not been adopted; a military approach and minimal concern for innovation are the norm.
Voluntary or self-referral	Yes
Compulsory	Yes
Methadone for detoxification	No
Substitution therapy	Yes (limited)
Most common type of treatment provided	Therapeutic community model with a military approach
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.8.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Three AFP liaison officers	AFP						Kuala Lumpur
MOU between the AFP and the Royal Malaysian Police is awaiting signature	AFP						

2.8.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Implementing a community outreach program among drug users	ILO	Universiti Sains Malaysia	2 years	Outreach Treatment and rehabilitation			
Implementing a community outreach program among drug users	WHO	Universiti Sains Malaysia	2 years	Outreach			

2.9 Myanmar

Population: 42,720,196

2.9.1 Overview of recent drug trends

Opium, heroin and amphetamine-type substances (ATS) are the most commonly used drugs in Myanmar. The use of cannabis, codeine and tranquillisers has also been reported but to a lesser extent. Heroin use predominates in the Kachin State, Northern Shan State and in the major cities, while opium use is more common in Eastern and Southern Shan State and in the Kayah State. Arrest and seizure data suggest that drug use is mainly a male phenomenon.

2.9.2 Prevalence of drug use

There were 62,000 registered drug users in Myanmar in 2002; however, this figure is considered to be a drastic underestimation of the overall number of drug users in the country. Estimates of the total number of drug users in Myanmar range between 300,000 and 400,000 people, of which about 140,000 use injection as their preferred method of administration.

In studies involving school-attending youth, about 15 per cent of students reported using drugs in their lifetime with non-prescribed cough medicine (9%), diazepam (4%) and cannabis (2%) being the most commonly reported.

There is an overall trend toward increased drug use in Myanmar.

2.9.3 Drug supply

Myanmar is the world's second-largest producer of opium and is thought to be one of the largest producers of ATS. In 2004, Myanmar produced 370 metric tonnes of opium and approximately 700 million ATS tablets, which corresponds to about 7.5 per cent of total global manufacture.

Sustained crop eradication efforts have consistently reduced the overall quantity of opium produced in Myanmar over the past 10 years. Opium cultivation has also been banned by leaders in the autonomously controlled special regions 1 and 2.

The reduction in opium production and disruption of some drug trafficking groups have corresponded with a reduction in the amount of heroin seized recently. ATS production grew rapidly in Myanmar from 1996 with a peak in 2001. Production is thought to have remained stable since then.

2.9.4 Drug-taking practices, risk factors and trends

As opium becomes less available, a number of new trends are emerging among drug users in Myanmar. There is a shift toward ATS and heroin use and rapid uptake of injecting as the preferred method of administration for heroin.

The greatest risk associated with IDU in Myanmar is HIV. It is estimated that about 30 per cent of all HIV cases in Myanmar are IDUs with HIV prevalence of 50–90 per cent among this group.

Needle sharing is the norm in Myanmar. Factors such as poor access to clean needles and poor knowledge about HIV lead many IDUs to share their injecting equipment.

2.9.5 Summary table

Estimated number of current drug users	300,000–400,000 (~140,000 IDUs)
Main drugs used	Heroin, opium, methamphetamines, cannabis, codeine and tranquillisers
Drugs injected	Heroin, sometimes mixed with tranquillisers
Estimated prevalence of HIV infection among IDUs	70%

2.9.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to ACCORD strategy for a drug-free ASEAN by 2015
National drug control policy	15-Year Narcotic Drug Elimination Plan
Main drug control legislation	<i>Narcotic Drugs and Psychotropic Substances Law</i> of 1993
Drug control policy lead agency	Central Committee for Drug Abuse Control (CCDAC)
Law enforcement bodies	CCDAC / Myanmar police force / Special anti-narcotics squads
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	Yes
Harm reduction	
	Several harm reduction programs operate in Myanmar. They include work with both non-government and government organisations.
Needle and syringe programs (NSPs)	Yes (limited)
Peer-based approaches	Limited
Supply reduction	
	Supply reduction is a major focus of both the Myanmar Government and the international community. Crop eradication and alternative development projects operate in Myanmar.
Crop eradication	Yes

Demand reduction	Demand reduction is a pillar of the national drug policy and involves mass media campaigns as well as school-based education, all focused toward abstinence from drugs.
Treatment	Involves a 42-day detoxification regime consisting of decreasing doses of tincture of opium together with some medicines for symptomatic relief of opium withdrawal. Only opioid-dependent patients are admitted to treatment.
Voluntary or self-referral	Yes
Compulsory	Yes
Methadone for detoxification	Yes, but limited
Substitution therapy	Limited pilot studies
Most common type of treatment provided	Detoxification
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.9.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
AFP				Two liaison officers in Yangon			
Burnet: Youth HIV/AIDS Training Facility	AusAID	Burnet Institute	3 years	Basic health and HIV/AIDS-related activities	Feb 2003 – April 2006	\$742,600	National
TEAR: Community Health Options Kachin	AusAID		3 years	<p>1. Build the capacity of local communities in Kachin and Northern Shan States to identify and address common priorities for improved health.</p> <p>2. In partnership with communities, develop and improve sustainable practices in primary health care, including effective approaches to HIV/AIDS and substance abuse issues.</p>	2001–2004 (project completed)	AusAID contributed \$598,860 over 3 years (the project's total budget was \$798,440)	
Food Assistance to Vulnerable Communities in Northern Shan State	AusAID	World Food Program		Increase food security Alternative development	2003–2004 (completed)	\$855,000	

2.9.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Joint program for HIV/AIDS Myanmar (joint funding mechanism coordinated through United Nations Expanded Theme Group on HIV/AIDS)	1. FHAM (Fund for HIV/AIDS Myanmar), UK (DFID), Norway, Sweden 2. Global Fund for HIV/AIDS, Malaria and TB	UNODC Myanmar (AD/RAS/02/G22) Medicines du Monde CARE International Asian Regional Harm Reduction Network Burnet Institute, Centre For Harm Reduction Central Committee for Drug Abuse Control Myanmar Anti Narcotics Authority		Broad range of service provision around drug use, including: <ul style="list-style-type: none"> • rapid assessment and baseline survey • needle and syringe programs • drug education • drug treatment • outreach • advocacy • technical support and coordination • development of IEC materials • training/ capacity building 	2 years (2004–2005) but will be extended	Total \$21.3 million \$15.7 million \$823,000 \$4.7 million \$19,221,525 approved for HIV/AIDS in March 2005	
Technical assistance to FHAM and non-FHAM partners working with drug users and their communities	FHAM	Burnet Institute, Centre for Harm Reduction	2 years	Technical assistance	2004–2006	\$400,000	National
AHRN – FHAM	FHAM	AHRN Myanmar	2 years	Technical assistance Implementation Advocacy	2004–2006		National
Technical assistance to the Department of Health	WHO	WHO, Myanmar	1 year	Technical assistance			
Establishment of a pilot methadone program	WHO	WHO, Myanmar	2 years	Treatment Technical assistance			
AD/MYA/04/H75	UNAIDS	UNODC Myanmar	1 year	Advocacy, technical assistance, education	June 2004 – May 2005		

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
AD/MYA/O3/G54 Reducing injecting drug use and its harmful consequences in the Union of Myanmar	European Union	UNODC Myanmar Medicines du Monde CARE International	3 years	Harm reduction, capacity building, treatment and support	2004–2007	\$1.1 million	National
RAS/C25 Drug control and development in the Wa region of the Shan State		UNODC		Policing and law enforcement, crop eradication Alternative development	2004–2007	\$6.4 million	Wa region of the Shan State
MYA/G45 Providing food security through irrigation and land development in the Mong Kar township		UNODC		Agricultural development	2004–2007	\$275,000	Mong Kar township
MYA/G43 Illicit crop monitoring in Myanmar		UNODC		Monitoring	Ongoing	\$600,000 from 2004	National
Shan Monk Training		Chiang Mai Centre for Harm Reduction		Training	2004	\$50,000	Shan State
Global Fund for HIV/AIDS, Malaria and Tuberculosis	Multiple	Multiple	5 years	Strengthen the prevention and control of HIV and malaria in the Union of Myanmar	2004? Yet to commence	\$19 million	National

2.10 Philippines

Population: 84,241,341

2.10.1 Overview of recent drug trends

The main drug of abuse is crystal methamphetamine hydrochloride, locally known as '*shabu*'. Domestically grown cannabis is the second most frequently abused drug, followed by cough and cold preparations, benzodiazepines and inhalants. Ecstasy is becoming increasingly popular as a drug of abuse.

2.10.2 Prevalence of drug use

The Dangerous Drugs Board is completing the 2004 National Household Survey on the Nature and Extent of Drug Abuse. As a result, 1999 figures are reported here. As a percentage of the 1999 population (79,345,812): 4.3 per cent were current users of illicit drugs, 2.2 per cent were regular users of illicit drugs, and 2 per cent were occasional users of illicit drugs.

2.10.3 Drug supply

The Philippines serves as a transit point for and producer of crystal methamphetamine and cannabis. In 1997, Philippine law enforcement dismantled 32 laboratories, a total of 2057 kilograms of shabu were recovered. Wild growth of cannabis occurs in the mountainous regions in the Philippines, generally cultivated in areas that are inaccessible by vehicles and/or are controlled by insurgent groups. Ecstasy is imported and used in the Philippines, regardless of its high price. Likewise, cocaine also enters the Philippines for transshipment and personal use, but at much lower levels than methamphetamine.

2.10.4 Drug-taking practices, risk factors and trends

The Philippines has one of the lowest rates of HIV infection in Asia. Unlike other countries in Southeast Asia, injecting drug use has not made a substantial contribution to reported HIV infections and AIDS cases in the Philippines. It is generally accepted that shabu is not injected – the mode of ingestion

is inhalation. The Behavioural Baseline Survey on HIV/AIDS among injecting drug users in the cities of Mandaue, Lapu-Lapu and Cebu (2005) reported that 58 per cent of those interviewed injected drugs more than once per day and the majority (71%) of respondents used needles and syringes used by others. Aside from injecting nubain, the respondents also used shabu, cannabis and cough syrup.

2.10.5 Summary table

Estimated number of current drug users	In 1999, an estimated 1.8 million people were regular illicit drug users.*
Main drugs used	Shabu (methamphetamines) and cannabis
Drugs injected	Injecting drug use in the Philippines is reported to be very limited.
Estimated prevalence of HIV infection among IDUs	Based on the National HIV Sentinel Surveillance System of the National Epidemiology Centre (DoH), no drug-related HIV case was recorded in 2003.

* A regular user is defined as having used illicit drugs once or twice per week for the six months prior to participating in the survey.

2.10.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions
National drug control policy	The Philippine National Drug Control Strategy – its vision is to attain a drug-free Philippines by 2010. A three-pronged approach is planned to accomplish this objective: supply and demand reduction campaign, development/reform package, and people empowerment campaign.
Main drug control legislation	<i>Comprehensive Dangerous Drugs Act 2002</i>
Drug control policy lead agency	Dangerous Drugs Board
Law enforcement bodies	Philippine Drug Enforcement Agency
Drug use addressed in last National HIV/AIDS Plan	Unclear
Possession of N&S unlawful	Under Section 12 of the <i>Comprehensive Dangerous Drugs Act</i> , possession of equipment, instrument, apparatus and other paraphernalia for dangerous drugs syringes is unlawful and can be used as evidence of drug use.
Harm reduction	
	Harm reduction interventions are limited and remain as pilot projects.
Needle and syringe programs (NSPs)	A small-scale NSP is operating in Cebu.
Peer-based approaches	The current STI/HIV/AIDS harm reduction program is anchored on a community outreach peer education system, although there is only one in the country.
Supply reduction	
	Supply reduction campaign led by the Philippine Drug Enforcement Agency
Crop eradication	Yes (cannabis)

Demand reduction	The supply/demand campaign consists of prevention and control measures against the production, processing, trafficking, financing, retailing and consumption of dangerous drugs, controlled precursors and essential chemicals and plant sources of dangerous drugs; so as to make illicit drug trade unprofitable and thereby accomplish the first national objective.
Treatment	Treatment stays are usually for 45 days. The government treatment centres subsidise treatment fees. Detoxification is delivered by some non-government treatment centres; however, 'cold turkey' is the standard approach. The average length of stay in a rehabilitation centre (government) is six months.
Voluntary or self-referral	Yes
Compulsory	Yes
Methadone for detoxification	No
Substitution therapy	No
Most common type of treatment provided	12 steps model
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.10.7 Australian involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
One liaison officer and an adviser in Manila	AFP			Law enforcement			
MOU with the Philippines National Police, Philippines Drug Enforcement Agency, and Philippines National Investigations Bureau	AFP			Law enforcement	July 2003		
Philippines Centre on Transnational Crime	AFP			Law enforcement	April 2004		

2.10.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Mid-Term Evaluation Meeting on F34 Project (PECs Control)	UNODC	Dangerous Drugs Board and PDEA					
Mid-Term Evaluation Meeting on the National Action Plan (NAP) relative to PECs Control	UNODC	Dangerous Drugs Board and PDEA					
Formulation of video documentary concerning PECs control in the Philippines	UNODC	Dangerous Drugs Board					
Scholarship programs for trainings/workshops	JICA, JICWELS, Colombo DAP and counterpart agencies			Training	2004		
International meetings, workshops, training courses	Colombo Plan Secretariat Advisory Programme UNODC and the Japan International Cooperation Agency						
Training	US Drug Enforcement Agency; Narconon						
AIDS Surveillance and Education Project	USAID	Department of Health, WHO, PATH, local government units, NGO partners		Behavioural and serological surveillance for 10 cities Prevention programs with high risk groups in 8 cities	Completed Sept 2003		
AIDS Surveillance and Education Program /LEAD LGU project	USAID	MSH in collaboration with DOH and LGUs manage surveillance & education activities		Behavioural and serological surveillance and prevention programs with high risk groups in 8 cities	Started Jan 2004		

2.11 Thailand

Population: 64,865,523

2.11.1 Overview of recent drug trends

According to a recently conducted national household survey, the most commonly used drugs in Thailand are amphetamine-type substances (ATS), followed by cannabis, kratom and inhalants. While heroin and opium use is common in some demographics (especially in the northern hill region bordering Myanmar and Lao PDR), they are not used significantly at a whole-population level. Limited use of ecstasy, cocaine and ketamine as well as of pharmaceutical drugs such as cough medicine and benzodiazepines has also been reported.

The overall number of drug users is thought to have reduced recently, but due to changes in reporting protocols evidence to support this claim is lacking.

2.11.2 Prevalence of drug use

Estimates of the number of drug users in Thailand range from between two million to three million people or about 5 per cent of the population. Drug use appears to be a mainly male phenomenon. Younger people tend to use more ATS and other stimulant drugs such as cocaine and ecstasy, while older drug users tend to use opium and heroin.

Estimates of the number of injecting drug users range from 48,000 to 240,000, with estimates towards the conservative end of this figure more plausible.

2.11.3 Drug supply

While drug production in Thailand has decreased over the past decade, opium and cannabis are still grown and amphetamine-type substances are still produced. The majority of heroin, ATS, cannabis, opium, MDMA, ketamine and cocaine is imported into Thailand, with opium, heroin and ATS thought to be sourced from Myanmar. Thailand's opium cultivation accounts for only about 1 per cent of the total crop cultivated in the region. Thailand serves as an important transit point for international drug trafficking.

2.11.4 Drug-taking practices, risk factors and trends

Methods of drug use in Thailand have remained stable in the past few years. While there are limited reports of injecting ATS, most ATS and opium users report smoking or ingestion as their preferred method of use. Heroin remains the most commonly injected drug in Thailand; however, there are increasing reports of other drugs such as domicom

being injected either in isolation or more commonly to enhance the effects of heroin. IDU and imprisonment remain significant risk factors for HIV in Thailand.

Increased mental and sexual health risks associated with ATS use, especially among young users, have also been reported in Thailand. Recent studies suggest that heroin injection is more prominent in southern Thailand than previously thought.

2.11.5 Summary table

Estimated number of current drug users	2–3 million (50,000–100,000 IDUs)
Main drugs used	ATS, cannabis, kratom, inhalants and opium and heroin
Drugs injected	Heroin and ATS
Estimated prevalence of HIV infection among IDUs	30–50%

2.11.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to ACCORD strategy of a drug-free ASEAN by 2015
National drug control policy	'War on Drugs' Policy
Main drug control legislation	<i>Drug User Rehabilitation Act 2002</i>
Drug control policy lead agency	Office of the Narcotics Control Board
Law enforcement bodies	Thai Police
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	Yes
Harm reduction	
	Limited harm reduction services operate in Thailand, these include pilot NSPs, drop-in centres and peer outreach.
Acceptance of HR approach	Uncertain
Needle and syringe programs (NSPs)	Yes (limited)
Peer-based approaches	Yes
Supply reduction	
	Supply reduction is focused on law enforcement efforts directed at drug selling, production and trafficking.
Crop eradication	Yes

Demand reduction	A major focus of Thailand drug policy is encouraging drug users into treatment. Treatment involves medical treatment as well as both mental and physical rehabilitation.
Treatment	There are official treatment centres and many programs run by public and private hospitals, as well as private clinics and NGO programs. In 2003, many drug users were treated in short-term military-style camps where physical activity, discipline and absence from drugs were enforced. Some monasteries conduct detoxification programs that combine spirituality and meditation.
Voluntary or self-referral	Yes
Compulsory	Yes
Methadone for detoxification	Yes
Substitution therapy	No
Most common type of treatment provided	Detoxification and military-style camps
Primary prevention	Yes
School-based education	Yes
Community education	Yes

2.11.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
The AFP has three liaison officers and two advisers in Bangkok and one liaison officer in Chiang Mai. One AFP officer is also seconded to Interpol in Bangkok.	AFP			Law enforcement			Bangkok, Chiang Mai
WHO Alcohol, Smoking and Substance Involvement	Australian Department of Health and Ageing	Drug and Alcohol Services South Australia (DASSA)	3 years	Outreach, treatment, education	2003–2006		Thailand (+ Australia, Brazil, India, USA and Spain)
Pilot Project Akha Hill Tribe	AusAID	Family Health International		Treatment and service provision			

2.11.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
ICPO / Interpol				International Criminal Police Organization / Interpol office for Southeast Asia is located in the Royal Thai Police, Bangkok			
Care and support to people living with HIV/AIDS	Family Health International	AIDS Access Foundation Thailand	1 year	Treatment, support, education and advocacy	March 2005 – Feb 2006		
Shan Outreach Project	Johns Hopkins University	Chiang Mai Centre for Harm Reduction	6 months ending May 2005 (seeking extension)	Education, prevention, outreach	2005	\$20,000	
Peer Intervention Trial amongst injectors in northern Thailand	Johns Hopkins University	Chiang Mai University Research Institute for Health Sciences	3 years	Research and HIV prevention	2002–2005		
O-zone Drop-in Centre		Population Services International (Thailand)		Drop-in centre			
Global Fund for HIV/AIDS, Malaria and Tuberculosis	Global Fund	Thai Drug Users Network		Advocacy and harm reduction	2005–2007		

2.12 Timor-Leste (East Timor)

Population: 1,019,252

2.12.1 Current illicit drug situation

For the current review, the World Health Organization, the United Nations Development Programme, UNICEF, Family Health International and the Ministry of Health were contacted in order to assess the current illicit drug situation in Timor-Leste.

The following is a summary of their responses:

- No data have been collected on the illicit drug situation in Timor-Leste.
- Illicit drug issues are not considered a priority in Timor-Leste at this time.
- There are too many immediate life-threatening illnesses and determinants of health to address in the short term.
- There is some discussion of the quantities of locally brewed alcohol consumed by individuals but not to the point that it is part of the public health agenda.
- There are no indicators that the situation has or could change from the current very low levels of substance abuse, especially intravenous drugs.

2.12.2 Drug-taking practices, risk factors and trends

HIV is present in Timor-Leste, but it has not spread widely. Prevalence is low, at 0.64 per cent of the adult population (2002). However, the prevalence of HIV among sex workers in Dili has been reported to be 3 per cent, with 15 per cent having curable sexual infections such as gonorrhoea and chlamydia. Over half of the sex workers involved in this study had not heard of AIDS, four out of ten did not recognise a condom, and none consistently used one. To date, the response to preventing an HIV epidemic in Timor-Leste has focused on the sexual transmission of the virus with little or no mention of injecting drug use. Findings from a study team in Dili are concerning because the prevalence of injecting drug use in the university student sample was 3 per cent.

In Australia, according to the Australian Institute of Health and Welfare, the proportion of people aged 14 years and over who have ever injected drugs is 1.9 per cent and who have recently injected (last 12 months) is 0.4 per cent (n = 811,920; Aust pop 2005 – 20,298,022).

2.12.3 Australia's involvement: Australian Federal Police

On 5 July 2004, the AFP and AusAID mobilised a team of police advisers into Dili as part of the Timor-Leste Police Development Program. The team comprises six AFP officers and six advisers. The purpose of the Program is to assist the Timor-Leste Police to promote and maintain a safe, stable environment in Timor-Leste, which will contribute to economic and social development and sustainable poverty reduction. The AFP has one liaison officer in Dili. (The liaison officer has liaison and intelligence-gathering functions regarding transnational crime while the focus of the mission is capacity building.)

2.12.4 International involvement – NA

2.13 Vietnam

Population: 82,689,518

2.13.1 Overview of recent drug trends

The drug of choice is heroin among the youth, particularly in the urban centres, while opium use remains popular mainly among the elderly and ethnic minority groups in rural areas, especially in the north-west regions. Other drugs used include cannabis, MDMA and methamphetamine, with the last two becoming increasingly popular nationwide. The use of MDMA and methamphetamines is not confined to youth, but is expanding into the general population. Cannabis is used but its popularity is not widespread. Cocaine is seldom used, probably due to poor availability. The use of glue as an inhalant appears to be increasing. 'Blackwater opium' is still used and injected by older users. A variety of pharmaceuticals are used to enhance the effects of opium or heroin.

2.13.2 Prevalence of drug use

Estimations of the number of drug users vary. Nevertheless there is agreement that the number of registered drug users is increasing each year. Figures released by the Ministry of Public Security in 2004 showed 170,400 registered drug users nationwide. There are no official estimates available on how widespread drug use is in the general population, but the real figure is far greater than those that have registered, according to many sources. The number of injecting drug users (IDUs) is elusive, but recently reported estimates range from a low of 70,000 to a high of 156,000 with a mid-range of 113,000.

2.13.3 Drug supply

As of 2003, it was reported that 1000 hectares of opium poppy were under cultivation. This is said to be mostly cultivated by ethnic minorities for local use: mainly by Hmong highlanders, in the provinces of Lai Chau, Son La, Nghe An and other north-western and central provinces bordering Laos and China. Cannabis is grown in remote parts of the Mekong Delta in the south and in some north-western highland areas, especially those bordering Laos and China. While most is grown for commercial hemp, some is cultivated for illicit consumption.

The production and stockpiling of amphetamine-type substances (ATS) are relatively new practices, found mainly in large cities. There is a trade in illegal harvesting of sassafras trees, which produce an essential oil called safrole, a precursor chemical for MDMA production. Other precursor chemicals used in the production of illicit drugs are known to have origins in Vietnam. While Vietnam does not produce substantial amounts of illicit drugs, it has for some years been an important transit country, but imported drugs are increasingly servicing the domestic market. Most heroin and some opium enter the country from the Golden Triangle, from either Thailand or Laos.

2.13.4 Drug-taking practices, risk factors and trends

The favoured method of administration for heroin is injecting, a method that appears to be increasing. The pooling of money to purchase drugs and the sharing of needles are common. While most drug users used unboiled water, boiled water or sterile water, blood has also been reported as being used to mix with the drug. The number of drug users who share any one needle varies, but it has been reported that in gaol around 30–50 would share the same syringe.

The HIV epidemic is currently concentrated among IDUs, with 60 per cent of all notified HIV cases. The movement of HIV from high-risk groups such as IDUs and sex workers to other groups in society is now well underway, with 40–120 people infected every day. HIV prevalence among IDUs has increased substantially nationwide from 10.1 per cent in 1996 to 32 per cent in 2002. There are, however, sites in Vietnam where sentinel surveillance has reported HIV prevalence among IDUs of 40–80 per cent. Co-infection with HIV and hepatitis C is endemic among IDUs.

2.13.5 Summary table

Estimated number of current drug users	As of 2004, there were 170,400 registered drug users. Unofficial estimates vary between 200,000 and 500,000.
Main drugs used	Heroin, opium, methamphetamine, ecstasy, cannabis, blackwater opium, diazepam, glue
Drugs injected	Heroin, blackwater opium, diazepam
Estimated prevalence of HIV infection among IDUs	60% of HIV cases are found among IDUs. HIV prevalence among IDUs is 40–80% in at least 8 provinces.

2.13.6 Country responses

Policy and legislation	
Agreements and treaties	1961, 1971, 1988 UN Drug Conventions. Signatory to ASEAN declaration for a drug-free ASEAN by 2015.
National drug control policy	National Drug Control Action Plan 2001–2005. The aim is to reduce the number of drug users by 10–20% annually. Approaches include mobilising all sectors of the community to fight against drug use, eradicate narco-plant cultivation, search for alternative development against re-cultivation, enhance drug control efforts to stop illegal trafficking, and to update the legal system on drug prevention and suppression.
Main drug control legislation	Law on Narcotic Drugs Prevention and Suppression (2001), which acknowledges that drug use is a social problem and that drug users should be viewed as needing assistance rather than as offenders or criminals.
Drug control policy lead agency	Standing Office on Drugs Control under the Ministry of Public Security and the National Committee for the Prevention and Control of AIDS, Drugs and Prostitution
Law enforcement bodies	Standing Office on Drugs Control, General Department of Customs, Border Army and Maritime Police
Drug use addressed in last National HIV/AIDS Plan	Yes
Possession of N&S unlawful	Yes (but only for those recorded or suspicious as an IDU)
Harm reduction	
	Harm reduction programs have been piloted and expanded in Vietnam since 1993. Support for the harm reduction approach is not uniform, with some local governments more supportive than others. There is a strong perception that current drug control laws are in direct conflict with the harm reduction approach. Harm reduction programs are usually of short duration (1 to 3 years), pilot in nature and dependent on international funding.
Needle and syringe programs (NSPs)	Yes (minor in number and limited in scope)
Peer-based approaches	Yes (minor in number and limited in scope)

Supply reduction	Authorities impose strict penalties for drug offenders, including the death penalty. Government has established and strengthened cooperation among relevant agencies controlling border areas, such as customs authorities and the border army. Bilateral cooperation with neighbouring nations has been implemented to stop trafficking along Vietnam's borders.
Crop eradication	Yes
Demand reduction	An enhancement of educational anti-drug messages and programs aims to prevent and suppress drug-related crimes and drug use. Such activities are both plentiful and diverse, reaching various sectors of the community – from school students to village and commune residents. There has been a major expansion of the number of treatment and rehabilitation facilities throughout the country.
Treatment	In 2003, the network of treatment centres expanded, with 74 such centres at provincial level and a further 700 detoxification bases at the district, ward and village level. Currently drug users stay in government treatment centres for two years. Treatment often involves the use of traditional medicines.
Voluntary or self-referral	Yes
Compulsory	Throughout the nation drug users are being rounded up and placed into such facilities or into prisons.
Methadone for detoxification	No, but it is possible it will be used with methadone, soon to be introduced.
Substitution therapy	No, but pilot study soon underway.
Most common type of treatment provided	Rehabilitation includes medical and psychological treatment, and 'moral education'. Relapse prevention, rehabilitation and integration back into the community do not appear to have a high priority.
Primary prevention	Yes
School-based education	Yes (but details have not been supplied)
Community education	Yes (but details have not been supplied)

2.13.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Two AFP liaison officers	AFP			Law enforcement			Hanoi & Ho Chi Minh City
HIV/AIDS Prevention and Care, Phase 2 Harm Reduction in Vietnam: Developing Sustainable Responses to Drug Use and HIV Infection among Drug Users	AusAID	NAC and the Macfarlane Burnet Centre for Medical Research		Reduction of HIV/AIDS transmission	1999–2004 (completed)	\$156,000	
UNDP HIV/AIDS Youth Awareness Raising	AusAID				2001–2004 (completed)	\$1,400,000	

2.13.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
HIV/AIDS Prevention and Care in Vietnam	Control Disease Center	MOH/LIFE-GAP			2000–2006		40 provinces in Vietnam
HIV/AIDS peer education in the 05/06 rehabilitation	Ford Foundation	Center for Community Health and Development (COHED)		Reduce risks of STD/HIV infection – technical assistance; education and outreach	April 2003 – May 2005		
IDU Interventions – FHI	US Government	USAID Vietnam		Peer-based and other outreach	2005		
Harm Reduction Program – Policy Project	US Government	USAID Vietnam		Law enforcement and advocacy	2005		
Intervention program targeting IDUs	USAID/US Government	Family Health International Vietnam		Outreach	1998 to present		
Preventing HIV in Vietnam	DFID/Norwegian Government	Implemented by WHO, which sends reports to DFID	7 years	Technical assistance			
Strengthening bilateral cooperation	Rockefeller Foundation	STDs/HIV/AIDS Prevention Center (SHAPC)	2 years	Advocacy, education, outreach HIV/AIDS prevention			
Community Reach	USAID	PACT Vietnam	1 year	Technical and managerial assistance to international and Vietnamese NGOs			
Harm Reduction in Vietnam	AusAID/Open Society	Centre for Harm Reduction	4 years	Advocacy, technical assistance, program			
Methadone program trial in Hai Phong and Cam Pha	Family Health International (FHI)	Drug and Alcohol Services South Australia (DASSA)		Technical assistance, treatment	2005		
Evaluation of Vietnam's Rehabilitation and Treatment Centers	UNODC	Drug and Alcohol Services South Australia (DASSA)		Technical assistance, treatment	May 2004 – April 2005		

2.14 The Pacific

Pacific overview includes Papua New Guinea (population 5,420,280); Fiji (population 880,874); Solomon Islands (population 523,617); Vanuatu (population 202,609); Samoa (population 177,714); Tonga (population 110,237).

2.14.1 Overview of recent drug trends

While the severity of drug abuse is purported to vary between the six island countries listed for this review, the main illicit drug of concern, cannabis, is the same. Key informants offered that drugs such as heroin, methamphetamines and cocaine are not commonly used due to their high cost compared to the average income. Cannabis is generally consumed with alcohol. Regionally, cannabis is mainly smoked but it is also chewed and sometimes baked with flour. All data sources agreed that cannabis use is strongly gender-linked, with significantly more males than females using it. The majority of cannabis users are young, aged approximately 15–20 years. Cannabis is also used in the expatriate community and by tourists. There were a number of anecdotal reports by key informants regarding inhalant use in the countries under investigation. The most widely used inhalant is petrol.

2.14.2 Prevalence of drug use

There are no formal surveillance systems in place for illicit drug use and its associated harms. Much of the research undertaken on substance use is anthropological in nature, principally concerned with traditional drugs and mainly undertaken in Papua New Guinea. There are some exceptions: for example, work has been published on the consumption of alcohol and other drugs in Oceania; and

more recently research has been undertaken on illicit drug use (mostly cannabis) in Papua New Guinea. There has, however, been little systematic research undertaken on drugs such as heroin, cocaine and methamphetamines in Papua New Guinea, Fiji, Solomon Islands, Tonga, Samoa and Vanuatu. Regional overviews undertaken by organisations such as the United Nations Office on Drugs and Crime, the US Drug Enforcement Agency, and the Bureau for International Narcotics Law Enforcement report on drug trafficking and seizures of heroin, cocaine and methamphetamines. Four case studies have examined substance use in particular settings.

2.14.3 Drug supply

Cannabis is the drug the region is known to produce. The Pacific environment provides ideal growing conditions for cannabis and allows for continuous year-round cultivation. Wild growth occurs in all of the countries listed for this review. Limited options and market opportunities in the agricultural sector have resulted in illicit cultivation of cannabis, predominantly for domestic consumption. Illicit commercial cultivation of cannabis occurs in island states such as Papua New Guinea, Fiji, Samoa and Tonga. According to key informants, cannabis cultivation is most significant in Papua New Guinea and Fiji. Historically, most cannabis cultivation was undertaken by individuals or small groups within village environments. More recently, it is believed, in a number of jurisdictions in the Pacific, that cannabis cultivation is being taken over by organised criminal groups on a national basis. The only documented international trading of drugs from the Pacific is of cannabis, originating from Papua New Guinea, trafficked mainly to Australia.

Of major concern to authorities is the trade of drugs for guns in Papua New Guinea. Trading usually takes place in coastal cities like Lae, Madang, Wewak or Port Moresby.

The major form of trafficking is transshipment – drugs produced elsewhere transit Pacific islands for the destination market. The concern for the Pacific region is, if large amounts of illicit drugs are moving through local communities, then seepage of the drugs into local communities will result and the social impacts of drug dependency will be experienced.

2.14.5 Summary table

Estimated number of current drug users	NA
Main drugs used	Cannabis
Drugs injected	NA
Estimated prevalence of HIV infection among IDUs	NA

2.14.4 Drug-taking practices, risk factors and trends

In addition to the direct impact of drug use to the individual, there is a plethora of socio-economic and community-level consequences, including: disruption and neglect of the family; increased crime; domestic/family violence (e.g. wife beating, marital rape, physical abuse of children); sexual violence (rape, gang rape); and exposure to HIV/AIDS and other sexually transmitted infections (through unprotected sex, sex work, and the disinhibiting effects of drugs). Increases in HIV have been noted in Papua New Guinea.

2.14.6 Country responses

Policy and legislation			
Agreements and treaties			
Country	1961 Convention on Narcotics Drugs	1971 Convention on Psychotropic Substances	1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances
Fiji	+	+	+
Papua New Guinea	+	+	- (under discussion)
Samoa	-	-	-
Solomon Islands	+	-	-
Tonga	+	+	+
Vanuatu	-	-	-
National drug control policy	No		
Main drug control legislation	The region is focused on developing and implementing new drug control legislation that provides a common base for law enforcement agencies to operate from both nationally and regionally.		
Drug control policy lead agency	Pacific Islands Forum Secretariat at a regional level		
Law enforcement bodies	Police, Customs, Excise Department, and Immigration. More recently the region has taken a whole-of-government approach to transnational crime issues and is working closely with the Navy, Defence, Police and Customs.		
Drug use addressed in last National HIV/AIDS Plan	No		
Possession of N&S unlawful	No		

Harm reduction	No interventions
Needle and syringe programs (NSPs)	No
Peer-based approaches	Yes, for sexual transmission of HIV/AIDS
Supply reduction	No regional policies in place
Crop eradication	No
Demand reduction	No regional policies in place
Treatment	No formal alcohol and drug treatment in the six countries. Drug use/abuse issues are generally targeted as part of life counselling or other programs undertaken by NGOs and churches. Psychiatric units in some countries such as Papua New Guinea, Solomon Islands and Fiji will treat some patients whose condition is linked to drug use.
Voluntary or self-referral	Yes
Compulsory	No
Methadone for detoxification	No
Substitution therapy	No
Most common type of treatment provided	Counselling
Prevention of HIV among drug users	No
Primary prevention	Apart from Papua New Guinea, there are no initiatives against primary prevention of illicit drugs.
School-based education	For Papua New Guinea, there is some education in schools about marijuana through the Ministry of Education, but there are no specific activities carried out by the Ministry of Health apart from health education campaigns on the general problems of alcohol and violence.

2.14.7 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Papua New Guinea Enhanced Cooperation Program (ECP)	Australian Customs		Next five years	Law enforcement			Papua New Guinea
Australia and Papua New Guinea (PNG) Police Assistance Package	AFP	Australian Police personnel working alongside the Royal Papua New Guinea Constabulary	The package will be geographically phased over five years	Law enforcement			Papua New Guinea
Two liaison officers in Port Moresby	AFP			Law enforcement			Papua New Guinea
Transnational Crime Unit in Port Moresby	AFP			Law enforcement			Papua New Guinea
The AFP has two liaison officers in Suva and one intelligence adviser attached to the Pacific Transnational Crime Coordination Centre	AFP			Law enforcement			Fiji
Samoa Police Project	AusAID		3 years	Law enforcement	Aug 2005 – Nov 2008	\$7,013,239	Samoa
The Regional Assistance Mission to the Solomon Islands (RAMSI)	AFP	Police from Australia, New Zealand, Tonga, Samoa, Vanuatu, Fiji, Cook Islands, Nauru, Tuvalu, Kiribati and Papua New Guinea are involved and are currently led by an AFP Federal Agent		Law enforcement	July 2003		Solomon Islands
STC Youth Outreach Project (YOP)	AusAID			Outreach	Dec 2003 – Dec 2006	\$701,387	Solomon Islands
ADRA Community Strengthening and Reconciliation	AusAID			Community linkages	Dec 2003 – Dec 2006	\$701,387	Solomon Islands

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
'BLESS: Building Livelihoods, Empowerment and Strategic Sustainability' – Young people	AusAID			Governance and community cohesion	Dec 2003 – Dec 2006	\$701,387	Solomon Islands
Two liaison officers in Port Vila	AFP						Vanuatu
Illicit drug forensic assistance to Vanuatu Police Force (upon request)	AFP						Vanuatu
Vanuatu Police Force Capacity Building Project	AusAID			Law enforcement	Feb 2002 – Feb 2004	\$4,600,587	Vanuatu
Establishment of the Transnational Crime Units	AFP			Improve intelligence sharing and investigation capacity in region			Fiji, Samoa, Tonga, Vanuatu

2.14.8 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
UNICEF programs: an Expanded Program of Immunisation; Prevention of Mother-to-Child Transmission of HIV; and Pacific Youth Health and Development	NZAID	UNICEF	3 years	Life skills	2005–2007	\$730,000	14 Pacific Island countries
STI/HIV and Development Program	NZAID	UNDP Suva working with UN regional programs in Fiji and Samoa				\$439,518	
Masculinity, Mental Health and Violence (MMHV)	NZAID	Foundation of the Peoples of the South Pacific (FSPI)	Over three financial years		Ending 2006–2007	\$861,756	Kiribati, Vanuatu, Fiji and Papua New Guinea, through FSPI affiliate NGOs
Student Teaching initiative	NZAID	Wan Smolbag, Vanuatu			Ends in 2005–2006	\$607,729	Solomon Islands and Fiji

Appendix A: Country profiles

A1. Brunei Darussalam

Geography	<p>Located in Southeastern Asia, bordering the South China Sea. Land border with Malaysia only. Flat coastal plain rises to mountains in east; hilly lowland in west.</p> <p>Arable land: 0.57% Permanent crops: 0.76% Other: 98.67% (2001)</p>
Government	<p>Constitutional Sultanate</p> <p>Chief of state: Sultan and Prime Minister Sir Hassanal Bolkiah (since 5 October 1967); the monarch is both the chief of state and head of government.</p> <p>Head of government: Sultan and Prime Minister Sir Hassanal Bolkiah (since 5 October 1967)</p> <p>Elections: none; hereditary monarchy</p>
Population	<p>365,251 (July 2004 est.)</p> <p>Urban: 75.5% (2002)</p> <p>Median age: 26.7</p> <p>Age structure: 0–14 years: 29.1% 15–64 years: 68% 65 years and over: 2.9% (2004 est.)</p>
Human development index	HDI Rank 33 (177 countries)
Unemployment rate	10% (2001 est.)
Language	Malay (official), English, Chinese
Literacy	<p>% Age 15 and over can read and write:</p> <p>Total population: 93.9% Male: 96.3% Female: 91.4% (2002)</p>
Religion	Muslim (official) 67%, Buddhist 13%, Christian 10%, indigenous beliefs and other 10%
Health	<p>Life expectancy: 74.54 years</p> <p>Male: 72.13 years Female: 77.09 years (2004 est.)</p>
Economics	<p>GDP: purchasing power parity – \$6.5 billion (2002 est.)</p> <p>Population living below poverty line: N/A</p>

A1.1 Narrative summary of drug vulnerabilities

Brunei Darussalam is a small, wealthy country with a per capita GDP well above most other developing nations. It is increasingly urbanised and in 2002 30 per cent of the population were aged less than 15 years. Despite its wealth, in 2001 (latest available figures) Brunei had a substantial unemployment rate of 10 per cent (United Nations Development Programme, 2004; World Health Organization, 2004d). Brunei borders only with Malaysia, which has a large number of drug users consuming heroin, ATS and cannabis. Unemployment and Brunei's geographical proximity to drug trafficking routes from the Golden Triangle create the potential prospect of a domestic drug use problem (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

Historical and cultural interactions with drugs

No information accessible.

A1.2 Prevalence of drug use and profile of drug users

There are no estimates, official or unofficial, of the number of drug users in Brunei; there have been no surveys of drug use among the general population or the student/youth population. A report that there was no injecting drug use in 2003 (United Nations Office on Drugs and Crime, 2004a) contrasts with HIV/AIDS notification figures, listing 3.8 per cent of diagnosed HIV infections as being linked to the sharing of needles (United Nations Office on Drugs and Crime, 2003). There is one suggestion, on unknown assumptions, of an estimated 3000–4000 *injecting* drug users (Aceijas et al., 2004b). The credibility of such a figure is likely to be disputed.

Police arrest data show a rapid increase in the number of young people using methamphetamine, mostly in urban areas and in labour-intensive industries (United Nations Office on Drugs and Crime, 2003). From prison treatment data, most of the methamphetamine users were male (94%) and aged between 28 and 32 years (United Nations Office on Drugs and Crime, 2004a); demand for drugs is suggested to be mainly among unemployed men of Malay ethnicity (United Nations Office on Drugs and Crime, 2003).

Data collection systems in place

Data are routinely collected from arrests and from treatment admissions; these data are publicly available from 1996. Information is shared between various national law enforcement agencies: the Royal Brunei Darussalam Police Force, the Royal Customs and Excise Department, the Immigration and National Registration Department, the Brunei Darussalam Research Department and the Internal Security Department. Meetings to share information occur when necessary, attempting to 'foster better coordination between the various law enforcement agencies' (United Nations Office on Drugs and Crime, 2004a).

A1.3 Drug supply, production, availability, cost and trade

No cultivation or production of any form of narcotics has been reported from Brunei as of 2003 (United Nations Office on Drugs and Crime, 2003). Despite the dense jungles and rivers along the borders and coastline of Brunei – ideal for drug trafficking, the size of the country allows government authorities to closely monitor its territory (United Nations Office on Drugs and Crime, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement

Affairs, 2001). The amount of drugs entering or transiting through Brunei is minor; those drugs smuggled into the territory are usually from Malaysia. Among Narcotics Bureau officials there is a growing concern that the country may be used a transit route for precursor chemicals; however, there is no formal prevention strategy in place (United Nations Office on Drugs and Crime, 2003).

In 2001, a reported typical retail price for heroin was US\$112 per gram. In 2002, herbal cannabis typically retailed at US\$0.10 per gram, while methamphetamine had a typical retail price of US\$0.40 per gram, indicating availability and therefore implying the existence of a market (United Nations Office on Drugs and Crime, 2004b). It must be noted these quoted prices appear too low when compared to other neighbouring countries and can be questioned for accuracy [attempts were made to validate the claims but communications proved unsuccessful]. However, if correct, the figures would suggest a major market and easy access, and therefore easy importation and possible local production.

Arrest and seizure data

There were 701 recorded offences for illicit drugs in 2003 (88% of whom were male), with 203 convictions that year, and 415 arrests for 2004 by August (Narcotics Control Bureau, 2004). In late 2004, a member of a law enforcement agency was arrested for alleged use of drugs and for being found in possession of several sachets of methamphetamine (Brunei Direct, 2004).

Seizures of the methamphetamines known as 'syabu' have fluctuated in recent years but show a general decrease: 248 grams seized in 2002, 139 grams in 2003, 343 grams to

17 August 2004; small amounts compared with the 1650 grams seized in 2000 [note there is a discrepancy between a decrease in seizures and the rapid rise in the consumption of methamphetamine; why this is the case has not been explained]. The last known seizure of heroin was of 3.6 grams in 2002. Seizures of cannabis are also declining, from 1332 grams in 2002 to 237 grams by August 2004. There have been no seizures of cough mixture since 2001, and only 10 MDMA/ecstasy pills have been seized since 2000 (Narcotics Control Bureau, 2004).

Crop studies and crop eradication statistics

Brunei is not a known producer of opiates or cannabis.

A1.4 Drug-taking practices, risk factors and trends

Most drug consumption would seem to be oral, and not by inhalation or injection (United Nations Office on Drugs and Crime, 2003). Information about drug-taking practices and associated risk factors has not been accessible. HIV infection was first identified in Brunei in 1986. By the end of 2004 there were a cumulative total of 609 HIV infections (males 89%) and 23 AIDS cases. Mode of transmission was reported for 542 of these cases, of which only one was injecting drug use (World Health Organization, 2001, 2005). There is no available information about injecting practices. [Note: there is a discrepancy with the number of HIV infections linked to drug injecting under the section on prevalence of drug use and current HIV infections and mode of transmission. Enquiries were made about this discrepancy, but they proved unsuccessful.]

A1.5 Summary table

Estimated number of drug users	Unknown
Main drugs used	Methamphetamine, cannabis
Drugs injected	Unknown
Estimated prevalence of HIV infection among IDUs	Unknown

A1.6 Country responses to drugs

Agreements and treaties

Brunei is a party to the Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971 and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988 (Narcotics Control Bureau, personal communication, 2005). Brunei is a signatory to the Association of Southeast Asian Nations (ASEAN) declaration for a drug-free ASEAN by the year 2015. As a result, Brunei has a political commitment to be a drug-free society by 2015.

Policy responses

Brunei's National Policy is based on supply and demand reduction. With regard to *supply reduction* the approach is to enhance enforcement activities and to harmonise drug laws with other legislation in the region. There is a specific *Drugs Laws and Poisons Act* that governs import, export and misuse of licit drugs.

With regard to *demand reduction*, the focus is on public awareness by promoting anti-drugs messages through the media to all community members.

The *Misuse of Drugs Act 1984* (MDA), Chapter 27, is the principal legislation for illicit drug trafficking and possession in Brunei Darussalam. The MDA covers a range of controlled drugs including narcotics and psychotropic substances. In 1998, an amendment upgraded methamphetamine from a class B drug to a class A drug.

In line with its neighbours Singapore and Malaysia, Brunei has enforced a provision for a mandatory death penalty for trafficking of the following amount or more of specific drugs: heroin – 15gm, morphine – 15gm, opium – 1200gm, cannabis – 500gm, cannabis resin – 200gm, cocaine – 30gm, and methamphetamine – 200gm.

There is a *presumption clause* that stipulates that anyone caught in possession of a certain amount of a 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 such purposes (Narcotics Control Bureau, 2001, 2004). Under Section 15 of the MDA a person is presumed to be trafficking if in possession of more than the following: 2gm of heroin, 3gm of morphine, 100gm of opium, 15gm of cannabis, 10gm of cannabis resin, 3gm of cocaine, or 20gm 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).

The government's position on national drug control is that law enforcement is a sufficient and suitable deterrent (United Nations Office on Drugs and Crime, 2003). The Narcotics Control Board is under the Prime Minister's Office (PMO), and as a result most policies are formulated by the PMO. The PMO has recently launched its strategic plan. Policies on drug-related issues are clearly stated in the plan and available to all [although at the time of writing a copy of the plan was not able to be accessed] (Narcotics Control Bureau, personal communication, 2005).

Law enforcement responses

The Narcotics Control Bureau (NCB) is the lead agency in dealing with drug-related issues. The annual budget for law enforcement with regard to drug-related issues is about BND\$7,000,000 (US\$4,000,000) (Narcotics Control Bureau personal communication, 2005). In 2003, there were 64 people inside prison receiving drug treatment in relation to methamphetamine use, lower than in 2002. The drug treatment program within prison consists of detoxification, counselling, civic treatment, work therapy (vocation), religious training, and moral and spiritual treatments (United Nations Office on Drugs and Crime, 2004a).

Mandatory drug rehabilitation takes place at the sole drug rehabilitation facility, which accommodates 60 men and 10 women: the Rumah Al-Islah Rehabilitation Centre, which is under the purview of the Prisons Department, Ministry of Home Affairs (Narcotics

Control Bureau, personal communication, 2005). The three ways of admission are by Court Order, Minister's Order and on voluntary order. Upon admission the person is required to undergo detoxification for a period not exceeding 14 days. After detoxification the inmate undertakes an orientation program for one week. The rehabilitation program includes physical, psychological, social, moral and civic rehabilitation (it is not clear how long the program runs).

After 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 (Narcotics Control Bureau, 2004). 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, 2004).

In 2003, the total number admitted to the supervision scheme by a referring agency that included Rumah Al-Islah, prison, court and the NCB was 257. Also in 2003, the number of violations of various sections of the *Misuse of Drugs Act* or Misuse of Drug Regulations while under a supervision order was over 100 cases (Narcotics Control Bureau, 2004). There are no reports, data or assessments of how successful such rehabilitation programs have been.

Health and drug treatment responses

Brunei offers a free medical and health care service, provided by government hospitals, health centres and health clinics throughout the country. In more remote parts of the country, primary health care is offered by Flying Medical Services. There are two private hospitals and a military hospital (World Health Organization, 2004d). However, drug treatment does not sit within the health system but under the Prisons Department, Ministry of Home Affairs (Narcotics Control Bureau, 2004) (see under *Law enforcement responses* for greater details).

There are no known NGOs that focus their efforts on drug users or drug use issues. The Government of Brunei considers drug problems a concern, but does not consider consumption to be widespread; in particular, there is little acknowledgement of the existence of IDU. As a result there has been little or no response to this issue. There are no drug substitution therapy programs in operation, nor are they under consideration. There is a strong belief that the draconian laws imposed against drug use should be a sufficient deterrent. All information, education and communication materials are strongly focused on demand reduction. It does not appear that there is any information specifically targeting drug users to minimise their risks except the message 'say no to drugs'. The number of people accessing drug treatment services in 2003 was 104 persons (Narcotics Control Bureau, personal communication, 2005). If a person under supervision was found to relapse, they would be brought to court for prosecution (Narcotics Control Bureau, 2004). It can be assumed a similar outcome would be implemented for those having relapsed following the completion of a drug supervision period of 6–24 months.

Other responses

School-based education

Anti-drug messages to create awareness about the risk and effects of drug use targeting school students were common. Representatives from various government departments including those from the Narcotics Control Bureau, the Royal Brunei Police Force, the Ministry of Health and the Prison Department would present anti-drug messages to students. The highlight of the presentation to students (at times with representatives from primary school years four to six) concluded with a demonstration of caning (of a dummy) on stage (Kon, 2004).

International funding

Brunei Darussalam does not receive any direct international funding to deal with drug-related issues from a law enforcement perspective or from health-related treatment or preventative education. However, Brunei Darussalam received many offers on courses and trainings related to drug issues from international bodies; for example, from International Law Enforcement Agencies (ILEA), Office of Narcotics Board, Bangkok, Thailand, and others (Narcotics Control Bureau, personal communication, 2005).

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A2. Cambodia

Geography	<p>Located in south-eastern Asia, bordering the Gulf of Thailand, between Thailand, Vietnam and Laos, Cambodia consists of mostly low, flat plains; mountains in south-west and north.</p> <p>Arable land: 20.96% Permanent crops: 0.61% Other: 78.43% (2001)</p>
Government	<p>Multi-party democracy under a constitutional monarchy established in September 1993 (source: CIA website – http://www.cia.gov/cia/publications/factbook/fields/2128.html – accessed 15 March 2005)</p> <p>Chief of state: King Norodom Sihamoni (since 29 October 2004) Head of government: Prime Minister Hun Sen (since 14 January 1985) and Deputy Prime Ministers Sar Kheng (since 3 February 1992), Norodom Sirivudh, Sok An, Lu Lay Sreng, Tea Banh, Hor Namhong, Nhek Bunchhay (since 16 July 2004) Note: The monarch is chosen by a Royal Throne Council; following legislative elections, a member of the majority party or majority coalition is named Prime Minister by the Chairman of the National Assembly and appointed by the King.</p> <p>Elections: National Assembly – last held 27 July 2003 (next to be held in July 2008); Senate – last held 2 March 1999 (scheduled to be held in 2004 but delayed)</p>
Population	<p>13,363,421</p> <p>Note: Estimates for this country take into account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (July 2004 est.).</p> <p>Median age: 19.5 years</p> <p>Age structure: 0–14 years: 38.3% 15–64 years: 58.6% 65 years and over: 3.1% (2004 est.)</p>
Human development index	HDI rank 130 (177 countries)

Unemployment rate	2.5% (2000 est.)
Language	Khmer (official) 95%, French, English
Literacy	Total population: 69.4% Male: 80.8% Female: 59.3% (2002)
Religion	Theravada Buddhist 95%, other 5%
Health	Life expectancy: Male: 55.71 years Female: 61.23 years (2004 est.) Infant mortality: 73.67 deaths/1000 live births Adult HIV prevalence: 2.6% (2003 est.)
Economics	GDP: purchasing power parity – \$25.02 billion (2003 est.) Household income or consumption by percentage share: Lowest 10%: 2.9% Highest 10%: 33.8% (1997) 36% (1997 est.) population below the poverty line

A2.1 Narrative summary of drug vulnerabilities

Poverty

Cambodia is one of the poorest countries in the world, with a per capita income of approximately US\$250–\$300; four out of ten citizens live below the poverty line (United Nations Office on Drugs and Crime, 2004).

Development challenges

Cambodia is faced with many development challenges following decades of war and political turmoil (Mith Samlanh–Friends, 2002; United Nations Office on Drugs and Crime, 2003). The Human Development Indices for Cambodia are among the lowest in Asia. There has been significant development, but the socio-economic situation is still critical and access to social services and economic opportunities remains severely constrained (Mith Samlanh–Friends, 2002). Physical

infrastructure is inadequate and access to it is extremely limited. Accordingly (Mith Samlanh–Friends, 2002) only 29 per cent of the population has access to safe drinking water and only 15 per cent to electricity.

Youth

The age structure of Cambodia reflects the effects of war and genocide: 45 per cent of the population are aged 1–14 years; and 52 per cent are aged 15–64 years.

Health and education

The Cambodian Government is able to commit only 3 per cent of its GDP to health and education, compared with 5 per cent for other low income countries (United Nations Office on Drugs and Crime, 2004). People have on average 0.35 medical contacts with organised health services per year (Mith Samlanh–Friends, 2002). Health care is not free (Mith Samlanh–Friends, 2002).

Cultural interactions with drugs

According to Reid and Costigan (2002), in the nineteenth century opium was a commodity of economic importance which the Cambodian monarch wished to maintain. Generally, opium and its use were confined to the Chinese business community and foreigners. Accounts of opium dens and the ritualistic use of opium in Phnom Penh at this time exist (Reid & Costigan, 2002). In 1863, during the French colonisation of Cambodia, independent opium monopolies were established to raise considerable revenue. Following Cambodia's independence from France, and up until the Lon Nol period during the 1970s, scattered accounts of opium dens continue. Between 1975 and 1978, as a result of the Khmer Rouge genocide and exodus of refugees, Cambodia lost nearly two million people. Opium use was eradicated until the Vietnamese invasion in 1978 (Reid & Costigan, 2002).

While Cambodia is situated near one of the world's major opium cultivation and amphetamine manufacturing regions, use of illicit drugs by local people was not recognised until the mid-1990s (Mith Samlanh–Friends, 2002). A rapid assessment in 1995, undertaken by the World Bank, reported that drug use in Cambodia was not a problem, at that time. Until then, cannabis and, to a lesser extent, methamphetamines were used by affluent Cambodians and foreigners, with heroin and opium users located mostly in Phnom Penh (Burrows, 2003). Since the mid-to-late 1990s the drug use situation in Cambodia has changed to include solvent use and use of ATS by all sections of society (Mith Samlanh–Friends, 2002). Surveys in recent times have revealed increasing use of glue and other inhalants by street children and rural poor and an increase of injecting drug use.

A2.2 Prevalence of drug use and profile of drug users

There are no national population estimates for drug use in Cambodia. The United Nations Office on Drugs and Crime (UNODC) provided assistance to the National Authority for Combating Drugs (NACD) and key ministers in the establishment of a basic drug use data collection network in nine priority provinces. Data are obtained monthly from up to four sources: law enforcement, local authorities, social affairs, and schools, using simple reports. The August 2005 report presents data from the first six months (June 2004 – December 2004) (National Authority for Combating Drugs et al., 2005). The total number of illicit drug users across the nine provinces is estimated to be 5044 people, equivalent to 0.08 per cent of the population in the nine provinces (or 0.15% of the population aged 15–64 years of age). UNODC estimates a population prevalence of 4 per cent for drug use, which suggests there are about 520,000 substance users in Cambodia (in a population of 13 million).

Defining the extent of the drug problem in Cambodia began with numerous situation assessments of drug use in Cambodia.

The majority of assessments undertaken in the past few years and the more recent analysis by the NACD (National Authority for Combating Drugs et al., 2005) point to the same conclusions with respect to type of drugs used in Cambodia: yama is the most frequently used drug, followed by cannabis, heroin, opium and ecstasy. According to the NACD report, half of the people who use drugs (55%) are aged between 18 and 25 years, one-fifth between 10 and 17 years, and one-fifth between 21 and 26 years. Few (3%) were aged more than 45 years. Data from the schools indicated that drug abuse is present from grade 6.

The study undertaken by Mith Samlanh-Friends in 2002 (Mith Samlanh-Friends, 2002) used a participatory method to carry out interviews and group discussions with 1121 people in three locations, including 905 street children. The assessment showed the most common drugs reportedly used by youth interviewed (n = 258) are glue (71%) and yama (65%). Glue is preferred mainly by younger (less than 15 years) and poorer youth, including girls. Other kinds of illicit drugs are available such as ecstasy, ketamine, cannabis and heroin and are used by smaller numbers of people. Heroin injecting was evident among male street children aged 14 years and over in Phnom Penh.

The most recent UNODC assessment (United Nations Office on Drugs and Crime, 2003) provides data from an integrated HIV, STD and behavioural surveillance survey conducted by the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) with the support of the CDC. The survey was conducted in 2003 in the Banteay Meanchey Province with 1556 people drawn from male military personnel (18%), male police (18%), male and female casino workers (10%), male and female patients being treated for tuberculosis (10%), women attending ante-natal clinics (21%), as well as direct and indirect female sex workers (23%). Of note, these data showed no reporting of injecting drug use amongst any of the groups surveyed in the Banteay Meanchey Province. The most common method for using illicit drugs was by smoking. Similarly, the 2005 NACD report (National Authority for Combating Drugs et al., 2005) noted that, of the total number of drug users reported in the nine provinces, the majority of drug users smoked yama (76%), 16 per cent snorted or swallowed yama, 4 per cent injected yama, 2 per cent smoked heroin and 2 per cent injected heroin. It is important to note that injecting of drugs was not found in five of the nine provinces.

A2.3 Drug supply, production, availability and trade

Cambodia shares borders with the world's major producers of opium and heroin. Based on seizures, street price and availability indicators, authorities report large quantities of illicit drugs are entering Cambodia for domestic consumption as well as transiting to other countries (United Nations Office on Drugs and Crime, 2004). Law enforcement authorities in Cambodia, Thailand and Vietnam believe that the Mekong River, flowing from Southern China through Thailand, Laos, Cambodia and Vietnam, together with the road network, is being used to traffic illicit drugs (Shaw, 2002).

Amphetamine-type substances

According to the UNODC, drug trafficking of ATS into Cambodia in 2004 increased ten times compared to 2003 (Shaw, 2002). On average 100,000 tablets are trafficked each day from the Lao border into Stung Treng Province in northern Cambodia and then to Phnom Penh (Shaw, 2002). The United Nations Office on Drugs and Crime and the National Authority for Combating Drugs (no date) highlighted in the 2005–2010 master plan that Stung Treng remains a 'hot spot' for methamphetamine trafficking from the Golden Triangle to Cambodia for use in Cambodia and overseas export. Moreover, methamphetamine is considered to be the major drug to be trafficked from Thailand into the western and north-western provinces of Cambodia.

Heroin

Since the mid-1990s Cambodia has been used for transiting heroin (United Nations Office on Drugs and Crime, 2004). The trafficking of heroin appears to be concentrated in northern and eastern Cambodia, transported from southern Laos. Some heroin is believed to enter and exit Cambodia via Sihanoukville, along the coastline to Koh Kong and Kampot, and to the river port Phnom Penh. The main province of concern remains Stung Treng (United Nations Office on Drugs and Crime, 2003). Heroin is mostly transited onto Vietnam, Australia and New Zealand.

Cannabis

Since the mid-1990s Cambodia has been used for transiting cannabis and it has become one of the largest sources of cannabis for the world market (United Nations Office on Drugs and Crime, 2004). Sihanoukville, on the Gulf of Thailand, is reported to be a major area of concern for trafficking of, among other drugs, sizeable quantities of dried cannabis (United Nations Office on Drugs and Crime, 2002).

Production

Two illicit drugs are produced within Cambodia, cannabis and methamphetamines. The north-western province of Battambang is the province where most law enforcement activities related to cannabis cultivation are undertaken (United Nations Office on Drugs and Crime, 2003). Cannabis cultivation for trade out of Cambodia, aimed at markets such as Vietnam and China, is still occurring, although the current magnitude of cultivation is unknown (United Nations Office on Drugs and Crime, 2003). There was an eradication campaign in 2001 (approximately 60 hectares) and it is believed that the acreage of cannabis plantations has been decreasing over the following years.

However, overseas seizures of containers in various parts of the world during 2003 of cannabis grown in Cambodia indicate that sizeable quantities are still being produced in-country, although possibly not to the extent experienced in the mid-to-late 1990s. The majority of production is believed to be undertaken by farmers who have been provided with seeds by foreigners (United Nations Office on Drugs and Crime, 2004). In the 1990s, large-scale plantations were the norm; however, today it is reported that the trend has moved to a smaller number of cannabis plants being grown by farmers, usually amongst other crops such as corn or tobacco, in more remote areas of the country (United Nations Office on Drugs and Crime, 2004). The wholesale price of cannabis in Cambodia during 2002 was about US\$7 per kilogram (United Nations Office on Drugs and Crime, 2002).

Little information is available on methamphetamine production in Cambodia (United Nations Office on Drugs and Crime, 2002). Tablets are reported to be manually produced from methamphetamine 'dough' imported from Thailand to western and north-western Cambodia (United Nations Office on Drugs and Crime, 2002). Cambodia is not a producer of precursor chemicals, although the government authorises the legal import of acetic acid glacial, chlorhydric acid, sulphuric acid, ethyl ether, acetone, toluene etc for industrial purposes (United Nations Office on Drugs and Crime, 2002). The NACD Secretariat is concerned about potential diversion of these chemicals for use in the production of illicit drugs (United Nations Office on Drugs and Crime & National Authority for Combating Drugs, no date). Indicators suggest that methamphetamine may increasingly be manufactured in Cambodia in addition to ongoing tableting of such ATS (personal communication, May 2005).

Arrest and seizure data

Amphetamine-type substances

In 2004, law enforcement agencies dealt with 234 cases relating to ATS offences, compared with 184 cases in 2003 and 77 cases reported in 2002 (National Authority for Combating Drugs, 2005). A total of 510 people were arrested for ATS-related crimes in 2004 (National Authority for Combating Drugs, 2005). This is a 46 per cent increase from 349 arrests in 2003, and a 128 per cent increase from 223 arrests in 2002 (United Nations Office on Drugs and Crime, 2002, 2003). The substantial increasing trend continues with the number of tablets seized from 2002 to 2004. A total of 875,702 tablets were seized in 2004 (National Authority for Combating Drugs, 2005), 209,527 in 2003, and 126,221 in 2002 (increases of 317% and 600% respectively) (United Nations Office on Drugs and Crime, 2002, 2003) (see Table A2.1).

There is little evidence as to where ATS are being manufactured in Cambodia (United Nations Office on Drugs and Crime, 2003). In 2003, one methamphetamine tableting machine was seized in Battambang Province, but no laboratories were seized during the year. In 2002, a methamphetamine production facility close to the Cham Yeam (Koh Kong) international border crossing with Thailand was found by local police and confiscated in November 2002 (United Nations Office on Drugs and Crime, 2003).

Heroin

In 2004, the number of cases, arrests and seizures relating to heroin were significantly lower than those of 2003, but similar to those of 2002 (National Authority for Combating Drugs, 2005; United Nations Office on Drugs and Crime, 2002, 2003). Three cases were reported in 2004 compared to seven in 2003

and one in 2002. Two people were arrested for heroin-related offences in 2004 compared to 22 people arrested on heroin trafficking charges in 2002, and one arrest in 2002. Just over 2 kilograms of heroin were seized in 2004 compared to a total of 46.72 kilograms of heroin seized in 2003 (one seizure was approximately 35 kilograms) and almost 2 kilograms in 2002 (see Table A2.1).

Cannabis

Official reports of cannabis seized and/or destroyed during 2004 are of 14,341 square metres, a significant reduction from the reports in 2003 of 63,454 square metres, although similar to cannabis seizures in 2002 (United Nations Office on Drugs and Crime, 2003). Seizures of cannabis made outside of the country (but cultivated within Cambodia) totalled more than 350 kilograms in 2003. During 2003, 52 people were officially reported to be detained for the cultivation of cannabis. Of these, six were sent to court and 46 were 'educated'. This is a marked increase from the two detainees in 2002 (United Nations Office on Drugs and Crime, 2003).

Precursor chemicals

According to UNODC reports (United Nations Office on Drugs and Crime, 2002, 2003), there has been an increase in the seizure of precursor chemicals by police and customs in Cambodia. Such chemicals have been seized in the southern provinces of Takeo, Kandal and Kampot and further seizures have been made in Banteay Meanchey and Battambang provinces which would indicate that precursors are being imported to Cambodia from Vietnam and Thailand. In 2004, 2624 kilograms of sulphuric acid was seized by law enforcement officials (National Authority for Combating Drugs, 2005).

Table A2.1. Summary of illicit drug-related arrests and seizures in Cambodia by law enforcement agencies, 2002–2004

Drug	Year	Cases	Arrests (people)	Seizures	Cultivation destroyed
ATS	2004	234	510	875,702 tablets	
	2003	184	349	209,527	
	2002	77	223	126,221	
Heroin	2004	3	2	2.15 kg (no data available for Dec 04)	
	2003	7	22	46.72 kg	
	2002	1	1	1.9 kg	
Cannabis	2004				14,341.25 m ²
	2003				63,454 m ²
	2002				11,950 m ²
Ketamine	2004	3	6	25,150 bottles (no data available for Dec 04)	
Precursors	2004	1		2624 kg of sulphuric acid	

Sources: National Authority for Combating Drugs, 2005; United Nations Office on Drugs and Crime, 2002, 2003

A2.4 Drug-taking practices, risk factors and trends

HIV, sexual practices and drug use

The first case of HIV in Cambodia was detected in 1991 (United Nations Office on Drugs and Crime, 2004). HIV prevalence via all transmission routes is 2.8 per cent (United Nations Office on Drugs and Crime, 2004). Due to the lack of surveillance data, the true nature and extent of drug-related HIV prevalence and risk in Cambodia remain unclear (United Nations Office on Drugs and Crime, 2003, 2004). From the limited data available, there is evidence to suggest an increase in injecting drug use in major urban centres, and, based on lessons from other countries in the region, there is a strong suggestion that factors for HIV transmission through IDU already exist in Cambodia (United Nations Office on Drugs and Crime, 2003). In 2003, through their pilot needle and syringe program, the NGO Mith Samlanh-Friends contacted 47 IDUs living in Phnom Penh – of these, 15 agreed to be tested for HIV/AIDS, with 45 per cent found to be HIV positive (Mith Samlanh-Friends, 2002).

Heroin and opium are the main injected drugs, according to almost all reports. The drugs are reported to be injected either raw or cooked. In the raw method, drugs are not mixed with a liquid or cooked before being put into the syringe. The drug is put into the syringe in a powder form, blood is drawn into the syringe, and the drug is dissolved in the blood before being pushed back into the vein. The cooked method mixes the drug with a liquid (distilled water, drinking water, coconut juice) (O'Connell, 2005).

The I-RARE study (O'Connell, 2005) reported that every injecting drug user they interviewed (exact sample size not reported) said they reused needles and syringes. The majority reported sharing, borrowing or lending, or using equipment after others had used it. Most reported that they would rinse the needles and syringe with water before reusing or sharing it; some mentioned cleaning the needle with a cloth, paper or a burning cigarette; no reports of using bleach. The majority of those interviewed reported buying and injecting drugs in groups. The authors identified several reasons for the previously listed risk behaviours: cost of needles and syringes (\$US 0.5–0.7); access and availability of syringes is limited; residual drugs remaining in the equipment may be enough to get someone high; and knowledge of HIV transmission is lacking among drug users. Data from IDUs showed that 60 per cent reported that HIV was spread through the needle, compared to the syringe, or barrel. The study (Mith Samlanh-Friends, 2002) showed that 18 per cent of youth interviewed in Phnom Penh reported injecting a drug (aged 16–22 years). All were polydrug users and most took at least two injections of heroin per day, with half having injected for more than one year. Most admitted to sharing equipment and paraphernalia, even though they knew it could lead to HIV transmission.

The methods of administration of glue and amphetamines do not pose a risk of HIV transmission, although behaviours associated with their use do increase HIV vulnerability (blue book) through high-risk sexual behaviour (non-condom use). Half of the interviewees in the I-RARE study (O'Connell, 2005) reported using drugs, particularly yama, in conjunction with sex (i.e. sex immediately after using drugs). Participants reported that smoking yama increased their sex drive and prolonged sex. In contrast, sex workers reported using yama for stamina and energy rather than to increase arousal. Most respondents reported sex with multiple partners, described as: sex workers, girls, sweethearts, clients, spouses. Sex workers reported having sex with both IDUs and non-IDUs and some men reported having both male and female sexual partners. Group sex was also reported. Forty per cent of participants reported irregular or no use of condoms.

In the past year there has been evidence of injecting of methamphetamine in Phnom Penh.

In Cambodia there is a culture of injecting related to health and wellness (Mith Samlanh-Friends, 2002). Cambodians commonly use injections for pharmacy medicine. For example, it is usual for a family to inject each other, using the same injecting equipment for the whole family, with vitamins or serum. The argument has been made by Mith Samlanh-Friends (2002) that these practices in the general population are likely to have implications for blood-borne virus transmission and to make the transition from oral drug use to injecting drug use relatively uncomplicated. There is no legal restriction on the distribution of needles and syringes; in practice, syringes are available without prescription from pharmacies (Burrows, 2003).

Selling blood

The data from the I-RARE study confirmed selling, brokering and collection of blood donations through multiple data sources (O'Connell, 2005). This behaviour is carried out in 'teams' taking turns to sell their blood in order to pool money to buy drugs. Blood sellers report no counselling or education is provided before or after blood collection.

A2.5 Summary table

Estimated number of drug users	520,000
Main drugs used	Amphetamines (yama)
Drugs injected	Heroin and methamphetamine
Estimated prevalence of HIV infection among IDUs	37% amongst youth in Phnom Penh

A2.6 Country responses to drugs

Agreements and treaties

Cambodia ratified the three international drug control Conventions (1961, 1971 and 1988) on 5 April 2005.

Policy responses

The NACD Secretariat

In 1995 the Cambodian Government established a ministerial-level committee, the National Authority for Combating Drugs (NACD), to make decisions on drug control policy and supervise drug control operations. The composition of the NACD has changed from its original structure in 1995, consisting of the two co-Prime Ministers as Chairmen, the Minister of Justice as Deputy Chairman and ten concerned ministers as members. As of 2000, the NACD has been chaired by the Deputy Prime Minister and Co-Minister of Interior (United Nations Office on Drugs and Crime, 2004). Members of the Authority are:

- Minister in Charge of Council Ministers
- Minister of Health
- Co-Minister of National Defence
- Minister of Foreign Affairs and International Cooperation
- Minister of Economy and Finance
- Minister of Education, Youth, and Sports
- Minister of Social Affairs, Labour, Vocational Training and Youth (MOSALVY)
- Governor of the National Bank
- The Minister of Commerce and the Minister of Agriculture, Fisheries and Forestry Royal were added in 2000.

The Secretariat is located in the Ministry of Interior and has a Secretary-General and four Deputy Secretaries-General.

In addition to its ministerial partners, the UNODC is also a very important partner of the NACD Secretariat. The NACD also works with foreign embassies, UN agencies, NGOs and the private sector.

The NACD Secretariat has been challenged in its ability to perform tasks on a national level, as intended, by political instability, lack of personnel, technical competence, resources and administrative and operational procedures, particularly regarding law enforcement capabilities and lack of a drug control strategy framework (United Nations Office on Drugs and Crime, 2004; United Nations Office on Drugs and Crime & National Authority for Combating Drugs, no date). Nevertheless, the NACD Secretariat has established itself nationally, regionally and within the donor community. Its commitment to regional collaboration on drug control has been formally demonstrated; Cambodia became a party to the 1993 sub-regional Memorandum of Understanding on Drug Control in May 1995. Moreover, it has played a pivotal role in bilateral drug control agreements with countries such as Thailand, Laos and Vietnam.

The Royal Government of Cambodia has adopted the following strategies for responding to illicit drug issues in the country:

- demand reduction
- supply reduction
- law enforcement
- reduction of risks caused by drug abuse (comprehensive approach to HIV/AIDS)
- strengthening of international cooperation.

Government policy-making on illicit drug use at the national level generally includes the following steps (Burrows, 2003):

- NACD seeks policy advice from a relevant Ministry.
- The relevant Ministry provides advice to NACD.
- The Secretary-General raises the issue, including the advice given, with NACD members at a regular meeting.
- NACD members decide on actions to be undertaken and by whom.
- NACD monitors the situation to observe its directive or recommendation implementation.

The NACD in its role of raising awareness organised a National Workshop on Drug Issues in Cambodia on 5–6 May 2003 (National Authority for Combating Drugs, 2003). This was one of the most prominent activities of the NACD. More than 550 people from various sectors of society, including monks, police, youth and provisional governors, attended to hear from international guest speakers and national authorities. A total of 26 actions were agreed upon (National Authority for Combating Drugs, 2003).

Moreover, Cambodia recently formulated its first ever five-year national drug control master plan (2006–2010). The plan outlines drug control activities, principles, strategies and objectives, resource requirements and financing, implementation for priority projects and cooperation in the region and world, and finally monitoring and evaluation. The UNODC facilitated NACD in its development of the plan through helping to chair various

workshops over a six-month period with government agencies, UN agencies, NGOs and civil society. Feedback was collected on the master plan, which included policy guidelines. NACD reviewed all inputs over the following six months which resulted in the final master plan.

In order to achieve its long-term objective of ensuring Cambodia becomes an illicit drug-free society in the region, the Royal Government of Cambodia has adopted the following long-term objectives:

- to eliminate the use, trafficking, production and cultivation of illicit drugs
- to control precursor chemicals
- to strengthen law enforcement.

The immediate objectives outlined in the Master Plan are:

- strengthening of the structure of the NACD and relevant institutions
- reduction of demand for illicit drugs: including public awareness, involvement of private sector and NGOs, integration of illicit drug and HIV/AIDS education into school education curriculum, monitoring and evaluation
- reduction of illicit crop cultivation: including alternative crop development, eradication campaign
- control of illicit trafficking and production
- legislation
- treatment, rehabilitation and reintegration.

Law enforcement responses

The Ministry of Interior is the key agency for law enforcement (G. Shaw, personal communication, 2005). Within the National Police, anti-drug units (700 personnel) have been established; the Phnom Penh Municipal Anti-Narcotics Police Unit (170 staff) also carries out drug enforcement operations in the capital. Ministry of Justice personnel are also active in the work of the NACD and in UNODC projects and training activities (G. Shaw, personal communication, 2005).

The Ministry of Health has responsibility for controlling manufacturing, importation, trading and distribution of licit drugs and psychotropic substances (G. Shaw, personal communication, 2005). This Ministry also works with Customs in controlling the imports of licit drugs and psychotropic substances (G. Shaw, personal communication, 2005). Most seized drugs are sent abroad for testing as the Ministry has only basic testing facilities; this arrangement has been shown to be time-consuming and impractical for judicial processing of drug cases (G. Shaw, personal communication, 2005).

Legislation/penalties/prison

The Law on the Control of Drugs 1997 covers the main legal issues relating to drug use in Cambodia. According to the UNODC (2004), while drug laws exist in Cambodia, they are rarely applied, and with insufficient law enforcement and judicial capacities the implementation of the law, to date, has been ineffective. Presently, the Ministry of Justice in collaboration with the NACD Secretariat is amending the laws on drug control.

All 87 lawmakers who attended the National Assembly session in March 2005 voted in favour of 49 amendments to toughen drug laws (United Nations Office on Drugs and Crime Cambodia, 2005). The time schedule for approval by the Senate and King is not stated. A press release by the UNODC (United Nations Office on Drugs and Crime Cambodia, 2005) reported that, under the new system, penalties will increase according to the quantity of drugs involved, gaol terms will be mandatory (previously it was up to judges whether a fine or prison term or both were imposed, severity of punishment was unrelated to drug quantities). For example, one amendment specifies that, for leading a drug trafficking ring, life imprisonment and a fine of 500 million riel (US\$125,000) will result, compared to life imprisonment or a fine of 100 million riel (US\$25,000) or both under the previous laws. However, the Prime Minister of Cambodia appears supportive of drug control laws that provide health and support for drug users rather than prison sentences (National Authority for Combating Drugs, 2003).

Prison system

No data currently exist on the number of drug users, HIV, prevention programs, interventions, etc in the Cambodian prison system. The NACD has no influence or authority over prison populations involved in drug issues in Cambodia, despite the Ministry of Justice being a member of the NACD.

Health and treatment responses

No drug treatment and rehabilitation services are currently available for the general population. The five-year master plan outlines the establishment of policies and services for drug treatment. Street children/youth in Phnom Penh and Poipet have access to limited counselling, treatment, rehabilitation and reintegration activities run by several NGOs. Methadone is not available because of costs and a pilot needle and syringe program has begun in the last couple of years.

At present the only government-run facility is the Youth Rehabilitation Centre, called Chom Chao Rehabilitation Centre (Ministry of Social Affairs), on the outskirts of Phnom Penh. However, it lacks trained medical personnel and has virtually no prevention or treatment interventions for detoxification or rehabilitation. The centre admits children who abuse drugs, and also serves as a youth detention centre (United Nations Office on Drugs and Crime, 2004).

The Ministry of Health has established a counselling and outpatient unit as part of the mental health unit of the Preah Sihanouk Hospital, Phnom Penh (United Nations Office on Drugs and Crime & National Authority for Combating Drugs, no date).

To address the lack of treatment for drug users, the Cambodian Government has approved, in principle, the establishment of one drug abuse centre in Phnom Penh (United Nations Office on Drugs and Crime & National Authority for Combating Drugs, no date).

The 2006–2010 Master Plan outlines the following activities in relation to its plans for treatment:

- Develop drug abuse treatment rehabilitation and reintegration policy for government approval.
- Establish drug treatment and rehabilitation services in Phnom Penh and in priority provinces.
- Create a counselling team for follow-up of patients at the community and family level.
- Encourage involvement of communities, NGOs, families, religions and former drug users in the treatment, rehabilitation and reintegration into society and follow-up of drug users.

Other responses

The NGO sector provide interventions for illicit drug users, on a limited basis, as part of their work with groups such as street children, commercial sex workers, fishermen, prisoners and migrant workers (Humeniuk et al., 2004; United Nations Office on Drugs and Crime, 2004). Efforts are concentrated in Phnom Penh and the north-west of the country (Humeniuk et al., 2004).

A pilot needle and syringe program (NSP), as part of a broad harm reduction program, is operating in Phnom Penh under authorisation from NACD (2004–2006 inclusive); a second NGO has received similar authorisation from NACD to commence another NSP in 2005 as part of a broader harm reduction program (personal communication, May 2005).

The groups or organisations undertaking work with drug users are listed below.

1. The Drug Abuse Forum (DAF) was established in 1999 to coordinate the efforts of international organisations, NGOs (health, social services, community development) and UN agencies, and promote understanding of drug abuse issues. UNODC acts as a secretariat to DAF with one full-time position assigned to this role.
2. Mith Samlanh-Friends works in three areas of Phnom Penh to provide a range of services – dissemination of materials, outreach education on drugs, HIV/AIDS and other topics, referral for HIV testing, medical assistance, advocacy and vocational training. Peer education for awareness raising is a critical component of the program. The target population includes about 20,000 street working and 2000 street living children. Friends services are estimated to reach around 1800 children each day in Phnom Penh. The program also includes a pilot needle and syringe program. The NSP has contacted 47 IDUs – of this group, 15 have agreed to be tested, and 45 per cent found to be HIV positive.
3. Goutte d'Eau in Poipet provides similar services to Friends yet on a smaller scale.
4. The Khmer HIV/AIDS NGO Alliance (KHANA), an umbrella organisation working with over 40 local social service-related NGOs, recently integrated drug issues into its strategic plan for future work. KHANA is working with UNODC on a HIV/AIDS working group which involves other NGOs, UN agencies and government agencies.
5. Khmer Youth Association – preventive education, awareness campaigns, outreach work, peer education, but more for general youth.
6. Khmer Development Organisation – preventive education, peer education, Phnom Penh.
7. Krousar Thmey and World Vision have integrated drugs and HIV education.
8. UNICEF recently agreed to incorporate drug issues into its HIV/AIDS vulnerability programs in Cambodia due to the increasing impact upon young people.
9. The UN Theme Group on HIV/AIDS agreed to establish a sub-group to investigate responses to HIV/AIDS transmission through drug use. UNODC will take the lead in establishing the group.
10. The NACD has signed a memorandum of understanding with the National AIDS Authority with the aim of preventing the transmission of HIV through intravenous drug use and unsafe sexual practices whilst under the influence of illicit drugs.
11. The Ministry of Education, Youth and Sports has integrated illicit drug awareness into multi-level school curricula (primary education to higher education).
12. Community education is limited. There is a pilot project by NACD / UNODC / UNICEF / Ministry of Social Affairs; training monks in Phnom Penh, Kandal, Battambang, Banteay Meanchey and Siem Reap provinces by NACD / UNODC to provide community-based education and awareness.
13. Preah Norodom Sihanouk Hospital, Phnom Penh, Psychiatric Department, only symptomatic treatment, both out-patient and in-patient.
14. Rehabilitation Center Chomchao, MoSALVY.
15. Damnok Toek, Rehabilitation Center in Wat Thmey, Poipet, Banteay Meanchey and in Neak Loeng, Prey Veng.
16. PKKO Center, Kandal Stueng, Kandal (vocational training and school education for street youth including drug users).
17. L-CDI (Leadership Character Development Institute), residential education program for poor young people from the provinces, including drug users.
18. Street Children Assistance and Development Programme (SCADP), Phnom Penh.
19. CCASVA, awareness campaigns, outreach work, peer education, Phnom Penh.
20. M'lop Tapang, work with street children including drug users in Sihanoukville.
21. Private clinic of Professor Ka Sunbaunath, Phnom Penh.
22. DARO, Mr Poeun Thy, director, Drugs and Alcohol Rehabilitation Organization.
23. Damnak Dangkau village, Kdol Taken commune, Borvel district, Battambang Province, under the initiatives of Brigadier-General Pov Saran, Commander of Battalion 53, and Colonel So Sam An, First Deputy Chief of Battambang Provincial Police Headquarters.
24. Military Camp, Sisophon, Banteay Meanchey.
25. Pagodas (in preparation, e.g. Wat Samraong Ondaet, Phnom Penh, upcoming trainings in Siem Reap and Battambang).

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A3. China

Geography	<p>Located in Eastern Asia, bordering the East China Sea, Korea Bay, Yellow Sea and South China Sea, between North Korea and Vietnam. Borders with Afghanistan, Bhutan, Burma, India, Kazakhstan, North Korea, Kyrgyzstan, Laos, Mongolia, Nepal, Pakistan, Russia (north-east) 3605 km, Russia (north-west), Tajikistan, Vietnam 1281 km, and has regional borders with Hong Kong and Macao. Mostly mountains, high plateaus, deserts in west; plains, deltas and hills in east.</p> <p>Arable land: 15.4% of a total land mass of 9,326,410 sq km Permanent crops: 1.25% Other: 83.36% (2001)</p>
Government	<p>Communist state</p> <p>Chief of state: President Hu Jintao (since 15 March 2003) and Vice-President Zeng Qinghong (since 15 March 2003)</p> <p>Head of government: Premier Wen Jiabao (since 16 March 2003); Vice-Premiers Huang Ju (since 17 March 2003), Wu Yi (since 17 March 2003), Zeng Peiyan (since 17 March 2003), and Hui Liangyu (since 17 March 2003)</p> <p>Elections: President and Vice-President elected by the National People’s Congress for five-year terms; elections last held 15–17 March 2003 (next to be held mid-March 2008); Premier nominated by the President, confirmed by the National People’s Congress</p>
Population	<p>1,298,847,624 (July 2004 est.)</p> <p>Urban: 37.7% of total (2002)</p> <p>Median age: 31.8 years</p> <p>Age structure: 0–14 years: 22.3% 15–64 years: 70.3% 65 years and over: 7.5%</p>
Human development index	HDI rank 94 (177 countries)
Unemployment rate	10% urban unemployment roughly; substantial unemployment and underemployment in rural areas (2003 est.)

Language	Standard Chinese or Mandarin (Putonghua, based on the Beijing dialect), Yue (Cantonese), Wu (Shanghaiese), Minbei (Fuzhou), Minnan (Hokkien-Taiwanese), Xiang, Gan, Hakka dialects, minority languages
Literacy	% Age 15 and over can read and write: Total population: 90.9% Male: 95.1% Female: 86.5% (2002)
Religion	Daoist (Taoist), Buddhist, Muslim 1–2%, Christian 3–4% Remainder are officially atheist (2002 est.)
Health	Life expectancy: 71.96 years Male: 70.4 years Female: 73.72 years (2004 est.) Infant mortality: 25.28 deaths/1000 live births HIV prevalence: 0.1% (2003 est.)
Economics	GDP: purchasing power parity – \$6.449 trillion (2003 est.) Population below poverty line: 10% (2001 est.)

A3.1 Narrative summary of drug vulnerabilities

According to the World Bank, an estimated 200 million people in China live on less than US\$1 per day. While the level of poverty decreased from 31.6 per cent to 3.5 per cent over two decades, Chinese authorities accepted that in 2001 there were at least 30 million people living impoverished lives, with at least a further 60 million people living precariously, poised to slip into absolute poverty. Poor people in China lack food security, experience higher illiteracy, often lack access to health care facilities, and in many of the poorest villages over half of the children will not attend school and thus be illiterate (AusAID, 2003; Australian Agency for International Development, 2004a; World Health Organization, 2004a). Overall, human development has improved in China but the gaps between the rich and poor have widened, in particular the income ratio

between the urban-rural population: excluding non-currency factors, this income gap is one of the widest in the world (World Health Organization, 2004a). In 2000, there were up to 121 million internal migrants of whom 85–100 million were rural-urban migrants: an estimated 20 per cent were 25–29 years old, a common age for potential drug use.

As a result of a unique household registration system in China, most migrants are unable to access public services even though the potential for increased vulnerability and greater health risks associated with drug use and the spread of HIV/AIDS are acknowledged (Anderson et al., 2003; Biao, 2004; du Guerny, Hsu & Hong, 2003; Liao, Schensul & Wolffers, 2003).

Ethnic minority groups are particularly vulnerable: although comprising only 7 per cent of the total population, they represent 40 per cent of China's poor and often live

in abject poverty. Ethnic minority groups have a long cultural association with opium, which over time evolved towards heroin consumption, often involving high-risk injecting practices. As a consequence, ethnic groups were hardest hit initially by the HIV epidemic, particularly those in Yunnan, Guangxi and Xinjiang, but this has now spread into the wider community of China (Australian Agency for International Development, 2004a; Reid & Costigan, 2002; Zhenglai, 2002).

China's vulnerability to drug use and trafficking is hugely enhanced by its borders with or close proximity to the Golden Triangle and the Golden Crescent, the world's leading production sites of opium, heroin and methamphetamines (Xinzhen, 2004; Zhenglai, 2002).

Historical and cultural interactions with drugs

Opium use has existed in China since the 8th century, but it was in the 16th century that European merchants discovered its commercial appeal and exported increasing amounts of opium from India into China. After 1650, the Dutch were exporting more than 50 tons of opium per year to China; 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 15–20 million being addicted (McCoy, 1991; Wu, 1998). Opium also had a major medical role in Chinese society, and was used as treatment for cholera and malaria, and as a prophylactic against the plague (Dikotter, Laaman & Xun, 2004).

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; United Nations Drugs Control Program, 2000; Walker, 1991). For the next three decades illicit drug use was controlled. The free market economic policies introduced in 1979, and especially the 'open-door' policy of 1982, produced a resurgence in illicit drug availability and use. The combination of China's proximity to the Golden Triangle (it borders Myanmar, Laos and Thailand) and the open border policy for international trade have contributed dramatically to the increase in the use of drugs (McCoy, 1991; UNAIDS & UNDCP, 2000; United Nations Drugs Control Program, 2000; Wodak, 1999).

A3.2 Prevalence of drug use and profile of drug users

China has witnessed an exponential growth in the number of drug users since the early 1990s. In 1990, there were 70,000 registered illicit drug users; at the end of 2003, the number was 1,050,000, a 15-fold increase, accounting for 0.081 per cent of China's total population (Chengzheng et al., 2002; Zhimin, 2004). The actual number of drug users in China is difficult to estimate. It has been suggested that the central government is unable to maintain an accurate picture of the situation, as data collection systems in place have systematic biases, and are noted for both over-reporting and under-reporting statistics, depending on the context (Shicun & Sisci, 2005). Government does however acknowledge that the number of drug users is much higher than those who are registered. Officially, some suggest the number of drug users ranges from an estimated 6–8 million; unofficially, estimates are as high as 12 million. However, it must be stated this is not based on scientific or epidemiological studies (Drug Enforcement Administration, Intelligence Division, 2004a; UNAIDS & UNDCP, 2000; Wu et al., 2002). Currently a community-based epidemiological survey is underway and the study is anticipated to finish at the end of 2005 (L. Zhimin, personal communication, 2005).

Drug availability and consumption have spread throughout the country; as of 2001–2002, of China's 2143 counties 2033 had reported drug problems, with at least 140 counties reporting 1000 or more registered drug users. It is apparent that drug use has spread from rural communities and border areas of the country to the larger central cities, particularly those that can be found along the main trafficking routes

(Burrows & Jianhua, 2003; Hao et al., 2002; Reid & Costigan, 2002; Sharma & Burrows, 2002; Yunnan Institute for Drug Use, 2003). Some provinces are noted to have a higher number of drug users than others: Yunnan is one such province, with an estimated 100,000 to 150,000 drug users (Jianhua, Jiapeng & Xiaoliang, 2002). For many young men living in rural villages, drug use has become increasingly attractive – these areas often experience widespread poverty, lack of opportunities and easy access to narcotics (Lim, 2004). The estimated number of injecting drug users ranges from a low of 356,000 to 3,500,000 with a mid-range figure of 1,928,000 (Aceijas et al., 2004b).

Drug Abuse Surveillance Stations (DASS) are found in all the provinces, autonomous regions and municipalities under the Central Government. Over a 12-month period in 2003–2004 DASS received 105,151 valid case reports related to drug use. These were submitted from 446 treatment institutions including 155 voluntary institutions, 155 compulsory institutions and 136 institutions for re-education through labour. The drug of choice is heroin (96.8%), followed by benzodiazepines (including triazolam, diazepam, clonazepam and nitrazepam), other opiates such as morphine and opium, cannabis, ketamine and amphetamine-type substances (ATS) such as 'ice' and 'ecstasy'. Heroin is by far the most widely used drug with an average proportion of users at the various sites of 79 per cent.

New drugs are constantly appearing; in 2003, there was identification of an amphetamine-type drug called 'Magu pill' from Myanmar, which had a mixture of methamphetamine with other psychoactive substances (National Narcotic Control Commission China, 2004a). In China's growing urban centres, use of MDMA has become increasingly popular

while cannabis use is widespread in Xinjiang. The use of ATS was very rare until 1995 but is now expanding rapidly with a current perception that ecstasy and methamphetamine pills are the most popular types consumed (Drug Enforcement Administration, Intelligence Division, 2004a; Li, Zhou & Stanton, 2002; United Nations Office on Drugs and Crime, 2004a).

The common profile of drug users in China is male (usually 80% and more) aged under 35 years. DASS statistics for 2003 show the average age of drug users is 31 years and those aged 26–35 years made up 56 per cent. Up to 80 per cent of heroin users are aged 20–30 years, and the average female user tends to be younger than male users. Chinese drug users are becoming younger. In 1991, 5 per cent of registered drug users were 16 years old; by 1996 this had increased to 15 per cent. In 1998, those aged less than 25 years made up 19 per cent; in 2000, the same age group made up 28 per cent. Since the early 1990s there has been a rapid increase in the number of female drug users in China. A recent survey in drug centres in 14 provinces, undertaken by the National Drug Control Committee, found female drug users made up 28 per cent of all drug users in some sites with an average of 17 per cent overall (Chu et al., 2003; National Narcotics Control Commission, 2004a, 2004b; Yunnan Institute for Drug Use, 2003).

The educational level of most drug users is low, most having received only primary or junior middle school education: overall, 70 per cent have received junior middle school education only. A vast number of the drug users are unemployed or in search of work. Others had various jobs, worked as farmers or were self-employed. For many drug users the need to obtain money for

drugs often results in other activities such as stealing, defrauding, prostitution and drug trafficking or other illegal activities. Data from relevant departments show 90 per cent of all male drug users have an involvement with some type of criminal activity, while most female drug users have been involved in sex work to access money to purchase drugs. It has been calculated that if each drug user consumed 0.3 grams of heroin every day, 740,000 heroin users would consume at least RMB 27 billion each year. In the DASS data, 45 per cent of users are married, the remainder being unmarried or divorced (National Narcotics Control Commission, 2004b; Wang & Lin, 2003; Yunnan Institute for Drug Use, 2003).

Data collection systems in place

Data are currently collected through three systems. The first is the National Surveillance System on Drug Abuse (NSSDA) run by the National Surveillance Centres on Drug Abuse (NSCDA). Secondly, there is the Narcotics Control Information System (NCIS), which is linked to the Office of the National Narcotics Control Commission (ONNCC). The NCIS is a part of the National Police Information System and maintained by the ONNCC as well as the Narcotic Control Bureau of the Ministry of Public Security. The NCIS collects electronic information on various aspects of drug control. Data collected within the NCIS start from drug control agencies at the prefecture level, are then passed on to the provincial level and then to the ONNCC for the final processing stage. NSSDA is supervised by the National Narcotics Control Commission and the State Food and Drug Administration and produces an annual drug abuse surveillance report to the ONNCC: the findings in the report play a role in the policy process.

As of 2003, a third addition to the data collection systems to better integrate information from the different data sources is the Drug Abuse Surveillance Stations (DASS) established in all provinces, autonomous regions and municipalities. The information collected focuses on the quantitative and qualitative research and treatment demand data. It is hoped that following installation of computers throughout the various DASS sites in 2004, the drug abuse surveillance system will be enhanced and allow a faster response to the dynamic drug situation.

As of 2004, there were eight data sources on drug use in China, including treatment and rehabilitation centres, hospital clinics and detention houses of the police. The information from these sources provides insights into most indicators of drug use in the country but not the prevalence of drug use in the wider population or mortality data among drug users (National Narcotics Control Commission, 2004a, 2004b; United Nations Office on Drugs and Crime, 2004a; United Nations Office on Drugs and Crime, Regional Centre for East Asia and the Pacific, 2003b).

A3.3 Drug supply, production, availability, cost and trade

In recent years the trafficking of drugs through China has increased substantially, primarily along the 2000-kilometre border with Myanmar. The proximity of the Golden Triangle and the Golden Crescent regions – the world's largest producers of opium, heroin and amphetamine-type substances – has been a major challenge for Chinese authorities in stemming the trafficking of narcotics across its national borders. It is reported that most heroin produced in Myanmar (70–80 tons per annum) is now trafficked through China, which has become an important transshipment route for the international market. This proliferation of drug trafficking in China largely emerged as a result of new routes from Afghanistan into western China, particularly Xinjiang Province, which complement the traditional routes from Myanmar. This and the economic reforms introduced by Deng Xiaoping in the 1980s have simply made the drug networks currently penetrating China less restricted (National Narcotics Control Commission, 2004b; Silk Road Studies Program, 2004; United Nations Office on Drugs and Crime, Regional Centre for East Asia and the Pacific, 2003a; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

Border crossing is easy, particularly along the long southern border, where high mountains and dense forest provide substantial cover. Yunnan Province, bordering on Myanmar, attracts a large number of drug traffickers and every means of transporting drugs is used, from trucks to human bodies. Another important trafficking route is the 200-kilometre border between Guangxi Province and Vietnam which is also mountainous and remote. In this area there is one official crossing and five 'semi-official' crossings where, for a fee of around US\$0.05, border crossing is permitted. In other parts of this area the border is essentially open – researchers for one recent report observed hundreds of people (no doubt including drug users and drug dealers) crossing with no intervention or supervision (Hammett et al., 2003; Zhenglai, 2002).

Drugs transit southern China to the provinces of Yunnan, Guangxi, Guandong and Fujian and onwards to south-eastern coastal areas by various overland methods. Once the heroin reaches Guandong, it is believed to be shipped to the cities of Xiaman and Fuzhou in Fujian Province before being transported to international markets. Heroin entering the north-eastern regions of China is not only from Afghanistan but also from Pakistan and Tajikistan. It is reported that up to 20 per cent of heroin entering Xinjiang Province has its origins from south-west Asia, particularly Afghanistan. Some parts of China are more noted than others for drug trafficking: 10 per cent of China's narcotics enter the country in the Lancang Prefecture located in Yunnan. New transit routes emerge

all the time and one report suggested heroin was transported from Myanmar to India and Nepal and then onto China (Drug Enforcement Administration, Intelligence Division, 2004a; Drug Enforcement Agency, 2002; French, 2004; Xinzhen, 2004).

Currently drug traffickers are reducing the size of their shipments to minimise loss during seizures. Increasingly, drug traffickers are found to be women, children and poor uneducated farmers, who carry the drugs on or inside their bodies from the Golden Triangle and then onto various districts of China. Women couriers swallow 400–500 grams of drugs encased in rubber, then fly from Kunming to other parts of China under the pretext of searching for employment. Most airports do not possess the inspection instruments for appropriate detection and thus most drug couriers are not discovered. In Yunnan Province, depending on the amount of drugs trafficked, a payback of 1 million Yuan (US\$120,000) was not an uncommon fee to offer those willing to walk the 30 kilometres into Myanmar and then return to China, where the drugs would then be sold to various crime syndicates (Drug Enforcement Administration, Intelligence Division, 2004a; French, 2004; Zhenglai, 2002). Cross-border drug trafficking among ethnic minority groups in south-western China has long been established, particularly because many of the ethnic groups in these various drug production areas share kinship connections, traditional friendships, common languages and customs (Zhenglai, 2002).

Cannabis is grown mainly in Xinjiang and Yunnan, primarily for domestic use. The ephedrine plant grows wild in many parts of north-east China and the chemical extracted from the plant is processed for pharmaceutical purposes. China, together with India, is the world's largest producer of the chemicals extracted from the ephedra plant. The production of methamphetamines, of which China is now a major producer, is based on the precursor chemicals pseudo-ephedrine and ephedrine. Methamphetamine laboratories are located in various provinces along the eastern and south-eastern coastal areas; most trafficking groups are involved with crime groups in Hong Kong, Taiwan and Japan. China in recent years has become a major source of methamphetamine for many Southeast Asian and Pacific rim nations.

Chinese law authorities also note a surge in the production of MDMA ('ecstasy'), mostly for the domestic market in Beijing, Shanghai, Nanjing, Guangzhou and Shenzhen. China also produces the chemical potassium permanganate, known to be sold to Latin America to refine cocaine. The National Narcotics Control Commission reports that up 3490 tons of precursor chemicals have been prevented from being shipped to foreign markets in 2003. The growing of illicit opium is as yet minor, and manufacturing of heroin within China's national borders has not yet been identified (Drug Enforcement Administration, Intelligence Division, 2004a; International Narcotics Control Board, 2004; Kulsudjarit, 2004; National Narcotics Control Commission, 2004b; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

As of January 2003 the wholesale price of heroin varied depending on location. On the Burmese border, 700 grams of heroin retailed for around US\$5,000 while in Guangzhou and Fuzhou the equivalent cost was US\$18,000. A typical retail price per gram for heroin in 2002 was US\$50, with a purity in the range of 22–57 per cent. The price of crystal methamphetamine per kilogram in 2003 in Guangzhou was US\$3,700, while a typical retail price per gram in 2002 was US\$48. To produce MDMA (ecstasy) tablets in China reportedly costs as little as US\$0.06 per tablet, but in the cities of Beijing and Shanghai a single tablet in 2003 could retail for as much as US\$27–36 (Drug Enforcement Administration, Intelligence Division, 2004a; United Nations Office on Drugs and Crime, 2004d).

Arrest and seizure data

Drug enforcement agencies at all levels have been launching increasingly concentrated campaigns against drug use and various drug-related crimes. In 2003, the National Narcotics Control Commission reported that 94,000 drug-related crimes were solved and that there were 63,700 drug-related suspects arrested: in 2002, there were 42,854 recorded offences related to drugs. Figures from the early 1990s show an increasing trend in the number of drug-related arrests in China. As with increasing drug arrests there was often an overall rise over the past decade in drug seizures. Seizures of heroin have been fluctuating in size, with 9.29 tonnes in 2002 dropping to 4.07 tonnes in 2003. In 2002, Chinese authorities were reported to have seized around 20 per cent of the world's heroin supplies.

Opium seizures have remained fairly stable over the decade, amounting to 1–2 tonnes per annum. Methamphetamine seizures have risen substantially since the late 1990s: in 2003, 4.53 tonnes were seized, but this was minor compared to the record figures of 20.9 tonnes in 2000. Cannabis seizures appear to be on the decline – from 4.493 tonnes in 2000 to 1.3 tonnes in 2002. Seizures of ecstasy pills are rising – 409,000 in 2003 compared to 225,000 in 2002. In 2003, 72,800 kilograms of precursor chemicals were seized (Berniker, 2003; Drug Enforcement Administration, Intelligence Division, 2004a; National Narcotics Control Commission, 2004b; United Nations Office on Drugs and Crime, 2004a; 2004d).

Between August and December 2004, Chinese police cracked down on over 1000 drug gangs (including 66 cross-border drug trafficking gangs), arrested over 10,000 drug suspects and seized over 6 tonnes of illegal drugs. These drug seizures include 2.03 tonnes of cannabis (33 times higher than 2003), 73.74 kilograms of ecstasy (16 times higher than 2003), 3.15 tonnes of heroin, 218.87 kilograms of opium, 436.24 kilograms of methamphetamines, 11.95 tonnes of opium poppies and 96.42 tonnes of chemicals for drug manufacture. During the campaign to dismantle the drug gangs and drug seizures, 12 police died. The number of deaths is not surprising as more drug gangs increasingly armed themselves with automatic weapons and grenades to protect their drug shipments from being seized by officials and/or other criminal gangs. The recent seizures led to a 126 per cent rise in the price of heroin in the south-western borders of Yunnan, while in south and central China the price jumped 50 per cent (China Daily, 2004; Xinzhen, 2004).

From August 2003 to January 2004, 13 south-eastern provinces and cities in Fujian and Guangdong provinces saw the launch of a special operation to crack down on the manufacturing, trafficking and transnational smuggling of methamphetamine and MDMA. During the operation 139 trafficking groups were exposed, 14 drug manufacturing and processing factories were destroyed, with over 450 kilograms of methamphetamine and 123,000 MDMA tablets seized (National Narcotics Control Commission, 2004b).

Crop studies and crop eradication statistics

Cannabis is grown illegally mainly in south-western China, in particular Xinjiang and Yunnan; in some parts of China hemp is grown for commercial rope manufacturing. Statistics on eradication of cannabis are not available. Illicit cultivation of opium occurs mainly in Yunnan, Ningxia, Inner Mongolia and remote parts of the north-west. The cultivation of licit opium poppy is controlled by government and in 2003 around 14 tonnes were grown for use in the domestic pharmaceutical industry. Statistics on eradication of illicit opium are not available (Drug Enforcement Administration, Intelligence Division, 2004a; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

A3.4 Drug-taking practices, risk factors and trends

Heroin is the main illicit drug of choice, consumed widely throughout China. The largest surveys conducted among drug users are most often confined to those receiving treatment in drug centres. Heroin injecting is common, with many studies showing 60 per cent and more of users choosing this method. While intravenous injecting is more popular, some heroin users prefer intramuscular injections. In Kunming, 77 per cent preferred intravenous injecting, while 11 per cent used intramuscular injections; in the Shanghai area, 77 per cent preferred intravenous injection with only 4 per cent choosing the intramuscular method (Garten et al., 2004; Yunnan Institute for Drug Use, 2003). In 2003, data from DASS showed 47 per cent of the respondents injected intravenously, while 5 per cent did so via intramuscular or subcutaneous routes (National Narcotics Control Commission China, 2004a).

In Guangxi, heroin comes in powder form, and drug users add mineral water, diazepam solution or pethidine to dissolve the heroin inside the syringe or other receptacle such as bottle cap, jar, cup or cigarette foil. Some drug users prefer to add diazepam as it produces a deeper sleep. In other circumstances the diazepam is used as water is not available or because the availability of heroin has decreased. Many drug users discard their needles after initial use for fear of being caught by police, being searched and arrested, and then having to perform a urine test. Syringes are commonly discarded in toilets, dustbins or into fields (Yap et al., 2002).

While the smoking of heroin is still popular, the trend towards injecting is well established. One method of smoking is to mix heroin and tobacco in a cigarette but it is more common to 'chase the dragon', which involves placing the heroin onto a piece of foil, heating it underneath with either a lighter or candle and inhaling the rising smoke (Hao et al., 2004; Yap et al., 2002; Yunnan Institute for Drug Use, 2003). Poly-drug use has become increasingly apparent, and while heroin may be the drug of choice there are 15 other kinds of opiates and 28 kinds of non-opiate substances such as ecstasy, methamphetamines and alcohol being used with a higher frequency. Users of opiates use different substances to seek different mental effects or to enhance the mental effects while using drugs (National Narcotics Control Commission, 2004a). Ecstasy is generally taken orally or by smoking while 'ice' is usually inhaled or smoked: there are reports of injecting ice, sometimes mixing it with heroin, but the widespread nature of this practice is difficult to gauge (Liu & Hao, 2002; Reid & Costigan, 2002).

According to DASS data, the location of drug use varies, but the use of their own house or the house of friends or a rented house is the most common (89%). Other popular places are public recreational spaces such as dance halls, tea houses, schools or public toilets, construction sites, illicit drug transaction places, cars and unfixed locations (National Narcotics Control Commission, 2004a).

Reports show that unsafe injecting is widespread among drug users, the greatest risk factor being the sharing of syringes and the use of non-disinfected syringes (Bezziccheri & Bazant, 2004; Hong & Cheng, 2004; Li, Feng & Liu, 2004; Ma et al., 2004; Ruan et al., 2004; Yunnan Institute for Drug Use, 2003). A survey in Kunming found more than 68 per cent of the respondents shared their syringes with and/or lent their syringes to others. In Yining City, Xinjiang, a study found the rate of sharing syringes among injectors to be 84 per cent (Ni et al., 2004; Yunnan Institute for Drug Use, 2003). A recent survey conducted with 668 IDUs in Kunming, Kaiyuan, Ruili and Yingjiang in Yunnan Province found more than one-third were involved in risky behaviours in the past month with 37.4 per cent sharing needles, 39.4 per cent sharing injecting equipment and 37 per cent drawing their drug from a common drug solution. While the respondents reported the availability of injecting equipment as high (91.2%), only two-thirds indicated the consistent use of clean needles and syringes (Population Services International/China, 2004).

Reasons for the widespread sharing of injecting equipment are varied and include: sharing with friends with whom it was believed they were safe from contracting any diseases; a state of desperation to relieve heroin cravings, consequently using any needle; lack of opportunity to buy equipment when clinics or pharmacies were closed; not having enough heroin to fill multiple syringes; lack of funds to purchase equipment; accepting second needles and syringes passed on by friends; and for some drug users the fear of contracting HIV/AIDS was a low priority when the heroin urge overwhelmed them. Most IDUs prefer plastic disposable syringes as they were widely available from pharmacies and cheaper than those made from glass (Yap et al., 2002).

It appears that many IDUs clean their injecting equipment for traces of blood, but it was not apparent that this activity was done to prevent blood-transmissible diseases. Many drug users cleaned the equipment with water but it was uncommon to use hot water and rare to use bleach, not always a common household product. Others have reported up to 39 per cent of a group of drug users cleaned their equipment with hot water and 34 per cent used an alcohol spirit to rub against the syringe. While one report described drug users using water or alcohol, drawing the liquid repeatedly in and out of the syringe to remove any visible traces of blood, generally cleaning techniques undertaken by drug users are inadequate (Yap et al., 2002; Yunnan Institute for Drug Use, 2003).

Sexual risk behaviours among drug users are alarming, with multiple sexual partners common and the rate of condom use being low. A recent report at various sites of Yunnan found 88 per cent of IDUs had unprotected sex with a regular partner while 64 per cent had unprotected sex with a sex worker (Population Services International/China, 2004). Studies in Kunming show that it is common for male drug users to have 2–5 sexual partners, but consistent use of condoms is rare (Yunnan Institute for Drug Use, 2003). Female heroin users in China are found to be more likely to exchange sex for drugs (Monitoring the AIDS Pandemic, 2004), and in one study of 171 participants around one-third had not used condoms. Of those exchanging sex for drugs, half were IDUs and, of these, 45 per cent reported sharing needles. For many of these women, exchanging sex is the only practical way for them to raise the money to purchase drugs (Wang & Lin, 2003). However, overall, female drug users in China are believed to be more likely to use condoms than males because of their involvement in sex work for drugs or money (Lin & Wang, 2003).

Major risks for IDUs are HIV/AIDS and other blood-borne viruses, in particular hepatitis C. The health status of drug users was often poor, as shown by a study in Shanghai in 2002 which showed that, of the over 23,000 participants, 77 per cent had bacterial and viral infections including hepatitis (70%) (Chengzheng et al., 2004).

By 2002 HIV was found among drug users in all 31 provinces, autonomous regions and municipalities. Reports from the 2003 national sentinel sites show the average HIV/AIDS prevalence among IDUs is 5–8 per cent. Nationwide, the average prevalence of HIV among IDUs has been increasing since 1995. In Yili, Xinjiang, average HIV prevalence has reached 89 per cent while in Guangxi it is over 20 per cent (State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China, 2004).

In 2001, 70 per cent of all HIV cases were found among IDUs (Reid & Costigan, 2002), but as of 2003 the proportion of reported HIV among IDUs had dropped to 44 per cent. However, IDU remains the main HIV transmission route in China. Current surveillance suggests the HIV/AIDS epidemic is spreading into the general population and that the spread of HIV from IDUs to other groups in society will continue to increase. In 2003, Chinese authorities estimated there are between 840,000 and one million people infected with HIV; UNAIDS suggests this figure could rise to 10–15 million cases by 2010 if no effort is implemented to curb the rise: since 1999 there was a 30 per cent annual rise in reported HIV cases (Settle, 2003; State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China, 2004; UNAIDS/WHO, 2004; Wu, Rou & Cui, 2004; Zhimin, 2004). The prevalence of hepatitis C among IDUs was high, and mostly above 70 per cent (Ruan et al., 2004; Yin et al., 2003).

A3.5 Summary table

Estimated number of drug users	1,050,000 registered but an estimated 6–12 million in total. Estimated number of injecting drug users ranges from 356,000 to 3,500,000.
Main drugs used	Heroin, benzodiazepines, amphetamine-type substances (methamphetamines, ecstasy), cannabis, opium, ketamine
Drugs injected	Heroin, methamphetamine, diazepam, pethidine, morphine
Estimated prevalence of HIV infection among IDUs	As of 2003 the proportion of reported HIV among IDUs was 44%. In some areas the prevalence rises above 80%.

A3.6 Country responses to drugs

Agreements and treaties

China is a party to the United Nations Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971, and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988. In 2003, China signed but has not yet ratified the UN Convention Against Transnational Organised Crime (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a). To enhance information sharing and coordination efforts by countries in and around Central Asia, China has been participating in drug control programs with Iran, Pakistan, Tajikistan, Turkmenistan, Uzbekistan, Russia and the United States. China has signed a drug control cooperation agreement with India and dialogue with Myanmar on counter drug issues on such matters as drug trafficking by the United Wa State Army is ongoing (Drug Enforcement Administration, Intelligence Division, 2004a). China is a signatory to the Association of Southeast Asian Nations (ASEAN) declaration for a drug-free ASEAN by the year 2015.

Policy responses

According to the National Narcotics Control Commission, China's drug policy focuses essentially on the following: 'Prohibiting trading in drugs, taking narcotics and planning poppies simultaneously, eradicating sources of drugs and obstructing channels of trafficking, enforcing the law strictly and solving the problems by examining both the root causes and its symptoms' (UNAIDS & UNDCP, 2000). The policies towards those consuming drugs according to China's legal system is for all drug users to receive medical and psychological treatment and education that will eventually lead to abstinence from drug consumption. Regulations towards

this goal are to be found in the Procedures for Compulsory Drug Addiction Rehabilitation formulated by the State Council. The government's policy is to actively rehabilitate drug users, first by admission into either voluntary or compulsory rehabilitation centres; if unsuccessful, drug users are sent to re-education through labour centres. According to the State Council, the Ministry of Public Security assumes overall leadership for China's narcotics control. In that role it is responsible for compulsory detoxification, and the decision to send drug users for drug rehabilitation programs is left with the county-level public security agencies. China's drug policies also include the implementation of a comprehensive drug control strategy, drug abuse prevention and education for the youth and to actively participate in and promote international cooperation in drug policy (Padmohoedojo, 2004; UNAIDS & UNDCP, 2000; United Nations Development Programme, 2003).

Law enforcement responses

The agencies specifically responsible for the control of illicit and licit drugs are the Ministry of Public Security, Ministry of Public Health and the Customs General Administration. Within the Ministry of Public Security, the Narcotics Control Bureau is responsible for all criminal investigations and the anti-trafficking of illicit drugs including heroin, opium and methamphetamine (Drug Enforcement Administration, Intelligence Division, 2004a). A legal framework for drug control was established in 1979, imposing severe punishment for the manufacture, trafficking and supply of illicit drugs. In 1990, a meeting of the Standing Committee of the 7th National People's 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 imprisonment for no less than seven years. The smuggling, trafficking or manufacturing of illicit drugs can result in either the death sentence or a life sentence: possession of 5 kilograms of cannabis resin, one kilogram of heroin or 50 grams of cocaine can result in the death penalty (UNAIDS and UNDCP, 2000; UNDCP, 2000).

Public sentencing rallies have a long history in China and were known as a shaming ritual acted out in public for deterrence and educational purposes. They were often conducted in public spaces such as market sites, stadiums and community halls. Drug-related crimes are also publicised in such a way and in 2001 it was reported in south-west China that, while police publicly burnt 30,000 grams of heroin, on the same day 10 people convicted of drug trafficking were publicly executed (Travaskes, 2003). The death penalty is routinely used against those convicted of drug use where previously the punishment may have been long-term imprisonment. In June 2002, it was reported that a minimum of 150 people were executed for drug-related crimes to mark the UN-designated International Anti-Drugs Day. In 2004, during the same month and to mark the same occasion, over one week, 50 people were executed for drug-related crimes in eight of China's provinces; overall, across China, the number was believed to be hundreds (Amnesty International, 2004; FIDH and Human Rights in China, 2004).

By 2003 the relationship between NNCC Beijing counter-narcotics efforts and those at the provincial level has grown closer, with increased training and exchange programs. The NNCC has implemented a program in which officers from different parts of the country are seconded to major counter-narcotics offences in China to learn how to deal more quickly and effectively with drug investigations (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

According to Chinese law, drug users must be rehabilitated, and consequently the country has adopted compulsory treatment as its main principle. It is the role of local government to organise Public Security, the Judiciary and the Public Health Department to run the compulsory rehabilitation centres (CRC) (UNDCP, 2000; UNAIDS and UNDCP, 2000; Information Office of State Council, 2000a; 2000b). While the NNCC has historically been supply- and demand-oriented, in June 2004 harm reduction was added as a third component with equal priority, during a National Conference on Drugs sponsored by the Ministry of Public Security (Harm Reduction Working Group, 2004). For information on the rehabilitation process, see under *Health and treatment responses*, below.

Health and treatment responses

An identified drug user is first sent to a compulsory rehabilitation centre (CRC) for 3–6 months, but as of late 2004 the Ministry of Public Security has been considering extending the length of detention to 12 months, to provide psychological support and job training (Harm Reduction Working Group, 2004). Detoxification is usually provided through a mix of western and Chinese medicines and herbs. At the main CRC in Kunming City, the information sheet states that the herbal remedy provided consists of *blood vine, small black medicine, hill full of fragrance, one cup fall over, bird that controls the river* and over 20 kinds of Chinese medicinal grasses and ethnic medicines (Human Rights Watch, 2003). Apart from the medicine, the program includes medical and psychological treatment, legal education and 'moral education'.

In 2004, there were 583 CRCs, providing 116,054 beds, administered by the Public Security Department (PSD) and accommodating mainly drug users who have been arrested. Government data show that the

number of people sent to CRCs from 1998 to 2003 totalled 1,493,000. In recent years the country has been forced to quadruple its capacity as a result of the increasing number of registered drug users. Around 12 new CRCs will be created in 2005, and an expansion of CRCs is included in the NNCC Five Year Strategy for 2004–2008. The number of drug users entering CRCs was over 220,000 per annum in 2003 (Harm Reduction Working Group, 2004, 22 October; Human Rights Watch, 2003; National Narcotics Control Commission, 2004a; Population Services International/China, 2004).

Decentralisation and health system reform have resulted in the CRCs being under pressure to generate their own income to support their operating costs. As of 2002 drug users were charged a fee of around US\$193 for two months' treatment, which included food, medicine and accommodation. For those unable to pay, arrangements for financial support can be accessed from the local county administration. When drug users complete a program, they are required to pay around US\$18 to be released and to be followed up every six months for urine tests for heroin residues. A failed test results in being sent once again for detoxification. However, tracking those who have been released for urine tests is problematic, and in Guangxi it was reported by officials that 80 per cent of the released drug users were difficult to locate (Population Services International/China, 2004; Yap et al., 2002).

Some CRCs are small while others hold 2000 detainees, such as the one in Kunming City, Yunnan – currently the largest in Asia. Reportedly the moral and psychological education provided there is more oriented towards a military-style camp than rehabilitation, with rote repetition of slogans, marching, exercises and shouting of numbers (Human Rights Watch, 2003). 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. There are 247 voluntary rehabilitation centres (VRC) providing more than 8000 beds. 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). Some of the VRCs resemble China's two star hotels, and while patients can have access to more facilities, the fee of about US\$10 per day on average is a considerable amount, beyond the reach of ordinary Chinese. In addition, in some places rapid detoxification is required, and counselling is not offered or is rare (Human Rights Watch, 2003; Population Services International/China, 2004; Yap et al., 2002). The Ministry of Health has strengthened the guidance of VRCs, and has drafted Standards for Drug Rehabilitation Treatment and organised writing and training materials (National Narcotics Control Commission, 2004b).

If a person relapses following discharge from a 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 165 RELCs in the country, administered by the Justice Department. It was reported that 61,500 people were sent to such labour centres in 2003 (National Narcotics Control Commission and Public Security, 2004c; Population Services International/China, 2004; Yap et al., 2002). In such centres detainees are compelled to work, are not paid for their labour and are charged for room and board at around US\$1.75 per day. Such centres raise additional income as the detainees produce goods that are then sold in local markets (Human Rights Watch, 2003; Thompson, 2004).

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 are poor. It is generally agreed that the relapse rates are very high, with estimates in the range of 80–100 per cent (Economic and Social Commission for Asia and the Pacific, 2003b; Human Rights Watch, 2003; Yap et al., 2002).

A methadone maintenance treatment (MMT) pilot program began in 2003, with the support of the Ministry of Health, the Ministry of Public Security, and the State Food and Drug Administration. In 2004, the first phase commenced in eight clinics in five provinces: Yunnan, Guizhou, Sichuan, Zhejiang and Guangxi. All MMT patients pay a daily fee of RMB5–10 (US\$1.20). The pilot project has 2000 drug users enrolled. Results have been promising, with a reduction in injecting behaviour in the last month from 70 per cent to 1 per cent and reduction of needle sharing in the last three months from 14 per cent to 3.5 per cent. The MMT Working Group is now reviewing 31 applications for an additional 26 national clinics in an expansion of the pilot sites. Based on the large number of drug users in China, it has been estimated that 1000–1500 methadone clinics are required, and these are planned to be in operation by 2007 (Harm Reduction Working Group, 2004). At the end of 2005 it is anticipated there will be 100 MMT programs operating in various parts of China (Wu, 2005).

Other harm reduction strategies appear to be gathering pace and recently the government announced that it hoped to expand outreach to 60 per cent of drug users within five years through 210 additional outreach centres. There has been an increased attempt to educate drug users about HIV transmission at detoxification centres by the Department of Public Security at some pilot sites or by inter-

national NGOs. Harm reduction approaches appear to be gaining gradual acceptance; some local authorities have embarked upon needle and syringe programs (NSPs): Yunnan legalised this approach in a March 2004 law. Similar programs have been implemented in six other provinces in areas where HIV is most prevalent among IDUs. Chinese NSPs function in three ways: by encouraging drug users to purchase new injecting equipment from pharmacies, to obtain free needles or vouchers at exchange centres (Thompson, 2004). In 2004, Yining City, Xinjiang, severely affected by HIV among IDUs, launched NSPs in three communities using 17 street outlets (including health clinics, small shops and specialty outlets) and mobile services. A total of 22,943 needle and syringe packages have been distributed and up to 24,000 used needles have been collected and disposed of in cremation facilities. As a result of this program, the sharing of needles has decreased by 52 per cent and condom use has increased by 44 per cent among IDU couples (Ni et al., 2006).

Other responses

School-based education

It is reported that schools and universities throughout the country promote counter-narcotics education by providing seminars and workshops on the dangers of drugs; these also include an HIV/AIDS component. There have been various education programs such as ‘100 Model Schools for Drug Preventive Education’ among middle school students, youth community law schools and ‘Staying away from Drugs’ by community youngsters (National Narcotics Control Commission and Public Security, 2004c; Silk Road Studies Program, 2004). The authors have not been able to access details of these programs.

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A4. Hong Kong (Special Administrative Region, China)

Geography	Located in Eastern Asia, bordering the South China Sea and China. Hilly to mountainous with steep slopes; lowlands in north. Arable land: 5.05% Permanent crops: 1.01% Other: 93.94% (2001)
Government	Limited democracy and a special administrative region of China. Chief of state: President of China Hu Jintao (since 15 March 2003) Head of government: Chief Executive Tung Chee-hwa (since 1 July 1997) Elections: Tung Chee-hwa was elected to a second term in March 2002 by an 800-member election committee dominated by pro-Beijing forces; the next election is scheduled to be held in 2007.
Population	6,855,125 (July 2004 est.) Median age: 39.4 years Age structure: 0–14 years: 14.2% 15–64 years: 73.3% 65 years and over: 12.5% (2004 est.)
Human development index	HDI rank 23 (177 countries)
Unemployment rate	7.3% (2004)
Language	Chinese (Cantonese), English; both are official
Literacy	% Age 15 and over have ever attended school: Total population: 93.5% Male: 96.9% Female: 89.6% (2002)
Religion	Eclectic mixture of local religions 90%, Christian 10%
Health	Life expectancy: 81.39 years Male: 78.72 years Female: 84.3 years (2004 est.) Infant mortality: 2.97 deaths/1000 live births HIV prevalence: 0.1% (2003 est.)
Economics	GDP: purchasing power parity – \$213 billion (2003 est.) Population below poverty line: N/A

A4.1 Narrative summary of drug vulnerabilities

Hong Kong is a highly developed industrial and commercial city with a per capita gross domestic product reaching US\$23,800 in 2002. Since 1997, when Hong Kong became a Special Administrative Region of China, economic prosperity has been relatively stable (United Nations Office on Drugs and Crime, 2004a; World Health Organization, 2004b). In 2000, youth aged 10–24 years comprised 20 per cent of the total population. At the same time youth unemployment among those aged 15–19 years was classified as serious. In 2003, for those aged 15–19 years the unemployment rate was 27.2 per cent compared to 10.5 per cent in 1997 (Hong Kong Trade Development Council, 2005). Those aged 15–19 years who do not possess skills can be left with limited opportunities and with jobs that often are low-skilled, low-paid and commonly without prospects (O'Higgins, 2002). Drug use cannot be isolated from other larger issues, such as the pressures of society upon the youth to achieve educational attainment, when at the same time opportunities for youth development and employment can be limited. Cross-border cheaper drug-seeking by some youth from Hong Kong into mainland China has been occurring since the late 1990s. Conferences are now jointly held by Guangdong (province of mainland China), Macao and Hong Kong on an annual basis to discuss ways of dealing with this issue (Health, 1999; Social Welfare Institute, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

Historical and cultural interactions with drugs

It is 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, Hodson & Traver, 2000). It was in the best economic interests of Britain to maintain the opium trade with China and, when the Chinese Emperor banned opium, war ensued. 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 (Cheung & Ch'ien, 1996; McCoy, 1991). In 1918, opium accounted for nearly 45 per cent of the colonial government's revenue, and 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 per cent of the male population smoked opium (McCoy, 1991). At the time it was estimated there were over 5000 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).

When opium was reclassified in 1946 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. 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 (Cheung & Ch'ien, 1996; Lam, 1997; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a; Westermeyer, 1976).

A4.2 Prevalence of drug use and profile of drug users

In 2004, the number of drug users registered with the Central Registry of Drug Abuse was 14,714, a 6.3 per cent fall from the 15,708 registered in 2003; the lowest in the past decade. In 2001, the number of registered drug users was 18,512, the highest it had been since 1996 when it reached 19,673. Of those registered in 2003, 4303 were newly reported persons, with the rest being previously reported cases. In 2003, of those registered, the majority were male (84.2%) and the mean age was 36 years. Since 2000, the percentage of female drug users ranged from 15.5 per cent to 16.3 per cent with a mean age of 25–28 years. Female drug users have been considerably younger compared to males over the past ten years (Narcotics Division, 2004b, 2005).

In 2003, the overall proportion of registered drug users under 21 years was 13.6 per cent compared to 21.1 per cent in 1994. In 2003, there were 2130 registered drug users under 21 years, the lowest in ten years: it has been suggested this is largely a result of under-reporting of non-narcotic drug use (J. Ch'ien, personal communication, 2005). In 2004, among newly reported cases, 27.8 per cent were female and 41.5 per cent were under 21 years of age (Narcotics Division, 2004a, 2004b, 2004c). In 2000, the estimated number of drug users was calculated, through the indicator dilution formula, to be 36,384 (Reid & Costigan, 2002). In 2001, the estimated number of heroin users was 21,000 (United Nations Office of Drug Control and Crime Prevention, 2001), of whom some 60 per cent were IDUs (Reid & Costigan, 2002). A study in 2004 reported the estimated number of IDUs from 13,000 to 40,000 with a mid-range figure of 26,999 (Aceijas et al., 2004b). There have been no other overall recent estimates of the number of drug users in Hong Kong.

In 2003, the majority of registered drug users were unemployed and 3 per cent were students. Primary or lower secondary education was completed by 79 per cent and only 1 per cent had achieved tertiary education. Most resided in public and aided rental accommodation, while 37 per cent lived in private housing (Cheung & Cheung, 2003; Narcotics Division, 2004c). Popular reasons for drug use overall among registered drug users in 2003 were 'to avoid discomfort of an absence of drug use' (51.9%), peer pressure (46.1%), curiosity (25.5%) and 'relief of boredom' (25.2%) (Narcotics Division, 2004a).

The major ethnicity among drug users was Chinese (95.1%). The majority of drug users in the 2003 drug user registry were reported to have prior convictions (75.7%), many with drug-related and other offences (Narcotics Division, 2004a). Among female drug users, peer and partner influence contributed to initiation into drug use, and for users of ketamine and heroin drug use was viewed as a potential escape from pressures and boredom related to school and family life (Narcotics Division, 2004d). In 2003, heroin was still the drug of choice (74.5%) but there has been a decline in its popularity – in 1998 the equivalent figure was 86.3 per cent. Heroin users spend a daily average of HK\$224 with a range of HK\$100–300. Hong Kong has witnessed a rise in the use of psychotropic substances over the decade with ketamine, triazolam/midazolam, cannabis, ‘ecstasy’ and methamphetamine commonly used (Ahmad Khabir, 2002; Narcotics Division, 2004c).

Among young drug users under 21 years old, the common drugs used in 2003 were ketamine (62.5%), ecstasy (34.1%), cannabis (28.4%), cough medicine (7.9%) and heroin (7.7%). The proportion of poly-drug use has been on the increase: 6.6 per cent in 1995 to 20.9 per cent in 2003 (Narcotics Division, 2004a, 2004c). The use of tranquillisers is widespread among drug users; among heroin users, they are commonly consumed to prolong the effects of the narcotics and to ease withdrawal symptoms. One such tranquilliser, which contains nimetazepam, with the proprietary name of ‘Ermin 5’, appeared on the market in 2003 (Narcotics Division, 2004a).

Data collection systems in place

Information about drug use and drug use trends is collated by the Central Registry of Drug Abuse (CRDA), which was established by the Narcotics Division of the Government Secretariat in 1972. Information is sent to the CRDA from as many as 34 agencies which include law enforcement, treatment agencies, welfare organisations, hospitals and clinics throughout Hong Kong. The primary function of the CRDA is to identify trends in drug use characteristics including type of drug consumed, the age when first started, reasons for drug use. Information is also collected about socio-economic characteristics, such as age, sex, educational achievement and employment status. Reporting agencies are requested to complete a record sheet on a voluntary basis whenever contact is made with known or suspected drug users. Reports are published on a regular basis. Information is handled with strict confidence and is available only to those directly involved with CRDA operations. Only in compelling circumstances are the records not immune from search and production in court. This level of confidentiality reportedly alleviates fears among drug users from seeking treatment and encourages the various agencies involved to cooperate (Narcotics Division, 2004c). In addition to CRDA, there have been school surveys conducted every two to three years since the late 1980s. The early surveys were conducted by the Narcotics Division; the last two to three surveys were commissioned to research teams of market research firms or academic groups in universities (Y. Cheung, personal communication, 2005).

A4.3 Drug supply, production, availability, cost and trade

Hong Kong’s role as a transit and transshipment point for large consignments of drugs from Southeast Asia to the international market has diminished considerably over the years, largely as a result of its law enforcement efforts and because of alternative drug trafficking routes through southern China. Heroin smuggled into Hong Kong is reported now to be mainly for the local market. Much of the heroin entering Hong Kong originates from the Golden Triangle, often transported through the provinces of Yunnan and Guangxi, with some drugs making their way towards Guangdong Province, where they are commonly stockpiled. There are syndicates in Guangdong Province that purchase a portion of the drugs to supply the Hong Kong market. Methamphetamines are similarly transported to Hong Kong following the same route as the heroin trade.

The heavy traffic volume and number of people crossing the land boundary between Guangdong and Hong Kong have produced many difficulties for law enforcement agencies (Narcotics Division, 2004c; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2003, 2004a). Bulky drugs such as cannabis (often transported from the Golden Triangle or Cambodia) are more likely to use sea routes, utilising the extensive maritime traffic in the waters surrounding Hong Kong (Narcotics Division, 2004c; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2003, 2004a). Air transport is the favoured route for the smuggling of drugs from distant countries such as ecstasy from Europe and cocaine from South America.

In 2004 there was a growth in the supply of cocaine in Hong Kong where the street value of the drug halved over 12 months (Narcotics Division, 2004c; China Post, 2004a). It is generally acknowledged that Hong Kong is not a producer of illicit drugs (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

In 2003, a typical wholesale price for heroin was HK\$256.638 per kilogram. In 2002, a typical street price for heroin per gram was HK\$420, rising by about an extra HK\$5 in 2003. The purity of the heroin available in 2003 increased to an average of 59 per cent compared to 41.5 per cent in 2002. An average wholesale price for ketamine in 2003 was HK\$57,125 per kilogram while a typical retail price was HK\$194 per gram. There has been a decrease in price for ecstasy from HK\$90 in 2002 to an average of HK\$85 per tablet in 2003. Cannabis commonly retailed for HK\$58 per gram in 2003, a drop from HK\$67 in 2002. In 2003, the wholesale price of cannabis was HK\$16.083 per kilogram. One gram of methamphetamine commonly retailed for HK\$374 in 2003, while a kilogram averaged HK\$54,458. The retail price of cocaine in 2003 was on average HK\$1,152 per gram but as previously reported this price appears to have fallen substantially in 2004 (United Nations Office on Drugs and Crime, 2004b; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

Arrest and seizure data

In 2003, 8652 people were arrested for drug offences, of both dangerous and other drugs, a decrease of 8 per cent when compared with 2002. Major drug offences, including manufacturing, trafficking or possession of large amounts, accounted for 2827 arrests. Since 1993 there has been an overall decline in the number of persons arrested for drug offences. Both major and other drug offences among young people have also declined in recent years (Narcotics Division, 2004c).

Seizures of illicit laboratories in recent years have included two crack cocaine laboratories in 2001, two cocaine laboratories in 2002, and in late 2004 police discovered a fish farming raft used as a cocaine factory in which 400 litres of the diluted drug was on board (China Post, 2004a; United Nations Office on Drugs and Crime, 2004b). In 2003, customs at the land boundary crossing with mainland China arrested 12 drug couriers with heroin seizures ranging from 100 grams to 1–2 kilograms. Overall, 42.16 kilograms of heroin was seized in 2003, a decline from 105.59 kilograms in 2002. In 2003, three heroin cutting centres were dismantled by the police and overall arrests in relation to heroin were down around 5.2 per cent compared to 2002 (Narcotics Division, 2004c; China Post, 2004a; United Nations Office on Drugs and Crime, 2004b).

Ketamine has become the most used drug amongst young people, closely linked to the popular rave/dance party music scene in Hong Kong. The number of arrests linked to ketamine declined in 2003 but was still 1770 persons. Seizures of ecstasy-type tablets (sometimes containing a mixture of ketamine and methamphetamine) substantially increased from 48,840 in 2002 to 142,912 tablets in 2003. In 2003, seizures of herbal cannabis amounted to a total of 233 kilograms while methamphetamine, mainly in crystalline form but sometimes in liquid form, amounted to a total of 38.64 kilograms. Cocaine seizures in 2003 amounted to 6.63 kilograms, slightly down from 8.30 kilograms in 2002. Seizures of medicinal preparations proved substantial in 2003: midazolam (39,331 tablets), chlorthalidopoxide (40,050 tablets), diazepam (29,856 tablets) and triazolam (13,390 tablets). In 2003, overall reported seizures of depressants in Hong Kong amounted to 633 kilograms (Narcotics Division, 2004c; United Nations Office on Drugs and Crime, 2004, 2004b).

Crop studies and crop eradication statistics

Hong Kong is not a known producer of opiates or cannabis.

A4.4 Drug-taking practices, risk factors and trends

Data from the Central Registry of Drug Abuse in 2003 show that, among heroin users, injection was the preferred method (54.9%), followed by fume inhalation (42.3%) and smoking (14.4%). Among the younger users of heroin, 66 per cent inhaled, 26 per cent injected and 17 per cent smoked (Narcotics Division, 2004a, 2004c).

Several studies have examined general behaviours and associated risks. A study that recruited participants from methadone clinics found that, of the 668 subjects, 51.2 per cent injected and, of 200 admitting to injecting in the previous week, most injected 5.8 times per week. Of 351 clients, 14.8 per cent had shared injecting equipment at one stage, and of this percentage 20 per cent had done so in the past 1–3 months. Of the 686 participants, 78 (11.4%) had injected drugs in mainland China; of this group, 23 clients had done so within the last three months (Wong et al., 2003). Voluntary blood donors have been examined for any HIV-related behaviours and, of the 2162 participants in the past 12 months, only 1.4 per cent of male respondents reported sharing a drug injecting syringe with others (Lau, Thomas & Lin, 2002).

Of increasing concern was mainland China's growing HIV/AIDS problem in which at least nine provinces were experiencing localised epidemics among IDUs, including Guangdong Province, which abuts Hong Kong. Guangdong has a substantially large number of drug users although estimates of the injecting population are not available. There

are high rates of needle sharing among IDUs in mainland China (Benitez, 2002). In 1999, over 90 per cent of the 267 HIV notifications in Guangdong Province were among IDUs (Lin et al., 2000).

Mobility of drug users travelling from Hong Kong into mainland China began in the late 1990s and continues to grow. In 2000, researchers found that, of a street drug-using population, 16 per cent of participants crossed the border into mainland China in search of cheaper drugs (Ch'ien, 2000). More recently a quantitative survey of 6420 participants aged 18–30 years found that 20 per cent had used drugs in mainland China in the past 12 months. Lower prices, peer influences and better availability of drugs in mainland China explained this drug-seeking behaviour. The most commonly used drugs were ecstasy (80%), ketamine, cannabis, methamphetamine and heroin (11% for males and 8% for females). Of those using drugs in this survey, many believed law enforcement measures in mainland China were less stringent and up to 80 per cent believed they had no chance or were at low risk of being arrested in mainland China due to drug use. The majority consumed alcohol prior to taking illicit drugs and sexual activities were common following drug consumption: information on the use of condoms was not described (Lau, 2003). With a high level of human traffic between Hong Kong and mainland China, those individuals who practise high-risk needle sharing and risky sexual behaviours constitute factors that will potentially spread HIV/AIDS inside Hong Kong (Chan & Lee, 2004).

A survey involving 95,788 school students found 2.6 per cent had used heroin at least once: this was a slight increase when compared to similar surveys with the proportion in 1996 (2.1%) and in 1992 (0.4%). For students who have ever used psychotropic substances, there was a 4.1 per cent increase when compared with the proportion in 1996 (2.7%). Of those ever having used psychotropic substances, 45.6 per cent used ecstasy, followed by cannabis (41.7%) and ketamine (36.5%). Cannabis and ecstasy were more common among the older students, while cough medicines and solvents were used by the younger students. For those having used heroin, the most common source of money was pocket money (39.5%) followed by an illegal source, commonly theft (28.5%). Sex after drug consumption was common (nearly 30%) but the use of condoms was not reported. Accessing heroin was considered easy/very easy by 10.5 per cent of all students and 13.9 per cent found it easy/very easy to obtain psychotropic substances (Lau, 2002). Recent studies show an increasing number of females, particularly aged less than 21 years, using illicit drugs (Wan & Rassool, 2003). A study of drug use among females showed the negative consequences of drug use, with problems related to mental and physical health, involvement in crime, violence and arrests and convictions (Narcotics Division, 2004d).

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

A longitudinal study of chronic drug users showed that, in the first series of interviews of 124 drug injectors, 90 (72.6%) did not share their needles with others and in following interviews over various time intervals the rate of not sharing diminished further between 82.4 per cent and 84.8 per cent (Cheung et al., 2003).

The Annual Street Addicts Survey (ASAS) first commenced in 1992. In 2002, the proportion of drug users injecting in the ASAS was 80 per cent. In 2001, the ASAS found that 20 per cent of injectors, 10 per cent of methadone users and 5 per cent of those attending in-patient treatment shared their needles (Department of Health, 2002). The rate of equipment sharing over the years has declined and current sharing may be a result of complacency among IDUs towards the high risks associated with sharing and/or the continuing low incidence of HIV infections among IDUs (Choi & Lee, 2000; Department of Health, 2002).

Of concern were unsafe practices for cleaning of injecting equipment, as shown in the 1998 street survey: 65 per cent of IDUs did not clean their injecting equipment appropriately (Ch'ien, Lo & Mau, 1998). The use of alcohol and bleach for cleaning requires continuous promotion. Many people assume needle and syringe sharing was rare as a result of disposable needles and syringes being available without a prescription at pharmacies for HK\$1 for a 10cc syringe (US\$0.13) and HK\$2 for a 20cc syringe (US\$0.26). Approaches to 24-hour convenience stores to stock needles and syringes have not been successful, as store owners are afraid drug users may frighten away ordinary customers from their premises at night (Reid & Costigan 2002).

The first HIV infection in Hong Kong was reported in 1984. As of 2003, there was a cumulative total of 2244 confirmed HIV infections and 669 AIDS cases. In 2003, there were 229 HIV notifications and 56 AIDS cases. The major route of transmission by exposure category is through sexual contact but 4 per cent were linked to injecting drugs in 2003. From April to September 2004 there were 11 new HIV cases due to injecting drugs. From 1984 to September 2004 there were 81 HIV notifications in which the mode of transmission was by injecting drugs. Injecting drug use as a risk factor for HIV infection makes up less than 5 per cent of all reported cases, but the situation is volatile. It is predicted there will be an increase in HIV infection

among drug users, particularly now with universal HIV testing programs introduced into all methadone clinics in 2004 (Department of Health, 2004a, 2004b; Lee, 2004a). The proportion of HIV infections among drug users has increased from not more than 3 per cent before 1998 to 10 per cent in 2003 and 2004 (Lee, 2004b). It is estimated that there could be 2500–3000 HIV-infected people among the 6.7 million population of Hong Kong (WHO, 2001).

Testing of drug users in treatment shows a rate of hepatitis C in 2000–2001 of 46.2 per cent, a decrease from 73.9 per cent in a previous study undertaken with the Department of Health in 1991–1992 (Department of Health, 2004c).

A4.5 Summary table

Estimated number of drug users	36,384 (2001) – updates not available
Main drugs used	Heroin, ecstasy, methamphetamine, ketamine, cocaine, cannabis, cough mixtures, solvents
Drugs injected	Heroin
Estimated prevalence of HIV infection among IDUs	The absolute number of HIV infections among drug users has increased to over 10% in 2002 and 2003.

A4.6 Country responses to drugs

Agreements and treaties

Hong Kong is a party to the Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971 and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988 (Narcotics Division, 2004c).

Policy responses

The strategic approach to deal with the drug problem is led by the Narcotics Division of the Security Bureau. The strategy is broad-ranging, in that it includes legislation (involving law enforcement, police and customs), preventive education and publicity programs, treatment and rehabilitation services, research and external cooperation and exchange of information with others involved in narcotic matters. The Commissioner for Narcotics acts on the advice of the Action Committee Against Drugs (ACAN). ACAN is an advisory body on policy matters that focuses on illicit drugs. It has a chairman and 17 unofficial members selected for their experience and expertise in the fields of social and community work. There are also two government officials, the Commissioner for Narcotics and a representative of the Director of Health. The Director of the Central Narcotics Bureau of Singapore is also invited to ACAN as part of a reciprocal arrangement between the Singapore and Hong Kong Governments. ACAN constantly reviews government projects related to drug issues and helps to enlist the support of the public to fight against drug use.

There are also three subcommittees – Prevention Education and Publicity, Treatment and Rehabilitation, and Research. These subcommittees are each headed by an ACAN

member. There are 64 subcommittee members from various fields ranging from social work to the legal and commercial sectors. There is also a Drug Liaison Committee, comprising 25 members, whose role is to facilitate co-ordination and communication between the Commissioner for Narcotics and voluntary agencies (Narcotics Division, 2004c).

Law enforcement responses

The Hong Kong Government has gone to great efforts to suppress illegal drug supply for over 45 years by vigorously imposing 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, 2004c). Possession of 10 grams of heroin can result in a 2–5 year sentence and up to 12 grams of methamphetamine can bring a 3–7 year sentence. Cannabis guidelines show possession of over 500 grams of cannabis resin can result in a 4–8 month sentence and the cultivation of cannabis or opium poppy brings a fine of HK\$100,000 (US\$12,821) and 15 years imprisonment. Managing a divan incurs a fine of HK\$5 million and 15 years imprisonment (Laidler et al., 2000; Narcotics Division, 2001, 2004c). The Narcotics Division has recently revised a Code of Practice for Dance Party Organisers as of 2003 in order to guide organisers of these events in the prevention of drug use and other crimes (Narcotics Division, 2004c).

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 compulsory 12-month statutory after-care supervision. If illicit drug use is detected during this supervision period, the person can be called back to the centre for further treatment. The CSD operates three treatment centres, one for men (capacity for 964 inmates) and the other two for women (capacity 190). The total number of inmates admitted into the compulsory drug treatment scheme was 1283 inmates, similar in number to 2002 (Laidler et al., 2000; Narcotics Division, 2001, 2004c).

Health and treatment responses

The Hong Kong health care policy states that no one should be denied adequate medical treatment due to lack of funds. As a consequence, the Department of Health and hospital authority provides a range of services and facilities to meet the needs of the public. Complementing these services are those offered by the private sector (World Health Organization, 2004b).

There are various facilities for people who voluntarily seek treatment and rehabilitation, many operated by NGOs. In 2003, there were substance abuse clinics in six hospital authorities' agencies offering drug treatment to 745 clients. The overall aims of the residential programs are detoxification, treatment, rehabilitation and the after-care of users requesting help to stay drug-free.

In 2001, the total number of voluntary residential beds was 1122 for males and 138 for females. The number of people admitted into these establishments has increased in recent years.

The Society for the Rehabilitation and Aid for Drug Addicts (SARDA) operates four residential treatment centres (for male and female patients), five halfway houses and post-discharge socio-medical care to more than 2000 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 provides counselling services to each of the 20 government methadone clinics focusing on both demand and harm reduction. At the end of 2003 nearly 2000 methadone clients received SARDA's counselling services (Narcotics Division, 2001b; 2004c; Laidler et al. 2000). Other treatment and rehabilitation centres include the Caritas Wong Yiu-nam Centre, Barnabas Charitable Service Association, Christian New Being Fellowship, Finnish Evangelical Lutheran Mission Ling Oi Centre, Glorious Praise Fellowship, the Christian Zheng Sheng Association, the Drug Addict Counselling and Rehabilitation Services, St Stephens Society, Wu Oi Christian Centre, the Hong Kong Christian Services PS33, Hong Kong Christian Service Jockey Club Lodge of the Rising Sun and Operation Dawn (Laidler et al., 2000; Narcotics Division, 2001, 2004c).

Methadone treatment programs have been in operation since 1972 and both maintenance and detoxification options are available for outpatients. In 2003, there were 20 clinics (most have facilities that also provide primary health care for all community members) scattered throughout Hong Kong

and operated by the Department of Health. Maintenance entails a dose each day, with the price remaining stable for many years at HK\$1 (US\$0.13). The operating times of the service are extensive: six operate as full day clinics from 7am to 10pm, while the rest operate in the evening from 6pm to 10pm. They operate seven days a week, all year round and, during typhoons, a system is in place to service clients in predetermined central locations. There are generally no nurses employed at these clinics, with the dispensing of methadone left to trained Auxiliary Medical Services, mainly volunteers who work in these sites for a modest hourly payment. No take-home medication is permitted and there is no 'waiting list' for methadone since the program was implemented. The methadone program has a high coverage and services 7000–9000 drug users on a daily basis with up to 98 per cent on maintenance. In 2003, the average daily attendance was 7056, while in 2000 it was 6501 (Ch'ien, Lee & Stadlin, 2002; Lee, 2004a; Narcotics Division, 2001, 2004c; Newman, 2004). In 2004, universal voluntary HIV screening using urine specimen commenced with an aim to cover at least 75 per cent of all registered drug users (Lee, 2004b).

As of 2005 it has been reported by the Hong Kong Government that there will be a HK\$7.67 million allocation from the Beat Drugs Fund for 20 anti-drug projects in the 2005–06 funding exercise, bringing the total number of projects sponsored to 289 and the funds dis-

bursed to HK\$133.76 million since the fund's establishment in 1996. Of the 20 projects approved, 12 are related to preventive education and publicity (HK\$476.7 million), three to treatment and rehabilitation (HK\$678,380), one to research (HK\$120,000), and four to mixed-type projects (HK\$2,103,364). The mixed-type projects, preventive education and publicity-related projects cover activities targeting high-risk youths, parents, teachers and youth workers as well as families with children with disabilities, single parents, new arrivals and ethnic minority groups (Hong Kong Government, 2005).

Other responses

School-based education

The Narcotics Division works with ACAN, NGOs and government bodies to reach young people with anti-drug messages. In the 2002–2003 school year anti-drug talks were delivered to over 100,000 students. Drug education programs are provided to primary and secondary school students, as well as students at the English School Foundation, international schools and the Hong Kong Institute for Vocational Education. The focus of the program covers common drugs of use, harmful effects, reasons for drug use and refusal skills. In 2004, there were 13 programs for over 4000 parents and 73 programs for youth and people at the workplace (Narcotics Division, 2004e; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

Community development

In 2003, community organisations conducted 20 anti-drug projects funded by government. A 24-hour, anti-drug abuse hotline provides information on how to manage abuse by young people in association with drug use, as well as information about preventive education, treatment and rehabilitation services provided by government and voluntary agencies.

The Hong Kong Jockey Club 'Drug InfoCentre', open since 2004, is a permanent education centre dedicated to drug prevention. The objective of the Centre is to educate the public about drugs, the harms caused and methods of prevention.

Numerous anti-drug publicity campaigns are held throughout the year using the medium of television, radio and advertisements. Each year on 26 June Hong Kong holds the International Day Against Drug Abuse and Illicit Trafficking (Cheong, 2004; Narcotics Division, 2004c, 2004e).

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A5. Indonesia

Geography	Located in south-eastern Asia, archipelago between the Indian Ocean and the Pacific Ocean. Borders with Timor-Leste, Malaysia and Papua New Guinea. Mostly coastal lowlands; larger islands have interior mountains. Arable land: 11.32% Permanent crops: 7.23% Other: 81.45% (2001)
Government	Republic Chief of state: President Susilo Bambang Yudhoyono (since 20 October 2004) and Vice-President Muhammad Yusuf Kalla (since 20 October 2004); Note: The President is both the Chief of State and Head of Government Head of government: President Susilo Bambang Yudhoyono Elections: President and Vice-President are elected by direct vote of the citizenry
Population	238,452,952 (July 2004 est.) Urban: 44.5% of total (2002) Median age: 26.1 years Age structure: 0–14 years: 29.4% 15–64 years: 65.5% 65 years and over: 5.1% (2004 est.)
Human development index	HDI rank 111 (177 countries)
Unemployment rate	8.7% (2003 est.)
Language	Bahasa Indonesia (official, modified form of Malay), English, Dutch, local dialects, the most widely spoken of which is Javanese
Literacy	% Age 15 and over can read and write: Total population: 87.9% Male: 92.5% Female: 83.4% (2002)
Religion	Muslim 88%, Protestant 5%, Roman Catholic 3%, Hindu 2%, Buddhist 1%, other 1% (1998)

Health	Life expectancy: 69.26 years Male: 66.84 years Female: 71.8 years (2004 est.) Infant mortality: 36.82 deaths/1000 live births (2004 est.) HIV prevalence: 0.1% (2003 est.)
Economics	GDP: purchasing power parity – \$758.8 billion (2003 est.) Population living below the national poverty line (27.1%), 1990–2001

A5.1 Narrative summary of drug vulnerabilities

The Asian financial crisis of 1997 impacted severely upon Indonesia, leading to major economic and political upheaval. A consequence of this period was massive migration and a continuous influx of individuals from the countryside to the cities. This led to substantial strains upon urban services, and afflicted the urban poor the most. Rapid inflation swept the nation, followed by a surge in unemployment, under-employment and hunger, and an overall decline in government spending in health services (Friedman & Reid, 2002; Paitoonpong, 2001; Reis, 2003; World Bank, 2003). In 1975, an estimated 20 per cent of Indonesians were urban dwellers; by 2025, an estimated 60 per cent of the population will reside in urban centres: an increase in more destitute individuals and families residing in urban slums will be the inevitable outcome.

In 1999, two out of five urban Indonesians were poor; currently, one-third to one-half of Indonesia's population have incomes below the poverty line (Australian Agency for International Development, 2004b; BPS – Statistics Indonesia, BAPPENAS &

United Nations Development Programme, 2004; World Bank, 2003). More than half the population is aged 12–30 years, with around 38 million people aged 15–24 years (Reis, 2003; United Nations Office on Drugs and Crime, 2003b): an age group common among drug users. Of increasing concern is youth unemployment, which stood at 19 per cent in 2000; the supply of labour exceeds available employment opportunities: under-employment has been an issue for a long time (O'Higgins, 2002). Indonesia was previously a transit rather than a destination country for illicit drug trafficking but this has recently changed, so that Indonesia is now a point of transit, a destination and a source of drugs (National Narcotics Board, 2003a). Following the end of the Suharto era there has been considerable growth in the drug trade and there is concern as to why this may be the case. Media reports have speculated that as the under-funded security services have lost control of lucrative businesses in the democratic era, they may be supplementing income by facilitating illegal business, possibly including drug distribution (Roosa, 2003).

Historical and cultural interactions with drugs

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 many incidents of 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 (Irwanto, 2001; McCoy, 1991). By 1862 the ruling Dutch established their own opium plantations in Java and Sumatra. Opium became important socially and economically; by 1929 there were over 1000 opium dens and 100,000 registered smokers, most being Javanese (McCoy, 1991). Prior to the Japanese invasion in 1942, opium was obtained through a rationing system under Dutch rule (Setibudhi, 1996; Setyonegoro, 1978).

By the late 1960s heroin, morphine, cannabis, 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 (Gordon et al., 2000; Spencer & Navaratnam, 1981; Widjono, 1979). In the late 1990s crystal methamphetamine (commonly known as *Sabu-sabu*) and heroin (commonly referred to as *Putauw*) emerged as popular drug choices, while the use of cannabis and alcohol continue to increase (Irwanto, 2001; Tantoro & Fidiansjah, 1999).

A5.2 Prevalence of drug use and profile of drug users

There have been various estimations of the number of drug users in Indonesia; what is not disputed has been the exponential increase nationwide in drug use, not confined to the large urban centres. It has been suggested that there has been a three-fold increase in the number of drug users from 1997 to 2000 (National Narcotics Board, 2002b; Utomo, 2003). Estimates of the numbers of illicit drug users are in the range of 1–3 per cent of the total population: 1.3–6 million people (Centre for Harm Reduction, 2004b; Moore, 2003a; Mumtazah, 2003; National Narcotics Board, 2003a, 2003b). One estimate has suggested one million drug users in the Jakarta region alone (National Narcotics Board, 2003a), although only 3217 individuals have been officially reported by the Ministry of Social Welfare (United Nations Office on Drugs and Crime, 2004a). Access to drugs has become increasingly easy, with drug use spreading to all sections of society. It is unclear from the data available as to what constitutes 'drug use', thus some drug use estimates are questionable. For example, if one million in Jakarta use drugs and 80 per cent of them are males 15–30 years of age (as most service records show), then six out of ten men in this age group are consuming drugs: the credibility of such a figure would have to be disputed (E. Pisani, personal communication, 2005).

A national surveillance survey undertaken in Jakarta in 2002 found that about 34 per cent of male high school students had consumed illicit drugs; for females, the figure was only 6 per cent. Close to half of the boys and 15 per cent of the girls said they had been offered drugs, and one-third of boys but fewer than one in ten of the girls stated they had been approached by a drug dealer (Ministry of Health, 2003). A national survey in 2003 with 13,699 participants from 26 provinces covering 179 junior high schools, 143 senior high schools and 57 universities found 5.9 per cent of the total had ever used various types of illicit drugs, 3.9 per cent in the past year (2.8 per cent in past month) and that there was a pattern of illicit drug dealing. The drugs commonly used included cannabis, sedatives, ecstasy, methamphetamine and heroin (National Narcotics Board, 2004b).

In 2005, national surveillance data from Jakarta high schools show that 42 per cent of boys and 6 per cent of girls have tried drugs (among the boys this is a substantial rise from 2003), but that injecting is not increasing – the data show that 1.5 per cent of the males had been injecting. The most consumed drug is cannabis, but 10 per cent of high school students say they are using methamphetamines and 9 per cent are using ecstasy (E. Pisani, personal communication, 2005). In a study of adolescents from Indonesia, Nepal, the Philippines and Thailand, the proportion of adolescent boys having ever used illicit substances was reportedly highest among those from Indonesia (Choe et al., 2004).

Estimates of injecting drug users range from 124,000 to 196,000 (Ministry of Health, 2003; Riono & Jazant, 2004; United Nations Office on Drugs and Crime, 2004a), although it has been suggested the figures could be considerably higher (Aceijas et al., 2004b). Quality control as to what information is

entered into the databases is often lacking, thus some higher estimates can lose credibility (E. Pisani, personal communication, 2005).

Since the late 1990s there has been an increasing trend towards the use of heroin, amphetamines and cannabis: heroin is the most common drug for which treatment is sought at treatment facilities. In recent years there has been some increase in the use of cocaine (United Nations Office on Drugs and Crime, 2004a).

The majority of drug users are male, most commonly aged between 15 and 25 years (60–80%): females on average make up 8–20 per cent of the total number of drug users: the data available do not identify if the suggested percentages relate to drug use and/or injecting drug use. It is believed that drug users are becoming increasingly younger, with many from junior and senior high schools. A retrospective study undertaken by the Asian Harm Reduction Network of 500 current IDUs in Jakarta, Bogor, Tangerang, Bekasi and Depok reporting on their drug use history found that most began drug use at 13 or 14 years of age. Most began with minor tranquillisers such as valium, while others used cannabis. The primary causes for initiating drug use were seen to be linked with wider availability, curiosity and peer pressure (Centre for Harm Reduction, 2005; National Narcotics Board, 2003a, 2003b; United Nations Office on Drugs and Crime, 2004a). Behavioural surveillance among injecting drug users (IDUs) in Jakarta, Bandung and Surabaya in 2002 found most IDUs lived with their parents, were 20–24 years (49–75%); less than 13 per cent had formal employment but the average monthly income (Rs700,000/US\$80) was higher than the minimum wage (Ministry of Health, 2003). Illicit drug use is not limited to the lower socio-economic groups but occurs also among the more affluent sectors of society (Riono & Jazant, 2004).

Data collection systems in place

There are various potential sources of information on illicit drug use in Indonesia including school surveys, studies on drug use, estimates of drug user numbers, drug-related HIV, treatment demand data, mortality data and arrest and seizures. However, there are substantial gaps in the data largely because the coverage of the sources is not comprehensive and often does not include the entire country. The majority of data collected focused on Jakarta; examples include government drug treatment centre admissions, which focus on the only specialised hospital of its kind in the country, the Drug Dependency Hospital (RSKO), and studies of drug use linked to patchy HIV surveillance.

The HIV surveillance system has just one official sentinel site among drug injectors (RSKO), which began in 1996. Other drug injector sites exist in other provinces but they report sporadically and it is not always clear which population is sampled (sometimes it is incarcerated IDUs; sometimes it is drug users in treatment, but not necessarily restricted to injectors).

Behavioural surveillance among IDUs began in Jakarta in 2000, and was expanded to three cities (Jakarta, Bandung and Surabaya) in 2002. The systems were taken over by the National Bureau of Statistics (BPS) in conjunction with the Ministry of Health in 2004. The 2004–2005 round will add a fourth city, Medan. As of early 2005 only the data for Surabaya and Bandung have been submitted (E. Pisani, personal communication, 2005). Data on arrests and drug seizures were the most developed, but are limited to drug supply trends.

A recent assessment of the drug reporting and recording (R/R) system in six provinces found that information on prevalence of drug use in the provinces is incomplete; there is no R/R system on drug use in most health facilities/drug treatment-related institutions (the focus was on morbidity reporting); drug use recording forms from various data sources have limited variables (a particular problem when reporting on amphetamine-type substance issues) and are generally unavailable or, if available, not used. The National Narcotics Board website, the Ministry of Health's database and the Information Centre for Drug Abuse collect and share drug information between different agencies, departments and institutions; the BNN and NGOs apparently have monthly meetings to share information.

Overall, the data collection systems in place have various shortcomings, including limited hardware/software for the recording and reporting of drug use (most is still done manually); competence in R/R of drug use is under-developed. The size of the country, its nature as the largest archipelago in the world, and decentralisation all hinder the communications and sharing of information; and coordination and communications between related institutions are limited (National Narcotics Board, 2004b; United Nations Office on Drugs and Crime, 2004a).

A5.3 Drug supply, production, availability, cost and trade

Illicit drugs can enter Indonesia through any of hundreds of points throughout the world's largest archipelagic country (17,000 islands), with a coastline of more than 8500 kilometres, with many remote, inaccessible areas, thick jungles, porous borders, steep slopes and uninhabited islands. Indonesia has a relatively weak customs service, with poorly paid officials and unsophisticated law enforcement techniques, contributing to great difficulty in control of smuggled illicit drugs (National Narcotics Board, 2003b; United Nations Office on Drugs and Crime, 2003a; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a). Drugs come into Indonesia from a variety of regions and nations: most of the heroin entering Jakarta has its origins in Afghanistan, entering via Pakistan. Heroin can transit from Thailand with a favoured route through Bangkok and Singapore into Jakarta (US State Dept, 2003), or from Afghanistan to Karachi (Pakistan), New Delhi (India) or Kathmandu (Nepal), and then on to Jakarta or Medan. Heroin from the Golden Triangle can be shipped through Bangkok on to Hat Yai, Penang, Medan, Denpasar and Jakarta (United Nations Office on Drugs and Crime, 2003c).

Ecstasy is smuggled into Jakarta from the Netherlands, Belgium and Germany, and increasingly from Ghuang Zhou in China. *Sabu-sabu* (crystalline methamphetamine hydrochloride) and ATS precursors are often trafficked from Chinese syndicates in China, Hong Kong and the Philippines, and most

often in collaboration with local Indonesian Chinese. Methamphetamine pills can originate from Myanmar and Thailand. Precursor chemicals produced in China often transit through Singapore aboard commercial flights, but also have their origins in the United States, Taiwan and India. Indonesian ecstasy is smuggled into other nations, particularly Malaysia, Singapore and Australia (National Narcotics Board, 2003a, 2003b; United Nations Office on Drugs and Crime, 2003b; United Nations Regional Task Force on Drugs and HIV/AIDS, 2002).

Cocaine from the Andes travels via Brazil onwards to Hong Kong, then to Denpasar, and often to Australia. Other cocaine routes are from Santiago to Frankfurt and on to Jakarta or from Colombia, Bolivia or Mexico more directly to Denpasar (National Narcotics Board, 2003a). Cannabis is grown and harvested in North Sumatra, and especially in the province of Aceh. Cannabis is also smuggled from Nanggroe Aceh Darussalam Province to Medan, Bandar Lampung, Jakarta, Bandung and Surabaya. Indonesian cannabis is trafficked to other Asian nations such as Malaysia and Japan (National Narcotics Board, 2003a, 2003b; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2003).

Indonesia has a variety of both domestic and foreign drug trafficking networks, especially Southeast Asian and West African drug syndicates. Those with a West African origin (often from Nigeria, Ghana and Liberia) are heavily involved in the trafficking of heroin in Indonesia, but there are also heroin couriers

(sometimes female) of Indonesian and Thai nationality. Europeans and smaller numbers of Americans and Australians also participate in drug smuggling (National Narcotics Board, 2003a, 2003b; United Nations International Drug Control Programme, 2002c).

In 2002, a typical wholesale price for heroin was US\$38 per gram; a typical wholesale price for cocaine was US\$49 per gram. Herbal cannabis in 2002 retailed on average for about US\$1 per gram. One ecstasy tablet reportedly sells for about US\$4–5, while a gram of methamphetamine costs about US\$30–35. Such drugs are commonly used in environments such as discos and organised drug parties (National Narcotics Board, 2003a, 2003b; United Nations Office on Drugs and Crime, 2004b). Heroin in West Kalimantan costs Rp40–50,000 per packet and there is a market in the exchange of gemstones (a natural resource to this region) for heroin (Moore, 2003b).

Arrest and seizure data

In 2004, the Jakarta police reported 4799 drug-related arrests, a 39 per cent increase from 2003, and the number of suspects apprehended increased to 6097 from 4554 in 2003. (Arrests are those who are detained and charged, i.e. those who go before a magistrate; suspects arrested are those who are detained for questioning and then released without charge.) These included ten suspects for drug production, over 2500 for drug dealing and the rest for drug consumption. Most were aged 19–30 years, with 283 others aged 10–18 years. The occupations for those arrested varied from

nightclub owners to sex workers, hospital staff to construction workers. Drug seizures in Jakarta also increased in this period: cocaine seized increased from 128.5 grams in 2003 to 6315 grams in 2004. Figures show that, in 2004, 8493.3476 kilograms of cannabis leaves, 0.6071 kilograms of hashish, 12.71213 kilograms of heroin, 251,000 ecstasy tablets and 28.39730 kilograms of methamphetamines were seized by the police (National Narcotics Board, 2004a).

The National Narcotics Board (BNN) data show that the number of nationwide narcotic-related arrests has increased by 58 per cent per annum over the past five years. There were 1833 such cases in 1999, increasing to 7140 in 2003: of the latter, 87 were below the age of 15 years. The vast majority of the cases were in Jakarta, North Sumatra and East Java. BNN data also showed a sharp rise in narcotic consumption among high school students in 2004 (Centre for Harm Reduction, 2004c, 2004f).

In 2002, 392 kilograms of methamphetamines were seized nationwide along with 76,724 tablets and 100 kilograms of ecstasy powder (United Nations Office on Drugs and Crime, 2004a). The Indonesian National Police have in the last five years destroyed 1200 tons of cannabis and confiscated over 400,000 ecstasy pills and over 400,000 grams of methamphetamine. The amounts seized varied considerably from a reported 0.6 grams of cannabis, seized from a 14-year-old offender, to 13.4 kilograms of cocaine intercepted in Soekarno-Hatta airport, Jakarta (Centre for Harm Reduction, 2004a; Emrys, 2004).

Drug seizures have been reaching record levels, indicating not only the large amount of drugs entering the country but also how much is being consumed. With an increase in the number of drug-related arrests, it has been estimated that the flow of trafficked drugs could amount to Rp1.10 trillion per day. In Jakarta alone, the Provincial Narcotics Agency suggested that 10 out of the 47 districts were now prone to drug trafficking (Centre for Harm Reduction, 2004g, 2004j; National Narcotics Board, 2003a, 2003b). It has been reported that over the last five years at least 8 kilograms of heroin were smuggled through the Soekarno-Hatta International Airport each month (Centre for Harm Reduction, 2004e).

Drug laboratories have been dismantled in recent years; a highly publicised one was found in Tangerang, West Java, capable of producing 150,000 ecstasy tablets per day, while another smaller factory in the same area was detected in late 2004 producing 10,000 ecstasy tablets per day for distribution to the cities of Jakarta, Bandung, Medan and Makassar (Centre for Harm Reduction, 2004h; National Narcotics Board, 2003a, 2003b).

Crop studies and crop eradication statistics

The illegal cultivation of cannabis has been a concern for government authorities for some years, largely because of the fear that production of this crop provided a source of income for insurgency groups opposing central government rule. Crop eradication and substitution programs have been undertaken periodically in Aceh. However, these have been postponed since the mid-1990s due to various economic, political and security constraints in this region (National Narcotics Board, 2003a, 2003b).

A5.4 Drug-taking practices, risk factors and trends

In 2004, the commonly used drugs and routes of administration were as follows: cannabis – smoked; heroin – snorted or injected; methamphetamine – smoked, snorted or injected; ecstasy – swallowed; depressants – swallowed; solvents – inhaled; codeine – swallowed; and cocaine – snorted or injected. Cannabis was the drug of choice, followed by ATS, heroin and sedatives (National Narcotics Board, 2004b). Heroin is most commonly injected, with rates of injecting appearing to be increasing throughout the country (Centre for Harm Reduction and AHRN Country Office Indonesia, 2004). However, heroin is not always injected: as well as smoking and inhaling, an unusual method of administration in West Nusatenggara is via self-inflicted shallow cuts to the skin, where the heroin is rubbed into the wound up to three times per day (Moore, 2003b).

Risk behaviours among IDUs were investigated in a 2002 study involving 650 males in Jakarta, the second largest city of Surabaya, and Bandung. While 98 per cent of the respondents knew that HIV could be transmitted by the sharing of needles and injecting equipment, 85 per cent reported using needles that had previously been used by another person within the past week, and 7 per cent loaded a drug solution into their own syringe from a communal syringe used by others. Cleaning of used syringes and injecting equipment was inadequate: less than 4 per cent used bleach to clean injecting equipment between uses, while 83 per cent used water from a shared container for cleaning of needles. After two years of prevention programming that did not include access to clean needles, needle sharing in the week prior to the survey had not changed in Surabaya. The 2004 sur-

veillance data found that around 90 per cent of those who accessed the outreach program and those who had not were continuing to share needles. Bleaching did increase, rising from 3 per cent to 16 per cent. It was highest among those who received bleach from the outreach program, at 47 per cent. Information from the same surveillance shows the major response for not carrying their own needles among those without needles was the fear of being found carrying a needle and being arrested; among the respondents 93 per cent in Surabaya and 80 per cent in Bandung expressed this fear (E. Pisani, personal communication, 2005).

Another study found IDUs using old needles and syringes, and not cleaning injecting sites prior to injecting (Moore, 2003a). Syringes and needles can be purchased from pharmacies in some parts of the country, but access is often difficult; in places like East Kalimantan, IDUs acquire injecting equipment from hospital refuse or by purchase from private health posts (Moore, 2003b).

The widespread sharing of injecting equipment (sometimes up to 100 per cent of participants in surveys share unsterilised equipment) has been an ongoing problem. Most injectors have used other illicit drugs for two to three years before starting to inject. While in some studies all respondents know that injections can spread HIV, the vast majority either use someone else's needle or pass their needle onto others after they have injected. The sharing of needles tends to decrease over time, with most long-time users more likely to use alone (Pisani, 2003; Pisani et al., 2003). However, not all drug users are aware of the link between HIV and the sharing of needles: for instance, among female drug users in South Kalimantan, where only one of the seven knew of the risk (Moore, 2003b).

Drug overdoses are also frequent, generally receiving minimal if any medical treatment for fear of police and parents (Djauzi et al., 2002; Lake, 2004; United Nations Regional Task Force on Drugs and HIV/AIDS, 2002). A recent study in Bali found that, of the 81 participants, 44 per cent had experienced an overdose at least once and most had known of friends who suffered from a fatal overdose (Yayasan Harapan Permata Hati Kita, 2003). In 2004, surveillance found 23 per cent of IDUs in Surabaya and 29 per cent in Bandung had experienced overdoses themselves, while 84 per cent and 95 per cent respectively had friends die of an overdose (E. Pisani, personal communication, 2005).

Drug users are commonly arrested and gaoled, and some people start their injecting careers while incarcerated. In the 2004 surveillance data, 21 per cent of the IDUs in Surabaya and 17 per cent in Bandung had been in gaol at some time in the last year; 31 per cent of them in Surabaya and 18 per cent in Bandung injected while in gaol (E. Pisani, personal communication, 2005). The use of drugs among inmates inside prisons is widespread, but while it is relatively easy to access drugs (most often as a result of corrupt authorities), access to clean injecting equipment is difficult. As a consequence, widespread sharing of contaminated injecting equipment is the norm and, with unsafe sex, the primary reason for the spread of HIV in prison cells (Dursin, 2002; Pisani et al., 2003). A recent study of juvenile offenders in Medan found most were poly-drug users, 20 per cent injected drugs while in prison, and common drugs used in the correctional settings included alcohol (62%), cannabis (85%), ecstasy (41%) and heroin (20%) (Fachruddin, 2004).

Sexual behaviours of drug users are a concern. A large study that examined the sexual risk behaviours of IDUs found 70 per cent had multiple partners over a 12-month period and that consistent condom use with wives, girlfriends and casual partners was below 10 per cent (Pisani et al., 2003). As is often found in other parts of Asia, large numbers of IDUs report buying sex from sex workers, with the vast majority seldom or never using condoms. A behavioural surveillance survey in 2004 showed that in Surabaya 52 per cent and in Bandung 43 per cent of male drug users bought sex; among the IDUs of Surabaya and Bandung, 45 per cent and 30 per cent respectively reported unprotected sex with sex workers. In recent years reports have emerged of drug users selling sex as a way of raising funds to purchase drugs; 11 per cent of male IDUs in Bandung and 5 per cent in Surabaya reported selling sex in the last year (E. Pisani, personal communication, 2005). It has been suggested that sex workers themselves are increasingly injecting drugs, such as heroin, as the drugs become more available (Setiawan, 2002), but overall this can be disputed. One recent study of 11,650 sex workers asked about their drug-consuming habits and well below 2 per cent had ever injected in either 2002 or 2004, although 14 per cent had taken other types of drugs, with no difference between the rounds (E. Pisani, personal communication, 2005). An estimated 230,000 sex workers in Indonesia serve several million men each year, adding to the increasing concern for the potential for HIV to move from the concentrated population of IDUs into the non-injecting population in the coming years (Pisani et al., 2003; Reid & Costigan, 2002; Riono & Jazant, 2004).

HIV infection and AIDS constitute a major risk for IDUs in Indonesia: there has been a dramatic rise in HIV prevalence among IDUs

in recent years, but this reportedly reflects changes in testing and reporting practices, not changes in epidemiology (E. Pisani, personal communication, 2005). In 1996, 81 per cent of notified HIV infections were as a result of sexual transmission; now, Indonesia has a concentrated HIV epidemic primarily among the IDU population. In 2003, 48 per cent of AIDS cases were a result of heterosexual transmission, with 34 per cent a result of injecting drugs. In 2004, the Ministry of Health stated 41 per cent of 5701 people notified as living with HIV/AIDS had been infected as a result of injecting drugs; in 2003, 80 per cent of new infections were linked to IDU (Centre for Harm Reduction, 2004i; Centre for Harm Reduction and AHRN Country Office Indonesia, 2004; Moore, 2003a; UNAIDS, UNICEF & WHO, 2004). HIV seroprevalence rates have been found to be as high as 40–53 per cent in various sites such as prisons and drug treatment centres (Ford et al., 2004). In the Salemba Penitentiary, Central Jakarta, the major remand centre for Jakarta, of 200 prisoners tested, 22 per cent were HIV-infected (Junaidi, 2002). In a poor Jakarta suburb known as Kampung Bali, of the 200 heroin users who volunteered to be tested from February 2001 to May 2004, 93 per cent were HIV-positive (Australian Broadcasting Corporation, 2004). As of March 2005, the program manager of this service reported that, of the IDUs accessing voluntary counselling and testing, 93 per cent tested HIV-positive (P. Joko, personal communication, 2005). Hepatitis C virus (HCV) infection is also rampant among IDUs: at a drug treatment and recovery centre in Bogor, West Java, which has been monitoring clients since 1999, the prevalence was 83 per cent at the end of 2003 (Yayasan Harapan Permata Hati Kita, 2004). As of December 2003, the total number of people living with HIV/AIDS was estimated to be 110,000 (UNAIDS et al., 2004).

A5.5 Summary table

Estimated number of drug users	1.3–6 million. Of these, 124,000 to 196,000 are IDUs; it has been suggested this figure could rise to 1 million.
Main drugs used	Cannabis, heroin, methamphetamine, ecstasy, depressants, solvents, codeine, cocaine
Drugs injected	Heroin, methamphetamine, cocaine
Estimated prevalence of HIV infection among IDUs	As of 2003, 80% of new HIV infections were linked to IDU.

A5.6 Country responses to drugs

Agreements and treaties

Indonesia is a party to the Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971 and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988. Indonesia is also a signatory to the Association of South-east Asian Nations (ASEAN) declaration for a drug-free ASEAN by the year 2015 (National Narcotics Board, 2003a, 2003b).

Policy responses

The National Narcotics Board is aware of a wide range of negative effects of illicit drug use and trafficking on general welfare and on the nation's economy, politics and security. They clearly imply that drug abuse is not the sole responsibility of the government, but of the community as well. They believe that efforts to control drug abuse and illicit drug trafficking should be comprehensive, multidisciplinary, coordinated and integrated to include the following areas: prevention (communication, information and education); community participation; law enforcement; treatment and rehabilitation; regional and international cooperation; control and super-

vision of legal drug market and precursors; and the enhancement of human resource development.

According to the BNN, professional and competent human resources are needed to address illicit drug use and trafficking, hence the need to enhance the capacity of manpower, at the National Narcotics Board, in related ministries and in the community, through training and education. Drug prevention and control should be done in a comprehensive and coordinated manner, involving related sectors, both government and the community. Mobilising community participation is essential in drug prevention involving all sectors in the community such as schools, families, community leaders and community groups. Coordination among related ministries, both departmental and non-departmental, should be enhanced in the field of drug prevention and control. Implementation of drug laws should be done firmly and consistently. The drug problem is a global issue and, as such, coordination at the regional and international level should be enhanced through bilateral and multi-lateral agreements. Drug abuse treatment and rehabilitation should also not be the sole responsibility of the government but also of the community. Communities should be

given wide opportunity to participate in the treatment and rehabilitation of drug users. With the increasing spread of HIV/AIDS among injecting drug users, priority should be given to prevention activities. Control and monitoring of legal drugs and precursors need to be enhanced to prevent illicit use.

Those who were involved in the formulation of these policies include the National Narcotics Board and a number of related ministries such as the National Police, Ministry of Justice, Ministry of Health, Ministry of Social Affairs, and Ministry of Education (National Narcotics Board, 2002a).

Law enforcement responses

In 1999, the Indonesian Parliament outlawed psychotropic drugs including ecstasy, and imposed penalties of up to seven years imprisonment for cannabis possession and a maximum of 20 years for cannabis trafficking (Narcotics 2001). Convicted heroin traffickers receive 8–17 years, but considering the low salaries of police officers it is purportedly easy for bribery and corruption to allow traffickers to be freed (Narcotics 1999). The death penalty was imposed in 1983 upon traffickers and, since 2000, 21 traffickers have been sentenced to death (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). However, executions are rare, with only one person executed in 2004, reportedly only the second person officially executed for drug-related offences since 1983 (Centre for Harm Reduction, 2004d). In the provisions of the law only the maximum penalty is specified, which may be up to the death penalty. Consequently, the minimum penalty can be very lenient. There is a belief that those caught trafficking drugs usually receive a *minimum* penalty, resulting in days or months of imprisonment and a minor fine (Reid & Costigan, 2002).

The number of narcotic investigations has increased by 5 per cent in 2003 to a total of 3729. Most investigations have focused on cannabis (39%), while others have been on methamphetamines (27%), ecstasy (19%) and heroin (14%) (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). There has been an increased focus on precursor control which involves control measures including document inspection, physical inspection and laboratory test and post-audit [post-audit refers to follow-up checking with the company (i.e. pharmaceutical) that received the precursor chemicals to prove that they used it for the officially sanctioned purpose; document inspection, physical inspection and laboratory work would be undertaken in the transport stages]. Recently a Special Task Force on precursor control has been formed, headed by the BNN Law Enforcement chief (National Narcotics Board, 2002b).

The BNN is the national drug control agency, directly under the President of the Republic of Indonesia, chaired by the national Police Chief, and supported by 25 ministries and agencies. The primary aim of the BNN is to prevent and control drug use, particularly among Indonesian youth, and to protect the general public from the harmful consequences of drug use and illicit drug trafficking. In recent years the BNN has shown greater concern about the rising HIV prevalence among IDUs and has suggested urgent serious attention be given to this area, which culminated in the signing of a memorandum of understanding between the BNN and the National AIDS Commission on HIV/AIDS Prevention and Drug Use Eradication (National Narcotics Board, 2003a, 2003b; National Narcotics Board and National AIDS Commission, 2004).

Although the use of contaminated injecting equipment is widely acknowledged to increase HIV risk to IDUs, injecting equipment related

to illicit drug use is confiscated. Officially, needles and syringes are only to be provided or distributed with a government permit. Needle and syringe programs continue to be slow to get started in Indonesia (E. Emrys, personal communication, 2005).

With regard to drug substitution programs, there are two small pilot methadone programs, in Bali and in Jakarta. As of December 2004 there are two additional, prison-based methadone pilots sites being launched in Krobokan Prison (Denpasar) and Cipinang Narcotics Prison (Jakarta). Drug users can obtain methadone under prescription, with a government permit and proof that it has been legally obtained. Attempting to keep IDUs out of prison, a judge can order a drug user to have treatment, whether or not a crime has been committed. If the drug user is found guilty of a narcotics crime, the sentence will also include the period of treatment. Children facing similar prosecution are provided with special protection, and any punishment imposed must be oriented towards the child's best interest. Penalties associated with narcotic and psychotropic crimes do not distinguish between drug users and drug dealers. Consequently, it is possible that those in possession of narcotics or psychotropics, no matter the amount, may receive a similar penalty to traffickers, such as a prison sentence or a hefty fine (Venning, 2003).

Health and treatment responses

An increasing number of drug users in Indonesia have experienced drug treatment and rehabilitation. In 2004, a surveillance survey found among the respondents 14 per cent in Bandung and 24 per cent in Surabaya had been in rehabilitation, with just over one-third more than once in the last year; with a mean and median rehabilitation episode in the last year of two (E. Pisani,

personal communication, 2005). Various drug treatment approaches have been implemented in Indonesia including medical detoxification, therapeutic communities, substitution programs, residential chemical dependency programs, and recently the introduction of drug treatment into correctional and detention centres. Medical and rehabilitation activities are under the control of the Ministry of Health, while social rehabilitation and care services for recovering drug users are coordinated by the Ministry of Social Affairs. Non-residential care is managed by the provincial/district Social Affairs Officer and the community. In 2001, just over 7000 people received services in government drug treatment centres, while fewer than 1000 patients were admitted to NGO treatment centres. The Ministry of Health has instructed that all government mental hospitals, teaching and general hospitals need to provide 10 per cent of their bed capacity for drug users (National Narcotics Board, 2002b).

There is only one government hospital in the country that specialises in treatment of those with substance-related disorders, the Drug Dependence Hospital, Jakarta (Rumah Sakit Ketergantungan Obat), commonly known as RSKO. It opened in 1972 and, as of 2000, up to 38,000 patients had received treatment as either in- or out-patients. The number of cases has been rising substantially: in 2002, 4694 drug users received treatment. RSKO had a capacity of only 40 beds as of 2002, but it is believed this may have increased in recent years (Sudirman & Hastuti, 2002; United Nations Office on Drugs and Crime, 2004a). As of 2002, there were six residential care centres under the Ministry of Social Affairs located in Jakarta, West Java, East Java, Central Java and North Sumatra. Non-residential centres are in 13 provinces. As a result of the dramatic increase in the number of drug users, there has been a surge in the

number of privately owned treatment centres – increasing in Jakarta alone from 10 in 1999 to 60 by 2000 (National Narcotics Board, 2002b). The current number is likely to be even greater.

While many centres claim to be detoxification centres, recovery centres, therapeutic communities and behaviour modification institutions, it is probable that many involved in such operations have little understanding of the complexity of addiction (Gordon et al., 2000). The costs of private treatment are well beyond the means of most drug users in Indonesia. However, a community-based support care and treatment program in a slum area in Jakarta provides cheap or free detoxification for teenagers; its detoxification service mainly deals with withdrawal symptoms, at a cost in 2002 of Rp75,000 (about US\$7) for each patient. It was mainly focused on home detoxification provided by a local community health centre (Djauzi et al., 2002).

As of 2002, the Ministry of Justice and Human Rights has introduced into ten correctional facilities and detention houses special correctional centres for drug-using prisoners, partially targeting young prisoners. The issue of HIV infection inside prisons has caused increasing concern. As of 2003, 14 narcotics prisons were established (although only two are fully functional). In 2003, the Department of Justice and Human Rights (now changed to the Department of Law and Human Rights) established a Working Group in HIV and Drug Use in Prison, which included members from the General Directorate of Corrections, National AIDS Commission, Department of Health, Social Welfare, several NGOs and donor agencies. It cannot be confirmed if there is representation from provincial AIDS commissions (E. Emrys, personal communication, 2005). Harm reduction strategies inside

prisons are being considered; leading this, the Bali prison authorities have recently agreed to provide condoms, bleach for the cleaning of needles and syringes, and to introduce methadone substitution programs (Angela, 2004; National Narcotics Board, 2002b).

Buprenorphine was introduced into four cities in 2001, and the manufacturers of the drug encouraged private practitioners to prescribe the medication to drug-dependent patients. This has proven problematic as most of the 40,000 private medical practitioners in the country have little or no experience in substance abuse management nor understanding of drug issues (Moore, 2003a; National Narcotics Board, 2002b). A methadone pilot project was introduced in 2002 in Jakarta and Bali, with positive results: there was a reduction of criminality, fewer heroin-related deaths and a reduction of risk behaviours associated with the spread of HIV among those satisfactorily maintained on methadone. This has led for a push towards the introduction of methadone into Indonesia. As of late 2004 it was available only in two hospitals, one in Bali and the other in South Jakarta, servicing a small client group (Centre for Harm Reduction 2004h; Emrys, 2004; National Narcotics Board, 2002b). Currently methadone is not scheduled like buprenorphine. The authorities have permitted the use of methadone for research purposes only. The step to making it officially available for prescription outside research settings has not yet been taken (E. Emrys, personal communication, 2005).

The introduction of needle and syringe programs (NSPs) remains controversial as an approach to dealing with the rising HIV infection among the nation's IDUs. A number of small NSPs have operated in Jakarta and Bali since 2000, relying on local government

and police support (and maintaining a low profile). Then from about 2003, a series of small NSPs were established in Makassar, Bandung and Jakarta, which reported to and received approval from vice-governors of provinces in their roles as heads of provincial AIDS commissions. Despite these efforts, adequately scaled distribution of clean needles to IDUs is not yet sanctioned by national authorities (E. Emrys, personal communication, 2005). While the various harm reduction approaches have been gathering momentum in recent years, only 5–10 per cent of all IDUs in the country have access to any form of harm reduction and consequently the challenge ahead is enormous (Angela, 2004; Atmosukarto, 2004).

Other responses

School-based education

As of 2002 there has been training of junior and senior high school teachers, school principals and student leaders on drug issues and HIV prevention. In 2002, 120 teachers and 580 student leaders from six provinces and 350 university students from various districts in Jakarta were selected for this educational package. Since 1999 a life skills program, including education on how to reject the use of drugs, has been integrated into the school curriculum.

A major drug prevention program features the establishment of student groups to promote and endorse drug-free activities in schools and universities. Additionally school talks about drugs linked in with the Ministry of Education were held in collaboration with some NGOs (Moore, 2003a; National Narcotics Board, 2002b). There is no evidence of the impact of these initiatives.

Community development

Parenting education programs for drug prevention at grass roots level have been initiated since 1999. An important feature of these programs is the Parent Peer Education group, which informs parents about drug issues in the neighbourhood, the effects of drugs and the promotion of a healthy drug-free lifestyle. The hope for the program was that parenting education would prove the gateway to community mobilisation for drug prevention. In 2002, the Ministry of Social Affairs established Coordination Teams on Drug Prevention in all provinces of the country. It was reported that 1620 community leaders have received training in mobilising communities for drug prevention. The BNN has introduced a national plan to train national NGOs about drug use prevention, with a focus on women's groups and community leaders in every province (National Narcotics Board, 2002b). Again, there is no evidence of the effectiveness of these programs.

Advocacy groups

The National Network of Harm Reduction Organisations, Jangkar, plays an important role in addressing the issue of HIV/AIDS in relation to IDUs and promotes harm reduction in the country. As of 2005 the network was made up of 38 NGOs focused on drug use and HIV/AIDS (Centre for Harm Reduction, 2005).

The Burnet Institute's Centre for Harm Reduction and the Asian Harm Reduction Network both established offices in Jakarta from 2003. Their purpose is to help promote and be supportive of political, policy, regulatory and social environments for harm reduction initiatives aimed at controlling the further spread of HIV and other adverse public health consequences associated with unsafe drug use and sex practices.

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Note: The Centre for Harm Reduction's *Indonesia Press Review* items were from published national and regional newspapers in Indonesia. The Centre was set up to monitor the print media on articles concerned with HIV and drug use.

A6. Laos

Geography	Lao PDR is located in south-eastern Asia, north-east of Thailand, west of Vietnam. It consists of mostly rugged mountains; some plains and plateaus. Arable land: 3.8% Permanent crops: 0.35% Other: 95.85% (2001)
Government	Communist state Chief of state: President Gen. Khamtai Siphadon (since 26 February 1998) and Vice-President Lt Gen. Choummali Saignason (since 27 March 2001). Head of government: Prime Minister Boungnang Volachit (since 27 March 2001); First Deputy Prime Minister Bouasone Bouphavanh (since 3 October 2003); Deputy Prime Minister Maj. Gen. Asang Laoli (since May 2002), Deputy Prime Minister Thongloun Sisolit (since 27 March 2001), and Deputy Prime Minister Somsavat Lengsavat (since 26 February 1998) Elections: President elected by the National Assembly for a five-year term; election last held 24 February 2002 (next to be held in 2007); Prime Minister appointed by the President with the approval of the National Assembly for a five-year term
Population	6,068,117 (July 2004 est.) Median age: 18.6 years Male: 18.3 years Female: 19 years (2004 est.)
Human development index	HDI rank 135 (177 countries)
Unemployment rate	5.7% (1997 est.)
Language	Lao (official), French, English and various ethnic languages
Literacy	% Age 15 and over can read and write: Total population: 66.4% Male: 77.4% Female: 55.5% (2002)
Religion	Buddhist 60%, animist and other 40% (including various Christian denominations 1.5%)

Health	Life expectancy: 54.69 years Male: 52.71 years Female: 56.75 years (2004 est.) Under 5 mortality rate: 87.06 deaths/1000 live births Male: 97.05 deaths/1000 live births Female: 76.69 deaths/1000 live births (2004 est.) HIV prevalence: 0.1% (2003 est.)
Economics	GDP: purchasing power parity – \$10.32 billion (2003 est.) Percentage of population living below the poverty line: 40% (2002 est.)

A6.1 Narrative summary of drug vulnerabilities

A number of factors place Lao People's Democratic Republic (PDR) in a vulnerable position to an explosion of both drug use and HIV. Lao PDR has a tradition of opium use, with dependent use reaching up to 10 per cent of the adult population in some regions. Rapidly decreasing local production of opium and an inefficient treatment system could result in traditional opium users shifting to heroin injection as was seen when hill tribe people of northern Thailand faced a similar situation in the 1990s. As governments push to open trade in the region, there is an additional risk that drugs will flow in to Lao PDR to fill the need that is being left by crop eradication.

Recently the Asian Development Bank and the Greater Mekong Sub Region Governments (China, Thailand and Vietnam) have begun funding the development of the Mekong Highway System. The goal of this system is to increase economic trade and partnership between the countries in the region by improving transport infrastructure. Two of these projects are of particular relevance to Lao PDR – the East West Corridor Project

which will link north-east Thailand to coastal ports in central Vietnam through Savanakheth in Lao PDR; and the Northern Economic Corridor Project which will provide road transport between the cities of Kunming in Yunnan Province in China and Chiang Rai in northern Thailand through Bokeo and Louang Namtha in central Lao PDR. Improved transport systems have the potential to increase Lao PDR's vulnerabilities to drug use by facilitating the movement of drugs and drug users into Lao PDR. Additionally, improved access to markets could see Lao PDR's farmers increasing opium production against the will of their government and the international community.

Improved transport systems, relaxed border security and large construction projects will facilitate the movement of both drugs and people throughout the region. As has been shown in northern Thailand and the north-east Indian State of Manipur (and to a lesser extent with ATS in Lao PDR), improved cross-border trade was also associated with the formation of new drug markets and trading routes. Drug use in these areas developed rapidly, as did the spread of HIV among IDUs.

The proposed Mekong Highway System links regions with high levels of IDU and high HIV prevalence with Lao PDR where these problems have not yet been documented. Drug-using peers from these regions have the potential to rapidly introduce new methods of drug use as well as HIV (Lyttleton et al., no date).

Poverty is also a major vulnerability to problematic drug use throughout the world. In Lao PDR, dependent opium use is disproportionately seen among marginal village communities in the north and centre of the country. Opium addiction can lead to loss of productivity, which further places a person at risk of poverty. Poverty is also linked to Lao PDR's poorly developed health infrastructure, which in turn limits access to, and delivery of, appropriate health services. The lack of health care services means drug users do not receive appropriate treatment, which results in high relapse rates and the continuation of drug use. Lao PDR's inefficient health infrastructure has also resulted in limited HIV/AIDS awareness among the general population (United Nations Office on Drugs and Crime, 2004c).

Corruption also plays a role in the link between poverty and drugs in Asia. The UNODC notes that the high profits associated with drug trafficking within and through Lao PDR is a potential source for corruption (United Nations Office on Drugs and Crime, 2004c). Corruption undermines social systems and prevents stable economic growth and development.

Historical and cultural interactions with drugs

Opium use and cultivation remained relatively confined to isolated hill tribe villages in the north of Lao PDR until the 19th century when Hmong immigrants fleeing conflict in southern China began to expand opium cultivation (Lyttleton, unpublished report). The economic value of opium was quickly realised by these new opium producers. Lao PDR opium was sold locally and exported to China to service the demands of the growing markets (Lewis, 2003).

In 1893, the French had successfully invaded Lao PDR and established colonial rule over the country, incorporating Lao PDR into Indo-China. Within a few years, the French colonial government had begun to control opium by supplying it through government opium shops. In 1918, there were 1512 opium dens, over 3000 opium retail shops and an estimated 100,000 dependent opium users in Indo-China. During the same year it was estimated that 175 tonnes of opium were sold in Indo-China, of which 60 tonnes were imported to supply the demand (McCoy, 1991; Reid & Costigan, 2002).

During World War II, Lao PDR was temporarily occupied by Japan until the French regained control in 1946. In 1949, the French-Laotian Government recognised Laotian independence as part of the French Union but this was not accepted by the anti-colonialists who used active resistance to overthrow the French and introduced a new treaty in 1953. Despite the rapid political and social change during this period, opium control and use remained relatively unchanged.

The first major changes to opium control came in 1971 when the Royal Lao PDR Government banned the use of opium. The law permitted opium addicts from ethnic minorities to apply for a permit allowing them to cultivate poppies for personal use. After the opium ban it was estimated that there were about 50,000 dependent opium users in Lao PDR. In early 1990 the Lao PDR Government under the influence of the international community began to implement large-scale crop eradication and alternative development projects aimed at reducing opium supply and use. In 1996, the Government also totally banned opium production and use. By 1998 surveys of opium began to report reduced use and production for the first time in a decade. However, it appears that a reduction in opium use is being paralleled by an increase in the use of other drugs such as ATS (Reid & Costigan, 2002; United Nations Office on Drugs and Crime, 2004b, 2004c).

A6.2 Prevalence of drug use and profile of drug users

The overall number of drug users in Lao PDR has not been estimated. However, figures are routinely collected about opium use. A number of studies have also been conducted looking at drug use in school-attending children, as well as service girls, unemployed youth and disco clients in Vientiane.

Data from the 2004 UNODC Opium Survey (United Nations Office on Drugs and Crime, 2004b) showed that daily opium use occurred in 237 of the 388 villages surveyed. About 60 per cent of households surveyed (n = 13,775) reported having at least one daily opium user. Opium use is more concentrated in areas of high opium production. The likelihood of becoming a daily user of opium appeared to increase with age.

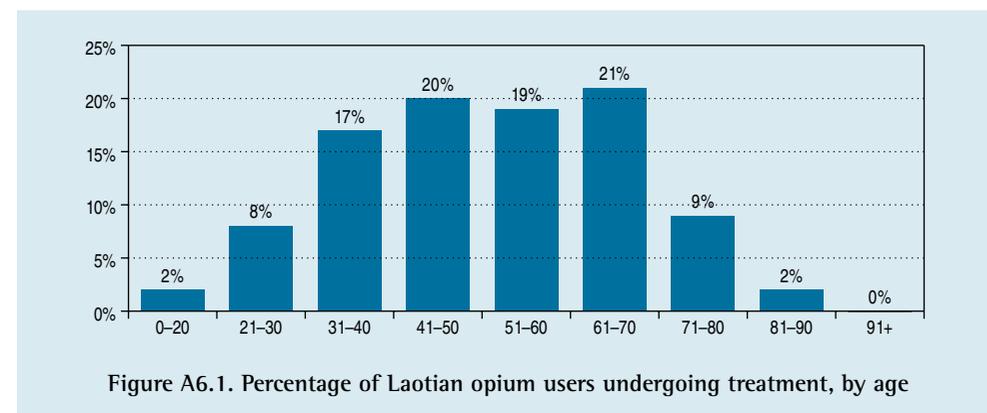


Figure A6.1. Percentage of Laotian opium users undergoing treatment, by age

Source: UNODC Opium Survey 2004, page 15

According to official Lao government statistics, the total number of opium users did not change much from 2003 (n = 29,961) to 2004 (n = 28,030). Of the 28,030 daily opium users, only about 1400 were women. Daily opium use occurs in about 2.6 per cent of the total population (United Nations Office on Drugs and Crime, 2004b).

The first cases of amphetamine-type substance (ATS) use were reported by the Provincial Committee for Drug Control in the Bako Province in 1998. ATS use appeared to increase rapidly and, within one year, the number of ATS-related cases treated at the Vientiane hospital increased from 89 in 1999 to 210 in 2000. Reports from other rural areas suggested that ATS users outnumbered or at least matched the number of opium users by 2002 (United Nations Office on Drugs and Crime, 2004c).

A recent qualitative study conducted in Lao PDR showed a normalisation of ATS (also commonly known as *yaba* in Laos PDR) use among some populations (Centre for Harm Reduction, 2004). The study suggested that it was common for young people to take *yaba* and that it was readily available. *Yaba* was commonly used at bars and nightclubs to facilitate social gatherings and to increase energy levels. Participants in the study (n not reported) acknowledged negative impacts of *yaba* use including problems with families, lifestyle issues and law enforcement. *Yaba* users generally didn't deeply consider why they took the drug; however, some reported the desire to try drugs, availability and peer pressure made it difficult not to participate in use.

With support from the American Government, the Lao PDR Committee for Drug Control and the Ministry for Education undertook wide-scale urine tests in schools during 2003. The test results from these studies have not been released, but according to media reports over 4000 cases were positive to ATS (Centre for Harm Reduction, 2004).

In 1999 and 2000, the Lao PDR Government, with assistance from the UNODC, surveyed 11,049 students at 43 educational institutions in three urban areas: Vientiane, Savannakhet and Luang Prabang. The students ranged from 12 to 21 years of age and were attending secondary school, vocational school or university. The studies showed that the most commonly used drugs were prescription drugs, cannabis, ATS and solvents. Lifetime prevalence of all drugs ranged from 17.5 per cent for students in Vientiane, to 7.6 per cent in Savannakhet and 5.5 per cent in Luang Prabang. Lifetime prevalence of ATS was less but showed a similar decrease across the sites (see Table A6.1 for figures). Monthly use of any drug ranged from 7.2 per cent in Vientiane to 2.5 per cent in Luang Prabang. The average age of initiation into ATS use was about 16 years. The use of prescription drugs and cannabis was also reported (United Nations Office on Drugs and Crime, 2004a).

Table A6.1. Prevalence of drug use for students at three sites in Laos

	Vientiane	Savannakhet	Luang Prabang
No. of students	2631	3534	4884
Lifetime prevalence (all drugs)	17.5%	7.6%	5.5%
Lifetime prevalence (ATS)	4.8%	2.1%	1.1%
Current abuse* (all drugs)	7.2%	2.9%	2.5%
Mean age of first ATS abuse	15.6	15.4	16.5

* Current abuse means use in the last 30 days

Source: UNODC Country Profile, 2003, page 21

Three additional studies were conducted in Vientiane which looked at drug use among disco clients (n = 50), service girls (n = 50) and unemployed youth (n = 50). The studies summarised in Table A6.2 revealed high lifetime prevalence of drug use, especially for

ATS across all groups. Current use (defined as monthly use) of ATS was also high when compared to population estimates. The high number (n = 23) of non-response from service girls should be noted when interpreting the result.

Table A6.2. Prevalence of drug use for three different population groups in Vientiane, Laos

Drug use prevalence	Disco clients (n = 50)		Service girls (n = 50)		Unemployed youth (n = 150)	
	No.	%	No.	%	No.	%
Lifetime prevalence	19	38	9	18	69	46
12-month prevalence	15	30	8	16	39	26
Current prevalence	9	18	7	14	31	21
No response	7	14	23	46	11	7
Mean age of first use	20.6		22		19	
Type of drug	ATS		ATS		ATS	
ATS lifetime prevalence	34		14		42	
ATS 12-month prevalence	30		14		25	
ATS current prevalence	18		14		20.7	

Source: UNODC Country Profile, 2003, page 21

Heroin use remains limited in Lao PDR. Reports from treatment centres show that patients are rarely admitted for heroin use. Some heroin use has been reported in border regions with Myanmar and Thailand and among some groups of refugees (United Nations Office on Drugs and Crime, 2004a). Anecdotal accounts of heroin injection in some social groups in Vientiane have also been reported (Centre for Harm Reduction, 2004).

The overall number of IDUs in Lao PDR is considered to be low. Aceijas et al. (2004) suggest there are about 8000 (C.I. 5000–11,000) regular injectors in Lao PDR, about 0.28 per cent of the population. Recent evidence suggests that injecting could be increasing, with some studies reporting a shift toward injecting ATS (Centre for Harm Reduction, 2004) and blackwater opium (Reid & Costigan, 2002). To date, no studies have been conducted that focus on IDU issues in Lao PDR (United Nations Office on Drugs and Crime, 2004c).

Data collection systems in place

The opium survey implemented in partnership between the UNODC and the Lao PDR Government is the only systematic annual research that is conducted into drug issues in Lao PDR. The opium survey researches opium cultivation, use and sale in 11 opium-producing provinces in northern and central Lao PDR.

Opportunistic surveys have been conducted in Lao PDR looking at drug use, through the assistance of UNODC. School surveys were conducted in 1999 and 2002. Other studies have investigated drug use in specific risk groups in Vientiane.

The Lao PDR National Commission for Drug Control and Supervision (LCDC), in collaboration with the UNODC Lao PDR office, have recently commenced the development of a national drug information system. The project is only in its infancy, with the first training workshop being conducted in Vientiane in March 2005. The goal of the information system is to develop national data collection networks based on the UNODC's 'Integrated Drug Information System' toolkit (United States Embassy, 2005).

According to the National Drug Demand Policy (Government of Lao PDR, 2003), the LCDC is also responsible for setting up a drug information clearing house in Vientiane which will collate existing data on ATS use, treatment utilisation as well as drug-related mortality. The current status of the clearing house is unknown and enquiries made about its status were not answered.

A6.3 Drug supply, production, availability, cost and trade

Opium

Lao PDR is the world's third-largest opium producer behind Afghanistan and Myanmar (United Nations Office on Drugs and Crime, 2004a). The Lao Government and the UNODC have undertaken opium surveys in Lao in 1992, 1996, 1998 and annually since 2000.

The 2004 Lao PDR Opium Survey discovered opium production in 11 of the 17 provinces. The six most remote northern provinces: Phongsaly, Oudomsay, Luang Namtha, Houaphan, Xieng Khouang and Luang Prabang, account for 90 per cent of Lao PDR opium production. It is estimated that 22,800 households were engaged in opium production, which represents about 5 per cent of households in the northern provinces (United Nations Office on Drugs and Crime, 2004b).

The total area under cultivation for the 2004 season was estimated to be about 6600 hectares, a 45 per cent decrease compared to the 2003 estimate of 12,000 hectares (United Nations Office on Drugs and Crime, 2004b). The reduction in cultivation along with unfavourable conditions during the growing season resulted in poor yields (average estimate about 6.5 kilograms/hectare) and an estimated total production of 43 tonnes. This represents a 63 per cent reduction compared to the 2003 crop.

Farmers commonly keep part of their harvest for personal consumption, for use at the village level as a means of payment and as a means to acquire food or small commodities (UNODC country profile 2003). The bulk of opium produced (79%) from the 2004

crop was traded and only 15 per cent was used for personal consumption. This is a marked decrease in comparison to the 2003 figure, which estimated that one-third of the crop was kept for personal use. Of the opium consumed locally, it is thought that about one-third is used for ceremonial and medicinal purposes (United Nations Office on Drugs and Crime, 2004c).

The majority of opium transactions (97%) occur locally within the village of production or the neighbouring village. According to the United Nations Office on Drugs and Crime (2004b) incomes in opium-producing households (US\$371) and non-opium-producing households (US\$396) don't differ greatly. On average it is thought that opium accounts for only about 12 per cent of the total income of the producer.

The price of opium has fluctuated greatly over the past 20 years. The 2004 crop fetched on average US\$218 per kilogram, which represents a 27 per cent increase compared to the previous year's prices. As in previous years the price of opium showed significant price variations between provinces with opium yielding about US\$735 in Luang Prabang and US\$250 in Phongsaly (United Nations Office on Drugs and Crime, 2004b).

Cannabis

No estimates are available on the extent of illicit cannabis production in Lao; however, seizure suggests that cultivation is significant. It is thought that commercial cannabis production is concentrated in the lowland regions of Lao PDR, particularly in the southern regions and the provinces of Vientiane, Bolikhamxay, Saravanh, Champasak and Savannakhet, all of which border the Mekong River (United Nations Office on Drugs and Crime, 2004a).

Heroin

Domestic production of heroin in Lao PDR is thought to be limited. The majority of heroin seized in Lao PDR has been in transit usually originating from Myanmar. A major heroin laboratory was detected in 1998 on the north-western border of Lao PDR and Myanmar and large quantities of heroin, precursor chemicals and equipment were seized. A smaller processing operation was seized in 2002 along with 5 kilograms of heroin, 8 kilograms of ATS and 4 kilograms of opium, as well as processing equipment. It is estimated that heroin in Vientiane has a street value of US\$4000–5000/kilogram (United Nations Office on Drugs and Crime, 2004a).

Amphetamine-type substances

Domestic production of ATS is thought to be limited in Lao PDR. Since the discovery in 2002 of the processing operation described above, there have been no other reports of ATS manufacture in Lao PDR. As stated below, Lao PDR is involved as a transit country for ATS trafficking and is increasingly developing its own market (United Nations Office on Drugs and Crime, 2004). It is thought that the growing internal demand for ATS in Lao PDR

is fed mostly from ATS produced in Myanmar and to a lesser extent in China and Thailand (United Nations Office on Drugs and Crime, 2004a). The increasing local demand, coupled with access to precursor chemicals and equipment, is likely to trigger ATS production in Lao PDR if it already hasn't.

The street price seems to have remained at about US\$0.70 and US\$1.10 in Vientiane over the past two years (Centre for Harm Reduction, 2004; United Nations Office on Drugs and Crime, 2004a).

Arrest and seizure data

No information was made available for this report on the number of people arrested or charged in relation to narcotic offences in Lao PDR.

As shown in Table A6.3 it is difficult to identify a pattern with regard to drug seizures in Lao PDR. The large opium seizure total in 2001 does not correspond with an increased production in that year and, like other fluctuations, is probably more indicative of a large seizure rather than increased trafficking. The extremely low figure reported for cannabis seizures in 2002 appears to be a mistake; however, attempts to confirm this were unsubstantiated.

Table A6.3. Amount of drugs seized in Lao PDR, 1999–2003

Drug type	1999	2000	2001	2002	2003
Opium (kg)	225.8	151.4	486.8	123.4	209
Heroin (kg)	14.8	20.0	49.7	17.24	39
ATS (pills)	862,000	1.95 mil	928,000	1.5 mil	1.2 mil
Cannabis (kg)	2.1 mil	1.8 mil	1.9 mil	3,038	NA

Note: Figures taken from Centre for Harm Reduction (2004); United Nations Office on Drugs and Crime (2004a)

Drug trafficking

Throughout the 1990s ongoing economic reform and the opening of country borders throughout Southeast Asia have encouraged regional trade. These reforms have also resulted in an increased trade in narcotic substances. In 2002, it was estimated that about half of the opium produced in Lao PDR (54 out of 112 tonnes) was destined for export (United Nations Office on Drugs and Crime, 2004a). The main trafficking routes are across the Thai/Lao PDR border via either land crossing or river crossings in the Bokeo and Oudomxay Provinces.

Heroin is reportedly trafficked through Lao PDR from Myanmar en route to Thailand, China, Vietnam and Cambodia. Heroin is mostly transported by land and river; however, some heroin is thought to be exported through the Wattay airport in Vientiane by either courier or mail (United Nations Office on Drugs and Crime, 2004a).

The majority of cannabis trafficking is thought to take place in the southern regions of Lao PDR. According to INTERPOL (1998), cannabis produced in Lao PDR continues to play a role in regional and international trafficking (United Nations Office on Drugs and Crime, 2004a). According to the United Nations Office on Drugs and Crime (2004a), cannabis production in Lao PDR is largely undertaken on contract for Thai nationals who smuggle it into Thailand and other destinations.

Lao PDR is becoming increasingly involved in the regional trafficking of ATS, as well as of precursor chemicals and equipment used in the production of ATS. It is thought that, due to the tightening of the Myanmar/Thai border, an increasing amount of ATS destined for the Thai market is trafficked through Lao PDR (United Nations Office on Drugs and Crime, 2004a). Large quantities of precursor chemicals are transported into Lao PDR through the official border crossings at Boten as well as the long land border from China en route to Myanmar and Thailand. Lao PDR is also used as an intermediary transit point in re-exporting precursor chemicals in an attempt to disguise their origin and destination (United Nations Office on Drugs and Crime, 2004a).

Crop studies and crop eradication statistics

In May 1999 an agreement was reached between the President of Lao PDR and the UNODC to eliminate opium production in Lao PDR by 2005. The voluntary eradication and public awareness campaigns that were launched by the government in 2003 continued in 2004.

Unverified government reports state that 2230 hectares of opium were eradicated in 2004 (figures do not break down eradication into voluntary and enforced). It was estimated that an additional 750 hectares did not reach the harvest stage due to unfavourable weather conditions.

A6.4 Drug-taking practices, risk factors and trends

Some reports suggest a trend toward the injection of ATS (Centre for Harm Reduction, 2004) which brings with it inherent HIV risks, risk of overdose and associated injection-related infections. While heroin use is limited in Lao PDR, a number of conditions exist that are common to rapid increases in injecting in neighbouring countries. For example, the continual reduction in the availability and increased price of opium could lead some users to inject heroin or blackwater opium as it is more economical. Furthermore, if Lao PDR continues to be used as a transit country for the traffic of heroin and ATS, availability will increase along the trading routes which could be associated with a rapid uptake of injection (as was seen in north-east India) (Reid & Costigan, 2002).

A6.5 Summary table

Estimated number of drug users	Not estimated (about 50,000 people)
Main drugs used	ATS, opium, prescription drugs and cannabis
Drugs injected	Heroin and ATS (limited)
Estimated prevalence of HIV infection among IDUs	Unknown

Another important factor to consider as opium becomes less accessible are the implications for daily opium users. During the heroin drought in Australia many dependent heroin users entered maintenance treatment (unavailable in Lao PDR) or took up ATS use (Dietzel & Hedlund, 2005). Without effective drug treatment, opium users could be forced to self-medicate with other drugs.

More apparent risks are associated with increased ATS consumption. It has been widely acknowledged that the public health implications of ATS use are unknown in the Asian context (Australian Agency for International Development, 2004). Experience from Thailand shows increased sexual risk is associated with the use of *yaba* (United Nations Office on Drugs and Crime, 2003), including sex exchanged for *yaba*. *Yaba* is also thought to be associated with increased mental health issues, violence and accidents (Centre for Harm Reduction, 2004).

A6.6 Country responses to drugs

Agreements and treaties

Lao PDR is a party to the 1961 United Nations Single Convention, the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention against Illicit Trafficking in Narcotics. Lao PDR has not ratified the 1972 protocol.

Lao PDR along with Cambodia, China, Myanmar, Thailand and Vietnam signed a UNODC Memorandum of Understanding covering a subregional action plan aimed at controlling precursor chemicals and reducing illicit drug use in the highlands of Southeast Asia. Myanmar is also a member of ASEAN and a signatory to the ACCORD 'drug-free ASEAN by 2015' agenda.

Lao PDR receives considerable assistance from the United States Government both financially and through technical assistance. US-Lao PDR programs are focused on the elimination of opium cultivation and suppression of illicit drug and precursor chemical trafficking (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004).

Policy responses

In April 2001, the 7th National Party Congress, the highest policy-making body in Lao PDR, set poverty reduction and opium poppy eradication as national priorities. The national drug control policy in Lao PDR is largely shaped by the UN Drug Conventions and is geared toward the ultimate goal of 'total elimination of opium poppy cultivation by the year 2005'. Lao PDR drug policy is also in line with meeting its ASEAN commitment of being drug-free by 2015.

The broad operational framework of the Lao PDR drug policy is based on the implementation of three strategies:

- prevention treatment and rehabilitation of drug users
- alternative options for illicit crop farmers
- enforcement of adequate laws to fight against traffickers.

The Lao PDR National Commission for Drug Control and Supervision (LCDC) was set up in 1990 to coordinate national drug control. The LCDC is a multi-ministerial committee and is chaired by the Minister from the President's office. In 2001, the Lao PDR President set up the Central Committee for Drug Control (CCDC). The CCDC is headed by the Prime Minister with the Public Security Minister and the Chairman of the LCDC as the two deputy heads. The CCDC is mandated to guide the LCDC and other local organisations in drug demand reduction and law enforcement; to mobilise community participation; and to raise funds to support drug rehabilitation (United Nations Office on Drugs and Crime, 2004c).

Other important drug control institutions in Lao PDR are Provincial Drug Control Committees chaired by the Provincial Vice-Governor which replicate the structure and mandate of the LCDC at a provincial level. Counter-narcotic units and the Department of Customs are also involved in drug control.

The potential risk of HIV among IDUs is recognised by the Lao PDR Government and is discussed in the National Committee for the Control of HIV's most recent National Action Plan on HIV/AIDS/STI (2002–2005). The plan lists five priority areas of which prevention of HIV/AIDS and STI among drug users is fifth. The plan also acknowledges the need for periodic monitoring of the drug situation,

especially IDU (United Nations Office on Drugs and Crime, 2004c). The plan aims to increase awareness around HIV/AIDS and STI such that, by 2005, 85 per cent of the population should have a basic understanding of HIV/AIDS and STI, which will increase to 100 per cent of the population by 2010 (United Nations Office on Drugs and Crime, 2004b).

Despite the National Action Plan on HIV/AIDS/STI (2002–2005) recognising the potential HIV risk associated with IDU, the United Nations Office on Drugs and Crime (2004c) states that policy coordination between the National Committee for the Control of HIV and the LCDC is minimal and needs to be improved.

No information was provided about how drug policy was formulated.

Law enforcement responses

Drug law enforcement is coordinated by the Counter-Narcotics Office. The office consists of five sections: Investigation, Suppression, Intelligence, Foreign Affairs and Administration. The Counter-Narcotics Office operates through decentralised units within provincial police units in ten provinces throughout Lao PDR (United Nations Office on Drugs and Crime, 2004c).

The Department of Customs, within the Ministry of Finance, is responsible for controlling the flow of goods across Lao PDR borders. The Department of Customs works closely with the Counter-Narcotics Office and police departments to investigate drug smuggling.

The trend in Lao PDR, as in other countries in the region, is to more severe punishment and stricter enforcement of drug laws. According to a review of local media reports, at least 34 people have been sentenced to death for drug trafficking since 2003 (Centre for Harm Reduction, 2004).

Legislation/penalties/prison

Article 135 of the Criminal Code on Drug Trafficking and Possession was introduced into the Penal Code in 1990 by the National Party Congress. Article 135 prohibited the manufacture and traffic of all narcotics, except opium. The production and possession of opium were made illegal when Article 135 was amended in 1996. The amendment also increased the penalties for other narcotics to those shown in Table A6.4. Those convicted of providing services for smoking opium face imprisonment of 3–10 years. Sentences for drug trafficking range from life imprisonment to death (UNODC review paper 2004).

Table A6.4. Penalties for narcotic possession in Lao PDR

Drug	Amount	Sentence
Heroin	Up to 2 grams	1–5 years prison or re-education without loss of freedom
ATS	Up to 3 grams	3 months to 3 years prison or re-education without loss of freedom
Cannabis	Smoking	Behavioural correctional sentence without loss of freedom

Very little published information exists about the prison system in Lao PDR. According to Amnesty International the health of detainees and convicted prisoners in Laotian prisons is extremely poor due to overcrowding, insufficient and poor-quality food, and poor sanitation. The report states that prisoners who lack funds, family or consular access were reported to be dependent on basic rations and on the goodwill of fellow prisoners, without which they become seriously malnourished (Amnesty International, 2005).

A recent report by UNICEF investigating children in detention centres highlights a number of critical issues. The report interviewed 153 children in 11 separate centres containing juveniles. The report indicated that the majority of children were detained for issues related to drugs, including use and/or selling of drugs. The report also highlighted a lack of appropriate rehabilitation facilities within the detention settings. Children were often housed in the same cells as adults, very few children had been formally sentenced, and a significant number of children detained were under 15 years of age (UNICEF, 2004).

Health and treatment responses

The Ministry of Health and the Police Department are jointly responsible for drug treatment and detoxification. Drug treatment in Lao PDR is abstinence-focused and predominantly set up to deal with opium users. Although methadone is available, its use is not common and is mainly reserved for assisting in detoxification (United Nations Office on Drugs and Crime, 2004b).

Drug treatment in Lao PDR is provided through government facilities such as hospitals, detoxification centres and re-education camps as well as through private clinics. Most patients enrol in treatment either as a result of family

pressure or because of law enforcement intervention. Typical detoxification involves the opium user being administered tincture of opium and herbal medicine over a 15–42 day period at an inpatient detoxification centre. A 15-day stay in a detoxification treatment centre costs on average US\$25.

Additional social stigmas around opium use are created by the targeted effort that many development projects place on reduced opium consumption. Cohen and Lyttleton (in press) report that Akha village women face increasing social stigma and isolation if they cannot convince their husbands to cease using opium. When considered in the light of high relapse rates after detoxification of around 90 per cent (United Nations Office on Drugs and Crime, 2004b), opium use can become a considerable source of social conflict. In addition to this, many patients perceive treatment as a punishment rather than an opportunity to stop using drugs. This is reinforced because the duration of treatment is often defined by the patient's family's willingness to take the patient back, not necessarily by the condition of the patient (Centre for Harm Reduction, 2004).

Models of ATS treatment currently follow opium-style residential detoxification based on 4–6 week stays. Psychosis related to ATS is treated by one of the two psychiatrists in Lao PDR at the Mahosot Hospital's mental health unit. However, due to funding shortages and lack of facilities, staff there raised concerns about their ability to respond appropriately to the need (Centre for Harm Reduction, 2004).

A limited number of outreach services for drug users are offered in Vientiane. While the main focus of these activities is around sexual health and HIV, drug awareness and prevention are sometimes incorporated into

the messages. Some organisations engage peer educators in outreach work (Centre for Harm Reduction, 2004).

Lao PDR drug treatment system appears to lack appropriate protocols for treatment especially with regard to the treatment of ATS. Confusion and concern have arisen concerning the distinction between treatment, re-education and compulsory rehabilitation camps. Additional problems relate to the lack of qualified treatment staff as well as budgetary constraints (United Nations Office on Drugs and Crime, 2004a).

The Ministry of Health emphasised the need for voluntary treatment with neither addiction nor treatment to be treated as crimes. It also recognises the need to expand the current focus on detoxification as the only treatment methodology including the ability to respond to mental health issues (Government of Lao PDR, 2003). Technical assistance in transforming the treatment system is currently being provided by Thailand (Office of the Narcotics Control Board Thailand, 2005) and the UNODC (United Nations Office on Drugs and Crime, 2004a).

Other responses

A major focus in dealing with drug issues in Lao PDR has been the implementation of alternative development programs. These programs aim toward the eradication of opium production through a consultative and integrated approach. Most alternative development projects in Lao PDR are beginning to recognise the need to respond to drug use in a more holistic way and thus involve income generation, strengthening educational services, upgrading health care,

improving infrastructure, gender mainstreaming and enhancing market skills with special attention given to the participation and empowerment of local people. Due to the broad focus of these programs their impacts are extremely difficult to evaluate. The success of programs implemented in Lao PDR has varied greatly as they often cannot control the obvious market forces at play. While the demand for opium exists, poor farmers living on marginal land will grow and use opium.

The varied interpretation of alternative development also complicates an analysis of such responses to drug-related issues in Lao PDR. Under the guise of alternative development, the Lao PDR Government has relocated many opium-producing communities to areas with better social services and arable land (Australian Agency for International Development, 2004).

In addition to supply and demand reduction activities, the Lao PDR Government also dedicates considerable efforts to primary prevention of drug use. In 2001, the Ministry of Education introduced a life skills curriculum into all primary and secondary schools. The curriculum focused on HIV awareness, general life skills and drug education. A similar approach was adopted at a village level by the Ministry of Health and engaged village committee leaders in the development as well as the dissemination of information (United Nations Office on Drugs and Crime, 2004a). Concern about the effectiveness of these programs has been raised due to low levels of school attendance and literacy among the population.

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A7. Macao (Special Administrative Region, China)

Geography	<p>Located in eastern Asia, bordering the South China Sea and China; generally flat.</p> <p>Arable land: 0% Permanent crops: 0% Other: 100% Note: “green areas” represent 22.4% (2001)</p>
Government	<p>Limited democracy and is a special administrative region of China</p> <p>Chief of state: President of China Hu Jintao (since 15 March 2003)</p> <p>Head of government: Chief Executive Edmund Ho Hau-wah (since 20 December 1999)</p> <p>Elections: Chief Executive chosen by a 300-member selection committee for up to two five-year terms</p>
Population	<p>445,286 (July 2004 est.)</p> <p>Median age: 35.2 years</p> <p>Age: 0–14 years: 18% 15–64 years: 74.2% 65 years and over: 7.8% (2004 est.)</p>
Human development index	N/A
Unemployment rate	6.3% (2003)
Language	Portuguese, Chinese (Cantonese)
Literacy	<p>% Age 15 and over can read and write:</p> <p>Total population: 94.5% Male: 97.2% Female: 92% (2003 est.)</p>
Religion	Buddhist 50%, Roman Catholic 15%, none and other 35% (1997 est.)
Health	<p>Life expectancy: 82.03 years Male: 79.2 years Female: 84.99 years (2004 est.)</p> <p>HIV prevalence: 1.98 per 10,000 residents (2003)</p>
Economics	<p>GDP: purchasing power parity – \$9.1 billion (2003 est.)</p> <p>Population below poverty line: N/A</p>

A7.1 Narrative summary of drug use vulnerabilities

Macao is relatively close to the Golden Triangle production regions for opium and amphetamine-type substances (ATS). It is also close to mainland China and Hong Kong, has a convenient transport system and retains a flourishing gambling and entertainment industry. These factors alone make it an ideal place for drug consumption and for transit of drugs (Social Welfare Institute, 2002). Macao is the only place in China where gambling is permitted, and during the 1990s gambling provided almost one-third of gross domestic product. Gambling is closely linked to drug trafficking and consumption and drug money laundering (Kwan, 2004). Closely associated with the drug trade is money laundering and it was identified in 2003 that Macao's banks were used as a repository for North Korea's trade in illegal drugs (Perl, 2003). In recent years there are many more immigrants from mainland China and an increased percentage of drug users in treatment have been found to be born in mainland China. Immigrants, particularly youth, have to adapt to a new culture, education system, habits and culture and it has been suggested the drug problem may be heightened as a result of these factors (Social Welfare Institute, 2001).

Historical and cultural interactions with drugs

Drug use has been a longstanding issue in Macao society, as it has in Hong Kong situated just 60 kilometres south-west of Macao, with opium historically 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 6000 narcotic users treated either in government hospitals or in prison (Belo, 1996; Reves & Cotta Guerra, 1963; Social Welfare Institute, 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 use problems, the Office for Prevention and Treatment of Drug Dependence was established. In December 1999, Macao became a Special Administrative Region of the People's Republic of China under the principle of one country, two systems (Belo, 1996; Social Welfare Institute, 2001).

A7.2 Prevalence of drug use and profile of drug users

In 2003, 634 drug users were registered with the authorities, an increase of 17.6 per cent over the 547 recorded in 2002. The latest figures include 384 people seeking voluntary treatment from government and NGOs, and 250 prisoners with drug addiction: this figure does not include those repeatedly registered. In 2002, of those registered, 55 per cent injected their drugs, with little change in 2003 (Social Welfare Institute, 2002, 2003, 2004). There has been no formal estimate of how many drug users there are overall, but a recent study has suggested a figure of about 3700 heroin users, or 0.87 per cent of the whole population (Social Welfare Institute, 2004). There were no official estimates of the number of injecting drug users (IDUs), but unofficial estimates suggest there are 500–900 (Aceijas et al., 2004). As injecting is the major mode of drug administration among heroin users, this is likely to be an

underestimate. Recently it was identified that adolescent drug users from Macao were crossing the border into mainland China, particularly Guangdong Province, for drug trafficking and consumption as a result of the cheap price of the drugs or having family connections in mainland China (Social Welfare Institute, 2003, 2004).

The dominant drug of choice remains heroin, however many drug users are known to use cannabis, 'ice' methamphetamine, ketamine, cocaine and various other pills, usually ATS – mainly ecstasy, MDMA and sedatives (Social Welfare Institute, 2003, 2004). In 2003, the use of heroin, cannabis and sedatives increased significantly compared to 2002. A review of new drug cases in 1999–2003 found that while heroin was the dominant drug used, its use has in fact been declining – from 90 per cent in 2000 to 72 per cent in 2003 (Social Welfare Institute, 2004).

From 2000 onwards the typical profile of those in treatment included mostly being heroin-dependent (64% in 2002), aged 20–29 years (60% were aged 30–59 years in 2002), mostly single males (90% in 2002), most with primary school education, and many being jobless (70% were unemployed in 2002). Most were born in either Macao or mainland China, with most beginning drug use as a result of curiosity or peer pressure (Social Welfare Institute, 2002, 2003, 2004).

Data collection systems in place

The Department of Prevention and Treatment of Drug Dependence monitors drug treatment services in Macao. This provides some insights of the drug use situation but most information is only from the registry

records of its outpatient centre (comprising data from voluntary drug dependants) and consequently does not represent the overall drug situation of Macao. A drug dependants central registration database system is planned, in order to enhance an exchange with the Health Bureau, Judicial departments and other frontline organisations to provide a more representative picture of drug issues in Macao (Social Welfare Institute, 2003).

A7.3 Drug supply, production, availability, cost and trade

There is no evidence to indicate Macao is a drug-producing area: the problems are of drug consumption and trafficking. The main sources of illegal drugs entering Macao are mainland China, Hong Kong and other parts of Southeast Asia: most of the narcotics originate from the Golden Triangle but mainland China is currently much more involved in the production of ATS (Social Welfare Institute, 2003; United Nations Office on Drugs and Crime, 2004a). Most illicit drugs are available locally but recently adolescent drug users from Macao have been detected crossing the border into mainland China, particularly Guangdong Province, for drug trafficking and consumption (Social Welfare Institute, 2003).

In 2002, a typical retail price (per gram) for heroin was US\$50 with a price range of US\$37–62. A wholesale price was not available. The retail price for cannabis in 2002 was typically US\$12 per gram, while methamphetamine typically retailed at US\$18 per gram. Ecstasy was typically sold for US\$22 per tablet (United Nations Office on Drugs and Crime, 2004b).

Arrest and seizure data

In 2004 the Judicial Police arrested 197 drug users (up from 130 in 2002) and 73 persons suspected of drug trafficking (74 in 2002). Of those arrested for drug use and trafficking in 2004, 65 per cent were male (Judicial Police, 2004). In 2004, drug seizures amounted to 54 grams of heroin (stable), 3169 grams of cannabis (increase from 125 grams in 2002), 231 grams of cocaine (increase from 27 grams in 2002), 498 grams of ketamine (down from 785 grams in 2002), 181 grams of methamphetamine (down from 640 grams in 2002) (Judicial Police, 2004; Social Welfare Institute, 2003). In 2002, 30 per cent of all those detained for drug trafficking and drug consumption were under 21 years of age. In one incident three male students in school uniforms smuggled drugs, valued at MOP\$300,000, from the hinterland to Macao. The number of people charged with drug-related offences increases with each year (Social Welfare Institute, 2002, 2003).

Crop studies and crop eradication efforts

Macao is not a known producer of opiates or cannabis.

A7.4 Drug-taking practices, risk factors and trends

Heroin is the drug of choice. According to drug treatment centre data in 2002, the favoured method of administration is injecting (55%). Fume inhalation is the next favoured method, commonly taking the form of 'chasing the dragon' (Social Welfare Institute, 2001, 2003).

An analysis of 384 persons in treatment in 2003 found that 52 per cent were intravenous users and 12 per cent were intramuscular users. Among the new treatment cases, intravenous injection was the main mode of administration between 1999 and 2003. There was a decreasing trend of inhalation of the drug – this is reportedly linked to an increase in the use of pills (Social Welfare Institute, 2004).

A recent study, 'Research of Drug Abuse Situation among the Youth from the Street in Macao', found through a convenience sampling method that the drugs of choice were ketamine, cannabis and ecstasy, and that most drank alcohol with these drugs; among females, the taking of pills was viewed as more acceptable than among males (Social Welfare Institute, 2004).

Another study, 'The Research of Drug Abuse Situation among University Students', interviewed 3639 students and found the use of pills, cannabis and heroin consumption were 3.4 per cent, 2.7 per cent and 1.5 per cent respectively. Of those interviewed, 24 per cent reported friends who consumed pills and cannabis, and 8.5 per cent used heroin. A final report, 'Study of Substance Abuse Situation and Evaluation of Treatment and Rehabilitation in Macao', showed an increase in the use of psychotropic substances and an increase in the number of addicted immigrants from mainland China entering the treatment facilities of Macao. It was also found that sharing of syringes among IDUs was common; as a consequence, the message of HIV and other diseases transmitted by shared syringes needs to be reinforced among this community (Social Welfare Institute, 2004).

Information about the purchasing of injecting equipment and the cleaning techniques used by this group was unavailable. Needles and syringes are easy to purchase from pharmacies without a prescription. Currently the cost of a syringe is similar to that of Hong Kong (approximately HK\$1 per needle and syringe). IDUs tend to have difficulty accessing injecting equipment at night when stores and pharmacies are closed and consequently their risk of sharing increases.

A major risk factor for IDUs is HIV/AIDS. The first HIV infection in Macao was reported in 1986 and, until the end of December 2004, there were 316 HIV infections: 30 of the HIV infections have progressed to AIDS. Cumulatively since 1986 the major route of transmission has been sexual (70.6%), predominantly heterosexual transmission (62.7%), with 9.8 per cent among IDUs (Public Health Laboratory, 2004).

A7.5 Summary table

Estimated number of drug users	Unknown, but an estimated 3700 heroin users and 500–900 injecting drug users (IDUs).
Main drugs used	Heroin, cannabis, ‘ice’ methamphetamine, ketamine, cocaine and various other pills, usually of ATS quality, mainly ecstasy, MDMA and sedatives
Drugs injected	Heroin
Estimated prevalence of HIV infection among IDUs	Unknown. Eighteen HIV cases among IDUs, comprising 60% of the total figure in 2004.

In 2001, there were 13 HIV cases among IDUs, 5 per cent of the total figure. In 2004, there were 18 HIV cases among IDUs, 60 per cent of the total. This significant proportion has become a matter of concern for public health authorities. HIV spread among Macao’s general population has been limited (a total of 30 HIV infection notifications in 2004), but there was a 25 per cent increase compared to 2003. An estimate of how many people in Macao are HIV-infected has not been made (Public Health Laboratory, 2001, 2004; World Health Organization, 2003).

In 2003, blood tests from 216 drug users undertaken by the public health laboratory found a hepatitis C prevalence of 69 per cent and a hepatitis B infection rate of 13 per cent. The phenomenon of infectious disease transmission by sharing injecting equipment is alarming (Social Welfare Institute, 2004).

A7.6 Country responses to drugs

Agreements and treaties

Macao is a party to the Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971 and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988 (Social Welfare Institute, 2003).

Policy responses

Drug control policy is mainly aimed at supply control and demand reduction and is implemented predominantly by public entities, under the supervision of the Under-Secretaries for Administration and Justice; Security (the related departments include Public Security Police, Judicial Police, Marine Police and Macao Prison); and Social Affairs and Culture (the related departments include the Health Bureau and Social Welfare Institute). The main contents of the policy include: the legislative means of implementing the law to stop crimes associated with drugs; and to focus on prevention and treatment of drug dependence (Social Welfare Institute, 2001, 2002).

In Macao, legislative work and judicial procedure about drug problems, treatment and prevention require cooperation and coordination from different departments of government. The Legislative Assembly, the Executive Council and the Secretary for Administration and Justice cooperate with one another to implement judicial procedures. The Secretary for Security and the Secretary for Social Affairs and Culture are responsible for carrying out the practical anti-drug tasks. The Public Prosecutions Office and the Courts are responsible for judicial procedures. The Macao Judicial Police is the criminal police body that specialises in crime prevention and investi-

gation and providing judicial assistance, with the stamping out of illicit drugs being one of its specific duties. The Department for Prevention and Treatment of Drug Dependence (DPTDD) of the Social Welfare Institute of Macao is responsible for the planning and execution of anti-drug prevention and treatment work. The DPTDD works closely with the Health Bureau, Macao Prison, the Judicial Police, NGOs, youth associations, schools and the community (Social Welfare Institute, personal communications, 2005).

The Judicial Police and the DPTDD take the lead in proposing to government amendments to drug law, drug control measures or policies. The government of Macao has set committees (for example, the Education Committee, the Youth Committee, the Health Committee) and there are many ways through these committees, or from the deputies of the Legislative Assembly, to collect suggestions or advice about policy matters dealing with the fight against drugs formally (Social Welfare Institute, personal communications, 2005).

Law enforcement responses

Capital punishment is not imposed for trafficking of illicit drugs. According to Law Number 5/91/M the highest penalty for trafficking drugs is 12–20 years’ imprisonment (when teenage victims are involved) or a fine of Macao Pataca (MOP) \$900,000 to MOP\$3,000,000 (US\$116,863–395,545). 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) (Social Welfare Institute, 2002). In light of the growth in ketamine trafficking and

consumption, the new Act 4/2001 provides that the production and trafficking of 19 substances, including ketamine and ecstasy pills, without the approval of the Health Department will result in severe punishment (Social Welfare Institute, 2003).

Unlike in mainland China, there is no specialised compulsory drug treatment centre or program in Macao. Those convicted are sent to a general prison. There is only one prison and it has a special unit created for people with drug-related problems (Social Welfare Institute, 2002). In 2003, there were 920 prisoners with the number incarcerated in that year being 302: of the 302 prisoners, 25 per cent were drug users (Social Welfare Institute, 2004). 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 drug user transferred to the government outpatient centre or an NGO program that provides treatment. Sometimes the court can request a drug user to stay in voluntary treatment for one year (Social Welfare Institute, personal communication, 2001). The treatment method adopted inside the prison is generally the 'cognitive behaviour therapy approach' and the length of the treatment and rehabilitation program is one year (Social Welfare Institute, 2004).

The Narcotics Section of the Macao Judicial Police is responsible for issues of drug trafficking, drug use and also the planning of larger operations to prevent drug-related activities. Its missions are supported by other security agencies. The Judicial Police has its own anti-trafficking section and over the past 40 years it has played an important role in the suppression of drug trafficking and consumption (Social Welfare Institute, 2002). Macao has not established drug courts.

In 2003, the second Guangdong, Hong Kong and Macao conference on policy to tackle drug abuse and trafficking took place. The delegates exchanged notes on progress of drug control strategies, law making and execution, and drug treatment and prevention. In the same year the third Hong Kong, Macao and mainland China conference on substance abuse, prevention and treatment was held. This conference focused on various issues including drug use tendency, experiences on prevention and treatment, and the results of trans-regional trafficking (Social Welfare Institute, 2004).

Health and treatment responses

A two-level health system is funded by the government. Free, universally accessible primary health care is available for all citizens through health centres and more specialised care is available through the central hospital (World Health Organization, 2004b). The Treatment and Social Rehabilitation for Drug Dependence Division is the main functional sector of Macao's government, providing services for drug users and assisting with their rehabilitation. In late 2002, it decided that medical treatment services for drug users needed to be enhanced. A protocol was signed with the Health Bureau, resulting in free physical check-ups for drug users and the creation of a Drug Treatment Complex Centre (DTCC) which included an outpatient unit and a short-term in-patient detoxification unit. The DTCC was also set up to provide support for NGO treatment centres, for example in technical assistance and training courses for NGO staff.

The outpatient clinic treated 295 voluntary clients in 2002, with the majority being returnees and long-term followed cases. The process at the outpatient clinic is for a social worker to evaluate each client's case, plan

the treatment and arrange medical assistance. The outpatient clinic service includes detoxification, motivation stimulation to cease drugs, medical nursing, family help and training for reintegration into society. Nurses usually follow up the treatment, and detoxification lasts on average 3–4 weeks. The client is requested to attend the clinic 2–3 times per week for assessment and assistance. Social workers follow up with clients post-treatment for rehabilitation (Social Welfare Institute, 2002, 2003).

The DTCC has a primary detoxification unit providing in-patient treatment usually lasting 14 days, in which clonidine and buprenorphine therapies are provided. In the last four months of 2002, 31 clients received detoxification treatment (Social Welfare Institute, 2003).

There are six NGOs providing in-patient treatment for drug users. All follow the traditional 'spiritual' detoxification model, which in essence means the 'cold turkey' approach of massage, hot baths and prayer. However, some NGOs are beginning to accept the use of medication 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 maintains a close relationship with the NGOs and offers technical and financial support where it is deemed appropriate (Social Welfare Institute, 2001). There are no NGOs with a focus on harm reduction.

In 2002, the Social Welfare Institute financially supported four of the six NGOs providing long-term rehabilitation services, outreach work and self-help group activities for drug users and ex-users. In 2002, the total capacity for long-term residential treatment places was about 66 clients, with the number receiving treatment amounting to 110 (Social Welfare Institute, 2003). In 2004, the Social Welfare Institute's financial support (Macao Pataca currency) for the NGO drug treatment sector amounted to the following: operation support (3,023,520) activity support (159,700) and equipment and other support (499,659) (Social Welfare Institute, 2004).

Macao has no needle and syringe programs as, according to the law of Macao, owning injecting equipment, including a syringe, may be unlawful. There are no plans to introduce a needle and syringe program, even with a rising HIV prevalence among IDUs in Macao. Buprenorphine maintenance programs have recently been initiated by the government, for those drug users who are HIV-infected. Methadone maintenance programs may be implemented in the near future but it is not yet clear who would be eligible to receive treatment (Social Welfare Institute, personal communication, 2004).

There is reportedly one government-funded NGO 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. Clonidine is provided in treatment (Social Welfare Institute, personal communication, 2001; Social Welfare Institute, 2003).

Other responses

School-based education

The Prevention of Drug Abuse Division is the body mainly responsible for anti-drug prevention education in schools. Since 2000 it has been implementing its Healthy Life Education Program, focused on health awareness and drug education for 5–12 year-old school children: reaching 55 schools and around 40,000 students so far. The aim is to enhance each primary school student's awareness of the benefits of a healthy lifestyle and of the dangers associated with drugs and other substances. In 2002, around 50 per cent of primary schools participated. In 2002, 30 anti-drug talks with nearly 8000 students from 21 primary and secondary schools were undertaken. In 2003, over 15,000 kindergarten and primary school students from 40 schools participated (Social Welfare Institute, 2003, 2004).

Community development

In 2002, there were 22 anti-drug talks offered to NGOs with the participation of young people and parents. In 2003, 70 professionals including teachers and social workers participated in training courses focusing on anti-drug messages. Each year there is an International Day Against Drug Abuse and Illicit Trafficking involving a series of anti-drug activities to raise public awareness of drug problems and to encourage a movement against drugs through exhibitions, posters, radio and television advertisements and stall activities. In 2003, 10 anti-drug exhibitions were held in various schools and communities throughout Macao (Social Welfare Institute, 2003).

International funding

Macao does not appear to receive any international funding for implementing any project about drug issues (Social Welfare Institute, personal communications, 2005).

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A8. Malaysia

Geography	<p>Located in south-eastern Asia, peninsula bordering Thailand and northern one-third of the island of Borneo, bordering Indonesia, Brunei and the South China Sea, south of Vietnam. Borders with Brunei, Indonesia and Thailand. The terrain is coastal plains rising to hills and mountains.</p> <p>Arable land: 5.48% Permanent crops: 17.61% Other: 76.91% (2001)</p>
Government	<p>Constitutional monarchy. Malaysia is headed by the paramount ruler and a bicameral Parliament consisting of a non-elected upper house and an elected lower house.</p> <p>Chief of state: Paramount Ruler Tuanku Syed Sirajuddin ibni Almarhum Tuanku Syed Putra Jamalullail, the Raja of Perlis (since 12 December 2001)</p> <p>Head of government: Prime Minister Abdullah bin Ahmad Badawi (since 31 October 2003); Deputy Prime Minister Najib Tun Razak (since 7 January 2004)</p> <p>Elections: Paramount Ruler elected by and from the hereditary rulers of nine of the states for five-year terms; election last held 12 December 2001 (next to be held 2006); Prime Minister designated from among the members of the House of Representatives; following legislative elections, the leader of the party that wins a plurality of seats in the House of Representatives becomes Prime Minister.</p>
Population	<p>23,522,482 (July 2004 est.)</p> <p>Urban: 63.3% of total (2002)</p> <p>Median age: 23.8 years</p> <p>Age structure: 0–14 years: 33.3% 15–64 years: 62.1% 65 years and over: 4.5% (2004 est.)</p>
Human development index	HDI rank 59 (177 countries)
Unemployment rate	3.6% (2003 est.)

Language	Bahasa Melayu (official), English, Chinese dialects (Cantonese, Mandarin, Hokkien, Hakka, Hainan, Foochow), Tamil, Telugu, Malayalam, Panjabi, Thai Note: In East Malaysia several indigenous languages are spoken, the largest are Iban and Kadazan.
Literacy	% Age 15 and over can read and write: Total population: 88.7% Male: 92% Female: 85.4% (2002)
Religion	Muslim, Buddhist, Daoist, Hindu, Christian, Sikh; in addition, Shamanism is practised in East Malaysia
Health	Life expectancy: 71.95 years Male: 69.29 years Female: 74.81 years (2004 est.) Infant mortality: 18.35 deaths/1000 live births HIV prevalence: 0.4% (2003 est.)
Economics	GDP: purchasing power parity – \$207.8 billion (2003 est.) Population below poverty line: 8% (1998 est.)

A8.1 Narrative summary of drug vulnerabilities

Malaysia's population has tripled and undergone rapid changes in composition since gaining independence in 1957, due in part to major economic development. Although it is currently experiencing a decline in birth rates, its previous high birth rates have, as in many other Asian nations, resulted in a population age structure that is substantially dominated by young people (Huang & Hussein, 2004). The Asian financial crisis of 1997 impacted upon Malaysia, weakened the financial sector, affected the economy and resulted in social dislocation. A soaring unemployment rate and inflation impacted hardest upon the urban poor, more so than on the rural poor. Unemployment is currently low but details of underemployment have

not been accessed (Paitoonpong, 2001; United Nations Development Programme, 2004). Malaysia has a relatively good record in the control of poverty, but the poor (both urban and rural) can experience difficulties accessing amenities and opportunities to secure reasonable earning jobs (Lee, 2002). As in other parts of Asia, an increasing number of people have settled in urban centres, rising from 38 per cent (1975) to 63 per cent (2002) (United Nations Development Programme, 2004). While Malaysia is not a major producer of illicit drugs, its close geographical proximity to the Golden Triangle and other Southeast Asian countries that produce heroin, amphetamine-type substances (ATS) and other drugs ensures its vulnerability to a rising domestic drug use problem (United Nations Office on Drugs and Crime, 2004a; UNDCP, 2004).

Historical and cultural interactions with drugs

Malaya (as it was known prior to independence) was never an opium-producing country – opium was always imported. The country has however had a long history of opium use, beginning in the early 19th century with the importation of migrant labour from China and South India. The smoking of opium was closely, although not exclusively, associated with the Chinese community, while cannabis was considered to be used mainly by the Malay and Indian communities (McCoy, 1991; Spencer & Navaratnam, 1981). Cannabis was regularly used, more so among the Malays, often for medical purposes (Navaratnam & Foong, 1989). In the mid-19th century there were an estimated 75,000 registered opium smokers; by 1929 this had declined to 52,313, with most reported to be Chinese (Kaur & Habil, 2002; McCoy, 1991). In 1930, following a League of Nations report on opium smoking in the Far East, international pressure mounted upon Malaya 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 (McCoy, 1991; Spencer & Navaratnam, 1981).

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 turned their attention towards heroin use. Heroin was mainly imported from the Golden Triangle (McCoy, 1991; UNAIDS & UNDCP, 2000). In 1952, Malayan authorities launched an anti-drug strategy largely as a result of what was seen to be a rising tide of drug-related crime. In the late 1960s the ‘hippie’ culture from the West made its impact upon Malaysia, perceived to be

escalating 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 use problem has been considered a grave concern and is referred to as ‘public enemy number one’ (McCoy, 1991; National Narcotics Agency, 2001; UNAIDS & UNDCP, 2000).

A8.2 Prevalence of drug use and profile of drug users

There are varying estimates of the number of illicit drug users in Malaysia, none particularly methodologically sound; the current literature suggests an increasing number of people using illicit drugs (Mohamed et al., 2004). The registration of drug users began in 1970; that year, there were 711 people registered. By the mid-1980s this had risen to 119,000 (Navaratnam & Foong, 1989), and throughout the late 1980s and into the 1990s estimates ranged from 180,000 to 400,000, of which 170,000–200,000 were believed to be opioid users (UNAIDS & UNDCP, 2000). It is difficult to tell, from Malaysian figures, whether these are cumulative or prevalent estimates.

In 2001, the prevalence of cannabis use for those aged 15–64 years was estimated at 0.5 per cent of the population (United Nations Office on Drugs and Crime, 2004b). In 2002, the National Drug Agency estimated there were more than 350,000 drug users in the country (Huang & Hussein, 2004) with the media in 2004 citing government sources reporting figures ranging from 400,000 to 500,000 (Chua, 2004). In 2003, the Director General of the National Drug Agency stated that if the problem of drug use was not contained, the number of drug users may reach 600,000 in ten years’ time (New Straits Times, 2003b).

Following a series of intensive law enforcement operations, figures from 1988 until March 2004 showed 293,987 registered drug users (again, probably cumulative) and from 2000 until March 2004 73,750 were classified as ‘hard core addicts’ (National Drug Agency, 2004).

Between 1988 and 1996 the National Drug Information System reported there were 127,000 non-duplicated drug users registered (UNAIDS & UNDCP, 2000). In 2002, 31,893 drug users were identified and of these 17,080 were new users (54%), while the rest were classified as relapse cases (Mohamed et al., 2004). A further rise in 2003 showed 36,996 drug users, of whom 55 per cent were classified as new cases: an average of 1683 new drug users placed onto the registration system every month and 56 on a daily basis (National Drug Agency, 2004; Sunday Star, 2004). From January to March 2004 there were 1931 new cases of drug users registered per month (Chua, 2004).

In 2002, a consensus meeting convened by the World Health Organization and the Ministry of Health estimated the number of IDUs could be 170,000 to 240,000 (Futures Group, 2003; Huang & Hussein, 2004). In 2004, the United Nations Reference Group on drug injecting issues suggested 150,000 to 240,000 IDUs with a middle range figure of 195,000. If the middle range figure is accepted, among the 13 million people aged 15–64 years in Malaysia the prevalence of those injecting drugs would be 1.47 per cent of the population (Aceijas et al., 2004).

Although amphetamine-type substances (ATS) (mainly in the form of crystalline methamphetamine) are increasingly popular and appearing to be more accessible in 2003, heroin followed by cannabis are by far the most common illicit drugs for which people sought and received treatment (United Nations Office on Drugs and Crime, 2004a).

In 2003, a profile of drug users compiled by the National Narcotics Agency showed most drug users were male (98%); the racial breakdown was Malay 70 per cent, Chinese 14 per cent, Indian 10 per cent, Lain-Lain 4 per cent, others 1 per cent and foreigners 1 per cent. The majority (71%) of drug users were aged 20–39 years. Their educational standard varied, with 36 per cent having achieved only third form secondary school education. Those with no schooling or up to primary level comprised only 16 per cent of the identified cases (National Drug Agency, 2004).

Data collection systems in place

The National Drug Information System collects information from drug treatment admissions and arrest data to enhance an understanding of the drug use situation. The Universiti Sains Malaysia’s Centre for Drug Research undertakes research in ATS use (United Nations Office on Drugs and Crime, 2004a). Evidence of the effectiveness of this data collection process is not available.

A8.3 Drug supply, production, availability, cost and trade

Malaysia is not a major producer of illicit drugs. However, its close geographical proximity to the Golden Triangle (Myanmar, Laos and Thailand) and other Southeast Asian countries that produce heroin and ATS has ensured that the supply of illicit drugs entering the nation is substantial. Drug trafficking through Malaysia most often stems from Golden Triangle countries, with trafficking overland across the long border Malaysia shares with Thailand, or through various and extensive sea routes between the two countries. Both nations have long-established fishing industries, and fishing boats not only trade in fish but also traffic in drugs as a result of their easy access to various sea ports (National Narcotics Agency, 2001; United Nations Office on Drugs and Crime, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). Heroin is commonly smuggled through Bukit Kay Hitam and Padang Besar, while cannabis is often smuggled using the Kelantan–Thai borders around Rantua, Panjang or Sungai Golok (Najib, 2004). Indonesians are reported to be regularly caught moving drugs into the northern region of Malaysia (Tagliacozzo, 2002).

Prices of illicit drugs fluctuate, varying from one region to another and over time. In 2001, in Kepala Batas, Penang, the price of heroin ranged from RM10 for a 3cm straw to RM50 for a 8cm straw (US\$1 = RM3.80 in early 2001); among IDUs needing to inject 4–5 times per day, an 8cm straw was required (Centre for Drug Research, Universiti Sains Malaysia, 2002). In August 2004, in Kuala Lumpur, a single dose of heroin was around RM10 (US\$2.63 approx.), a single dose of ATS (unspecified type) was RM10, an ecstasy

pill was RM50–100 (US\$13–26 approx.) depending on quality and type, and opium was purchased for around RM25 (US\$6.50 approx.), amounting to two doses. Morphine was available and consumed (UNODC, 2004) but currently in Kuala Lumpur the drug is rarely encountered, and information of its cost was unavailable (L. Ng, personal communication, 2004).

Arrest and seizure data

Clandestine laboratory activities mainly confined to the conversion of heroin base to the hydrochloride salt form have been identified in the past (UNAIDS & UNDCP, 2000) but more recently an amphetamine processing laboratory was uncovered in Semenyih, Selangor, by a joint China–Malaysia police operation (Andres, 2004). The trafficking of heroin into the country still remains a concern as reflected by drug seizures but also because heroin accounts for most drug treatment admissions and most drug-related arrests (United Nations Office on Drugs and Crime, 2004a). Seizures of heroin (Number 3) have fluctuated in the past seven years with 106 kilograms seized in 2000 increasing to 382 kilograms two years later, but falling to 128 kilograms in 2003. There were sharp dramatic rises in the seizures of raw opium from zero in 2002 to 63 kilograms in 2003. Substantial rises in the seizure of cannabis have reached record levels. From 1998 until 2001 around 1500–1600 kilograms of cannabis were seized; in 2003, this rose to 2199 kilograms (Polis Msia, 2004).

There were two commonly trafficked and used amphetamine-type substances (ATS) in Malaysia, called locally *Syabu* and *Yaba* (the chemical composition of this drug remains unknown but it is acknowledged it has similar characteristics to ‘ice’ methamphetamine). While seizures of *Syabu* have witnessed a

decline from 208 kilograms in 2000 to 19 kilograms in 2003, the number of seized *Yaba* pills sharply increased from 15,000 in 2001 to nearly 42,000 in 2003. Ecstasy pills were first seized in the mid-1990s, much still brought in from the Netherlands (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). Seizures of ecstasy continue to rise, from 66,000 pills in 2002 to 209,000 pills in 2003. Seizures of ketamine rose from 1 kilogram in 2000 to 82 kilograms in 2003. Cough mixtures – mostly containing codeine – were seized by authorities: 33,596 litres were confiscated in 2003, a sharp rise from 4.978 litres in 2002 (Polis Msia, 2004; United Nations Office on Drugs and Crime, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). Misuse of codeine cough mixtures was viewed as a serious problem as they were widely accessible from rogue pharmacies, medical clinics and underground sources, where they were smuggled in from neighbouring countries (United Nations Office on Drugs and Crime, 2003). The use of solvents was not widely researched but a previous study in East Malaysia had shown they were used mainly by young children and teenagers, and that respondents had been sniffing glue for periods between a few months to two years (Zabedah et al., 2001).

According to United Nations Office on Drugs and Crime sources, the number of recorded offences related to illicit drugs in 2003 was 24,815. Most offences were related to heroin (63%), followed by various forms of ATS (18%) and then cannabis (15%). Heroin and ATS were fairly easy to obtain at a street level (United Nations Office on Drugs and Crime, 2004a). Statistical data from different sources were conflicting, but common themes emerged.

In 2002, the number of prisoners in Malaysia was 49,243; among these, 11,854 (24%) had committed an offence linked to the *Dangerous Drugs Act of 1952*. There was a substantial incremental rise in the annual numbers of prison admissions from 1996 (then a total of 27,678) to 2002. A large number of people (37,882) were classified under the category of ‘Remand of Magistrate and Session Court’ in 2002 and while information on the types of offences these people had committed was not available, it can only be assumed, as with prisoners, many committed crimes linked to illicit drugs (Prisons Department, 2004). Of the reported 160,000 crimes in 2000, about 75 per cent or 120,000 of the property crimes were linked to those with chronic drug problems (Malay Mail, 2002).

The number of drug users entering government-run drug rehabilitation centres (DRCs) is increasing, and they are becoming increasingly overcrowded as law enforcement rules become more stringent. In 2001, 8178 people entered a DRC but by August 2004 the maximum number was 14,700. (The ‘actual’ number means how many beds the facility was supposed to accommodate (9300) – highlighting overcrowding as a problem, with many detainees sleeping on the ground or elsewhere.) In August 2004, weekly admissions numbered 278. The government also funds a rehabilitation centre in the Kajang prison and in August 2004 the number of detainees was 15,000, a stark contrast to the 8688 in 2001 (National Narcotics Agency, 2001, 2004).

A8.4 Drug-taking practices, risk factors and trends

In 2001, a study from Kepala Batas, Penang, showed on average that drug users progressed from smoking and 'chasing' to injecting over a period of two to five years (Centre for Drug Research, Universiti Sains Malaysia, 2002). While this transition period differs from one drug user to another, generally the time frame had shortened. Currently in Kuala Lumpur the period from smoking and 'chasing' to injecting is around three to four years (L. Ng, personal communication, 2004). Reasons for the shift to injecting differ: peer pressure; a price rise of heroin; decrease in heroin purity; a shortage in supply of heroin on the market; and a stronger desire to acquire a greater feeling of euphoria (Centre for Drug Research, Universiti Sains Malaysia, 2002). For a number of drug users, it is possible that financial circumstances gave rise to injecting practices, as injecting is a cheaper option when consuming drugs. It is not unusual for Malaysian IDUs to shift back to a non-injecting route of drug consumption as a result of possible health complications and/or a result of better quality heroin on the market (L. Ng, personal communication, 2004).

In 1998, 6324 drug users from 26 drug rehabilitation centres were surveyed: 65 per cent indicated they were IDUs. The Malaysian Drug Information System showed a trend towards smoking heroin increasing from 15 per cent in 1998 to 19 per cent in 2000 (United Nations Office on Drugs and Crime, 2001). The most common method of using heroin was 'chasing the dragon' at around 70 per cent (Kaur & Habil, 2002). In recent times, when the quality of heroin decreases, the trend in Kuala Lumpur is to 'chase' and to mix the heroin with methamphetamine, commonly known as 'ice' (L. Ng, personal communication, 2004).

Professional injectors are said to exist in Malaysia, injecting many customers with the same non-sterile injecting equipment, but contemporary evidence of this was not found. Some drug users purchased heroin in pre-prepared syringes that were sold in villages (Bolton, 1996; UNAIDS & UNDCP, 2000) – a study in 2001 reported two drug users purchasing ready-filled syringes from a drug dealer in a nearby town but with no knowledge if the syringes were new or had been used (Centre for Drug Research, Universiti Sains Malaysia, 2002). This practice of purchasing ready-filled syringes decreased the chances of being caught with drug-using paraphernalia, and avoids the difficulty of acquiring needles and syringes.

The routine involved in preparation of heroin varies from place to place and over time. In the mid-1990s, heroin was placed in a tablespoon containing a mixture of water and lime juice or lime powder to promote dissolution of the heroin. Currently, drug users place the heroin into a metal bottle cap, a convenient receptacle to carry. Heroin is heated only in water as the heroin on the market increasingly became the salt, which dissolves well (Navaratnam & Foong, 1996; L. Ng, personal communication, 2004).

A principal high-risk behaviour found among IDUs all around the world is the sharing of needles and syringes as well as other injecting paraphernalia. As it can be common practice to share drugs that have been commonly purchased, this form of drug-using etiquette extends to the sharing of drug injecting equipment. Malaysia declared a 'Year of Total War Against Drugs' in 2003, to work towards a drug-free generation by 2015 (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). The vast majority of drug users remain acutely aware of the dangers of being identified by law enforcement and

are reluctant to be caught in possession of injecting equipment, or purchasing such equipment from a pharmacy. Under section 37 of the *Dangerous Drugs Act 1952*, it remains illegal to carry injection equipment without a prescription, and possession of needles may result in up to two years' imprisonment (Wai, Singh & Varma, 1996; Wolfe & Malinowska-Sempruch, 2004).

Needles and syringes can be purchased from a pharmacy, officially requiring a prescription, although this was a moot point. The current average price for injecting equipment was RM1–2 (US\$0.25–0.52 approx.); an unofficial source reported the average price for a needle and syringe as RM1.50 (US\$0.39 approx.). While it could be assumed that accessing injecting equipment would be difficult, in Kuala Lumpur it was said to be relatively easy (L. Ng, personal communication, 2004). However, although accessibility and cost may not be an issue for some drug users, this is not universal. A study in 2001 observed there was a tendency among IDUs to use the needles until they were blunt (Centre for Drug Research, Universiti Sains Malaysia, 2002) which would accentuate trauma to an injecting site, increasing the risk of spreading blood-borne viruses.

In 2001, the average sharing group was 3–4 persons; sharing groups tended to form loose networks which were not permanent (Centre for Drug Research, Universiti Sains Malaysia, 2002). Currently in Kuala Lumpur the injecting groups tend to be 2–3 persons and, as a result of the frequent anti-narcotic raids, drug users are largely driven further underground. 'Shooting galleries' have become even more clandestine over the past two years, much more enclosed and remote from public gaze, mainly in the basements of abandoned buildings or in isolated areas around the city (L. Ng, personal communications, 2004). It was difficult to determine how widespread

'shooting galleries' were in Malaysia, as one study that focused on IDUs was unable to find one (Centre for Drug Research, Universiti Sains Malaysia, 2002) but undoubtedly most injecting locations are unhygienic.

A study involving 6324 drug users in DRCs throughout the country found 64.6 per cent administered drugs intravenously, and, of these, 65.4 per cent shared needles (Fauziah et al., 2003). In 2001, in Kepala Batas, Penang, a study of 30 IDUs found that while each person carried their own needle and it was observed sharing of needles had not occurred, participants shared the cooker, drug solutions, rinsing water and syringes. Users inserted their needle into the cooking device (bottle cap) and drew up their quantity of the drug. Injectors would normally withdraw blood a few times into the syringe, mixing it with the drug before flushing or injecting it, in the belief this would add to the euphoria. Empty syringes which had been used by others as a group were observed to show traces of blood. Cotton swabs used as filters were also commonly shared. While the IDUs were aware that they were at risk of HIV infection through the sharing of contaminated needles, this knowledge did not extend to all other drug injecting paraphernalia (Centre for Drug Research, Universiti Sains Malaysia, 2002).

In 2001, the drug mixed with heroin, depending on availability, was commonly a benzodiazepine such as *triazolam*. Benzodiazepines were purchased from pharmacies legally or illegally (Centre for Drug Research, Universiti Sains Malaysia, 2002). Another study reported that most heroin users used a combination of other drugs such as morphine, cannabis, cough mixtures, ATS, opium, benzodiazepines and alcohol. The spread of polydrug use is a major factor in the risk of drug overdose (Kaur & Habil, 2002). The frequency of injecting drugs appears to have

increased in correlation with the purity of the heroin and its availability. In the early 1990s it was common to inject on average twice per day, but by 2001 this increased to 4–5 times (Centre for Drug Research, Universiti Sains Malaysia, 2002). Buprenorphine was also known to be injected, but this is as yet not a widespread practice (L. Ng, personal communication, 2004).

Drug users are frequently sexually active; this is an area that has received little research attention in Malaysia. Among nearly 2000 respondents in 16 DRCs it was found that 64 per cent were sexually active, of whom 90 per cent did not use condoms. In the same study it was found that 20 per cent of the respondents were HIV-infected and, of these, 81 per cent shared needles and 28 per cent reported being sexually active (Jusoh, 2003). A study in 2001 among IDUs showed that respondents with wives did not use condoms while those visiting sex workers used condoms only as a result of the insistence of the sex workers (Centre for Drug Research, Universiti Sains Malaysia, 2002). The lack of use of condoms even among those informed of their HIV status remains a challenge for HIV control. In 1997 a study of 128 couples with HIV infections in Kuala Lumpur hospitals found only half of the respondents used a condom, even after receiving counselling (Jusoh, 2003).

In 2003, allegations that detainees in prisons and DRCs were accessing drugs from prison and police staff created media headlines (New Straits Times, 2003a). Drug use inside Malaysian prisons has been common since the 1970s. Drugs are generally inhaled, because injecting equipment is difficult to obtain and finding a safe and secure hiding place is also difficult. As a general rule the cost of drugs inside penal institutions was 5–6 times greater than street prices (L. Ng, personal communication, 2004).

The situation inside DRCs is somewhat different because accessing injecting equipment is easier, as inmates who work in poultry farms or in other such environments as part of their vocational training programs, have more opportunity to purchase needles and syringes. Drug use inside private DRCs is said to be rare (L. Ng, personal communication, 2004).

In 2004, there was only one known outreach program, based in Kuala Lumpur, introducing drug users to the concept of using household bleach for cleaning injecting equipment. In the past this program distributed bleach packages to clients but this has ceased, as the clients found carrying bleach bottles burdensome, and the cleaning process using bleach too time-consuming. In the current climate of heightened fear of being arrested by the police, there is a reluctance to remain too long in the shooting gallery to ensure injecting equipment is cleaned appropriately. This same program conducts irregular educational classes about cleaning of injecting equipment using bleach (L. Ng, personal communication, 2004).

The HIV epidemic in Malaysia has for over 15 years primarily affected the injecting drug-using community; during 1986–2002, 76 per cent of all HIV/AIDS cases were found among IDUs. Of the 6756 HIV infections reported in 2003, 75 per cent were among IDUs (Mesyuarat Penyediaan, National Strategic Plan on HIV/AIDS 2004).

A8.5 Summary table

Estimated number of drug users	350,000–500,000 and of these there are 150,000–240,000 injecting drug users
Main drugs used	Heroin, amphetamine-type substances (ATS), cannabis, ketamine
Drugs injected	Heroin, ATS
Estimated prevalence of HIV infection among IDUs	In 2003, 75% of all HIV/AIDS notifications found among IDUs

A8.6 Country responses to drugs

Agreements and treaties

Malaysia is a party to the Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971 and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988 (UNAIDS & UNDCP, 2000). The government previously aimed to have a drug-free society by 2023 which was to be achieved by providing treatment and rehabilitation to drug users, either by rehabilitation in an institution or under supervision in the community (National Narcotics Agency, 2001). The pace of progress towards this goal appears to have proved frustrating. However, in order to bring its programs in line with ASEAN goals (to which Malaysia is a signatory), Malaysia has declared it will be a drug-free society by 2015 (Sattler, 2004).

Policy responses

A National Drug Policy was originally launched in 1983 and revised in 1996 with a series of new strategies and priority areas of prevention, enforcement, treatment and rehabilitation, and regional and international cooperation. The prevention strategy focused on efforts to create an environment to protect individuals and the community from drug use. Essentially both the primary and general prevention

are based on demand reduction principles through education and promoting positive religious, moral and cultural attitudes and values to reject drugs and encourage healthier lifestyles. The enforcement strategy comprises interdiction (reduce the supply of drugs reaching the community), legislation (impose severe penalties with regard to trafficking and possession of drugs) and intelligence (focused on controlling syndicates and individuals involved in drug smuggling). Treatment and rehabilitation focus on eliminating drug dependency and preventing relapse among drug users. Lastly international cooperation is regarded as a strategy to control and prevent drug use and trafficking and strengthen international control and prevention (Navaratnam et al., 2002).

The key component of this drug policy is zero tolerance, largely the responsibility of law makers and enforcers. Striving to eliminate the supply and demand of illicit drugs and create a drug-free Malaysia by 2015 has resulted in an acceleration of draconian punishments of drug crimes. A committee for the formation of drug policy involves Cabinet Ministers from the highest levels. Drug policies undoubtedly have an impact upon the way illicit drug consumption significantly influences the HIV/AIDS scenario and have further implications for wider public health issues. Yet

health officials are not prominent on this committee and consequently their contribution to the drug policy debate is minor.

Law enforcement responses

The government has a long-held belief that drug use is a serious social problem, and a threat to the security of Malaysia. Ever increasingly, government officials have repeatedly termed drugs as 'public enemy number one', 'every addict a potential pusher' and 'drug abuse as one of the greatest threats still haunting the nation'. In the push to rid the nation of drug use there have been intensive campaigns to round up drug users. In corridors of airports, schools and offices there are graphic images of hangman's nooses with slogans such as 'Dadah Means Death' and 'Dadah Kills'. The government announced in 2003 a social evils campaign focusing on drugs and sex workers as the principal targets of law enforcement (Abdullah, 2002; Kuppusamy, 2003; UNAIDS & UNDCP, 2000).

A review of the number of arrests according to the Drugs Laws of Malaysia 1952 shows the outcome when intense law enforcement efforts have been implemented, aimed at ridding the nation of drug use by 2015. In 2000, under the *Lain-Lain Sek ADB (Dangerous Drugs Act) 1952*, 11,550 people were arrested; by 2003, the figure was 19,738. Under the *Ops Tapis (Tangkapan Penagih Dadah)* law, 80,893 people were arrested in 2000, increasing to 137,159 in 2003. (Ops Tapis operations are carried out by local police enforcement, along with respective other agencies such as medical representatives, religious leaders and so on; their action is to raid certain areas and whoever they suspect of being drug users is arrested and sent for testing (Polis Msia, 2004).)

A person is defined as a drug user if they test positive on urine testing, though it is not necessary to be in possession of any drugs or drug-using paraphernalia. It is claimed that drug testing strips are not of a high quality and the results not always accurate; but the police are not legally bound to use these strips, and can, on suspicion alone, order an official urine test conducted in a laboratory approved by the Health Ministry (Yahaya, 2002). The penalty for having a positive urine toxicology and the certification of a doctor is automatic admission to treatment in a DRC for a minimum of two years, although there is evidence that, not uncommonly, some are discharged after a year and a day (National Narcotics Agency, 2001; Sattler, 2004; UNAIDS & UNDCP, 2000). Previously in the mid-1980s the rehabilitation period was six months in government-run centres (Lee, 1985), but by the early 1990s, and thereafter, compulsory treatment involved a maximum of two years in a DRC followed by two years of follow-up care (Lee, 1985; Scorzelli, 1992).

Based on a court order, an individual could volunteer for treatment or be sent for compulsory treatment (Sattler, 2004). Upon discharge from the DRC the person is required to report to the nearest police station on a daily basis for another two years; the drop-out rate from this follow-up is about 70 per cent. For second- and third-time offenders there are prison sentences of 5–7 years, with caning not more than three times. Fourth-time offenders are imprisoned for 7–13 years and are caned 3–6 times (S.K. Sran, personal communication, 2004). In the mid-1990s there were seven after-care centres offering six-month residential programs (UNAIDS & UNDCP, 2000), but the current state of this program is unknown.

Malaysia's drug laws are internationally recognised to be very stringent. A mandatory death penalty for trafficking is applied to possession of 15 grams of heroin or morphine, 1000 grams of opium or 200 grams of cannabis. Possession of any amount of any illicit drugs, including cannabis, can result in a caning. Possession of less than 5 grams of heroin (an average 10 days' supply) can result in a life sentence (Haring, 1991; Scorzelli, 1992; UNAIDS & UNDCP, 2000). Malaysia has one of the stiffest drug laws in Asia with the Malaysian *Dangerous Drugs Act 1985* prohibiting the possession of syringes by anyone without a prescription (Mahathir, 2004a; Open Society Institute, 2004). The laws in place have yet to curb the epidemic of drug use and have played a substantial role in exacerbating HIV rates among IDUs (Mahathir, 2004b).

Health and treatment responses

In 2004, there were 28 government-funded DRCs, as well as a prison rehabilitation centre in Kajang. Eleven of the DRCs focus on group therapy, eight on self-realising therapy, six on family therapy, two on work therapy, and one on individual therapy (National Drug Agency, 2004). Since the early 1990s the DRCs have largely modelled themselves loosely on a therapeutic community concept and utilise a phase system in which the inmate progresses with increased responsibility and privileges based on behaviour (Scorzelli, 1992). There have been calls since the early 1980s to develop more flexible and individualised programs for those confined to an institutional setting (Johnson, 1983) but this has not been adopted; a military approach and minimal concern for innovation are the norm (Arokiasamy & Taricone, 1992; Habil, 2004; Lee, 1985). However, recent advice

is that nine existing DRCs are considering adopting different methodologies, though there is uncertainty as to what that may be (K.S. Sran, personal communication, 2004).

Currently, an inmate will follow a program structure of four phases over a period of two years, which includes a set period spent on various activities: from morning and evening marching to counselling, religion teachings and instruction on moral values.

Relapse rates among inmates discharged from DRCs remain very high, with estimates of 70–90 per cent (based on little data) (Habil, 2004; Pengasih Malaysia, 2004; Scorzelli, 1992; UNAIDS & UNDCP, 2000). Other programs have claimed relapse rates that are considerably lower, at about 35 per cent (Pengasih Malaysia, 2004), but systematic or scientific evaluations of such programs – crucially over an extended period of time – have not been conducted. There is an apparent general agreement that the success rate of drug users remaining abstinent in the long term is low.

The current rehabilitation approaches are seriously flawed and ineffective. A movement is emerging to have first-time offenders sent to DRCs to be segregated from 'hard core addicts' in an attempt to ensure bad influences are minimised (Bingkasan & Chin, 2004).

All government-funded DRCs are free-of-charge for inmates (Kaur & Habil, 2002). In 2002, the Human Rights Commission of Malaysia visited two rehabilitation centres and reported that detaining large numbers was essentially unsatisfactory and lowered the effectiveness of the outcome. As a result of the overcrowding, not all detainees could receive skills training nor could all

detainees interested in vocational training be accommodated (Human Rights Commission of Malaysia, 2003). Such problems have not been resolved while there is an increasing number of detainees in most DRCs.

In addition to the DRCs there are also 60 private drug rehabilitation centres approved by the National Drug Agency, and 121 private clinics that have been approved by the Ministry of Health to treat drug users (Mohamed, 2004a; National Drug Agency, 2004). About 300 private medical practitioners have received specific training to treat drug users, but up until early 2004 only 168 doctors, trained by the Malaysian Medical Association, had been issued with certificates allowing them to treat drug users. The main concern appears to be that the certificates may contravene some drug laws and that drug substitution therapies may be misused in the treatment of drug users (New Straits Times, 2004).

High relapse rates result in further drug-related offences; chronic drug users are being sent into a prison system that has become seriously overcrowded (International Centre for Prison Studies, 2004). In 2004, the Malaysian Inmates Report shows nearly 43,000 prisoners in a prison system with the capacity of 24,850 (Prisons Department, 2004; S.K. Sran, personal communication, 2004). In 2003, the Human Rights Commission of Malaysia visited nine of the 36 prisons in the country and found overcrowding to be common: the Penang prisons were housing 2481 inmates but the gazetted capacity was only 1200. There were similar findings in other prisons (Human Rights Commission of Malaysia, 2003).

In addition to the overcrowding in 2004, there are 1954 HIV-positive inmates and an increasing number infected with TB. Health training programs provide prison officers with basic information about HIV/AIDS along with counselling materials for selected officers to conduct the training. However, as of August 2004, only around 200 out of 1200 officers had attended the training sessions. Currently there are no health programs conducted for the inmates (S.K. Sran, personal communication, 2004). HIV-infected prisoners are segregated from other inmates, but no HIV treatment program is available (Open Society Institute, 2004). Inmates found to be HIV-infected are segregated in both DRCs and prisons, but there is no further isolation currently in place when HIV-positive inmates are found to be co-infected with TB (B. Venugopalan, personal communication, 2004). The further risk of TB spreading among other HIV-infected inmates housed in segregated buildings cannot be underestimated.

In 2003, the government spent about RM44 million on treating and rehabilitating drug users in the 28 DRCs; in 2002, RM12 million was spent to develop and maintain such facilities (Ismail & John, 2004). In 2001, the cost of each inmate in a DRC was reportedly RM362 per month (New Straits Times, 2001); it is likely that this amount has increased annually. In 2004, the per person costs were estimated to be RM12.7 per day. The excessive costs of running DRCs that consistently do not meet desired expectations has led to some discussion on the need to privatise the system, but there are no current plans to do so (S.K. Sran, personal communication, 2004).

Recent advocacy efforts by NGOs and medical professionals have resulted in increasing interest in substitution therapy programs. In 2003, the government consented to a piloted methadone program and the findings proved successful (Gill et al., 2004). A similar piloted program took place with the use of buprenorphine with impressive results (Hatim & Habil, 2004). Currently there appears to be increasing interest in introducing substitution therapy programs beyond the pilot phase, but it is not clear whether these will become long-term programs. Although the clinical trials showed impressive results, substitution still has its many sceptics who cannot be ignored (Izzaddin & Teoh, 2004).

Needle and syringe programs are not currently permitted in Malaysia but small-scale outreach programs targeting drug users can be found: funding for such programs however has limited time frames or remains precarious (L. Ng, personal communications, 2004; V. Balasingam, personal communication, 2005).

Other responses

School-based education

The National Drugs Agency (NDA) of Malaysia is involved in educational programs. A Student's Resilience and Interpersonal Skills Development Educational (STRIDE) program has been implemented at primary school level (students aged 7–12 years). In essence, the objective of STRIDE is to encourage students to 'say no to drugs', to resist peer pressures to consume drugs and to ensure Malaysian schools are free of drugs. In 2002, the STRIDE program was implemented in 416 schools (Poh Fah, 2004).

Community development

NDA conducts seminars and information meetings to introduce drug prevention programs in workplaces. In 2002, there were 65 such seminars (Poh Fah, 2004).

Information and publicity program

A mobile drug prevention unit was created in 1990 to travel throughout the country informing the general public about the drug using problem. In 2002, 300 exhibitions were organised for schools, institutions of higher learning, government departments and public places (Poh Fah, 2004).

Advocacy groups

In 2004, Malaysia's first Harm Reduction Working Group was established, with the Malaysian AIDS Council, in Kuala Lumpur.

A8.7 References

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A9. Myanmar

Geography	Myanmar is located in south-eastern Asia, bordering the Andaman Sea and the Bay of Bengal, between Bangladesh, India, China and Thailand. Its terrain consists of central lowlands ringed by steep, rugged highlands. Arable land: 15.19% Permanent crops: 0.97% Other: 83.84% (2001)
Government	Military Junta Chief of state: Chairman of the State Peace and Development Council Sr. Gen. Than Shwe (since 23 April 1992) Head of government: Prime Minister Gen. Soe Win (since 19 October 2004) Cabinet: State Peace and Development Council (SPDC); Military Junta, so named 15 November 1997, which initially assumed power 18 September 1988 under the name State Law and Order Restoration Council (SLORC); the SPDC oversees the Cabinet. Elections: none
Population	42,720,196 Note: Estimates for this country take into account the effects of excess mortality due to AIDS, TB, malaria and malnutrition; this can result in lower life expectancy, higher infant mortality and death rates, lower population growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (July 2004 est.). Median age: 25.7 years Male: 25.2 years Female: 26.3 years (2004 est.)
Human development index	HDI rank 132 (177 Countries)
Unemployment rate	4.2% (2003) (although this figure is questionable)
Language	Burmese, minority ethnic groups have their own languages
Literacy	% Age 15 and over can read and write: Total population: 85.3% Male: 89.2% Female: 81.4% (2002)

Religion	Buddhist 89%, Christian 4% (Baptist 3%, Roman Catholic 1%), Muslim 4%, Animist 1%, other 2%
Health	Life expectancy: 56.01 years Male: 54.22 years Female: 57.9 years (2004 est.) Under 5 mortality rate: 68.78 deaths/1000 live births Male: 74.78 deaths/1000 live births Female: 62.42 deaths/1000 live births (2004 est.) HIV prevalence: 1–5% (2003 est.)
Economics	GDP: purchasing power parity – \$74.53 billion (2003 est.) Percentage of population living below the poverty line: 25% (2000 est.)

A9.1 Narrative summary of drug vulnerabilities

Conflict, isolation and ceasefire agreements

Political and social isolation caused by years of conflict has resulted in greatly increased vulnerabilities to drug use and trade in Myanmar. First, a history of drug production has resulted in a disproportionate number of dependent heroin and opium users. Second, exclusion of NGOs from government development planning and their lack of access to provide services in these regions have resulted in poor health care, drug treatment and other interventions such as harm reduction services.

Opium eradication

The rapid eradication of opium in Myanmar has forced many opium farmers to seek alternative livelihoods. Despite considerable investment in alternative development, the impact of eradicating opium farming could have dramatic effects. When opium farming was banned by the leaders in Kokang Special Region 1 in Northern Shan State in 2003, 60,000 people were forced from their homes in search of food and money. This resulted in health clinics closing down, and increases in labour exploitation (Economist, 2005).

A potentially larger humanitarian disaster has developed in the Wa Special Region 2 where leaders have also enforced a total opium ban effective from April 2005. The United Nations Office on Drugs and Crime (UNODC) estimates there are about 300,000 people dependent on opium farming in the region. In an interview, Jen-Luc Lemahieu, UNODC representative in Myanmar, said: 'I don't see enough [alternative] income coming in for the opium poppy farmers and I am concerned that we will have a humanitarian crisis on our hands as a result' (Transnational Institute, 2003).

Jade mines

Labour exploitation, especially in the jade mines of northern Myanmar, highlights another vulnerability to drug use. It is estimated that one million people are employed in the jade mines, many of whom are dependent heroin users. Scott-Clark and Levy (2002) report that nearly all males (the majority of miners) who are employed in the mines use heroin.

Historical and cultural interactions with drugs

The traditional Wa people of Myanmar claim their relationship with the opium poppy and tobacco dates back to the death of *Ya Lem*, a beautiful goddess in the mountainous region of *Loi Mu*. The legend states that opium and tobacco sprouted from her dead body and have been grown by their people ever since (Hideyuki, 2002).

Actual accounts of opium trade, use and production in Myanmar date back to the late 16th century around the time opium

entered the markets of other Southeast Asian countries. By the early 17th century, influences from both the Chinese and the Dutch East Indian Company saw the production of opium increase in line with growing market demands and its profitability as a trading commodity (Reid & Costigan, 2002).

After annexing the southern region of Myanmar in 1852, the British began importing large quantities of opium from India and established a government-controlled monopoly. Opium use continued to increase among the Burmese and Chinese until the *Opium Act* was passed in 1878. The *Opium Act* precluded the sales of opium to anyone other than registered addicts. In 1906 the trading of opium was made illegal in Myanmar and in 1921 the sale of opium from government shops was totally banned. However, neither of these laws greatly affected the use or production of opium (Spencer & Navaratnam, 1981).

Since independence from the British in 1948, international politics and internal conflict have played a huge role in shaping drug trade in Burma. Shortly after independence, civil war engulfed Myanmar, largely due to disagreements between the U Nu Barman government and ethnic minority groups arguing for self-determination and autonomy. At the same time in northern Myanmar, elements of Chiang Kai-shek's Chinese Nationalist Army (KMT) withdrew into the Shan State and began developing opium trading networks to fund their army, thus beginning the history of opium being used to fund insurgencies in Myanmar (Transnational Institute, 2003).

By 1962 when General Ne Win took power from the U Nu government in a military coup, dissatisfaction among ethnic groups about their unequal position within Myanmar led to additional rebel armies in the Shan and Kachin states. In an attempt to control the uprising – especially in the Shan State – Ne Win introduced the Ka Kwe Program. This program provided arms for local militia groups to fight against the opposition groups, particularly the Shan State Army, in return for protection and the creation of autonomous regions. However, many of the militia groups became involved in the opium trade and increased rather than decreased lawlessness in the region. Further, and as a result of Ne Win's isolated socialist policies, the Burmese economy continued to fail, and led to the economic necessity for many of the opposition armies to continue their involvement in the opium trade, and increasingly in the heroin trade (Transnational Institute, 2003).

In 1988 large-scale political protests led to Ne Win's government being replaced by the State Law and Order Restoration Council (SLORC). Despite elections being held in 1990, the SLORC refused to hand over power to the elected National League of Democracy and continued to rule by way of a military dictatorship. The SLORC, however, changed the country's trade policy to a quasi-open market structure and initiated trade with China and Thailand. Also the SLORC quickly began negotiating with the rebel armies offering ceasefire agreements to them. The ceasefires, however, were merely military accords which allowed the opposition groups to control their own territories and maintain their arms. The ceasefires have brought an end to the bloodshed and

some civil rights abuses, but they had little effect on bringing economic stability to the areas or reducing the army's involvement in illegal activities such as drug trafficking, logging, gambling and human trafficking (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2003).

Focused international efforts have targeted drug supply in Myanmar with alternative development and crop eradication programs since 1985. While these have contributed to a continual reduction of opium and heroin production in the region, they have been unable to address the growing production of amphetamine-type stimulants (United Nations Office of Drugs and Crime, 2002a). Amphetamine production has increased dramatically in Myanmar since the mid-1990s when increased law enforcement activities in China and Thailand saw many manufacturing laboratories move into Myanmar.

Despite a reduction in the amount of opium and heroin produced in Myanmar, drug use has continued to increase from the 1970s with the estimated number of users more than doubling every 10 years until the 1990s (Reid & Costigan, 2002). This relationship highlights the increased local consumption of drugs in the region, and is associated with the rapidly expanding HIV epidemic among injecting drug users in Myanmar and the border regions, especially in Yunnan Province in China and Manipur State in north-east India, where Burmese drugs are filling an expanding market.

A9.2 Prevalence of drug use and profile of drug users

Data collection systems in place

Monitoring of population drug trends in Myanmar is poor; there is no national system to coordinate data collection about drug use. This is related to the strict control the government places on population-based surveys and the lack of independent verification of the limited research conducted. The longest functioning information system is coordinated by the Department of Planning and Statistics of the Ministry of Health and is derived from in-patient records from the country's drug treatment centres. Thus, this survey provides information only about drug users in treatment programs and provides few variables of epidemiological importance or that provide information about drug use in the community, risk factors or changing trends. The Myanmar Drug Law of 1993 prescribes compulsory registration of all drug users. While the majority of drug users are not registered, this system provides an additional data collection mechanism used to gather information about drug use in Myanmar.

In 2002, the first school surveys of drug use were conducted in Myanmar through the UNODC-funded Subregional Project for the Development of Institutional Capacity for Demand Reduction among High Risk Groups. The study surveyed 23,159 students in four cities and attempted to assess their knowledge, attitudes and behaviours around drug use (United Nations Office on Drugs and Crime, 2002b).

It is worth noting that two independent population-based surveys of drug use have recently been funded and approved to begin in Myanmar. The first, funded under the Fund for HIV/AIDS in Myanmar (FHAM), is a large-scale attitudes, knowledge and

behaviour study being coordinated by UNAIDS and implemented by the National AIDS Program with technical assistance from Compass. The second study will focus more on injecting drug use and HIV risk and will involve a rapid assessment being conducted in 18 sentinel sites around the country. The study will be coordinated by the Burnet Institute and commence in mid-2005 with Global Fund funding.

Opium crops have been surveyed in Myanmar since 1990 by the United States Government and by the UNODC since 2002. Viewed together with seizure and arrest data made available by the Central Committee on Drug Abuse Control (CCDAC), these surveys can assist in establishing a better understanding of the production and availability of illicit drugs in Myanmar.

Population estimates of drug use

Due to problems in collecting independent data in Myanmar, estimating the number of drug users is difficult. According to government records there were 63,149 registered drug users in Myanmar in 2002 (Central Committee for Drug Abuse Control, 2002). However, it is openly held that the number of drug users in Myanmar is significantly higher than is reflected by the drug registry. While CCDAC has no official estimate of the number of drug users in the country, it suggests that, based on reports from registered drug users about the number of drug-using associates who are not registered, the total number of drug users is likely to be between 300,000 and 400,000 (United Nations Office on Drugs and Crime, 2004).

Similarly, estimates about the number of IDUs vary greatly between reports. Prastuck (1997, UNODC report G22 from web page review and assessment) estimated there were 300,000 IDUs in Myanmar in 1997. Other studies

suggest this might be an over-estimation with a figure falling between 90,000 and 300,000 being more likely (Aceijas et al., 2004; Reid & Costigan, 2002).

Of the students surveyed in the most recent school survey, 3 per cent reported having a parent who had ever used drugs, while 7.5 per cent reported having a family member who had ever used drugs. About 15 per cent of students reported using drugs in their lifetime, with non-prescribed cough medicine (9%), diazepam (4%) and cannabis (2%) being the most commonly reported (United Nations Office of Drugs and Crime, 2002b).

The *World Drug Report* suggests that the most commonly used drug in Myanmar is opioids, followed by methamphetamine and cannabis. In a survey conducted by CCDAC of registered drug users in 2002, opium (54%) was the most commonly used drug followed by heroin (36%) and methamphetamines (16%). The survey also found that the method of use closely related to the drugs taken, with over half of those surveyed reporting smoking (opium and methamphetamines), with about 22 per cent reporting injecting as being their most common method of administration. The survey also revealed that heroin use predominates in the Kachin State, Northern Shan State and in the major cities, while opium use is more common in Eastern and Southern Shan States and in the Kayah State (Central Committee for Drug Abuse Control, 2002).

Arrest and treatment data suggest that drug use is predominantly a male phenomenon. However, recent situational assessments conducted in Myanmar suggest that there are a growing number of women drug users who are particularly vulnerable due to stigma and lack of access to services (Limbu, 2005).

A9.3 Drug supply, production, availability, cost and trade

Myanmar is the main producer of opium, heroin and amphetamine-type stimulants in Southeast Asia. It was estimated that Myanmar produced 370 metric tonnes of opium in 2004, surpassed only by Afghanistan as the world's largest producer (United Nations Office on Drugs and Crime, 2004). Reports consistently suggest Myanmar has also become one of the world's largest producers of amphetamine-type stimulants, producing approximately 700 million tablets a year, which corresponds to about 7.5 per cent of total global manufacture (Transnational Institute, 2003).

Despite still being a significant global producer of opium and heroin, over the last decade opium cultivation in Myanmar has reduced from 160,000 hectares in the mid-1990s to 44,000 hectares in 2004. According to the UNODC Opium Survey (United Nations Office on Drugs and Crime, 2004a), more than 90 per cent of Myanmar's opium production takes place in the Shan State where 95 per cent of villages are involved in the cultivation of opium.

The reduction in overall opium output in 2004 was a result of increased crop eradication – 2820 hectares, up 342 per cent from 2003 – and a severe drought that reduced opium yields to about 8 kilograms/hectare. The reduction in opium supply led to an increase in farmgate prices, with opium retailing for US\$234/kg in 2004. This represents a total farmgate value for opium in Myanmar of about US\$87 million, equivalent to about 1–2 per cent of the GDP (United Nations Office on Drugs and Crime, 2004a).

Processed heroin is estimated to cost US\$5–11 per gram (in Australia, US\$200) in Yangon, but is likely to be cheaper in areas closer to production (United Nations Office on Drugs and Crime, 2004b).

Estimating the production of amphetamine-type substances (ATS) is more difficult due to the clandestine nature of their manufacture and lack of treatment services tailored to amphetamine users. However, it is thought that amphetamine production continues to rise in Myanmar, particularly in the Wa region and Southern Shan State (Bezziccheri & Bazant, 2004). Amphetamine production boomed in 1996 when a number of methamphetamine laboratories moved into Myanmar from Thailand and China. The Thai Army accuses Myanmar of having about 30 amphetamine processing factories in operation along its shared border areas (United Nations Office on Drugs and Crime, 2002a).

While local consumption of illicit drugs in Myanmar has increased over recent years, the majority of drugs produced in the region is destined for other markets. It is estimated that 20 per cent of the heroin available in the United States of America originated in Myanmar (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004).

Traditionally China, India and Thailand have served as transit countries for Burmese drugs to be shipped to markets in Europe, Australia and America. However, growing local demand

for drugs in these countries has seen rapidly expanding markets in the areas bordering Myanmar. The supply chains that have developed to feed the local markets appear to be less formalised and more dispersed than the international trafficking routes (Transnational Institute, 2003). The trade of ATS across the border into Thailand has also raised considerable attention and caused political unease between the two countries.

With leadership from UNODC, Myanmar has recently developed a joint action plan with China, Laos and Thailand to increase efforts to suppress the trafficking of precursor chemicals and equipment used in producing ATS along common borders. This plan reflects the increasing trade of precursor chemicals in the region (United Nations Office on Drugs and Crime, 2005).

Arrest and seizure data

Data on seizures of both precursor chemicals and amphetamine tablets from Myanmar also suggest rapid growth in production within Myanmar. Table A9.1 shows that seizures increased rapidly from 1996 with a peak in 2001 followed by a slight reduction over the subsequent two years.

Table A9.1. Seizures of illicit drugs in Myanmar, 1996–2003

Year	Opium (kg)	Heroin (kg)	ATS (million tablets)	Precursor chemicals (litre)
1996	1300	504	5.9	23,234
1997	7884	1401	5.0	78,402
1998	5394	403	16.0	85,557
1999	1473	245	28.8	57,018
2000	1528	158	26.7	86,755
2001	1629	296	32.4	174,191
2002	1863	333	9.3	26,440
2003	1481	568	4.0	36,903

A reduction in heroin production is also suggested by a consistent decline in the number of heroin laboratories destroyed and the number of heroin seizures by law enforcement over the past decade. Heroin seizures reported by CCDAC have steadily decreased from 2234 cases in 1990 to 986 cases in 2003, while the number of laboratories destroyed has decreased from 33 to 7 over the same period (Central Committee for Drug Abuse Control, 2002).

In 2003, 2625 people were arrested on drug-related charges in Myanmar. Of these, 196 were not charged or were acquitted, the remainder were punished with sentences ranging from treatment orders to life imprisonment or death. In 2004, 16 people (14 male and 2 female) were executed for crimes related to drugs (Central Committee for Drug Abuse Control, 2002).

Crop eradication statistics

Myanmar commenced the New Destiny Project in 2002 with the explicit goal of total opium eradication by 2015. CCDAC reported that 2820 hectares of opium crops were eradicated in Myanmar in 2004, representing a 300 per cent increase in eradication from the 2003 season (CCDAC, 2004). The most significant eradication was in Southern Shan State where 2170 hectares were eradicated; 172 hectares were eradicated from the Northern Shan State, which was a significant reduction from 2003. The reduction in eradication was due to 'voluntary' abandonment of poppy cultivation enforced by local leaders in line with their commitment to eradicate opium cultivation by April 2005.

A9.4 Drug-taking practices, risk factors and trends

As opium becomes less available, a number of new trends are emerging among drug users in Myanmar. Several reports have highlighted the shift toward heroin use and the rapid uptake of injecting as the preferred method of administration (Aung, 2003; Birgin, 2004).

The greatest risk associated with IDU in Myanmar is HIV. It is estimated that there are between 541,100 and 832,900 people living with HIV in Myanmar, or about 1 in every 29 adults (Beyrer et al., 2003). Studies attribute 30 per cent of all HIV cases in Myanmar to IDU (United Nations Office on Drugs and Crime, 2002a).

HIV prevalence rates among IDUs in Myanmar are among the highest in the world. Sentinel prevalence studies and studies of IDUs at drug treatment centres show HIV prevalences of 50–90 per cent (Birgin, 2004; Central Committee for Drug Abuse Control, 2002; Doradjee & Htet Doe, 2002). This, coupled with the high mobility, high imprisonment rates and needle sharing among IDUs, all point to a continually expanding HIV epidemic.

Needle sharing is the norm in Myanmar. Factors such as poor access to clean needles and poor knowledge about HIV risks lead many IDUs to sharing their injecting equipment. Studies show that, as services to drug users such as needle and syringe programs increase, needle sharing is decreasing; but even with the increased availability of services to IDUs in Myanmar, the majority (66%) of users still report sharing needles (Doradjee & Htet Doe, 2002).

Recent program implementation by a group of international NGOs in Myanmar is beginning to address the lack of harm reduction services to IDUs. Projects coordinated under UNAIDS Joint Programs for HIV/AIDS in Myanmar are currently operating needle and syringe programs, drop-in centres and primary health care services for drug users. Limited pilot methadone programs are also underway. According to the Fund for HIV/AIDS in Myanmar – a major international funding source for HIV prevention in the country – over 400,000 needles were distributed in Myanmar in 2004 (Technical Coordination Unit, 2005).

In some parts of Myanmar it remains common for drug users to purchase a shot of heroin in a pre-prepared syringe, often at a shooting gallery. Drug users either inject themselves

or are injected by a professional injector who will inject their clients with their own syringes. This situation raises a number of risks. First, the syringes supplied in shooting galleries are often reused, increasing the risk of HIV and hepatitis C. Second, the shooting galleries are often small makeshift huts made from materials that are not conducive to good hygiene, increasing the chances of secondary infection associated with injection.

The level of condom utilisation among IDUs is low, which dramatically increases the likelihood of passing on HIV to a sexual partner. In a study conducted by CARE, 71 per cent of IDUs did not use a condom in the last sexual encounter (Doradjee & Htet Doe, 2002). These unsafe sexual practices provide a bridge for HIV to move into the non-IDU community.

A9.5 Summary table

Estimated number of drug users	300,000–400,000 (~140,000 IDUs)
Main drugs used	Heroin, opium, methamphetamines, marijuana, codeine, ephedrine and tranquillisers
Drugs injected	Heroin, sometimes mixed with tranquillisers
Estimated prevalence of HIV infection among IDUs	70%

A9.6 Country responses to drugs

Agreements and treaties

Myanmar is a party to the 1961 United Nations Single Convention, the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention Against Illicit Trafficking in Narcotics. In 1993, Myanmar enacted the *Narcotic Drugs and Psychotropic Substances Law* which, as well as dealing with drug law, addresses corruption, conspiracy, money laundering and international cooperation against drugs.

Myanmar along with Cambodia, China, Laos, Thailand and Vietnam signed a UNODC Memorandum of Understanding covering a subregional action plan aimed at controlling precursor chemicals and reducing illicit drug use in the highlands of Southeast Asia. Myanmar is also a member of ASEAN and a signatory to the ACCORD 'drug-free ASEAN by 2015' agenda.

Myanmar also has bilateral agreements relating to drug issues with China, Laos, India, Russia, Thailand, United States of America and Australia.

Policy responses

Myanmar has faced considerable international pressure to control drug production, especially opium and heroin, within its borders. International aid has funded crop substitution and eradication in the country from the mid-1970s and has remained the central pillar to Myanmar's response to drug issues.

Myanmar's stated policy toward drugs is the '15-Year Narcotic Drug Elimination Plan'. The policy was launched in 1999 with the goal of accelerating the anti-drugs campaign nationally, as well as the gradual elimination of the cultivation of opium, while improving the economic and social prospects of people who rely on opium as a livelihood. The 15-Year Plan will be implemented in three five-

year phases using law enforcement, supply elimination and demand elimination as the major tactics.

In line with the national policy of total eradication of poppies, leaders of autonomously controlled Kokang Special Region No. 1 and Wa Special Region No. 2 have also committed to the total eradication of poppies within their regions (Economist, 2005).

As stated above, the international community has played an influential role in shaping Myanmar's drug policy. Both the United Nations and the United States Drug Enforcement Agency have invested considerable resources in encouraging policies and programs involving the control of opium and heroin production. More recently, international pressure has been imposed on Myanmar to respond to the links between IDU and HIV in the country. The government's national strategic plan to respond to HIV has endorsed the UN-initiated Joint Program for HIV/AIDS in Myanmar, again highlighting the UN's role in high-level policy negotiation.

Historically the Ministry of Home Affairs, responsible for law enforcement, has been the lead agency for influencing drug policy in Myanmar. However, due to the HIV crisis in Myanmar, the Ministry of Health is increasingly important in shaping drug policy, particularly in relation to the health impacts of drug use.

The multi-ministerial CCDAC has a high profile within the government and wields considerable power in shaping policy at a central level. CCDAC has also become an important player in promoting health policies such as harm reduction within Myanmar.

The Health Minister of Myanmar, Professor Kyaw Mynit, has close associations with the National AIDS Program and has been influential in raising the importance of responding to HIV in recent years.

Several analysts have emphasised the central importance of the narcotics trade in Myanmar (International Crisis Group, 2004; Transnational Institute, 2003). It is estimated that revenue from illicit drug exports exceeds revenue from legal exports and forms an important source of income in Myanmar.

Law enforcement responses

CCDAC was established in 1975 in response to illicit drug problems in Myanmar. CCDAC is a multi-sectoral committee chaired by the Minister of Home Affairs, with the head of the Myanmar Police Force serving as secretary to the Committee. Under the control of CCDAC, Working Committees for Crop Substitution, Livestock Breeding, Treatment, Rehabilitation, Educating the Children and Youth, Law Enforcement, Public Relations, and Precursor Control have been formed. CCDAC has regional committees for drug abuse control at a state/divisional, district, township, ward and village level.

CCDAC oversees 21 Special Anti-Narcotic Squads deployed throughout the country and relies in part on military, police and customs personnel to execute law enforcement duties. Law enforcement resources are primarily focused on drug seizures, arrests and crop eradication.

With the recent introduction of harm reduction in Myanmar, CCDAC has advocated that law enforcement agencies relax certain laws that contradict some harm reduction services in certain pilot zones. CCDAC is also playing a lead role in training new law enforcement recruits in harm reduction and, together with the Burnet Institute and the Asian Regional HIV Project, is developing a specific law enforcement and harm reduction curriculum.

Legislation/penalties/prison

Myanmar has a number of laws pertaining to drug issues. The Myanmar *Narcotic Drugs and Psychotropic Substances Law* of 1993 (Law no. 1/93) remains the most important law with regard to drug use in Myanmar. The 1993 law repeals the 1974 *Narcotics and Dangerous Drugs Law* and aims:

- to prevent the danger of narcotic drugs and psychotropic substances, which can cause degeneration of mankind, as a national responsibility;
- to implement the provisions of the United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances;
- to carry out more effectively measures for imparting knowledge and education on the danger of narcotic drugs and psychotropic substances and for medical treatment and rehabilitation of drug users;
- to impose more effective penalties on offenders in respect of offences relating to narcotic drugs and psychotropic substances;
- to cooperate with the states parties to the United Nations Convention, international and regional organisations in respect of the prevention of the danger of narcotic drugs and psychotropic substances.

Law 1/93 enforces the registration and provision of medical treatment for all drug users. Once registered, drug users are subject to a minimum six-week compulsory detoxification. Drug users who fail to register face a prison sentence of a minimum of three years (up to five years).

Under the 1993 law the possession of any narcotic drug is illegal and punishable by imprisonment. Sentences range from 5 to 10 years for growing an illegal narcotic plant or for unlawful possession of a narcotic substance and between 10 years and life for possession of a drug to be sold. People found guilty of producing, exporting or importing a narcotic drug face a minimum 15-year prison sentence to a maximum sentence of death.

Law 1/93 also allows for the search and seizure of money, property and goods derived from involvement with illicit drugs.

Other laws important with regard to drug issues in Myanmar are the *Control of Money Laundering Law* (Law No. 6/2002), and the 1917 *Excise Act* which prohibits the possession, sale or distribution of hypodermic needles without a licence. Notifications 1, 2, 3/2002 and 1/2004 together update Law 1/93 and control precursor chemicals as well as additional psychotropic substances. Myanmar now controls 114 substances under Law 1/93.

Myanmar has 41 prisons (three of which are specific drug prisons, called Youth Rehabilitation Centres) and 55 work camps for convicted prisoners. As of 12 August 2002 there were 29,390 people imprisoned in Myanmar (Bezziccheri & Bazant, 2004).

At 1 August 2002 there were 1926 people imprisoned for drug abuse and 5844 for possession or trafficking of drugs. In the work camps in the same period there were 2211 people convicted for drug use and 438 convicted for possession of drugs (Bezziccheri & Bazant, 2004).

People arrested on suspicion of drug use are taken to a drug treatment centre for assessment. Assessment involves a drug history, a urine test, a physical examination and administration of Narcan to observe for withdrawal symptoms (Birgin, 2004). Results from the urine tests are used as the ultimate proof of drug use. The person accused of drug use is confined to the police station throughout this process, which may take up to three months in some cases. Drug users are then sentenced by a judge. Eligible drug users serve the final year of their sentence in one of the Youth Rehabilitation Centres. To be eligible for the Youth Rehabilitation Centres the prisoner must be towards the end of their sentence, free of HIV, between 20 and 40 years old, of Myanmar origin and 'willing to work for the sake of the country' (Birgin, 2004).

Prison medical staff are employed by Department of Health but are on loan to the Home Ministry which is responsible for the management of the prison system. CCDAC has a strong influence in the operation of the prison system and is advocating for HIV prevention and education initiatives to be implemented in prisons.

Health and treatment responses

As stated above, drug users are obliged by law to register for treatment or else be penalised for up to five years in prison. Drug users are obliged to appear with their parents when registering for treatment and are issued with an identity card they must carry with them to confirm they are registered (Gstrein, 2004).

Drug treatment in Myanmar is oriented toward total abstinence from drugs. Treatment involves a 42-day detoxification regime consisting of decreasing doses of tincture of opium together with some medicines for symptomatic relief of opium withdrawal. The treatment system in Myanmar consists of 26 major drug treatment centres (DTCs), 40 minor DTCs and 49 border area hospitals. The 26 major DTCs have a daily bed capacity of 450 and an annual capacity of about 3500 (Birgin, 2004).

The 42-day detoxification treatment in Myanmar costs about US\$60 for food and medicine. Clients are denied treatment if they cannot finance their stay, or if they are considered too old or too ill; only opioid-dependent patients are admitted to treatment. All those who are refused admission, and therefore registration, remain vulnerable to being prosecuted under Law 1/1993.

It is illegal for unauthorised practitioners (private clinics, traditional healers, monks etc) to provide treatment for drug users. However, many drug users seek treatment through these illegal settings because they are cheaper and can avoid the stigmatisation of registration (Birgin, 2004).

While very few studies have looked at treatment outcomes, it is estimated that 60–70 per cent of clients relapse in the first month of being released from detoxification treatment (Bezziccheri & Bazant, 2004).

Other responses

Alternative development is a major focus of both Myanmar and international donors. Alternative development programs aim to reduce opium-growing communities' reliance on opium by improving food security, developing alternative livelihoods and improving general living conditions, education and

health care services. In addition to several programs being conducted by international non-government organisations, the Government of Myanmar has set up specific Working Committees under the control of CCDAC to focus on crop substitution and livestock breeding. In the first five years of the 15-Year Narcotic Drug Elimination Plan, 22 townships have been involved in alternative development programs with opium crops being substituted with crops such as tea, wheat, maize, coffee, fruit trees, rice and oil-bearing crops. Livestock breeding, including pigs, cattle, fish and poultry, is another focus of alternative development programs.

Another major strategy of the Myanmar Government to eliminate drug use is community-based demand reduction. Prevention programs focus on education sessions for school children as well as public information campaigns via the media. Media campaigns have used famous media and music personalities to promote the 'Amazing life without drugs' campaign. The campaign includes sporting events, concerts, poster-billboards as well as media advertisements.

School-based education is oriented toward abstinence from drugs and focuses on the dangers of drugs as well as promoting healthy living practices and behaviours. Over 2000 teachers and 25,000 students received drug education in Myanmar in 2002 (Central Committee for Drug Abuse Control, 2002).

Drug user organisations

No drug user organisations exist in Myanmar.

Advocacy groups

No advocacy groups exist for drug users in Myanmar.

A9.7 References

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A10. Philippines

Geography	Southeastern Asia, archipelago between the Philippine Sea and South China Sea, east of Vietnam. The terrain is mostly mountainous with narrow to extensive coastal lowlands. Arable land: 18.95% Permanent crops: 16.77% Other: 64.28%
Government	Republic government. President and Vice-President elected by popular vote for six-year terms; election last held 10 May 2004. The elected President is Gloria Macapagal-Arroyo.
Population	Population: 84,241,341 Median age: 22.1 years Age structure: 0–14 years: 35.8% 15–64 years: 60.2% 65 years and over: 3.9%
Human development index	HDI rank 83 (177 countries)
Unemployment rate	11.4%
Languages	Filipino (based on Tagalog) and English; major dialects – Tagalog, Cebuano, Ilocan, Hiligaynon or Ilonggo, Bicolano, Kapampangan, Waray, Pampango and Pangasinense
Literacy	% Age 15 and over can read and write: 92.6%
Religion	Roman Catholic 83%, Protestant 9%, Muslim 5%, Buddhist and other 3%
Health	Life expectancy at birth: Male: 66.74 years Female: 72.61 years Infant mortality rate: 24.24 deaths/1000 live births Adult HIV prevalence: less than 0.1%
Economics	GDP: purchasing power parity – \$390.7 billion Income differentials: Lowest 10%: 1.7% Highest 10%: 38.4%

A10.1 Narrative summary of drug vulnerabilities

The country's population growth, at 2.36 per cent, is one of the world's highest, almost twice the global rate of 1.30 per cent. Population density is 270 people per square kilometre, however the population is unevenly distributed throughout the islands. Fifty-five per cent of the population lives on the island of Luzon with the greatest concentration in metropolitan Manila.

Poverty is a major problem and a serious threat to stability in the Philippines (AusAID, 2004c). The annual per capita poverty income threshold in 2000 was PHP13,913 (about US\$280). The poverty incidence of families was 34.2 per cent (2000) while that of the population was 40 per cent (2000) or about 31.8 million Filipinos living below the poverty line (WHO, 2005). The Philippines has one of the highest levels of income inequality in Asia, with the poorest 20 per cent of the population accounting for only 5 per cent of the total income or consumption (AusAID, 2004a).

Urbanised areas are rapidly expanding, attracting migrants from rural communities. Young people are also vulnerable to drug use and abuse. About 34.65 per cent of the population are below the age of 15 and 4.24 per cent are above the age of 65. Growing population and urbanisation are creating a 'youth bulge' (AusAID, 2004a).

Historical and cultural interactions with drugs

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 that 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 per cent 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 in other countries of the region (Reid & Costigan, 2002).

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 the American War in Vietnam, a steady flow of marijuana, anti-depressants, amphetamines and heroin arrived at the US military bases in the Philippines. 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. 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 (Reid & Costigan, 2002).

A10.2 Prevalence of drug use and profile of drug users

Until the completion of the National Household Survey on the Nature and Extent of Drug Abuse by the Dangerous Drugs Board (DDB) for 2004, more recent estimates than 1999 are not yet available. The survey was carried out with the general population aged 10–44 years, with a total of 16,927 respondents being sampled. The survey found that 1445 (8%) were users of illicit drugs. Of this number 4.3 per cent reported regular use. Based on the survey results, it was estimated 3.4 million people were current users of illicit drugs, 1.8 million were regular users, and 1.6 million were occasional users. As percentages of the 1999 population (79,345,812), 4.3 per cent were current users of illicit drugs, 2.2 per cent were regular users of illicit drugs, and 2 per cent were occasional users of illicit drugs.

The main drug of abuse is crystal methamphetamine hydrochloride, locally known as 'shabu'. Domestically grown cannabis is the second most frequently abused drug, followed by cough and cold preparations, benzodiazepines and inhalants. Ecstasy is becoming increasingly popular as a drug of abuse (Dangerous Drugs Board, 2005).

Records show that, in 2002, the number of barangays (basic political unit, e.g. a local government area) with households having members who are drug abusers was 8.68 per cent – 3654 of the country's total 41,946 barangays. Metropolitan Manila has the highest number of drug-affected barangays among the country's 16 regions, with 20 per cent of its 1694 barangays.

Data collection systems in place

The Philippines Dangerous Drugs Board (DDB) conducts the National Household Survey on the Nature and Extent of Drug Abuse every five years. Study sites include the National Capital Region, Luzon, Visayas and Mindanao with one thousand households in each study site. The sample is drawn from the following age brackets: 10–19 years, 20–29 years, 30–44 years. Simple random sampling is used.

The Integrated Drug Abuse Drug Information Network (IDADIN) is a project implemented by the DDB in collaboration with the Philippine Drug Enforcement Agency (PDEA) and the National Centre for Mental Health, in support of the UNODC F-97 regional project, 'Improving ATS Data and Information Systems'. The IDADIN aims to establish an infrastructure for better understanding of the patterns of ATS in the region and for exchanging data pertinent to ATS abuse prevention and control. Eight countries including the Philippines are signatories to the Memorandum of Understanding (MOU) regarding the implementation of the project at the national level. The other MOU countries include Cambodia, China, Laos, Myanmar, Thailand, Vietnam and Indonesia. The regional centre of the project is based in Bangkok, Thailand. Major data providers of IDADIN are:

- National Poison Control Center, Philippine General Hospital (national data on mortality and morbidity)
- Tondo General Hospital Detoxification Unit (national data on mortality and morbidity)
- East Avenue Medical Center Detoxification Unit (national data on mortality and morbidity)

- Detoxification Unit, National Center for Mental Health, Mandaluyong City (mortality/morbidity data)
- Therapeutic Community Center, Bureau of Corrections, National Bilibid Prisons (national treatment data)
- Bureau of Jail Management and Penology (national law enforcement data on drug-related cases)
- Dangerous Drugs Board (national treatment/research data/best practices)
- Addictus Philippines (NGO/ research data)
- PNP Drug Laboratory
- Kill Droga (NGO best practices).

Using standardised data collection forms, major data providers report their data on an established schedule to the Dangerous Drugs Board Integrated Drug Abuse Data and Information Network (DDB IDADIN), which collects and collates the data and submits the results to the UNODC Regional Centre.

The Integrated Central Case Registry and Monitoring System (ICCRMS) provides a monitoring system for outpatient and residential drug treatment facilities.

Surveys of youth from geographic areas with high levels of ATS use have been carried out as part of a rapid assessment study (United Nations Office on Drugs and Crime, 2003d). The DDB and UNODC conducted a rapid assessment to measure the extent of knowledge, attitudes and behaviour of Filipino youth on ATS abuse.

A10.3 Drug supply, production, availability, cost and trade

Crystal methamphetamine hydrochloride – shabu

Historically *shabu* was imported into the Philippines (United Nations Office on Drugs and Crime, 2003a). Since 1997, the Philippines has been considered a methamphetamine HCl producer. The discovery of a clandestine *shabu* laboratory in the northern area of the country in 1997 validated the shift from trafficking crystal methamphetamine to manufacturing the drug in the country (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2003a). There are various reasons for the relatively new shift to local production, namely: (1) the simplicity of processing ephedrine into *shabu*; (2) the crackdown on production facilities and processed methamphetamine HCl in other source countries; and (3) the reduced risk associated with trafficking precursor (ephedrine) compared to *shabu* (United Nations Office on Drugs and Crime, 2003a).

Cannabis

Wild growth of cannabis occurs in the mountainous regions in the Philippines. Its availability in the drug market can be estimated from the increase in cultivation sites and continuous seizures of large quantities of the drug (Dangerous Drugs Board, 2005). Data from UNODC (United Nations Office on Drugs and Crime, 2003a) state that in 1972 there were nine identified cannabis cultivation sites whereas today the number of sites has increased to 120, located in nine regions of the country.

There are no documented reports of clandestine hashish laboratories; however, there have been seizures of the drug in the drug market (Dangerous Drugs Board, 2005). Cannabis sales are estimated to generate about \$900 million per year (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2003). Cannabis is generally cultivated in areas that are inaccessible by vehicles, and/or controlled by insurgent groups (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2003).

Precursors and essential chemicals

The Philippines does not produce or manufacture ephedrine, nor legally import it in large quantities for licit pharmaceuticals (Dangerous Drugs Board, 2005). The Ma-hung plant (*Ephedra equisetina*), the source of ephedrine, grows naturally in China, India, Pakistan and Nepal. It is

assumed that the bulk of the ephedrine seized in various clandestine laboratories has been illegally imported. Some uncontrolled locally produced chemicals found in clandestine laboratories are alleged to have been acquired from legal wholesalers/retailers (Dangerous Drugs Board, 2005).

Availability

According to drug user self-reports the availability of *shabu* and cannabis is similar, with 26 per cent and 28 per cent of users indicating these drugs were easy to obtain (see Table A10.1) (United Nations Office on Drugs and Crime, 2003d). In contrast, 5 per cent of users rated ecstasy as easy to obtain. *Shabu* is typically sold in sachet packets at 100 peso per sachet. Ecstasy pills or capsules were usually sold at around 800 pesos with prices ranging from 500 to 2000 peso (United Nations Office on Drugs and Crime, 2003d).

Table A10.1. Availability ratings for ecstasy, shabu and cannabis by survey respondents, Philippines

How difficult is it to get the following drugs (n = 280)	Ecstasy	Shabu	Cannabis
% Impossible	20	7	6
% Difficult	20	32	26
% Easy	5	26	28
% No response	56	45	40

Source: United Nations Office on Drugs and Crime, 2003d

Drug seizures

Since 1997, Philippine law enforcement has dismantled 32 laboratories; a total of 2057.21 kilograms of *shabu* were recovered (Figure A10.1).

In 2004, combined law enforcement agency efforts conducted 24,778 anti-drug operations (Dangerous Drugs Board, 2005). The operations resulted in the seizure of illicit drugs worth P10.781 billion (approx.

AU\$250 million), precursor chemicals were valued at P9.406 billion (approx. AU\$215 million), and equipment worth P5.165 million (approx. AU\$118,000). Methamphetamine HCl accounted for 23 per cent of the overall value of the drugs seized (3676 kg valued at P7 billion) (approx. AU\$160,000) and cannabis products worth P428 million (approx. AU\$9 million). Table A10.2 shows statistics for drugs seized within the Philippines in 2004.

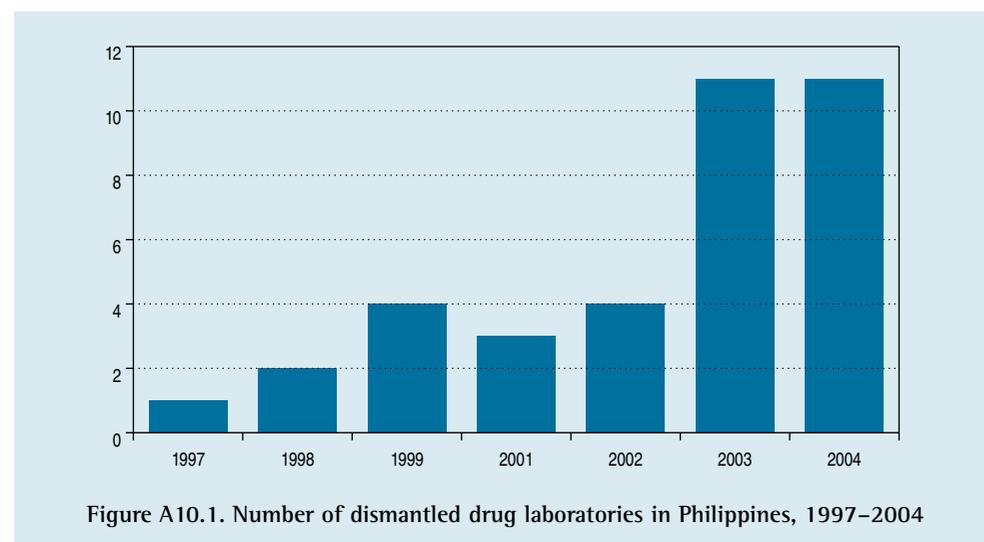


Figure A10.1. Number of dismantled drug laboratories in Philippines, 1997–2004

Source: Data received from Dangerous Drugs Board, 2005

Table A10.2. Seizures of illicit drugs in Philippines, 2004

Drug	Quantity
Methamphetamine HCl/shabu	11,001,795 grams
Cannabis plants	1,948,999 pcs
Cannabis seedlings	433,054 pcs
Cannabis seeds	5215 grams
Cannabis dried leaves	827,250 grams
Hashish	200 grams
Ecstasy	103 pcs
Cocaine	2421 grams
Opium poppy	9000 grams

Source: Dangerous Drugs Board, 2005

Drug trade

The Philippines serves as a transit point for and producer of crystal methamphetamine and cannabis. According to the United Nations Office on Drugs and Crime Regional Centre and the Dangerous Drugs Board, methamphetamine hydrochloride (*shabu*) is imported into the country through four main avenues:

- seaports, concealed in container vans or stashed inside cargoes
- international airports, the preferred trafficking avenue for small quantities (less than 1 kilogram to multi-kilogram shipments) using false compartments in luggage or through body packing
- mail and parcel services, preferred in foreign destinations that have large Filipino communities like Guam, the United States, Australia, England and the Middle East
- Philippine coastlines, the area where most of the huge shipments of both finished products and raw material (precursors) are imported. *Shabu* is imported into

the Philippines through the shorelines of Northern Luzon, Central Luzon (United Nations Office on Drugs and Crime Regional Centre, 2003), and Southern Tagalog regions, specifically the provinces of Batanes, Cagayan, Ilocos Sur, Pangasinan, Zambales, Aurora, Quezon and Mindoro. The report also lists Masbate, Palawan, Sorsogon, South Cotabato, Davao, Sulu and Tawi-Tawi as potential sites for *shabu* smuggling.

The Philippines also serves as a transshipment point for further export of *shabu* to Japan, Australia, Korea, the United States, Guam and Saipan (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2003a).

Cannabis

Most of the cannabis produced in the Philippines is consumed locally, with the remainder exported to Australia, Japan, Malaysia, Taiwan and Europe (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2003a).

Other drugs

Ecstasy is imported and used in the Philippines, regardless of its high price (Dangerous Drugs Board, 2005). The assumption by authorities is that it is being used in 'high-class bars'. Likewise, cocaine also enters the Philippines for transshipment and personal use, at much lower levels than methamphetamine. It is generally seized from mail parcels. The cocaine originates in South America and is apparently destined for the Philippines and onwards to other countries. The Philippines is also used as a transit point for commercial air couriers of heroin, but at much lower levels than methamphetamine. Heroin is transhipped from Thailand and Pakistan, and is destined mainly for the United States, Guam and Europe (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2003a).

Drug arrests

In 2004, as a result of law enforcement operations a total of 26,633 people were arrested (see Table A10.3) (Dangerous Drugs Board, 2005). The majority of arrests were for use of an illicit drug (52%), supply of an illicit drug to a drug user (45%); cultivation comprised 0.2 per cent of arrests. Forty per cent of arrests were in metro-

politan Manila, 20 per cent in Southern Tagalog or Calabarzon region, 8 per cent in Central Luzon and Central Visayas, and the remaining 24 per cent in 13 other regions. Fifty-six foreign nationals were arrested, 21 (38%) of whom were Chinese nationals, mostly involved in the manufacture of *shabu* (Dangerous Drugs Board, 2005).

Crop studies and crop eradication statistics

Intensified cannabis eradication was undertaken in 2004, with 94 operations yielding the uprooting of 1,948,999 plants and 433,054 seedlings and the seizure of 827,250 grams of dried leaves and other products (Dangerous Drugs Board, 2005).

Table A10.3. Category of drug-related arrests as a result of law enforcement operations

Category of arrest	#	%
Use of an illicit drug	13,876	52
Sale of an illicit drug to a user	12,016	45
Possession of an illicit drug	666	2.5
Cultivation	49	0.2
Financier	26	0.09

Source: Dangerous Drugs Board, 2005

Table A10.4. Drug prices in Philippines

Drug	Wholesale price US\$/kilogram	Retail price US\$/gram	Purity
Methamphetamine	36,500–44,611	32.4–40.6	–
Herbal cannabis	41–81	0.1–0.2	–
Ecstasy	–	32.4–36.5	–
Cocaine	–	90.1–128.7	–
Heroin	–	90.1–128.7	90%

Source: United Nations Office on Drugs and Crime, 2004e

A10.4 Drug-taking practices, risk factors and trends

It is generally accepted that *shabu* is not injected. The mode of ingestion is inhalation. The *shabu* is typically heated on foil and the fumes are then inhaled by the user. According to the DDB (personal communication, 2005), the drug of choice for injecting is the pharmaceutical analgesic Nubain (Nalbuphine hydrochloride).

The Philippines has one of the lowest rates on HIV infection in Asia (Mateo Jr et al., 2004). The epidemic has been characterised as 'low' and 'slow' (Mateo Jr et al., 2004). From January 1984 to December 2003, 2001 HIV-positive cases were reported to the HIV/AIDS Registry. At the time of report, 32 per cent (642) were symptomatic and of these cases 44 per cent (260) had died. The low prevalence / slow transmission scenario may reportedly not continue for long, because the ingredients for rapid spread of HIV are evident: (a) low level of condom use among high-risk groups; (b) low level of knowledge in correctly identifying preventive ways of contracting the disease; (c) increasing practice of anal sex; (d) high prevalence of STIs; and (e) high levels of needle sharing amongst injecting drug users in Cebu City (Mateo Jr et al., 2004).

Unlike other countries in Southeast Asia, injecting drug use has not made a substantial contribution to reported HIV infections and AIDS cases in the Philippines (Amadora-Nolasco et al., 2002). Injecting drug use in the Philippines is concentrated in several urban depressed communities such as Cebu, Mandaue, Lapu-Lapu, Gen. Santos, Zamboanga Cities and Tondo, Manila (personal communication, 2005).

It is difficult to determine HIV prevalence among IDUs as serosurveillance is conducted only in Cebu City (Mateo Jr et al., 2004). The worst scenario projected for IDU in Cebu City would be 1–3 per cent HIV seroprevalence (WHO, 2002; Mateo Jr et al., 2004). Nevertheless, sharing of needles and syringes among IDUs is common. A 2002 estimate of sharing amongst IDUs in Cebu City was reported to be 77 per cent (Mateo Jr et al., 2004).

The Behavioural Baseline Survey on HIV/AIDS among injecting drug users in the cities of Mandaue, Lapu-Lapu and Cebu (2005) reported on a convenient sample of 150 people aged between 15 and 54 years (median 32 years). Almost all of the interviewees were polydrug users. Aside from injecting nubain, the respondents also used *shabu*, cannabis and cough syrup. Fifty-eight per cent of the sample injected drugs more than once per day and the majority (71%) of respondents used needles and syringes previously used by others. While almost all of the sample (93%) cleaned shared injecting equipment, only 8 per cent used bleach and water. More than half of the respondents (63%) were sexually active in the month prior to the interview, with the majority not using condoms with any of their partners (70%).

A10.5 Summary table

Estimated number of current drug users	In 1999, an estimated 1.8 million people were regular illicit drug users
Main drugs used	<i>Shabu</i> (methamphetamines) and cannabis
Drugs injected	Injecting drug use in the Philippines is reported to be limited
Estimated prevalence of HIV infection among IDUs	Based on the National HIV Sentinel Surveillance System of the National Epidemiology Centre (DoH), no drug-related HIV case was recorded in 2003.

A10.6 Country responses to drugs

Agreements and treaties

The Philippines is party to the 1988 UN Drug Convention, the 1961 UN Single Convention, as amended by the 1972 Protocol, and the 1971 UN Convention on Psychotropic Substances. The Philippines also ratified the UN Convention against Transnational Organised Crime, the Protocol to Suppress and Punish Trafficking in Persons, and the Protocol against the Smuggling of Migrants.

Policy responses

The Dangerous Drugs Board has an expanded membership and shifted mandate to the previous Drug Board, operating under previous legislation. Its role is a policy-making and strategy-formulating body for the entire country.

The roles of the DDB are as follows:

- policy-making and strategy-formulating body for an integrated system of planning, implementation and enforcement of anti-drug policies, programs and projects
- policy studies, program monitoring and evaluation, and other research on drug prevention, control and enforcement
- orchestrates, coordinates and oversees the implementation of the National Anti Drug Program of Action by national government agencies, local government units, government-owned and controlled corporations and participating non-government organisations.

On 7 June 2002 the President signed comprehensive counter-narcotics law. The new legislation, *Comprehensive Dangerous Drugs Act of 2002*, replaced the *Dangerous Drugs Act of 1972* and took effect on 4 July 2002. Before the new law, drug law enforcement efforts were decentralised with separate law narcotics units in each law enforcement agency competing for funding and jurisdiction. The new law established the Philippine Drug Enforcement Agency (PDEA) modelled after the United States Drug Enforcement Agency. Under its mandate the PDEA absorbs existing counter-narcotics units and responsibilities. The Philippines 'National Anti-Drug Strategy' aims to attain a drug-free Philippines by 2010, using the following national objectives:

- To reduce to zero, or at least minimise, the profits derived from illicit drug activities through Supply Reduction and Demand Reduction, in order to fulfil the Freedom from Fear for our people;
- To address and eradicate, or at least alleviate, the deficiencies and risk factors in the country that abet the drug menace, in order to fulfil the Freedom from Want for its people and thereby pre-empt them from committing or becoming victims of drug related crimes; and
- To motivationally enlighten, empower and mobilise the people to participate in and support the Criminal Justice System and the Government Machinery in attaining the two aforementioned objectives, so that Participatory Democracy shall be institutionalised in their society.

Strategic Concepts

A three pronged approach has been forwarded, with each prong assigned to accomplish its objective.

1st Prong: Supply and Demand Reduction Campaign

It consists of prevention and control measures against the production, processing, trafficking, financing, retailing and consumption of dangerous drugs, controlled precursors and essential chemicals and plant sources of dangerous drugs; so as to make illicit drug trade unprofitable and thereby accomplish the first national objective.

2nd Prong: Development/Reform Package

It includes Alternative Development/Livelihood, Family solidarity, Education, Enhancement of the Criminal Justice System, Legal Reform, etc to address/mitigate the risk factors/deficiencies that breed/abet the drug problem in the country and thereby attain the second national objective.

3rd Prong: People Empowerment Campaign

It involves the conduct of motivational enlightenment, organisation and mobilisation of as many people as possible to participate in and support the 1st and 2nd Prongs as force/resource multipliers, and thereby accomplish the third national objective. The ultimate goal is to realise and harness people power against the drug menace nationwide.

The capacity of the media shall be tapped and brought to bear in all three prongs of the strategy. International cooperation will be enhanced and taken advantage of to strengthen an anti-drug campaign.

To properly operationalise the preceding strategic three-pronged concepts, the Broad Force Implications shall consist of the following:

- **Holistic Leadership:** Local Development Councils and Anti Drug Abuse Councils shall closely coordinate and integrate their programs, projects, and activities. At a national level, the DDB shall closely coordinate with National Economic Development Authority (NEDA) and its foreign counterparts.
- **Criminal Justice System:** It shall implement the Drug Supply and Demand Reduction Campaign with the support of National Government Agencies (NGAs), Local Government Units (LGUs), Non Government Organisations (NGOs), Government-Owned and Controlled Corporations (GOCCs), and the mobilised sectors of the society.
- **NGAs, LGUs, GOCCs, NGOs and Mobilised Sectors:** Shall undertake the Development/Reform Package of programs which shall be closely orchestrated from national down to local levels.
- **Citizenry:** They shall be the force/resource multipliers of the Criminal Justice System and the Government Machinery mobilised through People Empowerment and shall participate in and support both Supply and Demand Reduction Campaign, and Development/Reform Package Programs.

The National Anti Drug Program of Action (NADPA) (Dangerous Drugs Board) operationalises the National Anti-Drug Strategy consistent with:

- *Comprehensive Dangerous Drug Drugs Act 2002*
- *Anti-Money Laundering Act 2002*
- Presidential Decree 1619
- Presidential LOI Nr dated 4 July 2001
- UN Political Declaration, Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter World Problem of 1998
- ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD) Plan of Action of 2000.

In order to attain a drug-free Philippines in 2010, the following objectives have been set:

- To dismantle all drug syndicates, financiers, producers, traffickers, pushers and their protectors/coddlers
- To prevent all non-users from being initiated to drug use through education and information
- To intervene and convert all drug experimenters/casual users to non-users
- To treat, rehabilitate and empower drug dependents to become drug-resistant and productive members of society
- To address the risk factors and deficiencies in the environment that breed/abet the drug problem in society

- To strengthen legal research and work for legal reforms, so as to provide more legal weapons that can be wielded in the anti-drug campaign
- To empower all drug affected barangays as anti-drug self-policing communities
- To tap and mobilise all NGAs, LGUs, GOCCs and NGOs for greater community participation in the anti-campaign nationwide
- To motivationally enlighten, organise, mobilise and bring People Power to bear against the drug menace nationwide; and
- To enhance international cooperation and tap the International Community in our anti-drug campaign.

The *Comprehensive Dangerous Drugs Act of 2002* (Republic Act 9165) extends to the barangay (village) level which is mandated to establish a Barangay Anti-Drug Abuse Council (BADAC) whose objective is to gather information and monitor illegal drug activities. According to NGO key informants, this is helpful for policy purposes, however it sometimes breaks down for project implementation because it drives injecting drug user partners underground. NGOs approach this challenge by educating and informing barangay leaders on the positive effects of harm reduction programs.

Law enforcement responses

The details below are found in the 'National Anti-Drug Program of Action'.

Legislation/penalties/prison

The *Comprehensive Dangerous Drugs Act of 2002* established the Philippine Drug Enforcement Agency (PDEA), responsible for implementation and enforcement.

The PDEA is the lead agency in the conduct of supply and demand reduction campaigns, except prevention, control and financing. PDEA conducts anti-drug financing operations in coordination with the Anti-Money Laundering Council (AMLAC).

The PDEA also conducts supply reduction by implementing prevention and control measures such as:

- **Production control:** for example, crop eradication operations, investigation and prosecution of owners, planters, guards
- **Processing control:** for example, police search and destroy operations, enforcement of regulations and monitoring of the movement, processing and refining of precursor chemicals and raw materials, investigation and prosecution of those involved in clandestine laboratories
- **Trafficking control:** for example, customs operations to intercept shipments, border and coastal patrol operations, airport security, investigation and prosecution of traffickers

- Retailing control: for example, buy-bust operations, raids of drug dens
- Conducts intelligence operations to dismantle drug syndicates and neutralise drug personalities (levels I and II) both foreign and local
- Participates in the Drug Demand Reduction drive by conducting Primary Prevention Approach for non-users, such as public awareness, public education, attitude and behavioural change reinforcement, social and public action
- Participates in the People Empowerment Campaign
- Conducts controlled delivery schemes in collaboration with other NGAs and foreign counterparts
- Prevents/minimises the recycling of confiscated/seized/recovered drugs, precursors and essential chemicals, and plant sources; and
- Other tasks as appropriate.

The Department of Justice, through its National Prosecution Service, files and prosecutes drug cases in courts as well as supporting the PDEA in the enforcement of legislation (Republic Act No. 9165) through its National Bureau of Investigation, Bureau of Corrections and Bureau of Immigration.

Other important organisations involved in anti-drug operations and anti-money laundering include Philippine National Police, National Bureau of Investigation, Bureau of Customs, Armed Forces of the Philippines, Anti-Money Laundering Council, Bureau of Internal Revenue, Philippine Coast Guard, Philippine Postal Office, Bureau of Jail Management and Penology, Bureau of Corrections, Provincial Jails, Bureau of Immigration, Philippine Center for Transnational Crime.

Table A10.5 provides a brief description of some of the dangerous drug unlawful acts and penalties set out in Republic Act No. 9165 (*Comprehensive Dangerous Drugs Act of 2002, 2002*). The information presented in the table is not comprehensive and obviously does not represent all possible scenarios.

Table A10.5. Dangerous drugs – unlawful acts and penalties in Philippines

Unlawful act	Penalty
Sec. 4 Importation of dangerous drugs and/or controlled precursors and essential chemicals	Life imprisonment to death and a fine ranging from P500,000 to 10 million pesos for import of a dangerous drug; and imprisonment of 12 years and one day to 20 years and a fine (100,000–500,000 pesos) for import of any controlled precursor and essential chemical
Sec. 5 Sale, trading, administration, dispensation, delivery, distribution and transportation of dangerous drugs and/or controlled precursors and essential chemicals	Life imprisonment to death and a fine ranging from P500,000 to 10 million pesos for dangerous drugs; and imprisonment of 12 years and one day to 20 years and a fine (100,000–500,000 pesos) for controlled precursor and essential chemicals

Sec. 8 Manufacture of dangerous drugs and/or controlled precursors and essential chemicals	Life imprisonment to death and a fine ranging from P500,000 to 10 million pesos for dangerous drugs; and imprisonment of 12 years and one day to 20 years and a fine (100,000–500,000 pesos) for controlled precursor and essential chemicals
Sec. 11 Possession of dangerous drugs	Life imprisonment to death and a fine ranging from P500,000 to 10 million pesos for possession in the following quantities: 10g or more of opium 10g or more of morphine 10g or more of heroin 10g or more of cocaine or cocaine hydrochloride 50g or more of methamphetamines hydrochloride 10g or more of marijuana resin or resin oil 500g or more of marijuana 10g or more of other dangerous drugs such as MDMA, GHB If the quantity is less than the above amount the penalties shall be graduated
Sec. 13 Possession of dangerous drugs during parties, social gatherings or meetings	Maximum penalties provided in Sec 11 regardless of quantity and purity
Sec. 15 Use of dangerous drugs	Person apprehended or arrested who is found positive for use shall be imposed 6 months rehabilitation in a government center for the first offence; second offence, imprisonment from 6 years and one day to 12 years and a fine in the range of 50,000–200,000 pesos.
Sec. 16 Cultivation or culture of plants classified as dangerous drugs	Life imprisonment to death and a fine ranging from P500,000 to 10 million pesos

Source: Republic Act No. 9165

Health and treatment responses

The Philippines Department of Health is the lead agency in the conduct of treatment, rehabilitation and after-care of drug-dependent people (Dangerous Drugs Board, 2005). The roles of the Department of Health among others are:

- to participate and coordinate with other agencies in the conduct of secondary prevention (intervention)
- to participate in the conduct of primary prevention in coordination with PDEA and other NGAs; and
- to participate/coordinate with PDEA in the prevention/control of the diversion/misuse of medicines and legitimate production/importation of plant sources by drug traffickers/ clandestine laboratories/users.

Number of people accessing treatment services

As of January 2005, the number of residential and outpatient centres for drug-dependent people totalled 69 (Dangerous Drugs Board, 2005). In 2004, there were 54 residential and one outpatient facility reporting in the Integrated Central Case Registry and Monitoring System (ICCRMS) of the DDB. From all reporting facilities, a total of 5787 cases were reported in 2004 (81% new admissions; 15% readmission; 4% outpatient cases). From the figures of 2003, there is a decreasing trend in new admissions, relapse and outpatient cases. This trend has been attributed to the high cost of treatment, which has proved to be a deterrent for people to undergo treatment (Dangerous Drugs Board, 2005). For 2004, the majority of clients were male (9:1 ratio), single (53%), aged 20–29 years (41%), unemployed (38%). The most commonly abused drugs were shabu (85%), cannabis (32%), cough/cold preparations (4%), benzodiazepines (4%), inhalants (3%) and ecstasy

(1%). The route of administration reported by clients was inhalation, sniffing, smoking and oral ingestion (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2004b).

The National Poison and Control Centre of the Philippine General Hospital conducts a census of patients admitted and detoxified (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2004b). From January to December 2003, a total of 108 drug-related cases were recorded. Drugs identified as being used by patients were shabu alone or in combination with other drugs, cannabis and volatile substances. Drug dependence, drug/chemical abuse and drug-induced psychosis were identified as the cases of admission for both sexes. Five cases were recorded as drug-related deaths among male patients (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2004b).

The National Center for Mental Health Detoxification Unit attended to 123 in-patient and outpatient cases from January to October 2004 (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2004b). Of this number, 103 were male. The highest number of cases were diagnosed as drug-induced psychosis.

As of October 2004, a total of 249 inmates serving sentences for drug-related cases volunteered for treatment (Dangerous Drugs Board, 2005; United Nations Office on Drugs and Crime, 2004b). The therapeutic community program in prisons applies to inmates who (1) volunteer for treatment, and (2) have at least two years of their sentence remaining to serve in the Bureau of Corrections. Based on the intake interview of service providers in the Therapeutic Community Center, the commonly abused drugs of inmates prior to their incarceration were methamphetamines, cannabis and cough syrups.

There are also non-government treatment centres that include outpatient and residential treatment. Treatment fees are estimated at 75,000 peso for a 45-day treatment stay. The government treatment centres subsidise treatment fees. The patient typically pays for pre-administration examination, HIV tests, x-rays and a patient uniform.

Detoxification is delivered by some non-government treatment centres, however 'cold turkey' is the standard approach.

The 12 Steps is the model mostly used by government treatment centres along with the therapeutic community model, which is being used by a few treatment centres.

Formal schooling is provided in some government rehabilitation centres and patients receive skills training, and physical, mental and spiritual rehabilitation.

Multi-disciplinary teams are used in treatment centres.

The average length of stay in a rehabilitation centre (government) is six months. A person apprehended or arrested who is found positive for illicit drug use is imposed six months rehabilitation in a government centre for the first offence; a second offence requires imprisonment.

Other responses

Harm reduction

Harm reduction interventions are limited in Cebu, Mandaue and Lapulapu Cities. In Cebu, the organisation USPF currently conducts a small-scale needle and syringe program (NSP) through their community health outreach workers. They promote the cleaning of needles and syringes with bleach and water. The program is unable to access many IDUs in Cebu, so crude ways of cleaning needles and syringes remain widespread.

Demand reduction

For programs on drug demand reduction, see Dangerous Drugs Board (2005) and United Nations Office on Drugs and Crime (2004b).

Demand reduction initiatives among all age groups consist of three approaches, according to the DDB. The first is primary prevention for non-users with the DDB as the lead agency and involves collaboration with the Department of Education, Department of Labour and Employment, the Commission on Higher Education, and other government and non-government organisations. The mass media also play an important role. The second approach is secondary prevention for 'experimenters' and casual drug users. The Department of Health is the lead agency with support from the Department of Social Welfare and Development, local government units, and the Philippine National Police. The third approach is tertiary prevention for drug-dependent people. The Department of Health is again the lead agency supported by all law enforcement agencies, local governments and NGOs.

The DDB has established drug testing programs for schools, workplaces, the military, law enforcement and security personnel. Moreover, guidelines have been laid out for the establishment of Special Drug Education Centers in every province, which will have the role of sponsoring drug abuse prevention programs for out-of-school youth and street children.

In an effort to bring the drug abuse fight to the grassroots level, the Lakbay Kontra Droga (Caravan against drugs) was initiated. Various government and non-government entities have been mobilised to heighten the level of awareness among Filipino people on the government's current anti-drug campaign as well as the multi-sectoral initiatives. The project includes community anti-drug rallies

and a motorcade, and voluntary reporting of the barangays of their watch-list of drug users and 'pushers'.

In further pursuit of drug prevention and control, the DDB has conceptualised Barkada Kontra Droga (Peer groups against drugs), a peer-based anti-drug advocacy program. Alternative activities to drugs are included in the program, such as sports, indoor games, cultural and socio-civic activities, and the conduct of competitive activities that bear anti-drug messages. A series of training courses focusing on life skills, leadership, income generation and resource mobilisation are also provided. A citizens' brigade will be formed for the purpose of reporting on drug use and pushing. Reporting will be made via a call centre or text messaging.

The DDB also has plans to initiate the program 'Adopt a Drug Dependent' to help indigent clients who want to volunteer for treatment but are financially incapable. The program will be a partnership between the government and private sectors such as Rotary Club, Lions Club and other NGOs and private individuals who will pay the cost of the treatment and other incidentals. The program also encourages the sponsors to provide gainful occupation after treatment through job placements.

The National Drug Education Program (NDEP), Department of Education: Drug education is part of the learning area of Makabayan (Nationhood) from Grade 1 to 6 and also at high school level. Informal education approaches are also being implemented to support existing knowledge imparted in classrooms. Ancillary services such as counselling or related help are also being strengthened. Random drug testing shall be initiated among public and private high schools.

Sexually transmitted infections including HIV/AIDS (2004–2005)

The aim of this project is to provide technical assistance and support to address the STI and HIV/AIDS Program of the country with the Department of Health as the primary partner of cooperation. The program is supported with emphasis on advocacy, policy/guidelines development, resource mobilisation, capacity building and research. Special attention is provided for the following components of the program: condom use program for prevention, local governance, surveillance, ARV procurement, technical assistance, IDU baseline survey. Funding is from the national budget and other sources from regional budgets. Funding for the program is US\$60,000.

NGO involvement

The KATOTOHANAN Foundation is one of the most active NGOs involved in drug abuse prevention and control. Through DDB Regular Member representing the NGOs, Ambassador Miguel Perez-Rubio, the Foundation has engaged in activities in pursuit of their continuing campaign against dangerous drugs like radio guestings, advocacy campaigns, linking and co-ordination. These include the Lakbay Kontra Droga campaign, the establishment of links with Daytop International to enable it to conduct a therapeutic community (TC) training in the Philippines, among others. A major accomplishment of Ambassador Perez-Rubio was his request for Daytop International to conduct a training campaign on the TC, which shall be funded by the United States State Department so that the Department of Health may institute a comprehensive TC counselling methodology in the government-run rehabilitation centres.

Resource allocation to different sectors with respect to drug issues

National government expenditure 2005

The total proposed expenditure program for 2005 amounts to P907.6 billion (AU\$21.6 billion). Analysis by the Department of Health shows the proposed health budget is 9,826,727 thousand pesos (AU\$234,069). The Dangerous Drugs Board is allocated separate funding. In 2003, the DDB obligation was 83,193 thousand pesos (AU\$1,981). Education, not including universities and colleges, has a proposed budget of 102,629,586 thousand pesos (AU\$2,444,641), National Defence has a proposed budget of 46,036,935 thousand pesos (AU\$1,096,602).

Presently, a proportion of the gaming agency profits are allocated to DDB. The DDB is responsible for allocating funds to projects/agencies based on a predetermined set of criteria (personal communication, DDB, 2005).

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A11. Thailand

Geography	Thailand is located in south-eastern Asia, bordering the Andaman Sea and the Gulf of Thailand, south-east of Burma. Its terrain consists of central plain; Khorat Plateau in the east; mountains elsewhere. Arable land: 29.36% Permanent crops: 6.46% Other: 64.18% (2001)
Government	Constitutional monarchy Chief of state: King Phumiphon Adunyadet (since 9 June 1946). Head of government: Prime Minister Thaksin Chinnawat (since 9 February 2001) and Deputy Prime Ministers Chaturon Chaisaeng, Gen. Chawalit Yongchaiyut (Ret.), Purachai Piamsombun, Vishanu Krua-ngam (since 8 November 2003); Liptapanlop Suwat (since 1 July 2004); Somsak Thepsuthin, Phinit Charusombat (since 6 October 2004) Elections: None; the monarch is hereditary; Prime Minister is designated from among the members of the House of Representatives; following national elections for the House of Representatives, the leader of the party that can organise a majority coalition usually is appointed Prime Minister by the King.
Population	64,865,523 Note: Estimates for this country explicitly take into account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (July 2004 est.). Median age: 30.5 years Male: 29.7 years Female: 31.2 years (2004 est.)
Human development index	HDI rank 76 (177 countries)
Unemployment rate	2.2% (2003 est.)
Language	Thai, English (secondary language of the elite), ethnic and regional dialects

Literacy	% Age 15 and over can read and write: Total population: 92.6% Male: 94.9% Female: 90.5% (2002)
Religion	Buddhism 95%, Muslim 3.8%, Christianity 0.5%, Hinduism 0.1%, other 0.6% (1991)
Health	Life expectancy: 71.41 years Male: 69.23 years Female: 73.71 years (2004 est.) Under 5 mortality rate: 21.14 deaths/1000 live births Male: 22.49 deaths/1000 live births Female: 19.73 deaths/1000 live births (2004 est.) HIV prevalence: 1.5% (2003 est.)
Economics	GDP: purchasing power parity – \$477.5 billion (2003 est.) Percentage of population living below the poverty line: 10.4% (2002 est.)

A11.1 Narrative summary of drug vulnerabilities

A number of factors contribute to increase Thailand's vulnerabilities to drugs and their negative effects. Thailand has witnessed a shift away from opium and heroin use to a dramatic increase and expanding use of amphetamine-type substances (ATS). It is now estimated that up to 5 per cent of the population use ATS. The public health ramifications associated with this level of use within a population are not entirely clear. Reports have raised concerns about the effects ATS use has on mental and physical health of heavy users. Other studies have suggested the ATS use is associated with increased sexual health risks including HIV and STI. An additional risk of increasing drug use within the population is the number of

people facing criminal charges associated with drugs. Despite a policy shift toward treating drug use as a medical issue, many people are still imprisoned for drug-related offences.

Other factors that could predispose Thailand to increased problematic drug use result from the effect of the rapidly urbanising community. Increased use of cocaine, ecstasy and ketamine have been reported among the urban wealthy. Another, perhaps more worrying, effect of urbanisation is the inequality of access to drug-specific treatment and services. As Thailand shifts to a more private sector model of medical care, access for the most marginal (and most needy) to drug treatment and mental health services could become more difficult (Siriwanarangsana et al., 2004).

Ethnic minorities also face increased vulnerabilities to drug use due to the geographical location of many of these people along drug trafficking routes, lack of access to health services, education and the economy. While the government has made efforts to reduce the barriers, they still exist, as evidenced by the poorer health and education status of these populations (Lyttleton & Cohen, 2003).

An additional vulnerability to the negative effect of drug use is the lack of services to prevent the spread of HIV provided to drug users in Thailand. Thailand's response to the HIV/AIDS epidemic has often been cited as a model of success in HIV prevention. However, a number of authors have pointed to clear limitations, especially with regard to IDU. Although HIV infection rates among sentinel groups in Thailand have shown significant decreases since 1996, rates among IDUs have remained high and have increased in some places (Beyrer et al., 2003).

Thailand still does not provide maintenance therapy for dependent opiate users, needle and syringe programs are extremely limited, and drug treatment is based on abstinence models that do not suit the needs of all drug users (Sungkawan, 2004).

Historical and cultural interactions with drugs

Thailand has a long and complex history with drug use, production and trafficking. Opium use and cultivation remained relatively confined to isolated hill tribe villages in the north of Thailand until the British–China opium wars of the 19th century. During this time ethnic minority groups (primarily the Yao and Hmong) fleeing conflicts in southern China began to expand cultivation in Thailand, Laos and Myanmar (Lyttleton, unpublished). The economic value of opium was quickly realised by these new opium producers as China began to seek domestic markets to import opium in exchange for tea (Lewis, 2003).

Opium production continued to increase in Thailand with government support until late 1959, when Prime Minister Sarit banned the production, sale and use of opium with the *Harmful Habit Forming Drugs Act* (Renard, 2001). While this policy was slow to affect the production of opium in the region, three decades of intense sustained national and international pressure have seen a huge reduction in opium cultivation in Thailand. In fact, the United States Department of State's Bureau for International Narcotics and Law Enforcement Affairs (2004) notes that Thailand has had one of the most effective crop eradication programs in the world. Since the 1990s Thailand's opium production has accounted for less than 10 per cent of that produced by Laos and Myanmar, the other two countries that make up the Golden Triangle region where the three countries share borders with the Mekong River (Treerat et al., 2000).

As the availability of opium slowly decreased, heroin began to enter from refineries in the Golden Triangle (Gray, 1995; Treerat et al., 2000). Heroin production rapidly increased during the 1960s and 1970s, fuelled by the presence of 40,000 US servicemen fighting in the American War in Vietnam (Phongpaichit, 2004), the gradual closing of the Turkey-Marseilles heroin trading route to the United States of America (Lewis, 2003) and later supply for a burgeoning domestic market (Barrett, 2003).

Over the last three decades Thailand has also played an important role as a transit country in the global narcotics trade. Given its proximity to the Golden Triangle and porous borders, drugs flow easily into Thailand whence they are shipped to other cities via Bangkok's busy sea and air ports (Lewis, 2003). This constant flow of drugs also supplies the domestic market.

In the early 1990s, heroin use (almost exclusively by injection) was documented in 150 villages in northern Thailand, with 1145 people registered in the Community-Based Drug Abuse Control programs (Renard, 2001). However, the actual number of dependent users was estimated at well over 3000 (Punpanich et al., 2004). Injecting drug use quickly spread beyond the hill tribe villages of the north and was reported among urban youth, migrant fishermen and other marginalised groups (Lyttleton & Cohen, 2003). By 1997 4.2 per cent of young Thai males had reportedly injected a drug (Punpanich et al., 2004).

In 1996, the heroin market was disrupted by the surrender to the Burmese Government of Khun Saa, considered at that time as the leader of one of the biggest heroin trading networks in the world. Following this, heroin availability in the region decreased

significantly, causing the price to rise sharply after a long period of stability (Treerat et al., 2000). Many analysts suggest that the reduction in heroin supply and tightening law enforcement led to increased production of illicit methamphetamine (ATS) (Lewis, 2003; Phongpaichit, 2004).

Thailand had already witnessed a period of high prevalence of ATS use during the 1970s before the synthetic medulla drug, available over the counter, was taken off the market and classed as a narcotic (Treerat et al., 2000). However, various new forms of stimulant drugs, made from legal substances such as caffeine, ephedrine and pseudo-ephedrine, continued to be consumed by people working long hours, especially transport workers and unskilled labourers, as well as farmers and fishermen (Phongpaichit, 2004). Attempts to control the precursor chemicals for the production of these drugs by amending the *Psychotropic Substances Act* had little effect and, by 1988, 15 clandestine methamphetamine labs and over a quarter of a million methamphetamine pills were destroyed in Thailand (Treerat et al., 2000).

Lyttleton (no date) suggests that the dramatic increase in the use of ATS over the past two decades has been driven by both demand and supply factors. While the reduction in the availability of heroin during the mid- to late 1990s resulted in many opiate users shifting to ATS, this cannot account for the huge flood of ATS onto the market. Phongpaichit (2004) suggests that another factor contributing to the increased demand for ATS was that users shifted from orally ingesting the drug to smoking it, which resulted in a more rapid onset of its effects and feelings of increased euphoria. Similarly a growing market was being created among urban Thais, harnessing its effects for social events and nightclubbing.

These events also occurred at the same time as the 1997 Asian economic crisis which saw about 2 million Thais lose their jobs. Some Thais began using drugs as consolation and many began selling drugs as a means of income generation to replace lost income. The huge profit margins in methamphetamine pills which cost about US\$0.05 each to manufacture and which sell for US\$2–5 meant dealers could make a living from selling a few pills a day. The large mark-up also allowed many people to profit from the sale of the drugs along a supply chain and meant that dealers could afford to lose considerable amounts of drug to law enforcement efforts without it greatly affecting profits (Phongpaichit et al., 1998).

In parallel to increasing demand, producers in the Golden Triangle region, particularly in Burma, realised the profitability and ease of manufacture of ATS compared to heroin and began producing ATS in ever-increasing amounts. According to the UNODC *World Drug Report* (United Nations Office on Drugs and Crime, 2004c), seizures of ATS in South-east Asia accounted for 22 per cent of global ATS seizures in 1990, rising to 41 per cent in 1998, the same year Thailand had the largest seizures of ATS in the world.

Social concern and government campaigns to reduce demand rose in line with increasing prevalence of drug use in the late 1990s. The Thai Government recruited popular figures to communicate anti-drug messages. It began using the term '*yaba*' meaning 'crazy drug' to refer to methamphetamines and published many stories about the harmful effects of *yaba* in the media. At the same time the government raised the penalty for dealing *yaba* to death.

In 2001, the Thai public began to report methamphetamines as their worst perceived social problem (Phongpaichit, 2004).

Another important impact drug use has had on Thailand is its association with HIV. The first cases of HIV among injecting drug users were noted in patients treated at the Thanyarak Hospital in Bangkok (Razak et al., 2003). Following these initial cases HIV prevalence among injecting drug users in Bangkok rapidly increased from between 1 and 2 per cent in 1988 to about 40 per cent within a year (Vanichseni et al., 1991).

HIV/AIDS surveillance over the past 15 years in Thailand has shown a steady prevalence of about 30–50 per cent among IDUs throughout the country. HIV incidence studies among IDUs report rates ranging from 57 per 100 person years ((Kitayaporn et al., 1998) to 11 per 100 person years (Perngmark et al., 2003).

It is estimated that 5 per cent of all HIV infections in Thailand are related to IDU (United Nations Office on Drugs and Crime, 2004b). While HIV remains a major public health consequence of drug use in Thailand, rapidly changing drug markets, patterns of use and characteristics of users will continue to challenge policy makers, as well as health and law enforcement agencies.

A11.2 Prevalence of drug use and profile of drug users

Data collection systems in place

Thailand has a range of comprehensive routine data sources that include arrest data and seizure data, and national surveys conducted to assess prevalence of drug use among the general population and among school children.

A considerable amount of independent research is also conducted investigating drug use in Thailand. A proportion of this research is conducted and coordinated by the Administrative Committee on Substance Abuse Academic Network, which also organises an annual conference focused on substance abuse in Thailand.

Population estimates of drug use

Estimates of drug users in Thailand in 2003 ranged from two to three million or approximately 5 per cent of the population (Aceijas et al., 2004; Office of the Narcotics Control Board, 2003a; United Nations Office on Drugs and Crime, 2004d). The United Nations Office on Drugs and Crime (2004b) suggests that 25,000 naive drug users are initiated into drug taking each year.

According to the 2003 National Household Survey on Narcotic Use, the most commonly used drugs in 2003 were ATS ($n = 1,925,000$), followed by cannabis ($n = 667,000$), kratom* ($n = 643,000$) and inhalants ($n = 199,000$). It was estimated that 22,700 people used heroin in 2003. The survey suggests that

about 3,500,000 people have ever used ATS in Thailand (National Household Survey, 2003). About one million people reportedly used ATS in the previous year, representing a three-fold reduction in use as compared to the 2001 survey. Use of ATS in the previous 30 days was estimated at about 490,000 people, with 73 per cent of the population aged 12–24 years old reporting use in the previous 30 days (Klongyut, 2004). Heroin and opium use in the last 30 days was estimated at 94,000 and 123,000 people respectively.

The prevalence of the use of other drugs such as ketamine and cocaine was estimated at about 30,000 or 0.1 per cent of the population (National Household Survey, 2003). According to the Household Survey, about 100,000 people have ever used ecstasy in Thailand. Ecstasy users were typically male, aged 12–24 years and lived in major cities (National Household Survey, 2003). Use of ecstasy is thought to largely be confined to wealthy youth and students as well as night-time workers in entertainment compounds in the big cities (Office of the Narcotics Control Board, 2003a).

A number of recent studies have investigated drug epidemiology in more detail. A qualitative study conducted by Danthamrongkul et al. (2004) in southern Thailand revealed widespread use of cough medicine by students and adolescents. The research showed that cough medicine was widely available through peer networks, certain commodity shops or selected pharmacies and is most commonly consumed with soft drink. Other studies have shown increasing use of diverted anti-anxiety

medication (Assanangkornchi, 2004) and ice (Apinun, 2004). An increase in the use of performance-enhancing drugs by athletes has also been reported (Siripol, 2004).

Estimates of the number of injecting drug users are harder to obtain. Estimates range from 100,000 to 240,000 (United Nations Office on Drugs and Crime, 2001), while Aceijas et al. (2004) suggest that the figure may be as low as 48,000 (C.I. 20,076,000) people. This later figure seems to correspond more closely to the number of heroin users estimated by the National Household Survey.

A11.3 Drug supply, production, availability, cost and trade

While drug production in Thailand has decreased over the past decade, opium and cannabis are still grown and amphetamine-type substances are still produced. Heroin, ATS, cannabis, opium, MDMA, ketamine and cocaine are imported into Thailand.

Opium

Thailand's opium crop currently accounts for less than 1 per cent of the regional production of opium and is no longer a major source of opiates internationally. Opium cultivation occurs mainly in the northern border areas near Myanmar and Laos (Chiang Mai, Chiang Rai, Hong Son and the Tak Province). Since 1973, extensive development and crop substitution and eradication efforts have continually reduced opium production in Thailand. In 2003, UNODC estimated that 1.81 tonnes of opium were produced in Thailand, a 70 per cent reduction from 2001. It also estimates that 80–90 per cent of opium cultivated in Thailand is eradicated every year (United Nations Office on Drugs and Crime, 2003b).

Cannabis

Cannabis cultivation is scattered throughout Thailand with the most concentrated areas of cultivation in the north-eastern region of the country (United Nations Office on Drugs and Crime, 2003b). Phaileeklee and Kanato (2004) state that cannabis cultivation in Thailand has decreased over the past decade, with drugs imported from neighbouring countries making up the shortfall for local consumption and export. Large quantities of cannabis are still thought to be sent to Europe via air postal services from Thailand (Office of the Narcotics Control Board, 2003a).

Amphetamine-type substances

ATS production in Thailand still occurs, however authorities believe that the majority of ATS production is at the endstage of pressing powdered drugs into pills. Seven methamphetamine laboratories were discovered in 2003; however, none was capable of producing ATS from scratch (Office of the Narcotics Control Board, 2003a). The majority of ATS pills are believed to be produced and smuggled into Thailand from the Wa region of eastern Myanmar (Transnational Institute, 2003; United Nations Office on Drugs and Crime, 2005).

The cost of ATS pills has fluctuated in Thailand over the past three years. Before the Fight to Overcome Drugs the retail price for one methamphetamine pill along the northern border region was 15–35 baht (US 60–90 cents). During this time the price rose to about 100–300 baht a pill, but has subsequently returned to about 20–40 baht (Office of the Narcotics Control Board, 2003a). Currently the price of ATS is 80–100 baht in Chiang Mai and upwards of 200 baht in Bangkok. These price fluctuations are due

* Kratom is a tree native to Southeast Asia (Thailand, Malaysia, Myanmar). Its botanical name is *Mitragyna speciosa*. The leaves of kratom have been used as a herbal drug from time immemorial by peoples of Southeast Asia. Kratom is used as a stimulant (in low doses), sedative (in high doses), recreational drug, painkiller, medicine for diarrhoea, and treatment for opiate addiction.

to recent law enforcement efforts targeting smaller dealer networks, particularly those in the entertainment and sex industries (N. Thompson, personal communication, April 2005).

Heroin

Heroin production has not been detected in Thailand since 1999 (United Nations Office on Drugs and Crime, 2003). Retail price for heroin is about 800 baht per gram (US\$15) around the northern border provinces and 4000–7000 baht per gram in the southern provinces. In Bangkok, which is a major market for heroin (for both local consumption and export), heroin sold for 5000–7000 baht (US\$125–175) per gram (Office of the Narcotics Control Board, 2003a).

In 2002, 20 cases of heroin exporting were intercepted with a total of 39.05 kilograms of heroin seized. Eight cases involved attempts to courier heroin from Thailand, while 12 involved postal concealments bound for Malaysia, China, Hong Kong, Taiwan, Australia, the United States, Canada and the Netherlands (Office of the Narcotics Control Board, 2003a).

Treatment

Accurate contemporary treatment data are difficult to obtain from Thailand. Despite reports that the demand for drug treatment has increased rapidly in the past three years, little evidence to support this claim can be found.

According to Dr Apinum (Apinum, 2005) from the Northern Substance Abuse Treatment Network, the procedure around reporting drug treatment data changed significantly in 2003. New forms and reporting systems were rapidly introduced. Problems have been encountered with both the collection and analysis of treatment data since the new systems were introduced, which has resulted in the unavailability of treatment data since 2002.

The compulsory registration, enforced by the *Narcotic Addict Rehabilitation Act 2002*, caused a significant increase in people registering as drug users. Some studies suggest this resulted in 200,000 drug users registering themselves (Kanato, 2004). Drug treatment-related hospital admissions increased by 40 per cent at Thanyarak Hospital (Lewis, 2003).

Due to the constraints outlined above, the following figures are based on treatment data from 2002. According to government records, a total of 42,337 patients entered drug treatment in 2002. The majority of treatment admissions were male (92.4%) and were treated for either heroin or ATS use. Other admissions were related to cannabis, other opioids, alcohol and inhalants. People who received treatment for ATS were younger (mean age 23 years) than heroin users (mean age 31.5 years) and other opioid users (mean age 41 years) (Office of the Narcotics Control Board, 2003a). Over 80 per cent of people in treatment for heroin reported injecting as their most common method for taking the drug, whereas only 0.4 per cent of ATS users reported injecting (United Nations Office on Drugs and Crime, 2004a).

Arrest and seizure data

As can be seen in Table A11.1, narcotic-related arrests in Thailand remained steady through the late 1990s until 2002 at around 220,000 people arrested per year. The Office of the Narcotics Control Board (2003a) states that the huge reduction in the number of offenders in 2003 is a result of the enforced collapse of many drug cartels, causing dealers to stop selling drugs and diverting more users into treatment and away from prosecution.

This has impacted on *yaba* dealing, with arrests related to this drug decreasing from 166,098 in 2002 to 61,338 in 2003 and only 4737 cases reported in the first half of 2004. Cases of drug seizures that involved opium and volatile substances have remained constant over the past five years at about 13,000 and 2000 cases respectively, while

there has been an increase in cases related to the seizure of ecstasy, ice, ketamine and cocaine (see Figure A11.1). Cases involving heroin seizures have declined steadily over the past five years (Office of the Narcotics Control Board, 2003a).

Table A11.1. Narcotic-related arrests in Thailand, 1999–July 2004

Year	Numbers of cases	Numbers of offenders
1999	206,170	223,294
2000	222,614	238,380
2001	207,447	220,525
2002	206,717	217,742
2003	98,922	104,588
Jan–Jul 2004	20,896	22,823

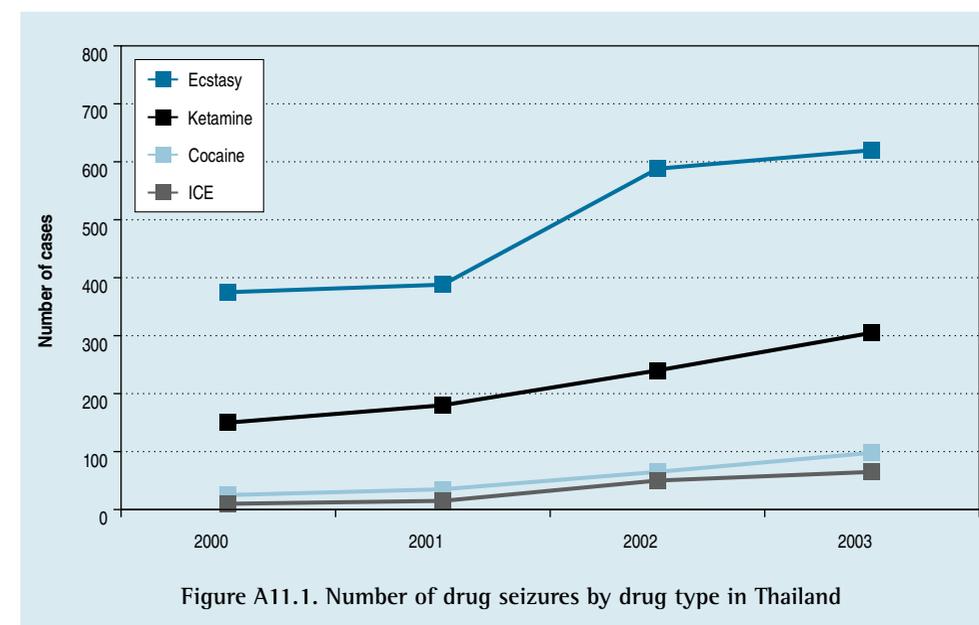


Figure A11.1. Number of drug seizures by drug type in Thailand

Despite reductions in the overall number of seizures, quantities of drugs seized in Thailand between 1999 and 2003 have generally increased. Seizures of heroin and opium have increased from 404 kilograms in 1999 to 635 kilograms in 2002, and from 2046 kilograms in 1999 to 4034 kilograms in 2002 respectively. There has been a seven-fold increase in the quantity of ecstasy seized from 1999 (21,000 tablets) to 2002 (147,000 tablets). Cocaine seizures have also increased dramatically from 0.62 kilograms being seized in 1999 to 14.73 kilograms seized in 2002 (Office of the Narcotics Control Board, 2003a).

Law enforcement activities and seizures of drugs bound for international markets continue to implicate Thailand, especially Bangkok, in international drug trafficking. In 2003, drugs were seized being imported for sale in Thailand, seized in transit through Thailand destined for other countries and seized being exported from Thailand (Office of the Narcotics Control Board, 2003a).

Crop studies and crop eradication statistics

The 2003 opium survey conducted by the Office of the Narcotics Control Board reflected trends in previous years of reduced opium farming in Thailand. It was estimated that 842 hectares were planted with opium in 2003. Findings from the 2003 survey also showed that farmers replanted areas that have been destroyed in previous years. Farmers also planted opium crops amongst legitimate crops in an attempt to avoid detection.

It is estimated that 767 hectares of the 842-hectare opium crop were destroyed in 2003, leaving an estimated yield of about 1.81 tonnes of opium. The Office of the Narcotics Control Board (2003a) predicts that opium production could increase in the 2004 season as opium prices are expected to rise due to the ongoing war in Afghanistan and successful eradication of opium from Myanmar.

A11.4 Drug-taking practices, risk factors and trends

Drug-taking practices in Thailand have remained stable over the last few years. High levels of ATS use prevail, with smoking being the most prominent route of administration. Several studies have suggested links with increased HIV risk associated with ATS use, especially among youth who report increased sexual contact and reduced condom use while intoxicated. Links between ATS use and mental health problems have also been reported (Lewis, 2003).

As discussed in the policy section, violence associated with recent policies of suppressing drug use and drug users are a major risk factor. There have been numerous reports of violence targeted at people suspected of being involved in the drug trade (Human Rights Watch, 2004).

Due to the lack of harm reduction services for IDUs in Thailand, HIV is a major risk factor associated with drug use. Recent reports from Thailand suggest that IDUs in metropolitan areas are injecting Domicom, a pharmaceutical drug with sedative effects, to enhance the effect of heroin. This practice increases the likelihood of overdose and also the chance of injecting-related infections. Recent studies suggest that heroin injection is more prominent in southern Thailand than previously thought (N. Thompson, personal communication, April 2005).

A11.5 Summary table

Estimated number of drug users	2–3 million (50,000–100,000 IDUs)
Main drugs used	ATS, cannabis, kratom, inhalants and opium and heroin
Drugs injected	Heroin and ATS
Estimated prevalence of HIV infection among IDUs	30–50%

A11.6 Country responses to drugs

Agreements and treaties

Thailand is a party to the 1961 United Nations Single Convention, the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention Against Illicit Trafficking in Narcotics.

Thailand, along with Cambodia, China, Laos, Myanmar and Vietnam, signed a UNODC Memorandum of Understanding covering a subregional action plan aimed at controlling precursor chemicals and reducing illicit drug use in the highlands of Southeast Asia. Thailand is also a member of ASEAN and a signatory to the ACCORD 'drug-free ASEAN by 2015' agenda.

Thailand has bilateral agreements relating to drug issues with Myanmar, the United States of America, Australia, France and Japan.

There is also a UN-convened Harm Reduction Task Force which is to monitor the implementation of harm reduction responses in Thailand, including support of the TDUN global fund grant. At this stage the functioning of this task force has not been investigated publicly.

Policy responses

In 1976 Thailand's parliament passed the *Narcotics Control Act*, setting up the Narcotics Control Board, chaired by the Prime Minister, and the Office of the Narcotics Control Board, which has the responsibility of coordinating all matters pertaining to drug control and serving as the secretariat to the Narcotics Control Board. Since the introduction of this Act, Thailand's drug control policy has focused on reducing drug supply through law enforcement, by crop control and by tightening access to pharmaceutical drugs including precursor chemicals used in the production of heroin and ATS.

Upon taking office in 2001 Prime Minister Thaksin declared the 'prevention and suppression' of narcotic drug abuse as one of the three major problems to be addressed by his Thai Rak Thai Party government. Integrated into the 9th National Economic and Social Development Plan (2002–2006), the government announced its drug strategy – *Ruam Palang Pandin* – which, literally translated, means the strengthening of national integrity to fight drug problems.

Taken from the Office of the Narcotics Control Board's website, it states that the policy aims to:

1. Stringently enforce the law and create a special process to control and suppress traffickers and all those involved in the manufacturing and trafficking of drugs in a strict, swift and just manner. Amend the law to increase the highest degree of punishment for political and government officials who are involved in drug trafficking. Provide rewards and special protection for public officials and citizens who cooperate with the Government in drug suppression.
2. Strictly control the importation of chemicals which may be used in the production of drugs. Strengthen the mechanisms of the public sector as well as legal measures so that they may be able to keep up with the evolution in technology involved in the production of drugs.
3. Foster cooperation with international organizations and the international community in order to control and eradicate drug production bases as well as transnational networks for the distribution of drugs.
4. Amend and revise laws that pose an obstacle to the obtainment of medical treatment as well as the physical and mental rehabilitation of drug addicts. Such addicts must be able to receive medical treatment and rehabilitation as soon as possible facing any legal charges. In addition, the Government will set up a system that will provide services for the treatment, rehabilitation, vocational training and acclimatization of drug addicts in order that they may be able to return to the mainstream of society. (Office of the Narcotics Control Board, 2005b)

On 31 May 2002 Prime Minister Thaksin issued the Prime Ministerial Orders 119/2544 and 228/2544 on the Action Plan to Overcome [the] Drug Problem. The Action Plan placed an emphasis on mobilising all members of society to eliminate drug problems. It stated that drug abuse would be tackled by prevention, suppression and rehabilitation, all of which would take place at a community level. The Action Plan also outlined the need to improve intelligence gathering in order to assist law enforcement as well as encouraged academic research to monitor and evaluate the government's drug control plans and programs.

According to the resource series 2004, Prime Ministerial Order 119/2544 established the operational guidelines for provincial, district and subdistrict operating centres responsible for drug suppression and prevention measures outlined in the Action Plan. These centres were required by the government to actively participate and support the activities of the police and the ONCB in illicit drug control, law and order as well as collecting information about drug trafficking and dealing.

On 14 January 2003, in an attempt to enhance and further integrate the Action Plan, Prime Minister Thaksin launched Prime Ministerial Order 29/2546 on the 'Fight to Overcome Drugs'. This order saw the establishment of the National Command Centre for Combating Drugs (NCCD). The NCCD was placed under the chairmanship of Deputy Prime Minister Chavalit Yonchiyudh and given the responsibility to enhance the integration and implementation of the national narcotic drug control policy (Sungkawan, 2004).

According to the Office of the Narcotics Control Board (2003b), this involved both suppression or supply reduction and demand reduction and targeted three main groups: the supply group made up of illicit drug producers, traffickers and dealers; the demand group consisting of drug users; and the potential demand group, identified as non-drug users who are at risk of becoming involved with drugs.

Supply reduction involved the suppression of drug supply by interrupting drug traffickers and producers, and by disrupting their trading routes as well as their access to precursor chemicals and equipment used in drug production. A number of strategies, including a national hotline and confidential postal boxes, were set up to assist community members to inform officials of suspected drug dealing or use. These methods were used to compile lists of people assumed of being involved with drugs to be later investigated (Sungkawan, 2004).

Law enforcement was used to 'encourage [those involved in the drug trade] to give up their illegal activities and contribute themselves to the development of their communities instead'. Small-scale drug dealers were encouraged to report themselves to officials and, in doing so, would avoid conviction and be 'brought to behaviour adjustment programmes' (Office of the Narcotics Control Board, 2003b).

Both the *Drug Users Rehabilitation Act of 2002*, which changed the drug user's status from criminal to patient, and the Fight to Overcome Drugs attempted to reduce drug demand in the community by encouraging drug users into treatment programs. Treat-

ment offered under the Fight to Overcome Drugs policy can be summarised into three types: voluntary, coercive and judicial.

The Fight to Overcome Drugs was implemented in three phases beginning on 1 February 2003 and ending on 30 September 2004. The initial phase from February to May targeted drug supply and encouraged drug users and dealers to report themselves to authorities to avoid prosecution. The second phase focused on demand and potential demand reduction by strengthening communities. The final stage focused on the sustainability of initial stages, as well as monitoring emerging drug trends.

While the Royal Government of Thailand proclaims the Fight to Overcome Drugs to be a huge success in combating drug abuse in Thailand, it has faced condemnation for the methods employed and the resultant deaths (Amnesty International, 2003; Nation, 2003; Human Rights Watch, 2004).

Another serious result of the Fight to Overcome Drugs Policy is the further discrimination and marginalisation of drug users increasing their susceptibility to HIV. A human rights report (Human Rights Watch, 2004) stated that one of the consequences was that it forced drug users into hiding, away from HIV/AIDS services. While numbers accessing treatment increased during this time, several drug users reported increased discrimination (Amnesty International, 2003) and the majority were subject to treatment regimes with little clinical efficacy. Danthamrongkul (2004) reports that few drug users in treatment remained abstinent, with many users substituting their choice of drug and using alternative supply sources such as private clinics and pharmacies.

Law enforcement responses

Legislation/penalties/prison

Thailand has a number of laws pertaining to drug issues. Table A11.2 groups these laws into four broad sections: laws that control the legal status of certain substances; laws that control access to precursor chemicals; laws pertaining to drug users; and laws relating to other activities often associated with drug trafficking. Thailand has made a considerable investment in modernising its legal system to respond to drug issues since signing 'Strengthening of Judicial and Prosecutorial Drug Control Capacity in East Asia'.

The *Drug User Rehabilitation Act*, passed in October 2002, reflects a significant change in Thailand's response to drug users. This Act set a new paradigm for drug users, legislating for drug users to be considered as patients who deserve access to medical, social and psychological treatment rather than being prosecuted as criminals. The Act introduces the diversion process into the criminal justice system with criminal sentencing being replaced by compulsory treatment regimes for offences of drug using and drug possession for using (Sungkawan, 2004). Table A11.3 outlines the maximum amount of drugs a person can be in possession of to be considered a drug user (United Nations Office on Drugs and Crime, 2003a).

Table A11.2. Legislation relating to drug issues in Thailand

Drug control	<i>Narcotics Act 1979</i> <i>Psychotropic Substances Act 1975</i> Emergency Decree on Controlling the Use of Volatile Substances 1990
Chemicals used to produce narcotics	<i>Commodities Control Act 1952</i>
Drug users	<i>Act on Measures for the Suppression of Offender in an Offence Relating to Narcotics 1991</i> <i>Drug User Rehabilitation Act 2002</i>
Laws providing special measures pertaining to drug issues	<i>Extradition Act 1929</i> <i>Mutual Legal Assistance in Criminal Matters Act 1992</i> <i>Money Laundering Control Act 1999</i>

Table A11.3. Maximum drug amounts (in possession) to be considered a drug user in Thailand

Drug	Amount
Heroin	not more than 100 milligrams
Opium	not more than 5 grams
Cannabis	not more than 5 grams
Cocaine	not more than 5 grams
ATS	not more than 5 tablets or 500 milligrams
MDMA	not more than 5 grams

Once arrested, drug users are sent to Narcotic Rehabilitation Centres to be assessed by subcommittees. Subcommittees act as a quasi-judicial unit and are made up of locally appointed officials, including a psychologist or psychiatrist and two qualified experts, and are chaired by a provincial public prosecutor. The subcommittees have the responsibility of sentencing people they identify as drug users to one of two treatment models. Drug users are initially required to undertake a 4–6 month treatment program which can be extended for up to three years if deemed necessary by the subcommittee. Drug users are sentenced to either confined or unconfined treatment settings. Confined treatment settings are further broken down into either intensive physical control settings or less intensive physical control settings. All drug users are required to participate in activities arranged for behaviour adjustment, including group counselling, social support group activities and educational and vocational training. If drug users escape from the confined settings or do not satisfy the requirements of their treatment program, they are referred back for consideration by the judicial system. If they satisfy the treatment requirements, they are released without charge (Sungkawan, 2004).

A number of problems have been identified with the *Drug User Rehabilitation Act*. These include confusion about the law at an enforcement level, resulting in only 2500 cases being tried under the new Act (Sungkawan, 2004) despite over 45,000 drug-related arrests being made during the war on drugs (Kanato, 2004). Drug users in Bangkok reported not understanding the new law and stated that it was rarely enforced.

Other law enforcement measures geared to reducing drug use are the strict control of entertainment venues. Police target nightclub, disco and karaoke bar patrons to conduct urine tests for illicit substances (Office of the Narcotics Control Board, 2003a). Law enforcement officials have also received criticism from a number of sources for their susceptibility to bribery, unequal application of the law and involvement in the drug trade (Phongpaichit et al., 1998).

Prisons

Recent figures from the UN suggest Thai prisons are amongst the most overcrowded and understaffed in the world (Lewis, 2003). As of 31 May 2002, 257,196 people were incarcerated in Thailand's prison system (Department of Corrections, 2002). This represents an incarceration rate of about 400 persons per 100,000, which is one of the highest in the world and the highest in Asia.

Due to the legal status of IDU in Thailand, IDU is strongly correlated with incarceration. Of the total prison population (n = 106,256), 66 per cent are incarcerated for narcotic-related offences. Choopanya et al. (1991) reported that, in a sample of 601 IDUs in Thailand, 70 per cent had been incarcerated at least once.

Incarceration has long been known to be a significant risk factor for HIV in Thailand. Choopanya et al. (2002) found that incarceration is related to the incidence of HIV infection through multiple pathways: injecting while incarcerated, recent incarceration without injecting and previous incarceration. Many studies have also highlighted the association of HIV, IDU and incarceration. Choopanya et al. (1991) found that IDUs in Bangkok were twice as likely to be HIV-positive if they had been incarcerated.

HIV prevention services within Thai prisons are limited to basic HIV education. Despite evidence of drug use within prisons (Choopanya et al., 2003), prisoners do not have access to clean needles and syringes or bleach. Other harm reduction tools such as drug treatment or condoms are also not available.

Health and treatment responses

As discussed above, Thailand's response to drug issues changed dramatically with the introduction of the *Drug User Rehabilitation Act* in 2002 and the subsequent *Fight to Overcome Drugs* which commenced in late 2002.

The Office of the Narcotics Control Board lists 12 official treatment centres on its website (Office of the Narcotics Control Board, 2005a). However, many other programs are run by both public and private hospitals, as well as private clinics and NGO programs. Some monasteries also conduct detoxification programs which combine spirituality and meditation to help drug users stop using drugs (Lewis, 2003; United Nations Office on Drugs and Crime, 2004a).

While all policies point toward increased access to a variety of drug treatment services, whether or not these policies have been implemented effectively is difficult to ascertain. According to Pol. Gen. Pracha Promnok, the Deputy Minister for Public Health, Thailand would be prepared to treat 600,000 drug users in 2003, 50,000 of whom would be treated as in-patients in hospitals and military camps and the rest in the community setting (Lewis, 2003). As stated above, treatment data are not available from the year 2002 onwards. While anecdotal reports suggest a large number of drug users entered treatment in 2003, there are no data available about the type of treatment patients received or about treatment outcomes.

Limited methadone treatment has been available in Thailand for 12 years. Methadone treatment is based on providing the drug user with a decreasing dose of methadone over a set period of either 21, 90 or 180 days. However, according to Sivalee (K. Sivalee, personal communication, April 2005), who is a former treatment provider in Thailand, doctors have some flexibility in tailoring methadone treatment for patients, including increasing doses over time. She further stated that once a patient has completed a program, they can apply to start another. According to Sivalee, buprenorphine-facilitated detoxification treatment is available at the Parmonkout Military Hospital.

The majority of drug treatment for ATS offered in Thailand is based around a combination detoxification and the Matrix model of treatment, which is an outpatient treatment experience that combines behavioural, educational and 12-step counselling techniques.

A report on the situation of drug treatment in Thailand is currently being prepared by Professor Vichai Poshyachinda, Head of the Drug Dependence Research Centre, Chulalongkorn University, but was not available for this report.

Other responses

Since the early 1990s Thailand has placed a strong emphasis on disseminating health information through media campaigns. The Ministry of Public Health in Thailand has orchestrated various drug education campaigns emphasising the negative aspects of drugs. They have also focused on awareness building around needle sharing as a major mode of HIV transmission among IDUs (Perngmark et al., 2003).

The most recent prevention education campaign is the 'Kingdom Unity for Victory over Drugs' campaign. In addition to mass media advertising, the strategy plans to recruit three million community-based volunteers who will provide education about the dangers of drugs and encourage drug users to register and to seek treatment.

Considerable attention is still being directed toward primary prevention of drug use. In association with Chulalongkorn University and the ONCB, the United Nations Office on Drugs and Crime has recently funded and published a research study looking at improving primary prevention of ATS abuse among Thai youth (Sthapitanonda, 2004). Education campaigns are focusing drug education messages to school children and through sporting clubs and at community events.

School-based education targets four sub-groups of students: those who have never used drugs, those who have tried drugs, those who have become addicted and those who have become sellers. Drug education is conducted through the Ministry of Education with the assistance from the ONCB (United Nations Office of Drugs and Crime, 2002).

Drug user organisations and advocacy groups

(a) Thai AIDS Treatment Action Group (TTAG)

Established December 2002

To promote equal access to AIDS treatment for all through policy advocacy, coalition building, and strengthening the capacity of people living with or highly vulnerable to HIV/AIDS to advocate for their human rights.

(b) Thai Drug Users Network (TDN)

Established December 2002

To promote the basic human rights of people who use drugs, in order to be able to live equally and with dignity in society.

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A12. Timor-Leste (East Timor)

Geography	<p>South-eastern Asia, north-west of Australia in the Lesser Sunda Islands at the eastern end of the Indonesian archipelago.</p> <p>Note: Timor-Leste includes the eastern half of the island of Timor, the Oecussi (Ambeno) region on the north-west portion of the island of Timor, and the islands of Pulau Atauro and Pulau Jaco.</p> <p>Borders Indonesia</p> <p>Arable land: 4.71% Other: 94.62% (2001) Permanent crops: 0.67%</p>
Government	<p>Republic</p> <p>The President elected by popular vote for a five-year term; election last held 14 April 2002 (next to be held April 2007); after the first legislative elections, the leader of the majority party was appointed Prime Minister by the President, suggesting a precedent for the future.</p>
Population	<p>Population estimate of 1,019,252</p> <p>Median age: 20 years</p> <p>Age breakdown 0–14 years: 37.8% (male 196,007; female 189,584) 15–64 years: 59.2% (male 308,254; female 295,584) 65 years and over: 2.9% (male 14,663; female 15,160) (2004 est.)</p>
Human development rank	HDI rank 158 (177 countries)
Unemployment rate	50% (including under unemployment 1992 estimate)
Language	<p>Tetum (official), Portuguese (official), Indonesian, English</p> <p>Note: There are about 16 indigenous languages; Tetum, Galole, Mambae, and Kemak are spoken by significant numbers of people.</p>
Literacy	<p>% Age 15 and over who can read and write:</p> <p>Total population: 58.6% (2002)</p>
Religion	Roman Catholic 90%, Muslim 4%, Protestant 3%, Hindu 0.5%, Buddhist, Animist (1992 est.)

Health	<p>Life expectancy: Male: 63.31 years Female: 67.92 years</p> <p>Infant mortality rate: 48.86 deaths/1000 live births</p> <p>HIV prevalence: NA</p>
Economics	<p>GDP: purchasing power parity – \$440 million (2001 est.)</p> <p>Income differentials: NA</p>

A12.1 Narrative summary of drug vulnerabilities

Timor-Leste is the world's newest nation and also one of its poorest (Family Health International, 2004). The majority of Timorese are very poor and live mostly in rural areas. The World Bank estimates that over 40 per cent of the population live below the poverty line. Today, two in five persons do not have enough food, shelter or clothing. One in two has no access to clean drinking water, and three in four have no electricity. According to AusAID, Timor-Leste faces considerable constraints to economic growth, such as skilled workers and weaknesses in public administration and law and justice. In addition, there are high incidences of tuberculosis, malaria, dengue fever and Japanese encephalitis. The health system is struggling to cope with these problems.

A12.2 Injecting drug use and HIV

HIV is present in Timor-Leste, but it has not spread widely (Family Health International, 2004). Prevalence is low, at 0.64 per cent adult HIV prevalence rate in 2002 (US Agency for International Development, 2004). However, the prevalence of HIV among sex workers in

Dili has been reported to be 3 per cent, with 15 per cent having curable sexual infections such as gonorrhoea and chlamydia (Family Health International, 2004). Over half of the sex workers involved in this study had not heard of AIDS, four out of ten did not recognise a condom, and none consistently used one (Rock, 2005).

To date the response to preventing an HIV epidemic in Timor-Leste has focused on the sexual transmission of the virus with little to no mention of injecting drug use.

Findings from a study team in Dili (Rock, 2005) are concerning because the prevalence of injecting drug use in the university student sample was 3 per cent. In Australia, according to the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare, 2005), the proportion of people aged 14 years and over who have ever injected drugs is 1.9 per cent and who have recently injected (last 12 months) is 0.4 per cent (n = 811,920; Aus pop 2005: 20,298,022).

Moreover, anecdotal evidence has reported 'shabu' smoking and suggests that benzodiazepines are readily available from retailers with associated potential for abuse.

For the current review, the World Health Organization, the United Nations Development Programme, UNICEF, Family Health International and the Ministry of Health were contacted in order to assess the current illicit drug situation in Timor-Leste.

The following is a summary of their responses:

- No data have been collected on the illicit drug situation in Timor-Leste.
- Illicit drug issues are not considered a priority in Timor-Leste at this time.
- There are too many immediate life-threatening illnesses and determinants of health to address in the short term.

There is some discussion of the quantities of locally brewed alcohol consumed by individuals but not to the point where it is part of the public health agenda.

There are no indicators that the situation has or could change from the current very low levels of substance abuse, especially intravenous drugs.

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A13. Vietnam

Geography	<p>Located in south-eastern Asia, bordering the Gulf of Thailand, Gulf of Tonkin, and South China Sea, alongside China, Laos and Cambodia. Low, flat delta in south and north; central highlands; hilly, mountainous in far north and north-west.</p> <p>Arable land: 19.97% Permanent crops: 5.95% Other: 74.08% (2001)</p>
Government	<p>Communist state</p> <p>Chief of state: President Tran Duc Luong (since 24 September 1997)</p> <p>Head of government: Prime Minister Phan Van Khai (since 25 September 1997); First Deputy Prime Minister Nguyen Tan Dung (since 29 September 1997); Deputy Prime Ministers Vu Khoan (8 August 2002) and Pham Gia Khiem (since 29 September 1997)</p> <p>Elections: President elected by the National Assembly from among its members for a five-year term; election last held 25 July 2002 (next to be held when National Assembly meets following legislative elections in 2007); Prime Minister appointed by the President from among the members of the National Assembly; Deputy Prime Ministers appointed by the Prime Minister</p>
Population	<p>82,689,518 (July 2004 est.)</p> <p>Urban: 25.2% of total (2002)</p> <p>Median age: 24.9 years</p> <p>Age structure (2004 est.): 0–14 years: 29.4% 15–64 years: 65% 65 years and over: 5.6%</p>
Human development index	HDI rank 112 (177 countries)
Unemployment rate	6.1% (2003 est.)
Language	Vietnamese (official), English (increasingly favoured as a second language), some French, Chinese and Khmer; mountain area languages (Mon-Khmer and Malayo-Polynesian)

Literacy	% age 15 and over who can read and write: 90.3% (2002)
Religion	Buddhist, Hoa Hao, Cao Dai, Christian (predominantly Roman Catholic, some Protestant), indigenous beliefs, Muslim
Health	Life expectancy: Male: 67.86 years Female: 73.02 years (2004 est.) Infant mortality rate: 29.88 deaths/1000 live births HIV prevalence: 0.4% (2003 est.)
Economics	GDP: purchasing power parity – \$203.7 billion (2003 est.) Population living below the national poverty line (%), 1990–2001: 50.9%

A13.1 Narrative summary of drug vulnerabilities

In late the 1980s a wide-ranging policy and institutional reform process known as *doi moi* was introduced. Since then, Vietnam has experienced a rapid process of social and economic transformation. While overall there has been major economic growth and rates of poverty have declined, approximately one-third of the population still live in poverty by international measures. Income and human well-being disparities have increased substantially, particularly among the poorest in the community and between urban and rural dwellers. Overall, incomes remain low, and poverty in the mountainous areas, where social services are few or absent, is recognised to be extreme. In recent years there has also been major and increasing migration of rural dwellers into urban centres in search of greater income-generating opportunities (AusAID, 2004b; Ministry of Public Security, Standing Agency in Drugs Control, 2003; World Health Organization, 2004c).

The country has experienced a rapid population growth, resulting in a disproportionately large number of adolescents and young people. Around 30 per cent of the population is now aged between 12 and 25 years, a situation likely to persist until at least 2010. The large youth population is creating concerns. Demand for lower and secondary schooling has increased substantially: ethnic minorities are often severely disadvantaged – for instance, 19 per cent of girls from ethnic minorities have never attended school. The availability of university places has decreased: only 14 per cent of those sitting entry examinations are accepted and those who do attend university must pay fees (O’Higgins, 2002; United Nations Country Team, 2004).

Youth unemployment and under-employment place a real burden upon the country. Unemployment in most cities in the late 1990s was of the order of 26 per cent among 15–19 year olds seeking jobs. Currently youth unemployment in most urban centres is 16 per cent, but nationwide it is estimated to be around 4–8 per cent. In recent years, an estimated

1.4 million people reached working age each year at a time when there were already 2.4 million people unemployed. Young women are disproportionately disadvantaged, with a national rate of 7 per cent unemployed, rising in some urban centres to 18.5 per cent. Youth under-employment is also widespread, with around 4.7 million youth willing to do more work, which is not available. Social pressures on youth have increased in large cities, are associated with unemployment and under-employment, and are contributing to drug use (O’Higgins, 2002; United Nations Country Team, 2004).

Adding to these social and economic issues is Vietnam’s proximity to the Golden Triangle, combined with its extensive borders with Cambodia (983 km), China (1281 km), and Lao PDR (1555 km) and its 3444 kilometres of coastline – all providing an environment for easy trafficking of drugs in and out of Vietnam (Rekart, 2002; United Nations Office on Drugs and Crime, 2003b).

Historical and cultural interactions with drugs

There is a long history of opium cultivation in Vietnam among some ethnic minorities in the mountainous areas of Vietnam (Westermeyer 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. As in China, 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 (Le, 1999; McCoy, 1991).

It has been estimated that 2 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 (Le, 1999; Nguyen, 1998). 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 2500 opium dens in operation (McCoy, 1991).

Patterns of drug use changed during the American war in Vietnam when opium smoking and, to a lesser extent, 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 (if they continued opiate use – most did not) (Robins & Slobodyan, 2003). 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, 1991). 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, but a small percentage of Vietnamese continued using opium (McCoy, 1991; Nguyen, 1998).

Before 1975 most drug users resided in the south of Vietnam, particularly in Saigon (re-named Ho Chi Minh City 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, including the injection of 'blackwater opium'; since the mid-1990s heroin has become the drug of choice and the popularity of amphetamines has been increasing (Ministry of Health & UNDCP, 2000; UNAIDS & 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 per cent. While this proportion has been decreasing, the levels of HIV infection among IDUs have remained high throughout the 1990s (Chung, 2000; Ministry of Health & UNDCP, 2000; National AIDS Committee, 1998; Nguyen, 2004b).

A13.2 Prevalence of drug use and profile of drug users

Estimations of the number of drug users vary, as there are differing classifications for drug 'addiction' and differing reporting requirements between organisations and departments. Whether the statistics are from the Ministry of Public Security (MPS), Ministry of Health (MOH) or the Ministry of Labour, War Invalids and Social Affairs (MOLISA), what is *not* disputed is that the number of registered drug users is increasing each year. In 1997, it was nearly 70,000, rising to 100,000 in 2000; by June 2003 it was 152,000, of which around 1000 were pupils and students (Drug Enforcement Administration, Intelligence Division, 2003; Ministry of Public Security, Standing Agency in Drugs Control, 2003; United Nations Office on Drugs and Crime, 2003b).

Figures released by the Ministry of Public Security in 2004 showed 170,400 registered drug users nationwide (Ministry of Public Security, 2005). There are no official estimates available on how widespread drug use is in the general population, but the real figure is far greater than those who have registered, according to some sources (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). In the late 1990s MOLISA estimated 185,000–200,000 drug users, of whom 69,000 were injecting drug users (IDUs) (UNAIDS & UNDCP, 2000). Unofficial estimates of the number of drug users vary between 200,000 and 500,000 (0.02–0.06% of the population) (Drug Enforcement Administration, Intelligence Division, 2003). The number of IDUs is elusive, but recently reported estimates range from a low of 70,000 to a high of 156,000 with a mid-range of 113,000 (Aceijas et al., 2004a).

There has been no nationwide survey to measure drug use in the general population; in 2001, a school survey randomly interviewed 20,000 students from 119 educational institutions and found 26 per cent of the students knew of someone who used illicit drugs; the use of other substances including sedatives and tranquillisers (but excluding alcohol and tobacco) was reported by 4.2 per cent of the respondents (United Nations International Drug Control Programme, 2002b). Another *out-of-school* survey of 650 youth (90% aged 18–25 years) who were either unemployed or under-employed was undertaken; more than 50 per cent were from Hanoi or Ho Chi Minh City. The results show 37 per cent used some kind of drug and 32 per cent used heroin followed by opium, cannabis, cocaine, sleeping tablets and tranquillisers (United Nations International Drug Control Programme, 2002b).

Urban centres have the greatest number of drug users: in Ho Chi Minh City, for example, the number of registered drug users has increased from around 17,000 in 2001 to 20,000–30,000 in 2003; 80 per cent of these are aged 18–25 years, and most are IDUs who inject 2–4 times per day (Centre for Harm Reduction, 2004a; Walsh, 2003). Nationwide, it has been estimated that 52 per cent of drug users are under 25 years and 82 per cent are less than 36 years. Most IDUs start their drug use when aged 15–24 years (Nguyen, 2004a; United Nations Country Team, 2004).

There are a number of subgroups of current IDUs for whom opiates, especially heroin, remain the drug of choice. The pre-1975 cohort mainly resides in southern and central Vietnam, most being in their late 40s, sometimes using opium occasionally mixed with benzodiazepines. Younger IDUs are found throughout the country, their choice of drug being heroin. A third group is female sex workers who also inject drugs, in various parts of the country (HIV/AIDS Program, 1997; Giang, 2000; Long, 1999). Street children (defined as less than 18 years of age, earning a living on the street, and without family support or guardian) are increasing in number, but current estimates are unreliable: in 2000, they were estimated at 20,000, of whom nearly 3500 were registered as drug users in 1999. In 2001, a survey was undertaken with 400 street children: 17 per cent used illicit drugs, of whom 77 per cent used heroin (United Nations International Drug Control Programme, 2002a).

The drug of choice is heroin among the youth, particularly in the urban centres, while opium use remains popular mainly among the elderly and ethnic minorities groups in rural areas, especially in the north-west regions. Other drugs used include cannabis, MDMA and methamphetamine, with the last two becoming increasingly popular nationwide. The use of MDMA and methamphetamines is not confined solely to youth, but is expanding into the general population: government officials have found these substances in 53 of the 61 provinces of Vietnam. High proportions of registered drug users are unemployed or under-employed, but it has been observed that a significant number are employed in the public sector. Cannabis is used but its popularity is not widespread. Cocaine is seldom used, likely due to poor availability. The use of glue as an inhalant appears to be increasing. 'Blackwater opium' is still used, injected by older users. A variety of pharmaceuticals are used to enhance the effects of opium or heroin, including diazepam, promethazine, pethidine, morphine, phenobarbitone and procaine (Ministry of Public Security, Standing Agency in Drugs Control, 2003; United Nations Office on Drugs and Crime, 2002b, 2003b; Walsh, Higgs & Crofts, 2004).

In the late 1990s private pharmacies were increasingly taking over distribution of licit drugs, and much drug dispensing was done without the need for prescriptions (Chuc & Tomson, 1999). It is possible this problem has not been curbed, thus ensuring easier access to the purchase of licit drugs for illicit purposes. The use of ketamine emerged in 2003 in major cities throughout the country, mainly found in nightclubs (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

Data collection systems in place

The two data sources routinely used are treatment demand data and arrest data. Data collected is not disaggregated by drug of choice or administration, so monitoring the drug situation in a more comprehensive manner is not possible. Data have been collected through a school survey of drug use and other studies focused on high-risk groups including IDUs, sex workers and street children.

Information about drug use is shared between different agencies and departments and organisations through the National Committee on AIDS, Drug and Prostitution Control, enabling some insight into drug trends. A network of staff from the various cited bodies share information focused on the areas of demand for drugs, supply information and crop cultivation. Summary reports are produced and disseminated regularly, and an annual report is issued by the Standing Office for Drug Control of Vietnam. A national register of death due to drug use is not yet in place (United Nations Office on Drugs and Crime, 2004a). It is not clear if the HIV sentinel surveillance system and HIV behavioural surveillance surveys are used as data sources to identify drug use trends.

A13.3 Drug supply, production, availability, cost and trade

As of 2003, 1000 hectares of opium poppy were reportedly under cultivation. This is mostly cultivated by ethnic minorities for local use: mainly by Hmong highlanders, in the provinces of Lai Chau, Son La, Nghe An and other north-western and central provinces bordering Laos and China. These crops produce annually about 10–15 tonnes of opium, only some of which is being converted to heroin. Cannabis is grown in remote parts of the Mekong Delta in the south (mainly in Dong Nai, An Giang, Binh Thuan and Dong Thap) and in some north-western highland areas, especially those bordering Laos and China. While most is grown for commercial hemp, some is cultivated for illicit consumption (Drug Enforcement Administration, Intelligence Division, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

The production and stockpiling of amphetamine-type substances (ATS) are relatively new, found mainly in large cities: one factory producing hundreds of kilograms of methamphetamine was found in 2003 in Ho Chi Minh City. There is a trade in illegal harvesting of sassafras trees, which produce an essential oil called safrole, a precursor chemical for MDMA production. Other precursor chemicals used in the production of illicit drugs, such as ephedrine and potassium permanganate, are known to have origins in Vietnam (Drug Enforcement Administration, Intelligence Division, 2003; Ministry of Public Security, 2005; Ministry of Public Security, Standing Agency in Drugs Control, 2003).

While Vietnam does not produce substantial amounts of illicit drugs, it has for some years been an important transit country, but imported drugs are increasingly servicing the domestic market. Many of Vietnam's borders are remote and difficult to control and consequently a limited portion is seized at the nation's border gates. Most heroin and some opium enter the country from the Golden Triangle, from either Thailand or Laos, and mainly going to Ho Chi Minh City or Hanoi. Heroin travels overland and along the Mekong River from Laos through Cambodia – it is known to arrive in Vietnam by boat via the Gulf of Thailand and the South China Sea.

Once in Vietnam, heroin is transported by ship, air or post to the Philippines, Australia, Hong Kong, Japan, Singapore and Taiwan. Cannabis is mainly from Cambodia, often trucked to Ho Chi Minh City where it is then distributed to other parts of the country or trafficked into China and on to international markets. ATS, primarily methamphetamines, are trafficked from Myanmar via China's Yunnan Province, Laos and Cambodia, the destination often being Ho Chi Minh City. Overall, the western border has the main points of drugs entry to the country; most large seizures occurred in these areas. It was reported in 2003 that increasing amounts of heroin and methamphetamine were being trafficked to Australia from Vietnam (Drug Enforcement Administration, Intelligence Division, 2003; Ministry of Public Security, Standing Agency in Drugs Control, 2003; United Nations Office on Drugs and Crime, 2003b, 2004b; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). The trafficking of drugs from Cambodia appears to be increasing; in late 2004 it was reported that Vietnam would double its anti-drug force in six south-western provinces in an attempt to curb the flow of narcotics from neighbouring Cambodia (China Post, 2004b).

In 2002, 'white' heroin retailed for US\$45 per gram. Prices for a single shot of heroin varied throughout the country (United Nations Office on Drugs and Crime, 2004d). In 2003, a typical price for one dose of heroin ranged between 25,000 and 50,000 VND (US\$2–3.30), and was either smoked or injected (Tran et al., 2004; Walsh, 2003). In early 2005 heroin could be purchased from as little as 10,000 VND in Hai Phong City (P. Higgs, personal communication, 2005). The price of blackwater opium in 2003 was around 12,000 VND. In 2003, the price of methamphetamine on the streets of Ho Chi Minh City was 90,000–200,000 VND per tablet (US\$6–14), used mainly by those with access to money (Walsh, 2003). The typical price of an ecstasy tablet in 2002 was US\$18 (United Nations Office on Drugs and Crime, 2004d).

Arrest and seizure data

Drug seizures and the number of arrests continue to increase with each year. In 1996, the number of drug-related cases was 3813 and the number of arrests was 6651. By 2002, the number of drug cases was 14,167 and those arrested numbered 23,199 (Drug Enforcement Administration, Intelligence Division, 2003; Ministry of Public Security, Standing Agency in Drugs Control, 2003). Hanoi and Ho Chi Minh City are recognised as hot spots for drug trafficking and use; in 2003, more than 3800 cases of drug trafficking were found in these two cities alone (Vietnam News Agency, 2004). Figures released in 2005 show that between 2001 and 2003 there were 35,296 drug cases and 56,007 offenders arrested (Ministry of Public Security, 2005). In 2002, drug seizures amounted to 57.4 kilograms of heroin, 612.6 kilograms of opium, 243 kilograms of cannabis, 110,232 ampoules of 'addictive' pharmaceuticals and 47,852 'synthetic tablets' (Ministry of Public Security, Standing Agency in Drugs Control, 2003).

In 2004, law enforcement agencies throughout the country seized 239.4 kilograms of heroin, 58.6 kilograms of opium, 1.021 kilograms of cannabis, 39,467 ATS pills (unspecified) and 5528 ampoules of pharmaceutical drugs, including psychotropics. The quantities of all these drugs have increased compared with 2003: 57.4 per cent for heroin, 46 per cent for synthetic drugs, 39.2 per cent for cannabis and 79 per cent for opium (Ministry of Public Security, 2005). It is believed that most groups involved in trafficking in Vietnam are relatively small, of 5–15 people, often family members or relatives; it is expected that larger syndicates will inevitably develop with the increasing transit of drugs (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). The largest known drug organisation network was discovered in late 2004, with 29 arrested and suspected of involvement in the trafficking of 800 kilograms of heroin from Laos and Cambodia (Associated Press, 2004).

Crop studies and crop eradication statistics

The Vietnamese Government has for some years been involved in eradication efforts to reduce opium poppy cultivation. The area of cultivation has decreased considerably, from 12,900 hectares in 1993 to around 1000 hectares in 2003 (although United States authorities believe this figure should be at least doubled). Assistance with the eradication efforts has been largely funded through UNODC; it has been suggested there should be more focus by government on socio-economic alternatives to alleviate some of the issues of poverty in these areas to sustain the eventual demise of opium production in Vietnam (United Nations Office on Drugs and Crime, 2003b; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

A13.4 Drug-taking practices, risk factors and trends

The drug of choice in Vietnam is heroin; the favoured method of its administration is injecting, a method which appears to be increasing (Centre for Harm Reduction, 2004a; Hammett et al., 2005; Hammett et al., 2004; Johnston et al., 2004; Minh et al., 2003; UNDCP, 2002; United Nations Office on Drugs and Crime, 2004a; Walsh, 2003). Frequency of injecting varies, but is commonly 2–3 times per day, with a range of 1–5 times. While men usually prefer to inject in the arm, women often inject into places that are less easy to detect, and some IDUs are known to inject into their upper palm, armpit or groin; IDUs often do not use a tourniquet when injecting and simply squeeze the arm (Minh et al., 2003; United Nations Office on Drugs and Crime, 2002a). The length of time between starting the smoking of drugs and initiation into injecting is getting shorter: the average time is 2.8 years for males and 2.5 years for females, but a substantial number of both males and females have been known to shift to injecting within 12 months (Loi et al., 2003). A study in Quang Ninh found drug users making the transition from smoking to injecting heroin within seven months on average (Hien, Long & Huan, 2004). A major reason for the shift to injecting is economic, with inhaling heroin being considerably more expensive. As one drug user stated: 'It can cost me 100–200,000 VND a day to inhale, while injecting only costs 30–50,000 a day' (Loi et al., 2003).

Of considerable concern is the widespread sharing of injecting equipment and the unhygienic methods used by IDUs (Hanoi School of Public Health, 2001; Lam, 2003; Tuyen, 2004; United Nations Country Team, 2003). Various approaches to drug injecting have

been described: one is to dissolve the drug in water, in a container, and with the only syringe available take an equal amount from the container to inject. The syringe itself is cleaned several times with water, but this is mostly undertaken to remove any visible blood. Some use cold boiled water but most believe any water to be suitable. Bleach is a rarity, although occasionally some use alcohol as a disinfectant (Tran et al., 2004).

The pooling of money to purchase drugs, and the sharing of needles is common, associated with economic necessity, and one of the major reasons for forming or joining a group of injectors. Among poor IDUs it is common to buy a packet of drugs, and when funds are short to purchase only one needle and syringe for all. Sharing injecting equipment is common, particularly so in confined settings. Reasons for sharing can be 'situational', often linked to poor accessibility, the urgency to inject and/or insufficient knowledge of the associated health risks (Anh & Giang, 2004; Institute for Social Development Studies, 2004; Tran et al., 2004; Vinh, 2002).

While most drug users used unboiled, boiled or sterile water, blood has also been reported as being used to mix with the drug. The number of those who share any one needle varies, but it has been reported that in gaol around 30–50 would share the same syringe (Walsh, 2003). For HIV-negative IDUs entering these institutions, where most inmates are HIV-infected, the risk of HIV infection is very high (Lam, 2003; Nam, Higgs & Reid, 2003). Opium and heroin smuggled into gaols, usually by inmates who worked outside during the day or by family members, can be purchased, but clean syringes are rarely available. Drug use inside the provincial treatment and rehabilitation centres ('05/06 camps') is hard to control (Nam, 2003; Nam et al., 2003; United Nations Office on Drugs and Crime, 2002a).

In recent years Vietnam has seen a rise in the number of sex workers who are also IDUs. Many of them are injecting regularly, sharing needles with regular partners who are drug users. Condom use is reported to be inconsistent or poor. Drug-injecting female and transsexual sex workers with HIV infection continue to engage in sex work because of the lack of other income-generation options. As early as 2000, 50 per cent of sex workers admitted to the Ho Chi Minh City re-education camp were IDUs (Centre for Harm Reduction, 2004a; Rekart, 2002; Tuan et al., 2004). In three provinces female sex worker IDUs were found to share needles more than male IDUs; most began injecting drugs before engaging in sex work (Messersmith, Kane & Tran, 2004), suggesting entry to sex work to fund their drugs. One paper suggests that many sex workers are provided with drugs to maintain their dependency, and as a result maintain associations with their suppliers (Ha et al., 2004).

The interactions between sex workers and the drug-using community through unsafe sexual relations and/or injecting drugs is established in various parts of the country; such risk behaviours are a potential bridge for HIV infection to the wider community. In some studies up to 40 per cent of male IDUs interviewed have reported paying for sex in the previous 12 months (Economic and Social Commission for Asia and the Pacific, 2003a; Hellard & Hocking, 2003; Minh et al., 2003; Nguyen, 2004; Tran et al., 2004). The use of condoms by drug users is poor overall (Hellard & Hocking, 2003; Lam, 2003).

The first case of HIV was identified in 1990; as of mid-2003 the cumulative number of HIV infections was 69,495. The HIV epidemic is currently concentrated among IDUs, with 60 per cent of all notified HIV cases. The movement of HIV from high-risk groups such as IDUs and sex workers to other groups in society is now well underway, with 40–120 people infected every day. An estimated 220,000 were believed to be living with HIV/AIDS at the end of 2003 (Hong, Anh & Ogden, 2004; Tuyen, 2004; UNAIDS/World Health Organization, 2004; United Nations Country Team, 2003).

HIV prevalence among IDUs has increased substantially nationwide from 10.1 per cent in 1996 to 32 per cent in 2002. There are, however, sites in Vietnam where sentinel surveillance has reported HIV prevalence among IDUs of 40–80 per cent (Bezziccheri & Bazant, 2004; Cohen, 2003; Ghys et al., 2003; Tran, 2004; Tran & Pham, 2004). Co-infection with HIV and hepatitis C (HCV) is endemic among IDUs: a survey in northern Vietnam found that, of those who had HIV, 98 per cent were co-infected with HCV (Vu et al., 2004; Walsh et al., 2004). As well as HIV/AIDS and hepatitis C, other and more unusual diseases associated with sharing injecting equipment have been identified, such as malaria (Chau et al., 2002).

A13.5 Summary table

Estimated number of drug users	As of 2004, 170,400 registered drug users. Unofficial estimates vary between 200,000 and 500,000
Main drugs used	Heroin, opium, methamphetamine, ecstasy, cannabis, blackwater opium, diazepam, glue
Drugs injected	Heroin, blackwater opium, diazepam
Estimated prevalence of HIV infection among IDUs	60% of the HIV cases are found among IDUs. HIV prevalence among IDUs is 40–80% in at least 8 provinces.

A13.6 Country responses to drugs

Agreements and treaties

Vietnam is a party to the United Nations Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971, and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988. In 2002, Vietnam signed the UN Convention Against Transnational Organised Crime (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004a).

Vietnam has signed counter-drug agreements with Myanmar (1995), Cambodia (1998), Laos (1998), China (2001), Russia (1998), Hungary (1998) and Thailand (1998) (Drug Enforcement Administration, Intelligence Division, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). Vietnam is a signatory to the Association of South-east Asian Nations (ASEAN) declaration for a drug-free ASEAN by the year 2015.

Policy responses

Addressing drug control and prevention is a high priority for the Vietnamese Government which maintains a firm commitment to supply and demand reduction. Action plans for anti-drug programs have been implemented since the late 1990s and for 2002–2005 the aim is to reduce the number of drug users by 10–20% annually. Despite the government's determination to oppose drug use, the national legislation on drug control and prevention has generally been fragmented. As of 2001, the Law on Narcotic Drugs Prevention and Suppression came into force. The new law acknowledges that drug use is a social problem and that drug users should be viewed as needing assistance rather than as offenders or criminals. If a person is found using drugs for the first time, they are detoxified and rehabilitated in the community, but if this does not succeed, they are then sent to a compulsory rehabilitation centre. Policy makers essentially believe the rehabilitation of drug users is the only solution that may explain why the duration spent in a compulsory rehabilitation centre has increased from six months in the past to two years today.

The Standing Office for Drug Control under the Ministry of Public Security has become the backbone of the government's drug control and prevention strategy. As of June 2000, the National Committee for the Prevention and Control of AIDS, Drugs and Prostitution (NCADP) came into existence following a merging of the former Government Steering Committee for Social Evils, the National Drug Control Committee and the National AIDS Committee. The NCADP has various roles that include assisting in policy making and monitoring and evaluating the work of those implementing policies and activities. The current committee is headed by the Deputy Prime Minister but also includes 19 member ministries and branches such as the Ministry of Health and Ministry of Public Security, as well as representatives from the Fatherland Front (a political mass organisation).

As part of a national drug control policy, the government has created a National Drug Control Action Plan 2001–2005 and this outlines the government's policies and strategies for all drug control issues. Currently in preparation is the government's National Drug Control Master Plan which will cover 2001–2010 with assistance provided by UNODC. This had not been published at the time of writing.

In recent years an important long-term drug control objective within drug policy has been to promote harm reduction, which is to involve combining preventative drug abuse control and HIV/AIDS programs. However, it has been suggested that a series of 'social evils' campaigns aiming to eliminate all drug use in the country has resulted in serious adverse health consequences, namely the ongoing HIV/AIDS epidemic that impacts upon IDUs (Ministry of Public Security, Standing Agency in Drugs Control, 2003; Oanh, 2004; United Nations Office on Drugs and Crime, 2003b, 2004c).

Law enforcement responses

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, 2000). Security regulations require police to detain those who are found in possession of or using drugs and to commit the person to a compulsory drug treatment centre or a drug re-education centre. Earlier the sentence was for six months (Quan et al., 1998) but currently it is two years and it can reportedly go up to five years: generally the terms are two years plus three years of vocational training. The program was originally only for Ho Chi Minh City and Hanoi but there was a decree for a national expansion of this project in 2003 (N. Walsh, personal communication, 2005). Drug users in these centres are dealt with by MOLISA and the Ministry of Public Health, while the Ministry of Health takes care of treatment, often using traditional medicines (Nam et al., 2003; Oanh, 2004).

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 that lead to the illegal use of drugs; and secondly, to organise drug treatment for users. 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 (Criminal Law, Article 199). 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 in the process of giving up use of drugs are imprisoned for up to 15 years. Causing death and organising illegal drug use merit a life sentence or the death penalty (Criminal Law, Article 200). Those who rent or let places for illegal drug use can be imprisoned for 15 years (Criminal Law, Article 198) (Nguyen Quoc Viet, 2001).

The death penalty may be imposed for those in possession of small quantities of heroin, opium or cannabis, but this is rarely carried through. However, a mandatory sentence of death, usually by firing squad, exists for those convicted in possession of 600 grams or more of heroin (although a figure of 100 grams has been noted as well) and/or 5 kilograms of opium (Ministry of Public

Security, Standing Agency in Drugs Control, 2003; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b). In late 2004 a man found trafficking 3 kilograms of heroin from Laos was executed by firing squad in the northern province of Bac Giang (Herald Sun, 2004).

From 1996 to 2001 the courts have handed out penalties for drug offenders that include: 288 death sentences, 255 life sentences, 2292 sentences of 10–20 years' imprisonment and 19,233 sentences of less than 10 years' imprisonment. Even so, it is recognised by the authorities that despite the regular use of strict penalties, drug-related crimes are rising (Ministry of Public Security, Standing Agency in Drugs Control, 2003).

Health and treatment responses

The expansion of the drug treatment centres began in the mid-1990s, under the control of MOLISA. These centres are run by provincial departments called DOLISA. Such centres are divided and referred to as '05' for sex workers and '06' for drug users. Every provincial administrator supposedly operates at least one or two such centres, but some provinces do not have such centres and consequently some residents are shifted to nearby provinces. Although there is officially a division between 05 and 06 camps, it is not unknown for some women drug users to be held in sex worker centres and some men have been held in sex worker camps. A few centres hold both male and female drug users (Uhrig, 2002).

In 2000, there were 56 centres to provide treatment and rehabilitation and, in 2001, 22,402 people received treatment in these facilities. During this time the treatment and rehabilitation offered were reportedly insufficient to meet the needs of the residents, and most centres were considered to be seriously overcrowded. By 2002, there were 46,723 people recorded as treatment cases, most related to heroin use. At the time only 2 per cent of residents were admitted due to ATS consumption. In 2003, there were 71 treatment and rehabilitation centres and more than 700 detoxification bases at the district, ward and village level (United Nations Office on Drugs and Crime, 2003b, 2004a).

In 2003, the network of treatment centres expanded, with 74 such centres at provincial level and a further 7100 treatment centres at the lower level. The capacity of these 06 centres varies from 100 to 3000 residents. Such centres continue to emerge. A new centre is being created in Ba Ria-Vung Tau for around US\$6.3 million, accommodating up to 2000 drug users, sex workers and those with HIV. Throughout the nation drug users are being rounded up and placed into such facilities or into prisons: in Hanoi during 2003, there were 1500 drug users in prison, 3500 in treatment centres and up to 7500 receiving community treatment. In Ho Chi Minh City the 06 centres held 33,577 residents in 2003. Part of the rehabilitation process is job creation, but this has not been functioning as planned: over a period of nine months in 2003, out of 9068 post-rehabilitation drug users, only 68 obtained employment (United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2004b).

It has been suggested that the substantial rise in the number of 05 and 06 centres is largely a product of an intensive campaign of stigma and discrimination towards drug users and sex workers who have frequently been labelled as 'social evils' and will not be tolerated (N. Walsh, personal communication, 2005).

According to MOLISA, in 2004 the detoxification centres provided treatment for 62,600 drug users, 39 per cent higher than targeted. In 2005, the government hopes to have 60,000 people go through detoxification and rehabilitation centres, and ambitiously aims to have 25,000 provided with employment and/or living skills by the end of their time in the centre (Vietnam Economics Times, 2005).

Harm reduction programs have been piloted and expanded in Vietnam since 1993. However, support for the harm reduction approach is not uniform, with some local governments more supportive than others. There is a strong perception that current drug control laws are in direct conflict with the harm reduction approach: this lack of an enabling environment has been a major obstacle for the implementation of HIV/AIDS prevention programs for drug users. Harm reduction programs are usually of short duration (one to three years), pilot in nature and dependent on international funding: once the funding is withdrawn, local resources are unlikely to sustain the programs in their entirety (Vu Doan Trang, 2001). Stigma and discrimination towards drug users are endemic and have been a major impediment to drug users being involved in project designs in most areas of the country (N. Walsh, personal communication, 2005).

There are only a limited number of programs that attempt to improve access to harm reduction programs (especially new needles and syringes). A number of projects supported by international organisations have been working throughout the country and many have been reported at both International AIDS Conferences and at International Conferences on Reduction of Drug Related Harm (Do, Higgs & Flassenkaemper, 2003; Eligh, 2004; Lacombe et al., 2004). One such project has taken place in a few districts located in northern Vietnam where there have been needle and syringe distribution and collection through peer education and outreach programs. In 2004, over a period of nine months 20 peer educators distributed over 81,000 needles. As a result of an intensive advocacy program which involved community buy-in and support from the commune leaders and local authorities at the sites (involving commune leaders and representatives of the police sitting on the board of management for the projects), these programs have been able to achieve about 75 per cent coverage among drug users (Centre for Harm Reduction, 2004b; Nguyen, Alford & Higgs, 2005).

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 appeared unconvinced by local and international evidence and the program remained extremely small-scale (Vu Doan Trang, 2001). However, in recent times interest in the introduction of methadone treatment programs has once again emerged and, in 2005, international funds from a range of donors for a large piloted methadone treatment program (MTP) are expected. This program will establish a protocol for methadone treatment in the country, including procurement, distribution and management of methadone. It is believed a comprehensive approach will be implemented, offering other services such as counselling and community support (Harm Reduction Working Group, 2004). In early 2005 it was announced that a pharmaceutical company had been producing naltrexone which blocks the effects of opiates. The first 10,000 naltrexone 50mg tablets will be provided to the 05 and 06 rehabilitation centre located in Danang City (Vietnam Economics Times, 2005).

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A14. Pacific overview

Papua New Guinea, Fiji, Solomon Islands, Vanuatu, Samoa, and Tonga

This overview is a synthesis of information reported by key informants, group interview participants, regional overviews undertaken by the United Nations Office on Drugs and Crime (UNODC) and the United States Drug Enforcement Agency, and other published documents. There are large gaps in publicly available documentation in relation to illicit drug use in the Pacific. There are no national population estimates for drug use in the Pacific. Moreover, concerted investigations to define the extent of the drug use, such as in-country rapid assessments, have not been undertaken in the last five years. For this reason, this desk-based situational analysis has taken an extremely conservative approach to the reporting of illicit drug use issues and the responses being undertaken in Papua New Guinea, Fiji, Solomon Islands, Vanuatu, Samoa and Tonga.

Geography

The Pacific Islands comprise a group of 22 small states (14 independent nations, 7 territories, 1 commonwealth) and numerous uninhabited islands. The area occupied by the islands ranges from 10,000 kilometres east-west and 5000 kilometres north-south. An estimated 7500 to 10,000 remote islands lie within this area (Central Intelligence Agency, 2004; United Nations Office on Drugs and Crime, 2003).

With the exception of Papua New Guinea, the majority of the Pacific countries are short of land and have few exploitable natural resources. Fertile, arable and well-mineralised soils are limited to the larger mountainous volcanic land masses of the south-west region (Papua New Guinea, Solomon Islands, New Caledonia, Fiji and Vanuatu) (Central Intelligence Agency, 2004; United Nations Office on Drugs and Crime, 2003).

Population

The Pacific is a region of great ethnic, social and cultural diversity, with a population of 7.6 million (2000 estimate) and more than 1200 languages and dialects (Nejo, 2001). Most of the countries in the Pacific share similar demographic attributes, a young population, low mortality and a highly mobile population and labour force (Central Intelligence Agency, 2004). In the Solomon Islands, Papua New Guinea and Vanuatu approximately 40 per cent of the population is under 15 years of age (Central Intelligence Agency, 2004). People in the Pacific live primarily in rural areas: in Melanesian countries such as Papua New Guinea, Vanuatu and Solomon Islands, over 80 per cent of the population live in isolated villages and outer island communities, while other countries such as Kiribati and Fiji have nearly half the population in urban centres. Rural-urban drift is, however, on the increase in many countries (Nejo, 2001).

Limited and unreliable data exist on the unemployment situation in the Pacific countries. Nevertheless, other social indicators and key informants suggest that there is a large unemployed youth labour force (Central Intelligence Agency, 2004; Nejo, 2001). The lack of sense of hope and purpose stemming from the lack of employment or education opportunities encourages risk-taking behaviour linked to drug and alcohol abuse.

Literacy rates are quite high in some areas of the Pacific compared to other developing countries (Central Intelligence Agency, 2004; Nejo, 2001). In Fiji, Vanuatu and Tonga rates of literacy are approximately 95 per cent. In larger Melanesian countries where basic education is not widely available, literacy rates vary from 20 to 64 per cent. Less than half of the Pacific Island youth complete secondary school (15–19 years of age) and only 1–5 per cent complete some form of tertiary education (Central Intelligence Agency, 2004; Nejo, 2001).

Politics and economy

Many of the countries obtained independence from their colonisers only in the last 30 years. Some, such as French Polynesia and New Caledonia, are still governed by distant state powers. Thus, the islands have inherited a range of legal and judicial systems that impede the establishment of regional policies on drug control (Central Intelligence Agency, 2004; Nejo, 2001).

Reliable economic data are unavailable for Pacific countries. However, indications are that the economic development of most of the Pacific Islands is hindered by the geographical factors of the area: small size, paucity of natural resources, isolation from foreign markets, periodic devastation from natural disasters, and inadequate infrastructure (Central Intelligence Agency, 2004; Nejo, 2001).

Table A14.1. Country profile summary for Papua New Guinea, Fiji, Solomon Islands, Vanuatu, Samoa and Tonga

	PNG	Fiji	Solomon Islands	Vanuatu	Samoa	Tonga
Geography	Arable land: 0.46% Permanent crops: 1.44% Other: 98.1%	Arable land: 10.95% Permanent crops: 4.65% Other: 84.4% (2001)	Arable land: 0.64% Permanent crops: 2% Other: 97.36% (2001)	Arable land: 2.46% Permanent crops: 7.38% Other: 90.16% (2001)	Arable land: 21.2% Permanent crops: 24.38% Other: 54.42% (2001)	Arable land: 23.61% Permanent crops: 43.06% Other: 33.33% (2001)
Population (2004 est.)	5,420,280	880,874	523,617	202,609	177,714	110,237
Median age	21 years	24 years	18.4 years	22.3 years	24.2 years	20.1 years
0–14 yrs	38.3%	31.7%	42.4%	22.3%	23.3%	37.1%
15–64 yrs	58%	64.3%	54.4%	22.3%	65.5%	58.7%
65 yrs+	3.8%	4%	3.2%	22.2%	6.3%	4.2%
Life expectancy (2004 est.)	Males: 62.41 years Females: 66.81 years	Males: 66.74 years Females: 71.79 years	Males: 69.9 years Females: 74.98 years	Males: 60.64 years Females: 63.63 years	Males: 67.64 years Females: 73.33 years	Males: 66.74 years Females: 71.79 years
Under 5 mortality rate	53.15 deaths/ 1000 live births	12.99 deaths/ 1000 live births	22.09 deaths/ 1000 live births	56.63 deaths/ 1000 live births	28.72 deaths/ 1000 live births	12.99 deaths/ 1000 live births
HIV prevalence	0.6% (2003)	0.1%	NA	NA	NA	NA
Human development index (2002) rank (out of 177 countries)	133	81	124	129	75	63
Income differentials	Lowest 10%: 1.7% Highest 10%: 40.5% (1996)	NA	NA	NA	NA	NA
Unemployment rate	NA	7.6%	NA	NA	NA	13.3%
Literacy (% age 15+ who can read and write)	64.6%	93.7%	NA	53%	99.7%	98.5%
Language	715 indigenous languages – many unrelated	English (official), Fijian, Hindustani	Melanesian pidgin English (1–2%); 120 indigenous languages	English, French, Pidgin, plus more than 100 local languages	Samoan (Polynesian), English	Tongan, English
Religion	Christian 66%, indigenous beliefs 34%	Christian 52%, Hindu 38%, Muslim 8%, Other 2%	Christian 96%, Indigenous beliefs 4%	Christian 76.7%, Indigenous beliefs 7.6%, Other 15.7%	Christian 99.7%	Christian
Government	Constitutional monarchy with parliamentary democracy	Republic	Parliamentary democracy tending towards anarchy	Parliamentary republic	Constitutional monarchy under native chief	Hereditary monarchy
GDP: purchasing power parity	\$11.48 billion	\$5.012 billion (2002 est.)	\$800 million (2002 est.)	\$563 million (2002 est.)	\$1 billion (2002 est)	\$236 million (2002 est.)

A14.1 Narrative summary of drug vulnerabilities

Geography

Reports and key informants have suggested that the geographical proximity of the Pacific to illicit drug-producing countries, such as in East Asia, facilitates illicit drug trade. Additionally, the isolation of the coastal regions offers useful transit points for drugs (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). Moreover, the terrain of the Pacific makes it very difficult for effective government administration of all territories and creates challenges for effective law enforcement. Transport across the region is problematic, except in cases such as Fiji, which is the regional air and sea entrepot, and in independent territories where transport services are heavily subsidised (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003).

The region has developed as a world tourist destination, particularly Fiji, Vanuatu, New Caledonia, Guam and French Polynesia. Subsequently, expansion of transportation links with Asia and North and South America have produced fears that the islands will be used more as transshipment routes for trafficking (Nejo, 2001).

Population growth and urbanisation

More than 35 per cent of the people of the Pacific Islands live in towns and the rate of urban population growth throughout most of the region is high (World Bank, 2000). Key drivers for this trend are: declining agricultural commodity prices, livelihood opportunities, insufficient rural land to confer social standing, as well as prospect of cash employment, educational opportunities

and the intrinsic excitement of urban areas (World Bank, 2000). Despite the many benefits of urbanisation, there is concern about the growth of town areas, including effect on customary traditions and relationships, providing and maintaining public infrastructure and services, proliferation of informal settlements, worsening environmental conditions and increasing social problems associated with unemployment and under-employment, which include drug use and abuse (World Bank, 2000).

Youth population

The Pacific countries under review have a growing youth population. Experience from elsewhere suggests this group is susceptible to licit and illicit drug use and abuse and its concomitant social and economic consequences. Moreover, low literacy rates in some countries and the lack of education and employment opportunities further increase the vulnerability of the Pacific societies towards substance abuse. A quote taken from Save the Children (Australia) (2004) highlights this point, 'they [young people] are still living in fear, with hopelessness, not knowing what their future will be like. The boys especially turn to drugs, that is their only solution' (peer educator, Guadalcanal) (Save the Children Australia, 2004).

Historical and cultural interactions with drugs

Pacific societies have a tradition of drug use, incorporated into culture. A range of psychoactive substances, including betel nut and kava have been used traditionally across the Pacific region (Posanau, 1997). Rapid socio-economic changes have led to changing patterns of consumption of these and other licit and illicit substances and the potential for abuse (Nejo, 2001). Trends have emerged towards the use of drugs such as cannabis

and crystal methamphetamine ('ice'). Cannabis is the primary illicit substance of abuse across the region. It is believed that cannabis was introduced into parts of Micronesia and Papua New Guinea by expatriates in the 1960s and 1970s (Nejo, 2001). The illicit use of cannabis spread to indigenous population groups, significantly youth, during the 1970s and 1980s. Heroin was thought to be introduced into Micronesia in the 1960s and 1970s (Nejo, 2001). In 1984–1985 there was serious heroin abuse in Palau with 50 people receiving professional treatment and several imprisoned for trafficking of heroin from the Philippines and Thailand (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). There are still reports of people using heroin in Palau, however it is not seen as a major concern today.

A14.2 Prevalence of drug use

Population estimates of drug use

A number of case studies have been conducted in a couple of Pacific countries, for example, in Papua New Guinea (Johnson, 1990, 1994, 1998), Vanuatu (McMurray, 2001) and Tonga (McMurray, 2003) The results from these studies are not reported as population estimates for drug use in the Pacific Island countries under review as they are often outdated, use qualitative methods or use small convenient samples.

Other estimates: expert opinions

While the severity of drug abuse is purported to vary between the six island countries listed for this review, use of the illicit drug of concern, cannabis, is the same. According

to key informants, cannabis is the illicit drug of choice for people living in the countries under review, due mainly to its availability and low cost (Drug Enforcement Administration, Intelligence Division, 2004). Key informants suggested that drugs such as heroin, methamphetamines and cocaine are not commonly used due to their high cost compared to the average income (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003).

Injecting drug use in the Pacific is believed to be very small (personal communication, May 2005). Heroin was being used in Palau in 1984–1985. More recently, methamphetamines (and other illicit drugs) are being used in the more affluent countries of the United States and French territories (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003).

Population estimates are not available, so only modest suggestions can be made as to the trends in drug use in the six research countries. The symbols used in Table A14.2 represent: use that is reported to be substantial (+) and increasing use (↑). The data have been derived from a number of sources: key informants, group interview, and a number of regional overviews (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003) and have been validated by external reviewers.

Data collection systems in place

Formal surveillance systems for drug use and abuse in the Pacific are not in place.

Table A14.2. Drug use in Pacific countries by drug type

	PNG	Fiji	Solomon Islands	Vanuatu	Samoa	Tonga	Micronesia
Cannabis	+↑	+↑	+	+ (less evident)	+↑	+	+↑
Inhalants							
Methamphetamines							+↑
Heroin							+
Cocaine	? maybe						+
Prescription drugs	+	+			+		+

Source: key informants

A14.3 Drug supply, production, availability, cost and trade

Cannabis

Cannabis is the drug the region is known to produce. The Pacific environment provides ideal growing conditions for cannabis and allows for continuous year-round growing cultivation (Pacific Islands Forum Secretariat, 2004). Wild growth occurs in all of the countries listed for this review (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). Limited options and market opportunities in the agricultural sector have resulted in illicit cultivation of cannabis, predominantly for domestic consumption (United Nations Office on Drugs and Crime, 2003). According to Ware (2001), cannabis is considered a convenient cash crop which requires little to no tending; it has no season, and is ready to harvest in months, unlike coffee, which takes six years to mature.

Illicit commercial cultivation of cannabis occurs in island states such as Papua New Guinea, Fiji, Samoa and Tonga (Drug Enforce-

ment Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). According to key informants, cannabis cultivation is most significant in Papua New Guinea and Fiji.

Historically, the majority of cannabis cultivation was undertaken by individuals or small groups within village environments. More recently, it is believed, in a number of jurisdictions in the Pacific, cannabis cultivation is being overtaken by organised criminal groups on a national basis (Pacific Islands Forum Secretariat, 2004).

The development and greater organisation of the cannabis industry in recent times have resulted in an oversupply of cannabis to local markets (Pacific Islands Forum Secretariat, 2004). As such, cannabis has been exported to other markets in the region, for example, from Samoa to American Samoa and from Fiji to Tonga (Pacific Islands Forum Secretariat, 2004). The only documented international trading of drugs from the Pacific is of cannabis, from Papua New Guinea, trafficked mainly to Australia (United Nations Office on Drugs and Crime, 2003).

THC content of varieties known as 'Spak Brus' or 'Niugini Gold' are reported to be very high, some of the most potent cannabis in the world (Ware, 2001). Niugini Gold is marketed as producing a 'superlative high'. Key informants suggested that the price of cannabis is variable and dependent on quality. In Port Moresby, Papua New Guinea, the *spak brus* is readily available. A 'roll', a homemade cigarette weighing less than a gram, cost 6 cents in a village, 15 cents in a town, and up to 60 cents in Port Moresby (prices in US cents). One source reported that 'Niugini Gold' was worth around AU\$500 per 28 grams on the streets of Sydney (1 kg – \$17,500) (Ware, 2001). Another report (United Nations Office on Drugs and Crime, 2003) stated that 1 kilogram of cannabis purchased in Papua New Guinea costs about 300 kina (AU\$300). The wholesale price of this same quantity in Australia is AU\$4500.

Of major concern to authorities is the trade of drugs for guns in Papua New Guinea. Guns such as the AK-47, SS1, AR-10 and M-203 are being brought into the country through the land border with Indonesia; on Southeast Asian ships; and in small numbers across the Torres Strait from Australia. Trading is usually done in coastal cities like Lae, Madang, Wewak or Port Moresby (Ware, 2001).

Crystal methamphetamine

The Pacific Islands region is developing into a significant transit region and a potential consumption area for crystal methamphetamine (Drug Enforcement Administration, Intelligence Division, 2004). The increasing significance of this was highlighted recently by the large seizure of crystal methamphetamine in Fiji (9 June 2004) (Drug Enforcement Administration, Intelligence Division, 2004). The New Zealand Police Clandestine Laboratory (Clan Lab) Team and the Australian Federal Police Forensic Services Unit assisted the Fiji Police Force and the Fiji Customs Service in seizing a crystal methamphetamine 'super laboratory'. As a result, 5 kilograms of finished crystal methamphetamine, 700 litres of liquid methamphetamine and enough precursor chemicals to produce an additional 1000 kilograms of methamphetamine were seized. Six individuals were arrested. They were associated with an Asian organised crime group that had been operating throughout Southeast Asia (Drug Enforcement Administration, Intelligence Division, 2004).

The concern by authorities is that the development of the cannabis industry will allow for profits to be invested in other commodities such as the production of methamphetamines.

Table A14.3. Commercial cultivation of cannabis in Pacific countries

	Home growing – personal use	Commercial – domestic markets	Commercial – export
Papua New Guinea	+	+	+
Fiji	+	+	+(small scale)
Solomon Islands	+		
Vanuatu	+		
Samoa	+	+	
Tonga	+	+	

Drug trafficking

The major form of trafficking is transshipment, in which drugs produced elsewhere transit Pacific Islands for the destination market. The geographic position of countries in the Pacific region facilitates the drug trade, both eastbound and westbound throughout the region (Australian Crime Commission, 2003; Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; Pacific Islands Forum Secretariat, 2004; United Nations Office on Drugs and Crime, 2003). South American cocaine is transported into Southeast Asia and Australia, while Southeast Asian heroin and methamphetamine are transported by couriers into Canada, and to a lesser extent into the United States (Australian Crime Commission, 2003; Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; Pacific Islands Forum Secretariat, 2004; United Nations Office on Drugs and Crime, 2003).

Drugs are trafficked through the Pacific by air and ship (Australian Crime Commission, 2003; Nejo, 2001). There are an estimated 5000 vessels transiting the Pacific on any given day (Nejo, 2001). Large shipments may be unloaded from a mother ship into a smaller vessel. The smaller vessel can subsequently move to an uninhabited island for transit to the next destination point. Expanding regional transportation links to Asia, as well as North and South America (Nejo, 2001). The primary trafficking methods for crystal methamphetamine are body couriers on commercial airlines and parcel delivery services (Drug Enforcement Administration, Intelligence Division, 2004).

A major concern for the Pacific region is that, if large amounts of illicit drugs are moving through local communities, seepage of the drugs into local communities will result and the social impacts of drug dependency will be experienced (Pacific Islands Forum Secretariat, 2004).

Drug seizures

There have been reports of a number of large seizures in the region (see Table A14.4). Since the drug market in the region is small, shipments of large quantities are reported to indicate that the drugs are destined for larger markets (Nejo, 2001). There have been discoveries of illicit drugs washed up on shores in countries within the region (Pacific Islands Forum Secretariat, 2004). The quantities found both on yachts and on shores indicate that trafficking is in bulk consignments and highly organised (Pacific Islands Forum Secretariat, 2004).

Cocaine

Availability and demand for cocaine remain limited in Oceania, with the exception of Australia. Seizures at the Australian border in 2001 doubled from the preceding year. Seizures have been made in recent years in Tonga and Fiji, and seizures in Australia have also indicated that the drugs transited some Pacific Islands (Australian Crime Commission, 2003; Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001).

Heroin

Large seizures of heroin have been made in Vanuatu and Fiji, destined for other markets (Nejo, 2001).

Crystal methamphetamine

In recent years, crystal methamphetamine has been trafficked through the Pacific (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; Pacific Islands Forum Secretariat, 2004; United Nations Office on Drugs and Crime, 2003). Due to the proximity to China and the Philippines, and their international airports, Guam and the Northern Mariana Islands are transit zones for crystal methamphetamine shipped to the United States West Coast and the Hawaiian Islands (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). Moreover, Guam and the Northern Mariana Islands are now considered consumer markets for crystal methamphetamine from China, Hong Kong, Japan, the Philippines, South Korea and Taiwan (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). There have been seizures of crystal methamphetamine in Palau, Northern Mariana Islands (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003).

A major concern from authorities is that the Pacific region is following the global trend towards ATS manufacture, importation and use (Pacific Islands Forum Secretariat, 2004).

Precursor chemicals

Another major concern for countries in the Pacific is insufficient legal power to control and prosecute the import and export of chemical precursors in the region (Pacific Islands Forum Secretariat, 2004). This issue is currently being addressed by the Oceania Customs Organisation (Pacific Islands Forum Secretariat, 2004). A recent case highlights this point. Pseudoephedrine was exported from a Pacific Island country to Australia and there were no legislative powers to prosecute for purchase, supply or export at the country of origin (Pacific Islands Forum Secretariat, 2004).

Cannabis

There have also been reports of large shipments of cannabis being trafficked from Pakistan, the Philippines and Thailand passing through New Caledonia and the Solomon Islands (Nejo, 2001).

Table A14.4. Seizures of illicit drugs in the Pacific, 2000–2002

Year	Heroin	Cocaine	Cannabis	Methamphetamine
2002	Vanuatu 150kg			
2001		Tonga 100kg		
2000	Fiji 357kg	Fiji 0.3kg	Fiji 106 kg/H	Fiji 0.3kg

Source: United Nations Office on Drugs and Crime, 2003

According to the UNODC Pacific regional overview (2001), subgroups of the Yakuza are actively involved in crystal methamphetamine trafficking on the island of Saipan. Reports state little evidence of a local presence in the Pacific Islands controlling transshipments; most reveal criminal syndicates operating from outside the Pacific. Seizures have revealed groups linked to Asian organised crime syndicates and a Tongan syndicate based in Hawaii. Cannabis trafficking between Australia and Papua New Guinea is reported to involve syndicates led by Australians with business links to Papua New Guinea (United Nations Office on Drugs and Crime, 2003)

There is little indication of any significant importation of drugs to the Pacific Islands. Most consider this to be due to traditional drug use patterns and low buying capacity. However, it is possible that some drugs destined for transshipment may be used for local marketing (United Nations Office on Drugs and Crime, 2003).

Arrest and seizure data

Violence against women and family, particularly in Melanesian countries (Papua New Guinea, Solomon Islands, Fiji), is common after abuse of cannabis and home-brewed alcohol. For example, a gynaecologist at the Port Moresby General Hospital said in a press release (Kapi, 2004) that 60 per cent of women face physical abuse and more than half of the domestic violence is related to alcohol. Moreover, the Director of the National Narcotics Bureau, Paita Towo, reported that 60 per cent of crimes committed in Papua New Guinea were drug-related (Ruahma'a, 2004).

There is a significant association between alcohol consumption and cannabis smoking with crimes committed by youth (Nejo, 2001). One study in Fiji in 1995 showed that, of drug-related arrests, over 60 per cent were in the 17–24 age group (99% Fijian residents). Cannabis features in nearly all arrests (Adinkrah, 1995, cited by Nejo, 2001).

In Papua New Guinea serious law and order issues prevail (Nejo, 2001). Murders, armed robberies, rape and car jacking are daily occurrences (Nejo, 2001). Moreover, corruption and white collar crimes are written about constantly in the newspapers. There are particular concerns regarding the association between cannabis cultivation and the trade for illegal guns. There are numerous press releases (2004–2005) reporting arrests that involve the trade of cannabis for guns.

For information on money laundering of proceeds of illicit drug trafficking, see Drug Enforcement Administration, Intelligence Division (2004); Nejo (2001); United Nations Office on Drugs and Crime (2003).

Official law enforcement figures were not able to be obtained for this review.

Crop studies and crop eradications: NA

A14.4 Drug-taking practices, risk factors and trends

Cannabis

Key informants and published reports indicated that cannabis is generally combined with alcohol. Regionally, cannabis is mainly smoked but it is also chewed and sometimes baked with flour (Nejo, 2001). All data sources agreed that cannabis use is strongly gender-linked, with significantly more males than females using it (Nejo, 2001). The majority of cannabis users are young, aged approximately 15–20 years (Nejo, 2001). Cannabis is used in the expatriate community and by tourists.

Methamphetamines

Methamphetamine abuse is not a major concern for the countries involved in the current situation assessment (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). It is a major concern in the United States Pacific jurisdictions (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). Reports state that ice smokers on Guam and in the Northern Mariana Islands are said to be moving to injection of methamphetamine; obviously this is concerning for HIV risks and blood-borne viruses (Nejo, 2001). It is concerning to authorities that methamphetamine abuse could become an issue for other Pacific Island countries in the near future.

Inhalants

There were a number of anecdotal reports made by key informants regarding inhalant use in the countries under investigation. The most widely used/abused is petrol.

Risks associated with drug use

Problems associated with alcohol and cannabis abuse are concerning. In addition to the direct impact of drug use to the individual, there are a plethora of socio-economic and community-level consequences, including: disruption and neglect of the family; increased crime; domestic/family violence (e.g. wife beating, marital rape, physical abuse of children); sexual violence (rape, gang rape); and exposure to HIV/AIDS and other sexually transmitted infections (through unprotected sex, sex work, the disinhibiting effects of drugs). Increases in HIV have been noted in Papua New Guinea. There is no confirmation that this increase is associated with intravenous drug use, particularly since intravenous drug use is not common.

A14.5 Country responses to drugs

Convention adherence

Fiji and Tonga are party to all three international conventions, while Samoa and Vanuatu are not party to any of the conventions. The Solomon Islands has ratified only the 1961 Convention on Narcotics Drugs. Papua New Guinea has ratified the 1961 and 1971 Conventions and adherence to the 1988 Convention is under discussion.

Policy responses

The identification of key organisations involved in policy and illicit drug-related initiatives was undertaken through a consultation process with key informants.

Regional and country structures

Pacific Islands key policy and law enforcement activities are conducted through the Pacific Islands Forum Secretariat at a regional level.

The Secretariat of the Pacific Community (SPC) has a regional public health role.

In Fiji, the National Substance Abuse Advisory Council (NSAAC), established in 1999 and organised under the Ministry of Education, focuses on promoting a healthy lifestyle and safe drinking practices, while promoting actions and advice to minimise social and economic harm resulting from alcohol or substance abuse in schools or the community.

In Papua New Guinea, the National Narcotics Control Board is the central government unit responsible for liaison and coordination of drug control policy. The National Narcotics Control Board coordinates activities of anti-drug organisations, churches, schools, and the com-

munity. Its secretariat, the National Narcotics Bureau, is responsible, among other things, for the conduct of surveys and the collation and evaluation of information on consumption, trafficking and manufacture of drugs and convictions for drug-related offences. There is no government authority mandated with the responsibility for precursors.

The Ministries or Departments of Health in island nations such as Samoa, Papua New Guinea and Fiji are responsible for the licit control of narcotic drugs and psychotropic substances.

Combined Law Agencies (CLAGs) are crafted as a response to the new trends in organised crime which pose considerable challenges. The CLAG is developed to facilitate inter-agency cooperation and belongs equally to all agencies participating. CLAGs are currently being established in Samoa, the Solomon Islands and Vanuatu.

Regional drug control policy

Presently, there is no overall regional or country-based drug policy in the Pacific (personal communication, Forum Secretariat, 2005). The inability of current illicit drug legislation within the region to provide a common base for law enforcement agencies to operate from at both a national and regional basis was noted with some concern at a recent Forum Regional Security Committee (FRSC) meeting (personal communication, Forum Secretariat, 2005). Legislation is not keeping pace with advances in technology, such as access to computers and financial records, the internet, ATS products and the issue of controlled deliveries, and there are no regionally consistent penalties.

In 2002, a joint working group was established to develop a common approach across the Pacific to illicit drug control. This working group consists of the South Pacific Chiefs of Police Conference (SPCPC), the Oceania Customs Organisation and the Forum Secretariat (personal communication, Forum Secretariat, 2005).

The working group has assessed current legislation and developed new legislation for illicit drug control. The purpose of the Bill (Illicit Drugs Control Bill draft, 2002) is to repeal existing laws and put in place laws addressing aspects of illicit drugs trade that have not otherwise been addressed under current laws or that require strengthening to allow for more effective investigation and enforcement (personal communication, Forum Secretariat, 2005).

Forum Secretariat leaders have signed off on the Bill and endorsed its adaptation to local environments (personal communication, Forum Secretariat, 2005). The Bill calls for illicit drug legislation to be consistent in the region with respect to: offences, penalties, classes of illicit drugs, and investigation and enforcement (search, seizure and forfeiture). The Illicit Drugs Control Bill has been used as the basis of legislation in Tonga, Fiji and the Northern Mariana Islands (personal communication, Forum Secretariat, 2005). Director of the National Narcotics Bureau, Papua New Guinea, reported in a press release (Ruahma'a, 2004) that the Bill would be brought to Parliament for approval during the June 2004 session. More recent information regarding the progress of the Bill in Papua New Guinea was unable to be obtained.

Table A14.5. Adherence to narcotics treaties by Pacific countries

Countries	1961 Convention on Narcotics Drugs	1971 Convention on Psychotropic Substances	1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances
Fiji	+	+	+
Papua New Guinea	+	+	– (under discussion)
Samoa	–	–	–
Solomon Islands	+	–	–
Tonga	+	+	+
Vanuatu	–	–	–

Source: United Nations Office on Drugs and Crime, 2003

Law enforcement

In general, the principal law enforcement agencies in the region are the Police and the Customs and Excise Department, as well as Immigration (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003). However, more recently the region has taken a whole-of-government approach to transnational crime issues and is working closely with the Navy, Defence, Police and Customs (personal communication 2005, Forum Secretariat).

Due to a lack of resources, training and the constraints of ineffective legislation, the police and customs administrations have difficulties fulfilling their extended role as drug enforcement agents and generally cooperate with other countries on illicit drugs enforcement as needed (Drug Enforcement Administration, Intelligence Division, 2004; Nejo, 2001; United Nations Office on Drugs and Crime, 2003).

Some of the law enforcement initiatives set up to respond to illicit drug issues are:

- The Pacific Transnational Organised Crime Coordination Centre: this is an information/intelligence collection point for national and transnational crime issues. The centre is staffed with an Australian Federal Police mentor, police from Vanuatu, Fiji, Samoa and Customs. The centre also has short-term attachments to other islands on a rotating basis.
- The Australian Federal Police funds Transitional Crime Teams: these are located in Fiji, Vanuatu, Samoa, Tonga and Papua New Guinea; the Solomon Islands will have a team this year.
- South Pacific Chiefs of Police Conference
- Oceania Customs Organisation
- Pacific Immigration Directors Conference – policy and legal issues
- Pacific Regional Policing Initiative (PRPI) – The initiative operates in Fiji. It is a long-term commitment by the governments of Australia and New Zealand to the development of policing services that will be valued throughout Pacific Island Forum member countries. The goal is to contribute to a safer, more secure and stable environment in Forum island countries. This objective will be pursued over the initial five-year life of the program, which commenced on 20 January 2004.

Penalties

In the Solomon Islands prosecution for cannabis use and kwaso brewing around Honiara is severe. Under Solomon Islands law, the penalty for use and possession of cannabis is imprisonment of 10 years or \$2000 fine. Penalties for first-time offenders are 6 months imprisonment or \$500 fine. Penalties for making kwaso are imprisonment for 3 years or \$1200 fine, or both imprisonment and a fine. Penalties for selling kwaso are \$200 fine for first offence, and \$400 fine for every offence thereafter (Save the Children, no date).

Some of the offences stated in the Illicit Drugs Control Bill (Fiji) relating to trafficking are:

- The unlawful import or export of an illicit drug may result in a maximum fine of \$1,000,000 or a sentence of life imprisonment upon conviction.
- Any person without lawful authority who knowingly possesses or trades in any controlled chemicals and/or equipment for the purpose of committing an offence ... will be liable upon conviction to a fine of up to \$250,000 or to imprisonment for up to 10 years.

Treatment/demand reduction

There is limited publicly available documented information on prevention and treatment interventions for drug users in the Pacific. Discussions with key informants point to the same conclusion – with the exception of the northern Pacific, programs or interventions do not specifically target drug users. Drug use/abuse issues are generally targeted as part of life counselling or other programs undertaken by NGOs and churches: topics include employment, family conflict, sexually transmitted infections, marijuana use/abuse, alcohol (particularly homebrew), unplanned pregnancies, and domestic violence.

The psychiatric units in Port Moresby General Hospital and some other hospitals in the provinces, and the National Psychiatric Hospital located at Laloki (outskirts of Port Moresby) treat some patients whose condition is linked to drug use (in the main alcohol and cannabis).

As in Papua New Guinea, treatment of drug use issues in Fiji and the Solomon Islands is conducted by general or psychiatric hospitals. For example, St Giles Hospital in Fiji treats people who experience cannabis-induced psychoses.

A14.6 References

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Appendix B: Regional aid projects, in full

B1. International regional efforts

UNODC

The United Nations Office on Drugs and Crime (UNODC) is mandated to coordinate and lead United Nations drug control activities. In East Asia and the Pacific, it provides financial and technical assistance to address illicit drug production, trafficking and abuse problems, as well as related legislative and institutional reforms. UNODC also assists governments to comply with the International Drug Control Conventions.

UNODC activities can be divided into three main areas:

- demand reduction
- supply reduction
- legislation and law enforcement

Project title

Reducing HIV Vulnerability from Drug Abuse (AD/RAS/02/G22)

Aims

The primary objective of the regional project is to foster a concerted approach to drug use and HIV/AIDS epitomised by an integrated and comprehensive strategy for drug demand reduction, with specific elements for the reduction of drug-related harm, by embedding HIV/AIDS prevention and intervention activities into drug abuse treatments.

Summary

In line with the regional strategies in the area of demand reduction, and in particular HIV/AIDS transmission from drug abuse, the UNODC-executed regional project *Reducing HIV Vulnerability from Drug Abuse (AD/RAS/02/G22)* advocates intersectoral collaboration and integrated work plans by the respective ministries of public health and security to jointly address the HIV/AIDS-injecting drug use interface at national and regional levels.

Timeframe

2002–2005

Percentage of project relating to drugs

100%

Project type

Regional coordination

Funding source

US\$1,400,000

Contact

UNODC Regional Office

*UNODC demand reduction projects***Project title**

Taking Action against Amphetamine-Type Substance (ATS) Abuse in the East Asia and Pacific Region (AD/RAS/00/F15)

Aims

To strengthen the capacity and preparedness of government and non-government agencies for the identification and resolution of emerging ATS-related problems.

Summary

Major outcomes to be achieved:

Regional and national collaborative mechanisms on ATS will be established.

There will be an increased understanding of risk factors for drug abuse among ATS abuser groups.

Prevention programs will be developed and delivered, and evidence-based treatment models will be initiated.

Timeframe

From mid-2000, with duration of five years

Percentage of project relating to drugs

NA

Project type

Demand reduction

Funding source

US\$5,996,700

Contact

UNODC Regional Office

Project title

Subregional Development of Institutional Capacity for Demand Reduction among High Risk Groups (AD/RAS/97/C75)

Aims

To improve the capacity of government and non-government institutions to identify and resolve emerging drug abuse problems among high-risk groups.

Summary

Major outcomes to be achieved:

Assessment methodology will be sustained and readily available in the subregion through identified agencies; understanding of drug abuse risk factors affecting youth in urban areas will be improved; an increased number of choices in selection of national program models to prevent or reduce the risks of drug abuse will exist; the confidence of the respective governments in program planning for risk reduction will be increased; and national institutions will be recognised for their actual and potential contribution to the reduction of high-risk drug abuse.

Timeframe

1999-ongoing

Percentage of project relating to drugs

NA

Project type

Demand reduction

Funding source

US\$1,889,800 (UK: \$1,780,000; Canada: \$45,000; required funds: \$64,800)

Contact

UNODC Regional Office

Project title

Improvement of Drug Abuse Data Collection Systems (AD/RAS/97/C73)

Aims

To improve the design and operations of drug abuse information systems within the subregion of East Asia and the Pacific.

Summary

Major outcomes to be achieved:

Basic infrastructure, coordinating mechanisms, and data collection procedures will be established in the respective countries; a core group of national trainees in data collection, analysis and interpretation will exist; drug abuse information systems in the participating countries will be operational; and a basis for subregional exchange of drug abuse information will be created.

Timeframe

2001-2005

Percentage of project relating to drugs

NA

Project type

Demand reduction

Funding source

US\$1,755,400

Contact

UNODC Regional Office

Project title

Reducing Illicit Drug Use in the Highlands of East Asia (AD/RAS/96/B53)

Aims

Project objective: To develop community, national and subregional capacities to reduce illicit use of drugs and related social problems among selected minority groups.

Summary

Major outcomes to be achieved:

Community-based drug demand reduction projects with socio-economic development components will be designed and implemented in selected localities. Network of advocates for the socio-economic development of highland communities will be established.

Timeframe

NA

Percentage of project relating to drugs

NA

Project type

Demand reduction

Funding source

NA

Contact

UNODC Regional Office

*UNODC alternative development projects***Project title**

Alternative Development Cooperation in East Asia (AD/RAS/00/C96)

Aims

To improve the effectiveness of alternative development projects through increasing knowledge, skills and capabilities of practitioners and policy makers in national agencies, sharing of lessons and experience, and networking between relevant development agencies.

Summary

Major outcomes to be achieved:

National capacity building and lessons sharing programs will be designed and conducted to strengthen knowledge and skills of policy makers and practitioners and to promote sharing of knowledge and experience on alternative development in East Asia. A comprehensive and accessible pool of knowledge on alternative development approaches, farmer experience, and the link to development effectiveness will be established in the subregion.

Timeframe

2000–ongoing

Percentage of project relating to drugs

NA

Project type

Alternative development

Funding source

Australian Government: US\$315,840

Contact

UNODC Regional Office

Project title

Monitoring and Verification of Opium Poppy Cultivation (AD/RAS/98/C25)

Aims

Project objective: To establish an objective and accurate method for monitoring and verification of opium poppy production that will employ internationally recognised methodology for general application.

Summary

Major outcomes to be achieved:

An internationally acceptable methodology for poppy monitoring and verification that employs the use of satellite, aerial and ground survey data will be developed. The validity of the system will be tested in the project area and the results of the technical design will be made available to other countries.

Timeframe

NA

Percentage of project relating to drugs

NA

Project type

Alternative development

Funding source

NA

Contact

UNODC Regional Office

UNODC law enforcement projects

The Law Enforcement Program comprises 12 ongoing projects (2 subregional action plan (SAP) projects and 10 other subregional projects). Two ongoing SAP projects are:

Project title

Development of Cross-Border Law Enforcement Cooperation in East Asia (AD/RAS/99/D91)

Aims

Suppression of drug trafficking

Summary

This phased project will progressively develop and expand in order of priorities the operational effectiveness of law enforcement agencies across and along the borders of countries which are party to the Memorandum of Understanding (MOU) and the Subregional Action Plan on Drug Control. The project will be implemented in two phases with the China–Laos, China–Myanmar and China–Vietnam borders to be covered by the first phase. The second phase will address identified needs at the Cambodia–Thailand, Cambodia–Vietnam, Laos–Thailand, Laos–Vietnam, Myanmar–Laos and Myanmar–Thailand borders. This will mainly entail building national and regional cooperation and enabling cross-border personnel to work as a team. The key components will be workshops and specialised training to develop skills and knowledge of drug control, initiatives to engender trust and confidence, and structures that favour close liaison. Enforcement activities conducive to trust building, practical and daily collaboration will be identified and encouraged.

Timeframe

Six years and three months (1999–2005)

Percentage of project relating to drugs

NA

Project type

Law enforcement

Funding source

Japan US\$2,809,100

Contact

UNODC Regional Office

Project title	Funding source
<i>Precursor Control in East Asia (AD/RAS/01/F34)</i>	US \$1,793,700
Aims	Contact
To control the traffic of precursor chemicals in East Asia	UNODC Regional Office
Summary	<i>Other ongoing projects</i>
In broad terms the overall strategy of the project is to suppress existing heroin and methamphetamine manufacturing centres through intensive action against precursor trafficking in these areas; prevent the establishment of new manufacturing centres of synthetic drugs in the region by improving precursor control in susceptible countries; assist MOU countries to further strengthen precursor control measures; and to promote cooperation among countries in the region.	<ol style="list-style-type: none"> 1. Support to Law Enforcement in East Asia and the Pacific (AD/RAS/99/D82) 2. Enhancement of Computer-Based Drug Law Enforcement Training (AD/RAS/97/C51) 3. UNODC Global e-Learning for Drug Control and Crime Prevention (AD/GLO/03/H17) 4. Expansion of Enhancement of Drug Law Enforcement Training (Computer-Based Training) (AD/RAS/02/G53) 5. UNODC Participation in the ASEM Anti-Money Laundering project (AD/RAS/02/G44) 6. Expansion of Computer-Based Drug Law Enforcement Training in the Pacific (AD/RAS/05/I11) 7. Computer-Based Training (CBT) Module on Human Trafficking (FS/RAS/03/R59)
Intensified control of licit trade and suppression of illicit trafficking in MOU countries; strengthened capacity of vulnerable countries neighbouring the MOU countries to prevent domestic and regional diversion and trafficking of precursors; enhanced cooperation among countries in East and Southeast Asia to prevent diversion and trafficking of precursors used by clandestine laboratories.	<i>New law enforcement projects planned to be launched in 2005</i>
Timeframe	Scientific Support to Strengthen Regulatory and Law Enforcement Control of ATS and Their Precursors in East, South and Southeast Asia (AD/GLO/03/H44)
Four years	
Percentage of project relating to drugs	
NA	
Project type	
Law enforcement	

United States Drug Enforcement Administration

The United States provides law enforcement training in the region. The US Drug Enforcement Administration (DEA) regularly offers training courses in the Pacific region.

USAID

Region

Mekong Region

Project implementer

Centre for Harm Reduction

Project title

Capacity Building for Drug Use Related HIV/AIDS

Aims

To build capacity of NGO, government and community-based organisations working with injecting drug users to strengthen HIV prevention, care and support services.

Summary

Developing and adapting technical and training resources for comprehensive introduction to drug use-related HIV/AIDS intervention and care in the Mekong Region.

Timeframe

1 year

Percentage of project relating to drugs

100%

Type of project

Technical assistance and training

Reports to

Family Health International, Asia Pacific Division

Funding source

USAID – Family Health International

Contact

Danielle Alford

US Bureau for International Narcotics and Law Enforcement Affairs (INL)

Region

Thailand, Vietnam, Lao PDR, Yunnan Province China

Project implementer

UNESCAP – Emerging Social Issues Division, Health

Project title

Reducing drug abuse and delinquency among youth in Thailand, Vietnam, Lao PDR, Yunnan Province China

Aims

More effective and comprehensive community-based treatment interventions will be in place to reduce problematic drug abuse among young people.

Summary

Phase II will build on Phase I which developed and delivered a train-the-trainer course covering an overview of youth drug use, prevention, treatment and continuing care, which was then delivered in each country, and a training manual on ‘Young People’.

Timeframe

2005

Percentage of project relating to drugs

100%

Project type

Treatment

Funding source

US Bureau for International Narcotics and Law Enforcement Affairs

Contact

Dr John Howard

Japan International Cooperation Agency (JICA)

Project title

Regional technical cooperation promotion program

Aims

Accurate drug analysis will be used practically to strengthen law enforcement capabilities in Cambodia, Laos, Myanmar, Vietnam and Thailand (CLMVT). Core staff of laboratories in CLMVT countries will acquire the knowledge and techniques on qualitative and quantitative analysis. Moreover, at least one drug analyst in CLMVT countries will acquire the knowledge and techniques on impurity analysis. During 2003 the JICA provided the National Authority for Combating Drugs with laboratory equipment and training of NACD laboratory specialists.

Timeframe

June 2002 (3 years)

Funding amount

NA

B2. Australia's regional efforts

Customs

World Customs Organisation (WCO)

Australian Customs contributes to World Customs Organisation (WCO) initiatives to counter the illegal traffic in narcotics. Information is shared with the Regional Intelligence Liaison Office for Asia and the Pacific, currently based in Beijing.

Oceania Customs Organisation (OCO)

Australia is an active Member of the OCO and works very closely with the OCO Secretariat. Australia is a member of the current advisory committee and is contributing to the development of the Regional Trade Facilitation Program, funded by AusAID and NZAID. As a member of the OCO, Australia delivers capacity-building assistance to fellow members as necessary and able.

Bilateral agreements

Australian Customs has taken a strong role in promoting cooperation among law enforcement agencies in the Pacific region. This cooperation encompasses the range of Customs activities including those relating to narcotics. In many cases this cooperation is encompassed in a bilateral agreement or a memorandum of understanding. Australian Customs has longstanding agreements in place with its counterpart agency in Hong Kong, New Zealand, Korea and Papua New Guinea. More recently agreements have been signed with: Indonesia (March 2003), Japan (June 2003), Fiji (October 2003), Thailand (December 2003) and China (April 2004).

Overseas posts

Customs has senior Australian representatives in six locations – Bangkok, Beijing, Brussels, Jakarta, Tokyo and Washington. Their duties include representing Customs at a wide range of narcotic-related meetings, seminars, conferences and working groups.

Project PRISM (*Precursors Required for Illicit Synthetic Manufacture*)

In recognition of the international nature of the diversion of precursor chemicals for illicit drug manufacture, Australia is participating in the International Narcotics Control Board's Project PRISM. Customs was recently appointed as the Central National Authority (CNA) for Australia's involvement in Project PRISM. The aim of Project PRISM is to prevent the diversion of amphetamine-type substance (ATS) precursors into illicit drug manufacture. As the CNA, Customs acts as the single contact point for domestic and international agencies in relation to Project PRISM requests and activities in Australia. Customs has also recently joined the Project PRISM Task Force, the central governing body of Project PRISM, as the regional focal point for Oceania.

CAPERS

Customs also works to foster international initiatives with narcotic-related applications. For example, Customs co-sponsors the Customs Asia Pacific Enforcement Reporting System (CAPERS), an internet-based secure communication platform.

Joint cross-border patrols

Australian Customs vessels have continued to support joint cross-border patrols by law enforcement officials from Australia and Papua New Guinea. The extended patrols visit remote coastal villages and island communities in the Torres Strait and the Western Province region of Papua New Guinea.

AusAID

Leadership role

Australia has taken a leadership role in the Asia-Pacific region on HIV/AIDS, which has been recognised by the Development Assistance Committee and Executive Directors of the Global Fund and UNAIDS.

Australia's programs in the Asia-Pacific region draw on Australian expertise to work in countries with increasing HIV prevalence rates such as Papua New Guinea (\$60 million over five years) and Indonesia (\$35 million over five years). While recognising the significant need to combat HIV/AIDS in Africa and other regions, Australia is a key donor in the Asia-Pacific region and gives priority to helping our closest neighbours.

The link between IDUs and HIV/AIDS and AusAID's HIV/AIDS strategy

The efficiency with which injecting drug use can transmit HIV means that it has emerged as a principal driving force for the epidemic across much of Asia. At least 50 per cent of IDUs in Thailand, Burma (Myanmar), Vietnam and Malaysia were estimated to be HIV positive in 2001.

In response to the strong link between injecting drug use and HIV transmission throughout much of Asia, a greater focus on tackling issues around the harm associated with injecting drug use will be required. Without a focus on HIV transmission between and from IDUs, the effectiveness of HIV/AIDS interventions within Asia will be limited and epidemics will continue to spread into the general population.

AusAID launched Australia's 'International HIV/AIDS Strategy: Meeting the Challenge' in July 2004. One of the five priorities identified within the strategy for HIV/AIDS programs within Australia's development cooperation program is 'Addressing HIV Transmission Associated with Injecting Drug Use'.

The Strategy states that:

AusAID will increase the emphasis on minimising the harm associated with injecting drug use. This will include access to clean needles and syringes and their safe disposal, effective drug treatment programs, peer-outreach and education programs that include targeted social marketing of condoms. It will also include access to voluntary counselling and testing for IDUs. AusAID will focus on expanding programs and facilitating their integration at the national level.

Prisons are an important area for implementation of HIV/AIDS initiatives. A very high proportion of custodial sentences within Asia are drug-related and there is an undoubtedly strong link between drug use, prisons and HIV/AIDS. International research shows that 50–75 per cent of prisoners have injected drugs before entering prison and as many as 25–50 per cent continue to inject within prison. Restricted access to injecting equipment increases the frequency of sharing and the risk of HIV transmission. AusAID will therefore include prisons in harm reduction initiatives, where applicable.

Issues of drug use and HIV/AIDS usually overlap multiple sectors, including health and law and order. AusAID programs will therefore seek commitment from and to coordinate efforts with the appropriate ministries and agencies. Advocacy to gain acceptance of these strategies by policy makers remains a major priority. In Vietnam, Australia is building institutional capacity in the law enforcement and health sectors to raise their awareness and capacity in relation to effective strategies to prevent HIV transmission among and from IDUs; and to build collaborative linkages between law enforcement and health authorities so that both sectors work together to develop a supportive policy environment for effective future interventions.

AusAID programs addressing HIV/AIDS associated with injecting drug use will be aligned, where possible, with wider national drug control policies and recognise the role of existing demand and supply reduction and other strategies.

Global Fund

Australia continues to actively engage with the Global Fund at both the headquarters and country level. Australia works closely with the Global Fund Country Coordinating Mechanisms in our region, taking an active part in helping the Global Fund achieve the best possible results in the Asia-Pacific region.

Leadership statement

Australia is pleased to note that the recent Leadership Statement on Injecting Drug Use, endorsed by nations at the International AIDS Conference, held in Thailand in July 2004, recognised that 'HIV/AIDS epidemics among injecting drug users can be prevented, stabilised and even reversed by timely and vigorous harm reduction strategies'.

Asia Pacific Leadership Forum

The Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) is a strategy aimed at engaging political and civil society leadership to reduce the spread and impact of the HIV/AIDS epidemic in the Asia-Pacific region. The APLF seeks to achieve this goal by increasing political leadership for effective national and regional action against the epidemic. The APLF provides decision makers and leaders in the region with opportunities to learn and apply strategies for extra-ordinary responses that have high-level political support.

Australia views the APLF as an important mechanism to promote high-level leadership for effective regional and national action on HIV/AIDS. Our recent announcement at the Second Asia-Pacific Ministerial Meeting of a new three-year \$3 million commitment to the APLF reflects the importance Australia attaches to this strategy.

UNAIDS' Three Ones Principles

Australia endorsed the Three Ones Principles at a meeting of donors on 24 April 2004. The principles aim to speed up action and make efficient and effective use of resources at the country level through strengthened coordination and partnerships.

The Three Ones are:

One agreed HIV/AIDS Action Framework that drives alignment of all partners.

One national AIDS authority, with a broad-based multisectoral mandate.

One agreed country-level monitoring and evaluation system.

Major current AusAID-funded programs

Asia Regional Program

Current activities totalling \$11 million focus on vulnerable mobile populations and on reducing HIV transmission through injecting drug use. Further activities estimated at \$12 million for support to high-level advocacy, associated national activities and UN HIV-related task forces are under consideration. The regional \$2 million drugs initiative will help support measures to reduce HIV transmission through drug use.

Indonesia

The HIV/AIDS Prevention and Care Program totals \$34 million over five years. It aims to build capacity to respond to the dual epidemics in Indonesia, one through injecting drug use and another through heterosexual transmission.

World Health Organization

Scaling-up HIV/AIDS/STI Prevention among Injecting Drug Users in the Asian Region project, totalling approximately \$500,000 per year.

Engagement with UNODC

The Asia-Pacific region is an area affected both by the production of illicit drugs and, increasingly, by the consumption of illicit drugs. In particular, Myanmar, Laos and Cambodia are emerging as areas of growing consumption. With the incidence of HIV/AIDS on the rise, and the increasing evidence that HIV/AIDS is linked to injecting drug use, we need to ensure that attention is being focused on these regions.

The Australian Government has consistently taken a strong stand against the abuse of illegal narcotics and recognises the importance of effective international cooperation to combat this global challenge. Australia is committed to support UNODC as a critical partner in the global fight against illicit drugs and would welcome an increased focus by the UNODC on issues concerning illicit drugs in the Asia-Pacific region. In particular, the Mekong area is the second largest producer of opium in the world and many communities that grow opium are struggling day to day to meet their basic needs.

Australia is also particularly keen for UNODC to focus discussions on amphetamine-type substances (ATS) – their production, consumption and trafficking. ATS is of particular concern for the Asia-Pacific region: The 2004 International Narcotics Control Board report notes that while the Greater Mekong Region has had substantial success in reducing opium and heroin production, it is now becoming a major producer of ATS and that there has been a rapid growth in illicit drug consumption in the region. The consumption of ATS, specifically ATS and injecting drug users, is also a concern in the region with regard to the spread of HIV/AIDS.

To ensure that the international community is able to provide the best advice in their policies and programs, Australia strongly encourages UNODC to better evaluate each of its activities and draw on lessons learned.

*AusAID global and regional projects***Project title***Annual Core Contribution to General Purpose Funds***Aims**

Annual core contribution to UNODC. Funds provided to the general purpose funds of UNODC and an untied voluntary contribution used to fund the support budget and to provide program flexibility by allowing investment in priority areas which have not attracted special purpose/earmarked contributions. Since 1991, a total of \$9,844,766 has been provided to UNODC. Since 2001, 50 per cent of the core funding has been earmarked to UNODC Regional Office in Bangkok where it is used to support the ACCORD (see below).

Timeframe

1991–ongoing

Funding amount

\$9,844,000 since 1991

Project title*Core Contribution – Regional Cooperative Mechanism to Monitor and Execute the ACCORD Plan of Action***Aims**

To establish and maintain a flexible and suitable coordination mechanism to facilitate the execution of the ACCORD Plan of Action among participating countries and partners; to monitor progress; to exchange information and in-depth analysis on drug control trends in the region.

Funding amount

AU\$800,000 since 2003–04

Projects in Regional East Asia – China, Laos, Burma, Thailand and Vietnam**Project title***Mekong Drugs Initiative – Alternative Development Cooperation in East Asia, Phase 1***Aims**

Alternative development.

Rationale: Following the Minister's announcement of \$1 million for drug control activities in the Mekong Basin, Australia signed an agreement with UNDCP, providing for whole or part funding of initiatives in demand reduction and alternative development. These activities are seen as complementary in addressing health and poverty aspects of illicit drug use. There was a policy preference for regional activities including Burma, which was the major source of heroin reaching Australia at that time.

Activity description: The project aims to improve efficiency of alternative development efforts, cross-border cooperation and networking of alternative development agencies. The short-term objective is to improve the skills and capabilities of policy makers and practitioners in national agencies relevant to the alternative development effort. Funding to support Narcotics Drug Control Commissions from China, Laos, Burma, Thailand and Vietnam – Alternative Development Cooperation in East Asia.

Timeframe

2000–2003 (project completed)

Funding amount

AU\$500,000

Project title*Colombo Plan Drug Advisory Program to Implement the Enhancing Life Skills/Social Competence Skills in Preventative Drug Education in South East Asia Project***Aims**

Demand reduction.

Rationale: Australia's initial contribution of \$120,000 was provided for Enhancing Life Skills/Social Competence Skills in Preventative Drug Education in South East Asia. The program was seen as having important regional impact and has produced valuable information and education materials, and Australia has continued to contribute \$30,000 per year as a recognised whole-of-government priority. Information and awareness raising.

Activity description: The project aims to reduce the incidence of drug use among school children by enhancing their life skills or social competence skills to resist the lure of drugs.

Timeframe

2001–ongoing

Funding

AU\$150,000 to date

Project title

UNODC Computer-based Law Enforcement Training Project

Aims

Law enforcement.

Rationale: This project aimed to provide a standardised, simulated problem-solving approach for drug law enforcement in Cambodia, China, Laos, Burma, Thailand and Vietnam.

Activity description: This project will develop interactive training programs for customs, police and specialist drug law enforcement officers in Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam.

Timeframe

2003–2004 (project completed)

Funding amount

AU\$100,000

Project title

Strengthening of Judicial and Prosecutorial Drug Control Capacity in East Asia

Aims

Law enforcement.

Activity description: This project will strengthen the judicial and prosecutorial capacity of Cambodia, China, Laos, Myanmar, Thailand and Vietnam to administer national drug control legislation and support subregional cooperation. A program of in-country legal training for drug control by national institutions to meet the specific needs of the countries and a mechanism for developing and implementing Mutual Legal Assistance Agreements and other initiatives to facilitate subregional cooperation will be established.

Timeframe

1999–2004 (project completed)

Funding

Part of core contribution to UNODC

Projects in Regional Southeast Asia – Greater Mekong subregion countries**Project title**

Support for Memorandum Of Understanding Partnership in East Asia

Aims

Law enforcement.

Activity description: This project is an instrument to put into action the commitment made by Greater Mekong subregion countries outlined in the 2002 Addendum on Partnership to the MOU with UNODC. The project aims to further strengthen the MOU consultative process and the development of and implementation of the rolling SAP through increased direct participation of the MOU governments and to expand efforts to broaden civil society involvement in drug policy.

Timeframe

2004–2006

Funding

Part of core contribution to UNODC

Projects in Regional Southeast Asia – Cambodia, China, Lao PDR, Myanmar, Thailand, Vietnam, Indonesia, Malaysia, Philippines**Project title**

Precursor Control in East Asia

Aims

Supply reduction.

Activity description: The project is aimed at curtailing the rampant diversion and trafficking of precursors in East Asia as the means to reduce manufacture of heroin and ATS in the region. It intends to achieve the goal by continuing to strengthen precursor control in Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam, where diversion and trafficking of precursors are most serious; improve control of illicit trade in precursors in Indonesia, Malaysia and the Philippines to prevent further development of ATS manufacture in these countries; and to enhance regional cooperation between countries in East Asia to address the regional problem.

Timeframe

2001–2006

Funding

Part of core contribution to UNODC

Projects in Regional East Asia**Project title**

Strengthening Drug Demand Reduction Programs in East Asia and the Pacific

Aims

Demand reduction.

Activity description: To strengthen the development of demand reduction programs in East Asia (with a particular focus on MOU countries).

Timeframe

1998–2005

Funding

Part of core contribution to UNODC

Projects in Regional South Asia – China, Burma and Vietnam**Project title**

Asia Regional HIV/AIDS Project (ARHP)

Aims

Reduction of HIV/AIDS transmission.

Rationale: The project supports regional action to strengthen the capacity of countries to take a more strategic and evidence-based approach to policy making, planning and programming for reducing HIV transmission through injecting drug use. Taking a regional approach to this aspect of HIV epidemics facilitated cooperation between sectors and countries that was less feasible using bilateral approaches.

Activity description: The goal of the project is to reduce HIV vulnerability, transmission and impact in the Southeast Asia region. The strategic approach used is to reduce HIV harm associated with injecting drug use. The project will respond to the needs for regional support of selected countries which are especially vulnerable to the injecting drug use-related epidemic (China, including Yunnan and Guangxi provinces, Burma, Vietnam). ARHP provides \$9.5 million to support regional action to strengthen the capacity of countries to take a more strategic and evidence-based approach to policy making, planning and programming to reduce HIV-related harm associated with injecting drug use. While the major project activities will be country-based, linkages will be built to regional bodies so that lessons learnt will have a regional impact, and will encourage neighbouring countries to support the target countries' exploration of interventions.

Timeframe

April 2001 – July 2005

Funding

AU\$9,500,000

Project implementers

Guangxi Center for HIV/AIDS Prevention and Control

Projects in Regional Pacific**Project title**

Maritime Security in the Pacific Project

Aims

Law enforcement.

Rationale: Shipping is vital to trade in the Pacific region but is threatened by terrorism and other transnational crimes such as piracy, drug trafficking and people-smuggling. Maritime transport is also a security risk factor for national governments in the region including Australia. Most Pacific Island countries (PICs) lack the necessary governance mechanisms, such as cohesive maritime policy or an adequate legislative and planning framework, to meet new international legal standards.

Activity description: The project aims to help Pacific Island maritime institutions cope with the rapidly changing regulatory environment, particularly as they relate to the security concerns in the maritime sector. To be run out of the Secretariat of the Pacific Community's Regional Maritime Programme (RMP), the focus of the project is to assist PICs to meet international security and safety standards in shipping and ports. It also provides support to continuing institutional development and training initiatives, recognising that security concerns cannot be addressed in isolation from other challenges in the sector.

Timeframe

Jan 2005–2007

Funding amount

AU\$3,000,000

Project title

Pacific Regional Policing Initiative

Aims

Law enforcement.

Rationale: Announced jointly with the Prime Ministers of New Zealand and Fiji in August 2003 at the Auckland Pacific Islands Forum leaders' meeting. The Pacific Regional Policing Initiative (PRPI) represents a significant long-term commitment to policing which will be available to all Forum member countries.

Activity description: The fundamental focus of the PRPI is on improving basic policing skills through training and other practical assistance to enhance the operational and investigative capability of police officers. Regional Training Teams will develop curricula and training materials for basic police skills at the Fiji Police Training Academy. Training will be delivered both in Suva and around the Pacific, according to demand and the training needs of individual countries. The PRPI will involve police at all levels, from new recruits through to senior management and police executives – up to 900 Pacific police will receive training each year.

Timeframe

Jan 2004–2008

Funding amount

AU\$17,000,000

Projects in Regional Asia and Pacific**Project title**

Support to Drug Law Enforcement in East Asia and the Pacific

Aims

Law enforcement.

Activity description: The project's objective is to increase the capacity of drug law enforcement agencies in East Asia and the Pacific to develop and implement effective drug control programs. Strategic, operational and technical advice provided to governments of the region will aid the development, implementation and evaluation of the programs/projects in the fields of law enforcement and criminal justice at national and subregional levels. In addition, the project will monitor, analyse and report on drug control issues, particularly those related to law enforcement. The main input will be services of a Regional Law Enforcement Adviser posted to UNDCP Regional Centre, Bangkok.

Timeframe

1999–2005

Funding

Part of core contribution to UNODC

Project title

Development of Global Guidelines and Training Resources on Preventing HIV Transmission among Injecting Drug Users – Phase 3

Aims

Reduction of HIV/AIDS transmission.

Activity description: This project follows on from two previous grants provided to the World Health Organization of \$500,000 each in 2002 and 2003 for the project 'Scaling up of HIV/AIDS/STI prevention efforts in the Asia-Pacific region with a focus on vulnerable populations'. Phase 3 will focus on strengthening country capacity to scale up harm reduction programs in Phase 2 countries and develop country capacity to do so in countries like India, China, Nepal and Thailand.

Objectives: To provide normative guidance; strengthening WHO's capacity to respond to the needs of countries; strengthening the capacity of countries to implement and scale up harm reduction programs.

Timeframe

2003–2004 (project completed)

Funding amount

AU\$1,510,000

Australian Federal Police

The Australian Federal Police (AFP) has strong cooperative operational and intelligence relationships with overseas law enforcement agencies through the AFP International Network. As at 31 January 2005, the AFP International Network comprised 65 people located in 26 countries. The network comprises 47 liaison officers, five analysts, three attachments to Interpol, and one short-term attachment in Fiji.

The AFP's international capability is further augmented through the International Deployment Group and Law Enforcement Cooperation Program (LECP), which seek to build capacity and enhance cooperation with overseas law enforcement agencies. Major activities include the missions into Papua New Guinea, the Solomon Islands, Nauru and Timor-Leste.

Goals of the Law Enforcement Cooperation Program include:

- strengthening the capability of overseas law enforcement agencies to gather information and evidence against illicit drug traffickers through education and training programs for the practitioner and modest provision of equipment;
- developing a greater capacity to meet Australia's international priorities by being able to more effectively gather international law enforcement intelligence to support AFP operations;
- improving law enforcement infrastructure of specified countries within the program and operational understanding of international crime; and
- fostering closer personal and institutional linkages.

Recent relevant LECP initiatives include:

- facilitating significant joint operational activities with Malaysia, Fiji and Thailand through the provision of personnel and equipment to assist the promotion of joint investigations into major narcotics syndicates operating across multiple jurisdictions, including Australia
- the provision of training and equipment to the Samoan Police Service to develop its internal security capacity for hosting major events
- funding the establishment of the Pacific Transnational Crime Coordination Centre in Suva, Fiji, and Transnational Crime Units in Fiji, Samoa, Tonga, Vanuatu and Papua New Guinea
- funding the placement of a full-time AFP program manager and Pacific Island police officer in the South Pacific Chiefs of Police Secretariat in Wellington, New Zealand
- the ongoing provision of specialised police training courses to foreign law enforcement agency partners in Asia, the Pacific and the rest of the world.

In late 2004, the AFP hosted the 3rd Asia Region Heads of Criminal Intelligence Working Group in Hong Kong. Delegates from 18 agencies in 15 Asian countries participated in the working group in addition to observers from seven other agencies who attended to provide their experience in criminal intelligence. The working group achieved a number of productive outcomes in the form of broad regional development needs, strategies and potential projects to be pursued.

In late 2003, the AFP hosted the 32nd annual South Pacific Chiefs of Police Conference (SPCPC) in Brisbane. Delegates from 21 member countries and a number of observers from other law enforcement agencies attended. Delegates achieved a number of important outcomes including the drafting of a strategic plan for the SPCPC.

International projects undertaken by Australian organisations

Project title

A Review of Drug Injection and HIV in Prison

Summary

This desk review reported HIV prevalence and transmission and levels of injecting in prison in developing and transitional countries.

Timeframe

8 months

Percentage of project relating to drugs

100%

Project type

Research

Reports to

UNAIDS

Funding source

UNAIDS

Contact

Program of International Research and Training, Kate Dolan

Project title

A Review of HIV Prevention among Young Injecting Drug Users

Summary

To review HIV prevention programs for young injecting drug users and produce a guide for researchers.

Timeframe

6 months

Percentage of project relating to drugs

100%

Project type

Research

Reports to

WHO

Funding source

WHO

Contact

Program of International Research and Training, Kate Dolan

Project title	Project title
<i>Assess the Best Documents on HIV Prevention and Care among Injecting Drug Users</i>	<i>Injecting Drug Use and HIV/AIDS Risk Reduction, Prevention and Treatment</i>
Timeframe	Aims
2 months	To review IDU and HIV/AIDS risk reduction, prevention and treatment for women drug users.
Percentage of project relating to drugs	Timeframe
100%	6 months
Project type	Percentage of project relating to drugs
Education	100%
Reports to	Project type
International Harm Reduction Association	Research
Funding source	Reports to
UNAIDS	Centre for Addiction and Mental Health, Canada
Contact	Funding source
Program of International Research and Training, Kate Dolan	Centre for Addiction and Mental Health, Canada
	Contact
	Program of International Research and Training, Kate Dolan

Project title	Project title
<i>Injecting Drug Use and HIV/AIDS Risk Reduction, Prevention and Treatment Measures for Prison Populations</i>	<i>International Review of Methadone in Prison – ‘Document all countries with prison methadone programs’</i>
Timeframe	Timeframe
6 months	6 months
Percentage of project relating to drugs	Percentage of project relating to drugs
100%	100%
Project type	Project type
Research	Research
Reports to	Reports to
Centre for Addiction and Mental Health, Canada	WHO
Funding source	Funding source
Centre for Addiction and Mental Health, Canada	WHO
Contact	Contact
Program of International Research and Training, Kate Dolan	Program of International Research and Training, Kate Dolan

Project title	Project title
<i>International Review on the Effectiveness of Prison-based Interventions</i>	<i>Assess the Best Documents on HIV Prevention and Care among IDUs</i>
Timeframe	Timeframe
6 months	2 months
Percentage of project relating to drugs	Percentage of project relating to drugs
100%	100%
Project type	Project type
Research	Education
Reports to	Reports to
WHO	International Harm Reduction Association
Funding source	Funding source
WHO	IHRA
Contact	Contact
Program of International Research and Training, Kate Dolan	Program of International Research and Training, Kate Dolan

Project title
<i>Prison-based Syringe Exchange Programs: a review to document various aspects of prison based needle and syringe programs</i>
Timeframe
6 months
Percentage of project relating to drugs
100%
Project type
Research
Reports to
ACT Government
Funding source
Centre for Harm Reduction
Contact
Program of International Research and Training, Kate Dolan

B3. Country efforts

B3.1 Cambodia

Australian Federal Police

The AFP has two liaison officers and an adviser in Phnom Penh. The AFP has assisted in the establishment of a Transnational Crime Coordination Centre in Cambodia to improve intelligence sharing and investigation capacity in the region.

AusAID

Project title

Strengthening the Secretariat of the National Authority for Combating Drugs (NACD) and National Drugs Control Program of Cambodia

Aims

Law enforcement. To establish a multi-sectoral national drug control program and to establish the NACD Secretariat in a sustainable manner as the government's primary institution for national drug control and as the focal point for regional and international drug control cooperation.

Timeframe

April 2001 – September 2005

Funding amount

Part of core contribution earmarked for this project by UNODC.

United Nations Office on Drugs and Crime

Project title

Reducing HIV Vulnerability from Drug Abuse

Aims

Institutions of selected countries in East Asia will adopt effective measures for the prevention and reduction of drug abuse and to strengthen government and non-government responses in Southeast Asia to the drug abuse-related transmission of HIV/AIDS.

Timeframe

April 2002 – March 2004

Funding amount

\$1.4 million (UNAIDS/UK Luxembourg)

Project title

Nationwide Assessment of High Risk Behaviour and Institutional Opportunities for Intervention and Intervention Design among Selected Sub-populations

Aims

To strengthen national capacity for monitoring, evaluation and research through the identification of emerging vulnerability factors and populations at risk of HIV/AIDS transmission through illicit drug use and to develop evidence-based and community-centred interventions designed for selected sub-populations considered as being at higher risk of HIV infection.

Timeframe

December 2002 – June 2005

Funding amount

\$65,000 (from US CDC through UNAIDS)

Project title

Drug Abuse Data Collection Network

Aims

Establishment of a monthly data collection network comprising nine priority provincial drug control committees and selected government and NGO institutions within each province.

Timeframe

2004–ongoing

Funding source

UNODC national project (CMD/F14) in collaboration with ATS data and information systems (RAS/F97) and ACCORD monitoring project in Cambodia (RAS/F73)

Project title	<i>World Health Organization</i>
<i>Community-based Drug Abuse Counselling, Treatment and Rehabilitation Services</i>	Project title
Aims	<i>Injecting Drug Use and Related HIV/AIDS Risk in Phnom Penh and Poipet, Cambodia, using I-RARE</i>
Establishment of service centres in four selected locations.	Aims
Timeframe	To strengthen national capacity to conduct rapid assessments relating to risk behaviour for HIV/AIDS
mid 2005 – end 2008	Timeframe
Funding source	January 2003 – final report 2005
Trust Fund for Human Security – Japan	Funding amount
Funding amount	\$65,000 (US CDC through UNAIDS)
US1.1 million	
Executing agency	
UNODC, Cambodian Ministry of Health, Drug Abuse Forum	

United States Drug Enforcement Agency

The UNODC project office has a good working relationship with the US DEA Bangkok. The US DEA Bangkok periodically seeks and receives cooperation from Cambodian law enforcement agencies on matters of mutual interest.

German technical support

The German Centre for International Migration and Development (CIM) has provided an integrated expert to help support the activities of the NACD, particularly related to demand reduction, treatment and rehabilitation. The expert is located within the NACD Secretariat and will provide capacity building for a period of two years (with possible extension for an additional two years).

Government of Sweden

Sweden has provided support to the development of the drug control sector in Cambodia through the UNODC project (AD/CMB/01/F14) since 2001, totalling over US\$1 million.

United States Centers for Disease Control and Prevention (CDC)

The US CDC provided \$20,000 direct financial support in 2003 for the national workshop in Cambodia. In 2003, the CDC also provided technical assistance and data analysis to the NACD Secretariat and UNODC. Contributions by the CDC to NACD, UNODC, National AIDS Authority and the expanded UN Theme Group on HIV/AIDS throughout 2003 also included skills development in relation to HIV/AIDS issues. The CDC also supported the joint NACD/UNODC project proposal to donors to undertake a national baseline quantitative survey of illicit drug use and associated HIV/AIDS risk.

*UNAIDS and WHO***Project title***Programme Acceleration Fund***Aims**

UNAIDS will undertake the assessment of high risk behaviours and intervention institutional opportunities. WHO will undertake qualitative assessment of HIV/drug use interface.

Timeframe

Information is not available for the UNAIDS aspect of the project. The WHO component is one year in duration, Oct 2003 – October 2004.

Funding amount

US\$65,000 + \$65,000

Funding source

US CDC and UNAIDS

B3.2 China*Australian Federal Police*

The AFP has two liaison officers in Beijing and three liaison officers in Hong Kong.

*AusAID***Project title***Xingjiang HIV/AIDS Prevention and Care Project***Aims**

Injecting drug use is currently the major transmission route for HIV in China. Xingjiang Uygur Autonomous Region has one of the highest incidence rates for HIV in China. The project is supporting local-level implementation of China's new national HIV policy framework, focusing on harm reduction for injecting drug users, including by supporting a needle exchange pilot program and voluntary counselling. The project is currently focused in Yining City, investing in volunteers, training of police and communities.

Timeframe

2004–2007

Funding amount

\$15,000,000

Project title*China Integrated Development Program***Aims**

The hardest-hit areas re HIV are the provinces of Yunnan, Sichuan and Henan mainly due to drug trafficking, prostitution and illegal blood transfusions (Kunming City and Xichang City are both located along the major drug trafficking routes). Thus, HIV/AIDS has become an increasingly significant problem for the local authorities, and information and support services are greatly needed for the population to minimise the risks. The objectives of this project are to reduce the incidence of poverty in three provinces in China through the implementation of a multi-sector integrated development program. Significant outputs include HIV/AIDS Prevention and Support Program.

Timeframe

Sept 2004 – Aug 2005

Funding amount

\$87,000

Project title*Peer-Driven Intervention among IDUs***Aims**

To reduce/stabilise HIV incidence among IDUs in Guigang City

Summary

Using the peer-driven intervention model, which is somehow related to respondent-driven sampling, IDUs are trained to teach peers on safe injection and safe sex practices. Incentives (award system) are used to encourage IDUs to educate their peers.

Timeframe

2 years

Percentage of project relating to drugs

100%

Project type

Intervention; research

Reports to

ABT Associates, Bob Broadhead

Funding source

ABT Associates (via NIDA)

Organisation

Guangxi Center for HIV/AIDS Prevention and Control

Contact

Wei Liu

Project title*HIV Prevention Trials Network (HPTN)***Aims**

Stage 1: To assess HIV sero-incidence among a cohort of IDU and baseline prevalence

Stage II: Currently preparing the site to implement a substitution therapy trial using buprenorphine/naloxone

Summary

For stage I, socio-demographic and risk behaviour data were collected at three time points. Prevalence was 24.5 per cent (172/702) and incidence was 3.1 per 100 person-years.

Timeframe

4 years

Percentage of project relating to drugs

100%

Project type

Research

Reports to

Johns Hopkins University

Funding source

Johns Hopkins University (via NIH)

Organisation

Guangxi Center for HIV/AIDS Prevention and Control

Contact

Wei Liu

Project title*Cohort Development***Aims**

Develop a cohort of IDUs in two locations; strengthen local research capacity; observe HIV incidence

Summary

Beginning in 2000, the Cohort Development has explored HIV prevalence and incidence in different locales. They have also been able to perform HIV subtype and sequence analysis on the collected samples.

Timeframe

5 years

Percentage of project relating to drugs

100%

Project type

Research

Reports to

Johns Hopkins University

Funding source

Johns Hopkins University (via NIH)

Organisation

Guangxi Center for HIV/AIDS Prevention and Control

Contact

Wei Liu

B3.3 Indonesia*Australian Federal Police*

The AFP has a liaison officer in Bali and four liaison officers and four advisers in Jakarta.

The AFP signed a Memorandum of Understanding with Indonesian National Police in June 2002.

The AFP has assisted in the establishment of a Transnational Crime Coordination Centre in Indonesia to improve intelligence sharing and investigation capacity in the region.

*AusAID***Project title***Indonesia Australia Specialised Training Project, Phase 2***Aims**

This activity was part of a \$60 million specialised short-term training project. The overall focus of the project was to strengthen good governance in Indonesia. The rationale of this project was to build the capacity of the Indonesian National Narcotics Board to measure, understand and respond to Indonesia's growing injecting drug problem. This bilateral project works with the Indonesian National Narcotics Board to deliver drug information courses focused on a balance of harm, demand and supply reduction strategies for a range of professional and community leaders in order to assist them to address the injecting drug use problem in their local areas.

Timeframe

Oct 1999 – Dec 2004 (completed)

Funding amount

\$1,313,000

Project title

Indonesia HIV/AIDS Prevention and Care Project Phase 2

Aims

This project is AusAID's primary response to the growing HIV/AIDS epidemic in Indonesia. The focus of Component 3 (of Phase 2) on injecting drug use reflects the body of evidence showing that up to 80 per cent of new infections are caused by the sharing of infected needles. Component 3 of this bilateral project seeks to reduce HIV transmission through injecting drug use using a public health approach. Specific strategies include oral substitution pilots and a range of other behavioural change activities for injecting drug users focusing on specific settings like prisons.

Timeframe

2002–2007

Funding amount

\$34,000,000

Project implementers

Centre for Harm Reduction
(Danielle Alford)

Project title

HIV Prevention among Vulnerable Groups

Aims

To enhance the capacity of identified vulnerable population groups in Indonesia to reduce their risk of HIV infection; to enhance the capacity of identified partner NGOs to develop and implement HIV responses targeting selected vulnerable population groups. Includes the continuation and expansion of activities that aim to reduce HIV risk and stimulate behaviour change among vulnerable groups such as sex workers and injecting drug users.

Timeframe

July 2004 – June 2005

Funding amount

\$46,000

Project title

Harm Reduction Advocacy in Indonesia

Aims

To help promote a supportive political, policy, regulatory and social environment for harm reduction initiatives aimed at controlling the further spread of HIV and other adverse public health consequences associated with unsafe drug use and sex practice.

Summary

Advocacy with national level government agencies (across sectors of law enforcement, health and criminal justice), media, training and strategy development for prisons-based initiatives. Working in collaboration with Asian Harm Reduction Network Indonesia.

Timeframe

3 years

Percentage of project relating to drugs

100%

Type of project

Advocacy; technical assistance

Reports to

Family Health International Aksi Stop AIDS Indonesia

Funding source

USAID – Family Health International

Organisation

Centre for Harm Reduction

Contact

Danielle Alford

Project title

The National Action Framework 2005–2007

Aims

The National Action Framework for HIV/AIDS will create an environment in which government, civil society and communities work in partnership to maximise impact on the epidemic.

Summary

The goal is to establish an effective and sustainable multi-sectoral response to the HIV/AIDS epidemic. The purpose is to increase capacity to halt and begin to reverse the spread of HIV/AIDS infection in concentrated areas and core transmission groups.

Timeframe

3 years

Percentage of project relating to drugs

20%

Type of project

Technical assistance

Reports to

Program Steering Group with UNAIDS as Secretariat

Funding source

Department for International Development (UK)

Organisation

Department for International Development (UK)

Contact

Jane Wilson

B3.4 Laos

Project title

*Beng Alternative Development
Micro-Project*

Aims

Improved income for at least one-half of the villagers living in the target villages. Health status and education improved.

Reducing opium production and area under poppy cultivation by at least 40 per cent in the target villages and 25 per cent in the rest of the project area in Nahome.

Complete detoxification process for 50 per cent of all opium addicts, no more than 50 per cent relapse after six months, and the number of new addicts each year (excluding relapses) reduced to half of the rate at the start of the project.

Summary

The objective of the Beng project is through alternative development to reduce opium production and consumption among ethnic minorities in the highland district of Beng through interventions in participatory community development, agriculture, income generation, environmental management, education, health and demand reduction.

Timeframe

NA

Percentage of project relating to drugs

NA

Project type

Alternative development

Reports to

NA

Funding source

NA

Organisation

UNODC Laos

Contact

Patrick Ackerman

Project title

Drug Control Capacity Building in Lao PDR

Aims

Establishing a comprehensive data collection system in Lao PDR.

A new drug control legislation adopted in line with the three UN Conventions; and the 1988 UN Convention ratified.

Training judges and prosecutors in drug control and establishing a training module in the new judge training institute.

Developing and establishing a new comprehensive national program for the elimination of opium poppy cultivation.

Developing and establishing a new comprehensive national demand reduction program.

Summary

This project aims at developing/strengthening a comprehensive and sustainable drug control framework in Lao PDR by addressing the structures, data collection, program development and legislation. The President of Lao PDR and the Executive Director of UNDCP reached an historic agreement in May 1999; together eliminating opium production and abuse by 2006. Building the drug control capacity of the government is a key element for the success of the opium elimination program.

Timeframe

NA

Percentage of project relating to drugs

NA

Project type

Coordination/law enforcement

Reports to

NA

Funding source

NA

Organisation

UNODC Laos

Contact

Patrick Ackerman

Project title*Laos–American Project***Aims**

To eliminate opium production and addiction

Summary

The flagships of the bilateral program are two Lao–American Integrated Rural Development Projects (LAP). These two projects comprise about 80 per cent of the non-administrative program budget. The US Bureau of International Narcotics and Law Enforcement Affairs also supports small programs in demand reduction (to battle the rapidly rising amphetamine problem) and law enforcement (to support counter-narcotics police).

Timeframe

Ongoing

Funding source

\$2 million (2004 financial year)

Organisation

NA

Contact

American Embassy, Laos

Project title

Health Risks of Ethnic Groups along the Lao–Thai Border: social and economic consequences of the National Road 3 construction

Aims

Research the health risks of ethnic groups along the Lao–Thai boarder: social and economic consequences of the National Road 3 construction

Summary

This research will measure the social impact of increased mobility and the effect it has on HIV and vulnerability and substance use along the Lao–Thai border

Timeframe

2005–2007

Percentage of project relating to drugs

NA

Project type

Research

Reports to

NA

Funding source

Rockefeller Foundation

Organisation

Department of Anthropology, Macquarie University

Contact

Dr Chris Lyttleton

Project title

Drug Use and HIV Risk Reduction

Aims

Assess extent of ATS use and HIV implications in three provinces. Assess the level of injecting drug use in three provinces.

Summary

NA

Timeframe

3 months

Percentage of project relating to drugs

100%

Project type

Training; rapid assessment

Reports to

Lao PDR National Commission for Drug Control and Supervision/UNODC/National AIDS Council

Funding source

UNODC

Organisation

Burnet Institute, Laos

Contact

Dr Niramoh

B3.5 Malaysia*Australian Federal Police*

The AFP has three liaison officers in Kuala Lumpur.

A Memorandum of Understanding between the AFP and the Royal Malaysian Police is awaiting signature.

Project title

Implementing a Community Outreach Program among Drug Users

Aims

The aim of the project is to make treatment and rehabilitation in the country more community-based.

Summary

The project is still ongoing, hence we are unable to provide a summary.

Timeframe

2 years

Percentage of project relating to drugs

100%

Project type

Outreach

Reports to

Malaysian Government

Funding source

World Health Organization

Organisation

Universiti Sains Malaysia

Contact

Vicknasingam Kasinather

B3.6 Myanmar

Australian Federal Police

The AFP has two liaison officers in Yangon.

AusAID

Project title

Burnet: Youth HIV/AIDS Training Facility

Aims

Burma HIV/AIDS-related activities are funded under the Burma Community Health Program Round 3 which had as a priority basic health and HIV/AIDS-related activities. This was in response to the HIV/AIDS-related challenges being faced in Burma. The program goal is to reduce the vulnerability of young people to HIV infection and transmission in selected areas of Burma (by improving the quality and effectiveness of programs). HIV/AIDS skills training and capacity building programs for local staff of selected international and local NGOs, UNICEF and Government Township Aids Committees (TACs). Skills will be strengthened in conducting assessments of vulnerability to HIV infection, participatory youth research at the community level; developing strategic plans to respond to HIV in young people; and specific areas such as behaviour change communication; STI diagnosis and treatment; care and support, including stigma reduction; harm reduction related to injecting drug use; and prevention of parent-to-child transmission of HIV.

Timeframe

Feb 2003 – April 2006

Funding amount

\$742,600

Project title

TEAR: Community Health Options, Kachin

Aims

This project's main development objectives are: (1) to build the capacity of local communities in Kachin and northern Shan States to identify and address common priorities for improved health; and (2) in partnership with communities, to develop and improve sustainable practices in primary health care, including effective approaches to HIV/AIDS and substance abuse issues.

Timeframe

2001–2004 (project completed)

Funding amount

AusAID contributed \$598,860 over three years (the project's total budget was \$798,440).

Project title

Mekong Drugs Initiative: community-based demand reduction in Northern Shan State, Burma

Aims

Following the Minister's announcement of \$1 million for drug control activities in the Mekong Basin, Australia signed an agreement with UNDCP, providing for whole or part funding of initiatives in demand reduction and alternative development. These activities are seen as complementary in addressing health and poverty aspects of illicit drug use. There was a policy preference for regional activities including Burma, which was the major source of heroin reaching Australia at that time.

Activity description: This project aimed to reduce the incidence of drug abuse in north-east Burma by extending an existing community-based demand reduction program from a few selected villages near Muse to key townships along the road to Mandalay. Using community-based offices, the project provided and monitored revolving loans for community-based demand reduction and social development activities to villages within these townships; provided health education; detoxification programs and training in community management, financial management and gender awareness.

Timeframe

2000–2003 (completed)

Funding amount

\$490,000

Project title

Food Assistance to Vulnerable Communities in Northern Shan State

Aims

Alternative development – food security. Burma WFP funding falls under the rationale of the Burma Humanitarian Framework (the Humanitarian Framework guides program planning in Burma), which stresses the provision of humanitarian assistance to vulnerable groups, particularly those in the border areas of Burma.

Activity description: This project aims to prevent a decline in food security of ex-poppy farming and vulnerable households, increasing school enrolments and preventing mass migration to neighbouring areas and lowlands.

Timeframe

2003–2004 (completed)

Funding amount

\$855,000

*Other funding sources***Project title**

Joint Program for HIV/AIDS: Myanmar 2003–2005

Aims

Enabling and supporting capacity for prevention and care of HIV/AIDS in Myanmar improved.

Summary

The purpose of the joint program is to 'change behaviour to reduce the transmission of HIV and to improve the health of people living with HIV/AIDS'. The joint program sets the framework for all HIV projects in Myanmar. It has been articulated around five major outputs:

- individual risk of sexual transmission of HIV reduced
- individual risk of HIV transmission among injecting drug users and their partners reduced
- awareness of HIV/AIDS among the general population, particularly young people, increased
- access and quality of care, treatment and support for people living with HIV/AIDS increased
- essential elements of the enabling environment for an effective expanded national response strengthened.

Timeframe

3 years

Percentage of project relating to drugs

NA

Type of project

Technical assistance

Reports to

UNAIDS collates reports from implementing partners

Funding source

A range of funding modalities will be available for donors to support the joint program. These include: (a) Fund for HIV/AIDS in Myanmar; (b) direct official development assistance funding through agencies in Myanmar; (c) direct funding through individual agency core resources; (d) funding through regional United Nations project mechanisms; (e) funding through bilateral projects; (f) global partnership agreements; and (g) Global Fund for HIV/AIDS, Malaria and Tuberculosis.

Organisations

UNODC Myanmar (AD/RAS/02/G22)

Medicines du Monde

CARE International

Asian Regional Harm Reduction Network

Burnet Institute, Centre for Harm Reduction

Central Committee for Drug Abuse Control

Myanmar Anti Narcotics Authority

Contact

Brian Williams

Projects funded under the Fund for HIV/AIDS in Myanmar (FHAM)

Enabling and supporting capacity for prevention and care of HIV/AIDS in Myanmar improved.

Project title

Technical assistance to FHAM and non-FHAM partners working with drug users and their communities

Aims

To improve the capacity and quality of services for drug users and their communities through the appropriate and timely delivery of technical assistance

Summary

The Centre for Harm Reduction (CHR) at the Burnet Institute will deliver technical assistance including training and mentoring sessions with local and international organisations working in Myanmar. CHR will also develop materials to improve the capacity of systems in Myanmar.

Timeframe

2 years (end March 2006)

Percentage of project relating to drugs

100%

Project type

Technical assistance

Reports to

UNAIDS

Funding source

Funds for HIV/AIDS in Myanmar (FHAM)

Organisation

The Burnet Institute's Centre for Harm Reduction

Contact

Simon Baldwin

Project title	Organisation
<i>AHRN – FHAM (Asian Harm Reduction Network – Funds for HIV/AIDS in Myanmar)</i>	AHRN
Aims	Contact
Enabling and supporting capacity for prevention and care of HIV/AIDS in Myanmar improved.	Willy De Maere
Summary	<i>Other organisations doing work in Myanmar</i>
HRN-Myanmar is carrying out activities under three of the program's components: Component #2 – Reduce individual risks of HIV among injecting drug users, their sexual partners and their families; Component #3 – Increase awareness of HIV/AIDS among the general population, particularly young people; and Component #5 – Strengthening essential elements of enabling environments for an effective expanded and national response.	CARE
AHRN focus on advocacy, training, outreach and service delivery	<ul style="list-style-type: none"> • Outreach services • Peer education activities for primary prevention of drug abuse • HIV awareness raising in prison
Timeframe	SARA (Substance Abuse Research Association)
2 years (end March 2006)	<ul style="list-style-type: none"> • Drug treatment • Health education • Family-focused relapse prevention
Percentage of project relating to drugs	Lashio Outreach Project
NA	<ul style="list-style-type: none"> • Outreach services • Needle and syringe exchange • Condom distribution • Drop-in centre • HIV awareness raising • Drug abuse rehabilitation • Counselling and referral
Project type	Medicine du Monde and Artsen Zonder Grenzen also do work with drug users in Myanmar.
Advocacy, training, outreach and service delivery	
Reports to	
UNAIDS	
Funding source	
Funds for HIV/AIDS in Myanmar (FHAM)	

Project title
<i>Technical assistance to the Department of Health</i>
Aims
To build capacity within the Department of Health to develop national technical guidance tools adapted to the injecting drug user population.
Summary
With WHO technical assistance, the Department of Health will develop and further adapt and disseminate technical guidance tools such as VCT (voluntary counselling and testing) guidelines and ART (anti-retroviral therapy) guidelines for IDUs. It will also adapt several international tool kits developed by WHO and other partners.
Timeframe
2 years
Percentage of project relating to drugs
100%
Project type
Technical assistance
Reports to
Funds for HIV/AIDS in Myanmar (FHAM), UNAIDS
Funding source
Funds for HIV/AIDS in Myanmar (FHAM)
Organisation
WHO Myanmar
Contact
Oscar Barreneche

Project title
<i>Establishment of a Pilot Methadone Program</i>
Aims
To support the Department of Health starting a pilot methadone maintenance treatment (MMT) program in selected drug treatment centres in Yangon area.
Summary
In 2004, with the support of WHO, the Department of Health developed the technical guidelines for methadone therapy. Selected physicians were also trained. This project will support the Department of Health to start a pilot MMT in selected drug treatment centres.
Timeframe
1 year
Percentage of project relating to drugs
100%
Type of project
Treatment; technical assistance
Reports to
WHO
Funding source
World Health Organization
Organisation
WHO Myanmar
Contact
Oscar Barreneche

Project title <i>AD/MYA/00/E76</i>	Project title <i>AD/MYA/03/G54</i>
Aims Community-based drug demand reduction project in three key townships in the northern Shan State: To strengthen the capability of the communities and the local institutions to carry out community-based demand reduction programs in Lashio, Kutkai and Muse.	Aims To reduce injecting drug use and its harmful consequences, especially the HIV/AIDS infection among injecting drug users and their families and communities, through increased access to information and services for drug users.
Summary The project aims to reduce the incidence of drug abuse in northern Shan State by extending the sub-regional community-based demand reduction program from a few selected villages near Muse to key townships along the Mandalay.	Summary The aim of this project is to reduce injecting drug use and its harmful consequences, particularly focused on reducing the transmission of HIV/AIDS among injecting drug users and their families and communities, through increased access to information.
Timeframe 4 years (Sept 2000–2004)	Timeframe 3 years (2003–2005)
Percentage of project relating to drugs 100%	Percentage of project relating to drugs 100%
Project type Community-based drug demand reduction	Type of project Treatment; rehabilitation; outreach; advocacy
Reports to UNODC, Vienna	Reports to UNODC and EC
Funding source AusAID	Funding source EC
Organisation UNODC – Burma	Organisation UNODC – Burma
Contact Jean-Luc Lemahieu	Contact Jean-Luc Lemahieu

Project title <i>AD/MYA/04/H75</i>	Project title <i>UNODC Wa Project</i>
Aims To improve the knowledge on HIV/AIDS prevention, among the police personnel and their families, especially new recruits, so that they are able to protect themselves and continue the HIV/AIDS education activities by themselves.	Aims Reduce the reliance of farmers on opium cultivation.
Summary The aim for this project is to increase the awareness on HIV/AIDS prevention among uniform services, particularly among the police personnel and their families. The target groups are new police recruits (both officers and other ranks) and police personnel.	Summary The UNODC Wa Project employs a multi-sectoral approach, focusing on education, health care, infrastructure and livelihood development to improve food security in the project area. Using a community-based approach, the project aims to create the conditions for a sustainable and humanitarian opium reduction by reducing farmers' dependency on the cultivation of opium.
Timeframe 1 year (June 2004 – May 2005)	Timeframe NA
Percentage of project relating to drugs 100%	Percentage of project relating to drugs NA
Project type Advocacy; technical assistance; education	Project type Alternative development
Reports to UNODC, UNAIDS	Reports to NA
Funding source UNAIDS	Funding source NA
Organisation UNODC Myanmar	Organisation UNODC Myanmar
Contact Jean-Luc Lemahieu	Contact Jean-Luc Lemahieu

Project title	Timeframe
RAS/C25: <i>Drug Control and Development in the Wa Region of the Shan State</i>	NA
Aims	Percentage of project relating to drugs
The Kokang and Wa Initiative, KOWI, is a broad partnership aiming to provide for the basic human needs of poor farmers and their families in the Kokang and Wa regions to live in dignity without their primary income traditionally derived from opium cultivation.	NA
Summary	Project type
This partnership includes UN agencies and international NGOs that are providing pre- and post-emergency aid to communities in the Kokang and Wa regions in order to help local populations cope with the imposition of opium bans. In the Kokang, a total ban on opium cultivation came into effect in 2003, and a similar ban will take effect in the Wa in June 2005.	Alternative development
To help communities in the Kokang and the Wa regions deal with these opium bans and the associated loss of income, UNODC and its partners seek to provide assistance to ensure food security and cover basic human needs, including health care and education.	Reports to
KOWI is designed as a mechanism to coordinate on-the-ground assistance to expand the expertise and scope of present interventions in the region. Two Technical Coordination Units (TCUs), one in the Kokang and one in the Wa, will play an integral part in supporting KOWI partners by providing shared data, maps and logistical capabilities with the goal of coordinating interventions to avoid overlap and ensure coverage of the most vulnerable populations.	NA
	Funding source
	NA
	Organisation
	UNODC Myanmar
	Contact
	Jean-Luc Lemahieu

Project title	Timeframe
MYA/G43: <i>Illicit Crop Monitoring Program</i>	NA
Aims	Percentage of project relating to drugs
Monitor opium production in Myanmar	NA
Summary	Project type
The UNODC Illicit Crop Monitoring Program (ICMP) assists member states in producing internationally comparable data on the cultivation of illicit crops. In Myanmar, the ICMP conducts an annual opium survey to measure changes in the levels and patterns of opium cultivation.	Crop monitoring
The survey combines data from satellite images and ground surveys. For the 2003 survey, a total of 1962 villages were surveyed in Shan State, with findings from this sample extrapolated for estimates on state-wide production levels. Information is collected through interviews with village leaders and farmers, and by physical measurement of the opium fields. The 2004 survey has expanded its coverage to include Chin and Kachin states, as well as Sagaing division.	Reports to
	NA
	Funding source
	NA
	Organisation
	UNODC Myanmar
	Contact
	Jean-Luc Lemahieu

Project title	Project title
<i>Shan Monk Training</i>	<i>Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis</i>
Aims	Aims
To train Shan monks in HIV awareness and prevention	Strengthen the prevention and control of HIV and malaria in Myanmar
Summary	Summary
NA	Myanmar's submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was approved in February 2005 with a commencement date set for mid-2005. It will target the prevention and control of HIV and malaria. The project will target responses geared toward vulnerable groups such as injecting drug users and sex workers. Treatment care and support for people living with HIV are another major focus of the GFATM.
Timeframe	Timeframe
6 months	5 years
Percentage of project relating to drugs	Percentage of project relating to drugs
100%	70%
Project type	Project type
Training	Large-scale implementation
Reports to	Reports to
Burnet Institute, Centre for Harm Reduction	UNDP Myanmar is the primary recipient
Funding source	Funding source
Withheld	Multi-donor funding mechanism through the Global Fund to Fight AIDS, Tuberculosis and Malaria
Organisation	Organisation
Chiang Mai Centre for Harm Reduction	Many
Contact	Contact
Maddie O'Hare	UNDP

B3.7 Philippines

Australian Federal Police

The AFP has a liaison officer and an adviser in Manila.

The AFP signed an Memorandum of Understanding with the Philippines National Police, also including the Philippines Drug Enforcement Agency and the Philippines National Investigations Bureau in July 2003. The AFP also assisted in the establishment of the Philippines Centre on Transnational Crime in April 2004.

International involvement

The Dangerous Drugs Board (DDB), as the policy-making and strategy-formulating body on all matters pertaining to drug abuse prevention and control, has maintained strong linkages and established harmonious cooperative and coordinative relationships with other countries such as the United States of America, Australia, Japan, China, Korea and member countries of ASEAN, including those of the East Pacific countries. Strong ties were also formed with regional and international organisations such as the Association of the ASEAN Senior Officials on Drug Matters (ASOD), Heads of National Law Enforcement Agencies (HONLEA), World Health Organization (WHO), International Criminal Police Organization (ICPO-INTERPOL), International Narcotics Control Board (INCB), United Nations Office on Drugs and Crime (UNODC), the Drug Advisory Programme (DAP) of the Colombo Plan Secretariat, Japan International Cooperation Agency (JICA), Japan International Cooperation Welfare Services (JICWELS), Asia-Pacific Non-Governmental Organization on Drug and Substance Abuse Prevention (ASPAC-NGO), and ASEAN International Federation of Non-

Governmental Organizations (ASEAN-IFNGO). The Dangerous Drugs Board is the recognised contact point of these organisations, being the official representative and signatory to the UN Conventions of 1961, 1971 and 1988.

The commitment and cooperation forged with these countries, agencies/offices and organisations further enhanced the overall concerted effort in the fight against the drug abuse problem and international drug trafficking. The up-to-date and continuing exchange of data and information and the systematised networking of the various drug demand and supply reduction programs provide closer multilateral working relationships among the countries and organisations involved.

Activities undertaken by the Board on international cooperation

The following are the activities undertaken by the Dangerous Drugs Board in furtherance of international cooperation:

a. Hosting of the 25th ASOD & ACCORD Joint Task Forces Meetings

For the year 2004, the Philippines hosted the 25th ASOD Meeting, which was held 20–22 September 2004 at the Shangri-la Hotel in Makati City. Then DDB Executive Director, Under Secretary Jose C. Calida chaired the prestigious meeting as well as the ASEAN-China Cooperative Operations in Response to Dangerous Drugs (ACCORD) Joint Task Forces Meeting, which immediately followed the ASOD meeting on 23 September 2004. Ten ASEAN countries, represented by a total of 96 delegates along with their heads of delegation, were in attendance including the members of ASEAN Secretariat and observers from ASPAC-NGO, IFNGO, ICPO-INTERPOL and UNODC.

b. United Nations Office on Drugs and Crime projects

The UNODC has been very active in supporting the Philippines' campaign against drug abuse and illicit trafficking of dangerous drugs and PECs (precursors and essential chemicals) through the number of projects that it has sponsored with DDB officers as National Project Coordinators.

Aside from the earlier mentioned UNODC and DDB tie-up project called the IDADIN, the DDB, as the focal point of UNODC, has undertaken the following activities of UNODC:

- conduct of mid-term evaluation meeting on F34 Project (PECs control)
- conduct of mid-term evaluation meeting on the National Action Plan (NAP) relative to PECs control
- conduct of initial meeting in preparation for the formulation of video documentary concerning PECs control in the Philippines.

The meetings were held to evaluate the status of the projects and to determine the accomplishments and problems encountered. The first two projects have been implemented by the Philippines Drug Enforcement Agency.

c. Submission of reports to international organisations

As part of the DDB's international commitment as a signatory to the 1961, 1971 and 1988 UN Conventions, the Board has provided the requested information to the UNODC through submission of the following:

- reports on Statistics of Imports and Exports of Narcotic Drugs and PECs to the International Narcotics Control Board
- duly accomplished UNODC questionnaires
- duly accomplished ECOSOC questionnaires
- duly accomplished INCB questionnaires; and
- Summary Report of the Mid-Term Evaluation and Video Documentary meetings to UN Project Coordinator on PECs Control.

d. Attendance at international forums

The Dangerous Drugs Board was the recipient of various scholarship programs from JICA, JICWELS, Colombo DAP and counterpart agencies. Participation in the said trainings/workshops enabled DDB officers and staff to gain knowledge, to enhance expertise, and to share and exchange experiences on the different aspects related to drug abuse prevention and illicit trafficking control.

For the year 2004, two locally held seminars, 'Wireless IP Networks Seminar', sponsored by JICA, Manila, and 'Nordic Secure Seminar', sponsored by a group of European countries, were initiated by foreign organisations and participated in by DDB staff.

The international cooperative undertakings for the year included the attendance and participation of Philippine Government representatives at 13 international meetings, workshops and training courses in coordination with the Colombo Plan Secretariat Advisory Programme (DAP-CPB), United Nations Office on Drugs and Crime (UNODC) and the Japan International Cooperation Agency (JICA). The United States Drug Enforcement Agency provided assistance through international law enforcement conferences and technical assistance. The Australian Federal Police also provided law enforcement cooperation and program support to the Philippines Drug Enforcement Agency while Narconon provided training for drug education and specialist training.

NGO involvement

The KATOTOHANAN Foundation is one of the most active NGOs involved in drug abuse prevention and control. Through DDB Regular Member representing the NGOs, Ambassador Miguel Perez-Rubio, the Foundation has engaged in activities in pursuit of their continuing campaign against dangerous drugs like radio guestings, advocacy campaigns, linkaging and coordination. These include the Lakbay Kontra Droga campaign, the establishment of links with Daytop International to enable it to conduct therapeutic community (TC) training in the Philippines, among others. A major accomplishment of Ambassador Perez-Rubio was his request for Daytop International to conduct a training campaign on the TC, which shall be funded by the United States State Department so that the Department of Health may institute a comprehensive TC counselling methodology in the government-run rehabilitation centres.

World Health Organization

WHO supports activities of the Department of Health and the IDU group. During the last AIDS Surveillance and Education Program (ASEP), WHO funded the surveillance component for the 10 selected highly urbanised cities in the country. Out of the 10, two sites included the IDUs as target high risk groups, Cebu City and General Santos City wherein fishermen were the target IDUs. In December 2003, ASEP was finished and now these sites are under the LEAD (Local Enhancement and Development for Health) LGU (Local Government Units) project of USAID handled by Management Sciences for Health (MSH).

In 2004, WHO had a country mission to assess the IDU situation in the two areas mentioned above. From that report WHO will move forward by prioritising activities like the conduct of the rapid assessment of other areas identified as areas where IDU activities are ongoing. The Department of Health has already included the activity in its plans.

The AIDS Surveillance and Education Project (ASEP)

Funded by the US Agency for International Development, PATH Foundation and the World Health Organization managed the education and surveillance components of the project which focused on preventing the rapid increase of HIV/AIDS in the Philippines by establishing mechanisms in the public and private sectors that encourage vulnerable groups to adopt and practise behaviours that reduce HIV risk.

After ASEP ended in September 2003, LEAD through MSH continued to support the HIV/AIDS prevention activities.

Sexually transmitted infections, including HIV/AIDS (2004–2005)

The aim of this project is to provide technical assistance and support to address the STI and HIV/AIDS program of the country with the Department of Health as the primary partner of cooperation. The program is supported with emphasis on advocacy, policy/guidelines development, resource mobilisation, capacity building and research. Special attention is provided for the following components of the program: condom use program for prevention, local governance, surveillance, ARV procurement technical assistance, IDU baseline survey. Funding source: country budget and other sources from regional budget. Funding amount in US dollars: \$60,000 and c/o Regional Office.

B3.8 Thailand

International Criminal Police Organization / Interpol

The International Criminal Police Organization (ICPO) / Interpol office for Southeast Asia is located in the Royal Thai Police, Bangkok. Interpol's drug liaison officer has been appointed to Thailand. The exchange of information and intelligence between ICPO/Interpol and Thailand has been conducted with good cooperation since 1972.

Australian Federal Police

The AFP has three liaison officers and two advisers in Bangkok, and one liaison officer in Chiang Mai. One AFP officer is also seconded to Interpol in Bangkok. The AFP signed a Memorandum of Understanding, in respect of combating transnational crime and developing police cooperation, with the Royal Thai Police in June 2003.

Other Australian involvement

For the past few decades, the Australian Government has provided hundreds of training courses and international meetings for Thai officers as well as intelligence equipments for Thai authorities.

The following countries also have liaison offices in Thailand:

- Belgium
- Canada
- France
- Germany
- Indonesia
- Israel
- Italy
- Japan
- Korea
- Malaysia
- Netherlands
- New Zealand
- Nigeria
- Peru
- Poland
- South Africa
- Spain
- Sweden
- Switzerland
- United Kingdom
- United States of America

Project title

Care and Support to People Living with HIV/AIDS

Aims

Increase access to counselling and home-based care for people living with, or those affected by, HIV/AIDS.

Summary

This program will expand the service currently available and create an appropriate service for IDUs and will also advocate to include such a service into the National Health Security Scheme.

Timeframe

1 year (2005–2006)

Percentage of project relating to drugs

35%

Project type

Treatment; support; education; advocacy

Reports to

Family Health International, Thailand

Funding source

Family Health International

Organisation

AIDS Access Foundation, Thailand

Contact

Nimit Tienudom

Project title	Timeframe
<i>WHO Alcohol, Smoking and Substance Involvement Thailand</i> (+ Australia, Brazil, India, USA and Spain)	2003–2006
Aims	Percentage of project relating to drugs
Determine the validity, reliability and acceptability of a screening instrument for the detection of illicit drug use in primary health care settings.	100%
Summary	Project type
The ASSIST is a brief screening questionnaire to find out about people's use of psychoactive substances. It was developed by the World Health Organization (WHO) and an international team of substance use researchers as a simple method of screening for alcohol and substance involvement.	Outreach; treatment; education
	Reports to
	Australian Government Department of Health and Ageing; and WHO
	Funding source
	Australian Government Department of Health and Ageing
	Organisation
	Drug and Alcohol Services South Australia (DASSA)
	Contact
	Rachel Humeniuk

Project title	Project title
<i>Shan Outreach Project</i>	<i>Shan Monk Training</i>
Aim	Aim
Train outreach workers to deliver HIV education and prevention to people of Shan origin living in Chiang Mai, Thailand.	To train 20 Shan monks and 20 novices in HIV prevention
Summary	Summary
The project aims to provide basic education about HIV/AIDS and modes of transmission to Shan migrant youth working as labourers and/or in the sex industry in Chiang Mai. The project aims to effect behaviour change amongst this target group via workshops and ongoing peer education and support.	The project aims to build upon the resources and lessons learnt from previous monk training undertaken by the Sangha Metta Project and to include harm reduction and work with drug users within a general framework of HIV/AIDS education, care and support.
Timeframe	Timeframe
6 months (seeking extension), ending May 2005	6 months
Percentage of project relating to drugs	Percentage of project relating to drugs
50%	NA
Project type	Project type
Education; prevention; outreach	Training and education
Reports to	Reports to
Johns Hopkins University	Johns Hopkins University
Funding source	Funding source
US \$20,000 Johns Hopkins University	US \$15,000 Johns Hopkins University
Organisation	Organisation
Chiang Mai Centre for Harm Reduction	Chiang Mai Centre for Harm Reduction
Contact	Contact
Maddie O'Hare	Maddie O'Hare

Project title	Project title
<i>Pilot Project Akha Hill Tribe</i>	<i>Peer Intervention Trial amongst injectors in Northern Thailand</i>
Aim	Aim
To provide harm reduction services to nine Akha villages in Chiang Rai	Peer-based harm reduction mentoring among injectors and their social networks
Summary	Summary
To provide community-based services with the goal of HIV reduction in nine Akha villages in Chiang Rai. Services include long-term methadone treatment, counselling, and needle and syringe programs.	NA
Timeframe	Timeframe
Ongoing	2004–2005
Percentage of project relating to drugs	Percentage of project relating to drugs
NA	NA
Project type	Project type
Treatment and service provision	Research; HIV prevention
Reports to	Reports to
NA	NA
Funding source	Funding source
AusAID	Johns Hopkins University
Organisation	Organisation
Family Health International	Chiang Mai University Research Institute for Health Sciences
Contact	Contact
NA	NA

Project title	Project title
<i>O-zone Drop-in Centre</i>	<i>Global Fund for HIV/AIDS, Malaria and Tuberculosis (Thai Drug Users Network)</i>
Aims	Aims
To contribute to the reduction in HIV/AIDS among injecting and non-injecting drug users in Chiang Mai.	To strengthen its policy advocacy work, expand services for drug users, and build the capacity of drug users to advocate for their human rights.
Summary	Summary
The drop-in centre attempts to contribute to the reduction in HIV/AIDS among injecting and non-injecting drug users by increasing the adoption of voluntary drug cessation, and consistent condom use. This is achieved through targeted delivery and promotion of appropriate products, services and information.	Through advocacy, the Thai Drug Users Network (TDN) hopes to raise awareness in the Thai population of the importance of protecting drug users and those around them from HIV, hepatitis and other illnesses as well as of the reality of drug users' lives, a key to reducing population misconceptions and prejudices against drug users.
Timeframe	Summary
NA	In addition the TDN's work will also revitalise Thailand's National Harm Reduction Task Force, a body representing government, local and national NGOs, and international agencies, with the mandate to review and recommend improvements for drug policy in Thailand. The Task Force is also active in improving the public's understanding of drug policy issues and developing technical guidelines for opiate substitution and other programs.
Percentage of project relating to drugs	
NA	
Project type	
Drop-in centre	
Reports to	
NA	
Funding source	
NA	
Organisation	
Population Services International (Thailand)	
Contact	
NA	

Timeframe	2005–2007
Percentage of project relating to drugs	100%
Project type	Advocacy; harm reduction
Reports to	Global Fund (through Rak Thai Foundation)
Funding source	Global Fund
Organisation	Thai Drug Users Network
Contact	Karyn Kaplan

United States of America

Most Thailand–USA cooperation on drug control has been conducted through US government agencies attached to the US Embassy in Bangkok.

Main cooperation with Narcotics and Law Enforcement Affairs Section (NAS):

- narcotics law enforcement
- narcotic crops control
- demand reduction
- regional narcotics control assistance
- Drug Enforcement Administration

Table B3.9.1. Narcotic-related financial assistance by US Government in Thailand, 2003

Areas of support	Amount US\$
Narcotics law enforcement	1,313,208
Narcotic crop control	700,000
Demand reduction	438,000
Regional narcotics control assistance	150,000

Canada

Canada has contributed 397,860 baht (US\$10,000) since 2001 to support the Empowering Youth against Drugs project. Through the Department of Foreign Affairs and International Trade and the Canadian Embassy in Bangkok, Canada has granted almost three million baht (US \$120,000) to the Office of the Narcotics Control Board.

Japan

Thailand received support from the Japanese Government and the National Police Agency of Japan for the initiation of a project on ‘Drug Analysis and Identification’ and ‘Drug Profiling/Signature Analysis’. The objective of the project is to develop and enhance the capability of its forensic laboratory in drug analysis with the expectation to utilise it as an effective means to support drug law enforcement and intelligence.

Thailand also received a fellowship from the Japan International Cooperation Agency to send officers to attend the Seminar on Drug Control Offences in Tokyo and from Japan International Cooperation of Welfare Services (JICWELS) to send an officer to attend the Study Program for Overseas Experts on Drug Abuse and Narcotics Control.

Netherlands

The Netherlands Government has provided financial assistance to the project on Highland Coffee Research and Development Centre since 1983. Other assistance included equipment and vehicles for law enforcement.

United Kingdom

For the past few decades, the United Kingdom has provided assistance to Thailand, in areas such as forensic laboratory equipment, audiovisual aids for training activities, establishment of studios, training and study program fellowships in the UK and intelligence equipment.

B3.9 Timor-Leste (East Timor)

Australian Federal Police

On 5 July 2004, the AFP and AusAID mobilised a team of police advisers into Dili as part of the Timor-Leste Police Development Program. The team comprises six AFP police officers and six advisers. The purpose of the program is to assist the Timor-Leste Police to promote and maintain a safe, stable environment in Timor-Leste, which will contribute to economic and social development and sustainable poverty reduction.

Areas of focus of the program include:

- crime prevention and community safety
- investigations and operations
- training and development
- administration, oversight and strategy, including financial, human resource and logistics and asset management.

The AFP has one liaison officer in Dili. (The liaison officer has liaison and intelligence gathering functions regarding transnational crime, while the focus of the mission is capacity building.)

B3.10 Vietnam

Australian Federal Police

The AFP has a liaison officer in Hanoi and a liaison officer in Ho Chi Minh City.

AusAID

Project title

HIV/AIDS Prevention and Care Phase 2: 'Harm Reduction in Vietnam – Developing Sustainable Responses to Drug Use and HIV Infection Among Drug Users'

Aims

Reduction of HIV/AIDS transmission. A review of HIV/AIDS in Vietnam in 1997 by UNAIDS and the National AIDS Committee of Vietnam (NAC) concluded that the epidemic of HIV/AIDS was primarily among IDUs, and that an opportunity existed to ameliorate the epidemic. Harm reduction programs were seen as the most appropriate approach, and a program of work to establish this approach in Vietnam was seen as a major priority. Discussions between the NAC and the Macfarlane Burnet Centre for Medical Research resulted in a proposal being put to AusAID for assistance under the Vietnam Program's NGO window.

Project objectives are: to increase self-reliance in development and implementation of programs throughout Vietnam for prevention of HIV infection and other harms among injecting drug users and their families; to improve the capacity of the NAC in policy development, strategic planning, research and program management in relation to harm reduction and HIV prevention.

Major outputs aim to rapidly increase Vietnam's capacity to respond to the current major HIV epidemic among injecting drug users and to develop new and more effective methods for responding to the harms caused by injecting drug use. Technical assistance will be provided for development of a Vietnamese training package and workshops with follow-up activities including local planning and national networking for prevention of harm for drug use, especially HIV infection. It will also support development of pilot projects identified at the local level through workshops.

Timeframe

1999–2004 (completed)

Funding amount

\$156,000

Project title

UNDP HIV/AIDS Youth Awareness Raising

Aims

The increase in HIV/AIDS infection among young people in Vietnam signals that this population group has not developed a sense of personal risk to prevent them from practising high risk behaviours, to motivate them to change their behaviour or to motivate them to minimise the risk of HIV/AIDS infection. In 2001, 59.46 per cent of detected infections were among people in the 13–29 age group. Rapid social change and economic transition are expanding choices affecting lifestyle decisions for young women and men, including their sexual and drug-taking decisions. The sensitivity surrounding these behaviours means they do not necessarily have access to information or the personal support needed to develop skills to protect themselves from HIV transmission. Young women and men in rural areas have limited access to HIV/AIDS prevention information and tend to live in a more conservative social environment. In this situation it can be more difficult to learn about sexuality and to obtain counselling and support.

The projects aimed to (1) strengthen the capacity of the Vietnam Youth Union at all levels to develop community-based HIV/AIDS activities; (2) build up information, education and communication materials and raise HIV/AIDS awareness among young people; and (3) implement community-based life skills and HIV/AIDS education activities to facilitate behaviour change among young people, especially those in high-risk categories. This was to be achieved through a mix of training inputs and study tours. The provinces chosen for project implementation, based on existing or potential high HIV/AIDS prevalence and the organisational management capacity of the provincial Youth Union, were Ha Tinh, Can Tho, Son La and Tay Ninh.

N.B. As this project was funded by an upfront grant to UNDP, no expenses are shown after 2001, but it ran for three years.

Timeframe

2001–2004 (completed)

Funding amount

\$1,400,000

Other funding sources

Project title

HIV/AIDS Prevention and Care in Vietnam

(40 provinces in Vietnam)

Aim

NA

Summary

NA

Timeframe

2000–2006

Percentage of project relating to drugs

30%

Type of project

NA

Reports to

Control Disease Center Office

Funding source

Control Disease Center

Organisation

Ministry of Health/LIFE-Global AIDS Program

Contact person

Ha Viet Dong

Project title

HIV/AIDS Peer Education in the 05/06 Rehabilitation

Aims

The overall goal of the project is to reduce risks of STD/HIV infection and transmission among injecting drug users and sex workers and their partners, and to provide care and support for those affected and infected with HIV.

Summary

This was a two-year project started in April 2003 and completed by 1 May 2005. It was implemented in three city/provinces including Hanoi, Khanh Hoa and Thai Nguyen by four stakeholders.

Timeframe

April 2003 – May 2005

Percentage of project relating to drugs

100%

Project type

Technical assistance; education; outreach

Reports to

The Ford Foundation/Vietnam

Funding source

The Ford Foundation

Organisation

Center for Community Health and Development (COHED)

Contact

Mai Hoa Dao

Project title

IDU Interventions – FHI

Aims

To support peer-based and other outreach to IDUs, drop-in centres, and ‘half-way houses’ that provide safe spaces for IDUs and allow for more intensive counselling.

Summary

Drop-in centres will offer peer-based counselling to support users to reduce needle sharing and unsafe sexual partnerships. These centres will also refer active users who desire to stop drug use to ‘half-way’ houses that offer social and peer support; voluntary counselling and testing.

Timeframe

Proposed for 2005–2006

Percentage of project relating to drugs

60%

Type of project

Peer-based and outreach

Reports to

US Country Team for Vietnam and Office of the Global AIDS Coordinator

Funding source

United States Government

Organisation

USAID Vietnam

Contact

Thu Vuong

Project title <i>Harm Reduction Program – POLICY Project</i>	Project title <i>Intervention Program Targeting IDUs</i>
Aims To assess, engage and address provincial HIV/AIDS and other provincial authorities concerns regarding harm reduction activities and to promote greater community awareness and understanding of the harm reduction approach.	Aim To prevent HIV transmission among IDUs
Summary The program consists of three components: (1) developing an effective National Harm Reduction Policy; (2) developing a legal framework for harm reduction at the provincial level; (3) promoting a media campaign for harm reduction.	Timeframe Since 1998 – present
Timeframe Proposed for 2005–2006	Type of project Outreach
Percentage of project relating to drugs 100%	Reports to USAID/United States Government
Type of project Law enforcement; advocacy	Funding source USAID/United States Government
Reports to US Country Team for Vietnam and Office of the Global AIDS Coordinator	Organisation Family Health International Vietnam
Funding source United States Government	Contact Vuong Thi Huong Thu
Organisation USAID Vietnam	
Contact Duc Tran	

Project title <i>Preventing HIV in Vietnam</i>	Project title <i>Strengthening Bilateral Cooperation</i>
Aim Preventing a generalised HIV epidemic in Vietnam by reducing the vulnerability amongst those whose behaviour puts them at greatest risk of contracting and transmitting HIV.	Aims Strengthening bilateral cooperation between Nghe An Province, Vietnam, and Xieng Khoang Province, Laos, in HIV/AIDS prevention, making a contribution to a decrease in the spread of HIV in two provinces, especially those bordering Ky Son (Nghe An)
Summary The goal of the project is to prevent a generalised HIV/AIDS epidemic in Vietnam. The purpose is reduced vulnerability to HIV infection in Vietnam. The outputs will be: national and provincial policies, strategies and practices supportive of effect.	Summary This is a comprehensive program which focuses on HIV/AIDS awareness raising and education for border populations, especially the ethnic minority groups. The program is realised by a series of activities such as community outreach for IEC effort and training.
Timeframe 7 years	Timeframe 2 years
Project type Technical assistance	Percentage of project relating to drugs 30%
Reports to Implemented by WHO, which reports to the Department for International Development (UK)	Project type Advocacy; education; outreach
Funding source Norwegian Government	Reports to Rockefeller Foundation
Organisation Department for International Development (UK)	Funding source Rockefeller Foundation
Contact Heather O'Donnell	Organisation STDs/HIV/AIDS Prevention Center (SHAPC)
	Contact Tran Thi Nga

Project title*Community Reach***Aims**

To provide technical and managerial assistance to international and Vietnamese NGOs engaged in HIV prevention, care and treatment activities undertaken with US government funding.

Summary

The international and local NGOs supported by PACT in Vietnam are engaged in a wide array of activities in HIV/AIDS prevention, care and treatment. Given the nature of the epidemic in Vietnam, many of these activities target IDUs.

Timeframe

1 year

Percentage of project relating to drugs

approx 25%

Project type

Technical assistance

Reports to

USAID

Funding source

USAID

Organisation

PACT Vietnam

Contact

Diana Measham

Project title*Harm Reduction in Vietnam***Aim**

To build capacity to respond to the HIV epidemic at the national, provincial and community level.

Summary

National and provincial level advocacy. Establishment of successful pilot projects in two sites of northern Vietnam in conjunction with the provincial health authorities.

Timeframe

4 years

Percentage of project relating to drugs

100%

Project type

Advocacy; technical assistance; program implementation

Reports to

AusAID

Funding source

Open Society Institute

Organisation

Centre for Harm Reduction

Contact

Danielle Alford

Project title*Methadone Program Trial in Hai Phong and Cam Pha***Aims**

The planning and development of a opioid substitution treatment program. Family Health International (FHI) is supporting the implementation of intervention projects targeting injecting drug users to assist Vietnam to reduce the demand for illicit drug use, in particular, heroin, and to help curtail the increasing prevalence of HIV.

Timeframe

2005

Percentage of project relating to drugs

100%

Project type

Technical assistance; treatment

Reports to

Family Health International

Funding source

Family Health International

Organisation

Drug and Alcohol Services South Australia (DASSA)

Contact

Robert Ali

Project title*Evaluation of Vietnam's Rehabilitation and Treatment Centres***Aims**

To provide technical advice and training for an evaluation of Vietnam's rehabilitation and treatment centres.

Summary

The evaluation will promote best practice in the treatment of drug dependence and HIV/AIDS prevention and care through: an examination of the characteristics, knowledge, attitude and behaviours of residents and the performance of the 05/06 centres.

Timeframe

May 2004 – April 2005

Percentage of project relating to drugs

100%

Project type

Technical assistance

Reports to

UNODC

Funding source

UNODC

Organisation

Drug and Alcohol Services South Australia (DASSA)

Contact

Robert Ali

B3.11 The Pacific

NZAID

1. The UNICEF partnership with NZAID is for \$NZ 2 million over three years (starting this financial year) and will include funding for three key UNICEF programs: an Expanded Programme of Immunisation; Prevention of Mother-to-Child Transmission of HIV; and Pacific Youth Health and Development (elaborated on below).

Pacific Youth Health and Development focuses on three main components: peer education through master trainers at community level, integration of the curriculum into the primary and high school curricula, and communication activities. The program objective is to build up the life skills of at least 20 per cent of young people (80,000 of the 400,000 young people aged between 15 and 24 years old) in the 14 Pacific Island countries covered by UNICEF; integrate life skills into late primary and high school curricula and develop creative communication materials to reinforce skills building for young people and HIV/AIDS prevention.

2. STI/HIV and Development Program aims to increase Pacific Island capacity for a more effective and sustainable response to the spread of HIV/STI and the care for those with AIDS. The program takes a multi-dimensional approach to HIV/STI, giving recognition to economic and social development issues (including governance, employment, poverty,

gender equality and the impact on children and families). The project is managed by UNDP through the Suva office, working with the UN regional programs based in both Fiji and Samoa. NZAID has committed \$600,000 to the initiative, ending next financial year.

A range of project activities have been undertaken, including a number of workshops and training sessions on HIV/AIDS and STIs for key health workers and government officials, research surveys on key HIV/AIDS and STI issues in the Pacific, national legislative reviews, counselling for people living with HIV/AIDS and their families, weekly newspaper columns on HIV/AIDS prevention, condom distribution through NGOs, and the development of curriculum materials. Alongside project activities, the program has also supported a full-time UNAIDS coordinator position located in Suva. NZAID's funding for this program will end next financial year.

3. Masculinity, Mental Health and Violence (MMHV) project aims to: 'reduce the growing trend of young Pacific men using violence to deal with depression and assert their masculine power'. The project is managed by the Foundation of the Peoples of the South Pacific (FSPI). The MMHV project is carried out in Kiribati, Vanuatu, Fiji and Papua New Guinea, through FSPI affiliate NGOs. NZAID has committed \$1,176,410 to the initiative over three financial years, ending in 2006-07.

All four NGOs have completed their situation analyses (SA) focusing on young men and mental health, which will inform the target groups, types of activities and promotion/advocacy strategy for the project. The SA includes a literature review, stakeholder interviews, community action participatory process consultations (CAPP) and a knowledge, attitude and practice (KAP) survey. The CAPP process was adopted from a Papua New Guinea model titled 'Promoting Health through Community Action Participation' originally developed by the Papua New Guinea Department of Health's Health Promotion Branch and the Women's and Children's Health Project, funded by AusAID. A further process utilised by the Vanuatu Red Cross Society was also integrated into the process when targeting non-traditional settings. This approach has been documented and both successes and lessons learnt will be documented in a model which the project hopes to share with the whole Pacific Island region.

Final SA drafts will be completed between the end of February and end of March with work plans for activities and commencement of same to begin immediately after. What is perhaps the first education and awareness model for communities, workplaces and parliamentarians has been developed in collaboration with expertise from the Fiji School of Medicine, the University of the

South Pacific and the private sector. It will be given to the region for comments, finally pre-tested by the national managers, and then developed firstly for the four countries, and then replicated for the region within a year of piloting.

4. NZAID has committed \$829,477 to a student teaching initiative, which ends in 2005-06. The project is managed by Wan Smolbag and takes place in Vanuatu, the Solomon Islands and Fiji. The project aims to increase the use of innovative teaching methods to stimulate self-expression and debate of key development issues, in both formal and non-formal education. Small groups of Wan Smolbag trainers work with individual schools, teacher training establishments and non-formal educators. The trainers model the use of videos, audiocassettes and guides in workshops with teachers and NGO trainers. So far the project has given Wan Smolbag the capacity to create new materials on good governance, HIV/AIDS, substance abuse and the environment. The materials for use in communities and the classroom are backed up with DVD and audiocassettes to bring the subjects alive.

B3.11.1 Papua New Guinea

Customs

Papua New Guinea Enhanced Cooperation Program

Customs is contributing its experience and expertise to the Papua New Guinea Enhanced Cooperation Program (ECP). This whole-of-government assistance initiative was established to improve Papua New Guinea governance through economic enhancement and other law and justice sectors including Customs and police.

Under the Papua New Guinea Enhanced Cooperation Program, Australian Customs is tasked with building the capacity of both the PNG Customs organisation and its personnel to cope with its corporate obligations, nationally, regionally and internationally. The Customs program will be extensive over the next five years in assisting PNG Customs to achieve its designated outcomes. This program includes all border enforcement issues including narcotics detection.

Australian Federal Police

The Australia and Papua New Guinea Police Assistance Package is a component of the broader Enhanced Cooperation Program (ECP) which was agreed by the two governments at a Ministerial Forum in December 2003. The policing assistance package aims to assist the Royal Papua New Guinea Constabulary (RPNGC) to strengthen its capacity to perform its core functions and in turn to improve the law and order situation in Papua New Guinea. The package will be geographically phased in over five years. This will be achieved jointly with Australian Federal Police personnel working alongside their RPNGC counterparts.

The AFP has two liaison officers in Port Moresby.

The AFP has also assisted in the establishment of a Transnational Crime Unit in Port Moresby.

B3.11.2 Fiji

Australian Federal Police

The AFP has two liaison officers in Suva and one intelligence adviser attached to the Pacific Transnational Crime Coordination Centre.

The AFP assisted in the establishment of the Transnational Crime Coordination Centre to improve intelligence sharing and investigation capacity in the region.

B3.11.3 Samoa

Australian Federal Police

The AFP assisted in the establishment of a Transnational Crime Unit in Samoa.

AusAID

Project title

Samoa Police Project

Aims

Law enforcement

Activity description: The project aims to create a safe, secure and stable environment in Samoa through strengthening the Samoa Police Service (SPS) to enable it to contribute to economic growth, social stability and ensure equitable access to efficient police services for all Samoans. The Samoa Police Project will take an incremental approach to addressing current and emerging policing issues in Samoa. Project also incorporates a Safer Samoa Awareness Campaign which has an element of awareness in relation to substance abuse (most likely in relation to marijuana).

Timeframe

Aug 2005 – Nov 2008

Funding amount

\$9,000,000

B3.11.4 Solomon Islands

Australian Federal Police

The Regional Assistance Mission to the Solomon Islands (RAMSI) marked the first time that Australian police deployed a complete tactical operations team into an overseas mission. The first contingent of police and troops flew into Honiara on 24 July 2003 as part of Operation Helpem Fren. The police involvement is expected to take some years. Immediate law and order issues are being tackled as well as development and training to rebuild the reputation, capacity and effectiveness of the Royal Solomon Islands Police. Police from Australia, New Zealand, Tonga, Samoa, Vanuatu, Fiji, Cook Islands, Nauru, Tuvalu, Kiribati and Papua New Guinea are involved and are currently led by an AFP Federal Agent.

The AFP has a liaison officer in Honiara.

*AusAID***Project title***STC Youth Outreach Program***Aims**

The Youth Outreach Program (YOP) focuses on fostering increased recognition of the potential of young people, and on greater participation of young people in their own affairs, in decision making in families and in local communities, engagement in community affairs, involvement in local programs and in giving a voice for young people in national policy and planning. In doing so, the YOP also targets key concerns of young people (e.g. alienation, violence, substance abuse, etc) and will make a contribution to improving to engage in the national policy arena.

Timeframe

Dec 2003 – Dec 2006

Funding amount

\$900,000

Project title*ADRA Community Strengthening and Reconciliation***Aims**

The program aims to utilise the strength, experience and community linkages of Adventist Development and Relief Agency International (ADRA) and the infrastructure of Seventh-Day Adventist churches in Solomon Islands to work with communities to improve their internal cohesion and capacity to address their own identified development needs. The church's health and education networks, women's and youth organisations are to be used to devise locally appropriate means of addressing basic development issues including preventative health education; improved sanitation; and sustainable livelihood improvement.

Objectives include to reduce the incidence and effects of common health problems within participating communities; and to reduce the levels of substance abuse and resulting violence in communities, particularly among youth.

Timeframe

Dec 2003 – Dec 2006

Funding amount

\$900,000

Project title*'BLESS: Building Livelihoods, Empowerment and Strategic Sustainability' – Young People***Aims**

This program aims to strengthen governance and community cohesion from the grass-roots. The program aims to increase people's understanding of and confidence in the system's ability to take account of their needs, concerns and aspirations by investing youth and women's capacity to participate and contribute effectively to the economic, social and political development at village, provincial and national levels.

Objectives include: Strengthening the capacity of target groups in community outreach and advocacy on issues of concern (for example, violence, substance abuse, healthy lifestyles, livelihood) and develop specific youth and women's programs.

Timeframe

Dec 2003 – Dec 2006

Funding amount

\$900,000

B3.11.5 Tonga*Australian Federal Police*

The AFP has assisted in the establishment of a Transnational Crime Unit in Tonga.

B3.11.6 Vanuatu

Australian Federal Police

The AFP has two liaison officers in Port Vila.

The AFP has assisted in the establishment of a Transnational Crime Unit in Port Vila and has provided illicit drug forensic assistance to the Vanuatu Police Force as requested.

AusAID

Project title

Vanuatu Police Force Capacity Building Project

Aims

Following discussions between Australian Foreign Minister Downer and Vanuatu Prime Minister Natapei in 2001, Australia agreed to provide assistance to the Vanuatu Police Force (VPF). An identification mission in March 2002 recommended an 18-month interim phase of assistance to assist the VPF prepare for a longer-term institutional strengthening project. The objective of the interim phase is to 'provide immediate support to VPF management to enable the organisation to be more strongly positioned to benefit from an institutional strengthening project'. The project includes involvement from two Operations Advisers whose role, in part, it is to mentor Vanuatu Police Force members, and provide on-the-job training. They also support the development of basic policing training; operational guidelines, standard operating procedures etc. The advisers have a broad range of activities to assist the VPF build their capacity across general and investigative policing. (N.B. Their focus, and the project's focus, is not specific to illicit drugs.)

The project also supports the VPF in its approach to community policing and associated remote policing policy. However, this is in its early and basic stage. The VPF is not currently positioned to focus on the broader community policing principles which in general instances would create specific strategies linked to various 'drug' projects. It is anticipated such support will be provided in the future.

Timeframe

Feb 2002 – Dec 2004

Funding amount

\$5,900,000

B4. Multi-country projects

Project title

Cross Cutting: Substance Abuse

Aims

To provide substance abuse-related training to three international collaborators in India, Laos and Thailand – India: Sharan Society for Urban Poor (NGO); Laos: National Committee for Control of AIDS (Ministry of Health); Thailand: Research Institute for Education Sciences (Chiang Mai University).

Timeframe

4+ years

Percentage of project relating to drugs

100%

Project type

Prevention; research; training

Reports to

United States Department of Health and Human Services, National Institutes of Health, Fogarty International Center

Funding source

NIH Fogarty International Center

Contact

Johns Hopkins University, Chris Beyrer

Project title

Substance Abuse in South and Southeast Asia

Aims

To provide prevention research training in India, Pakistan, Thailand, Vietnam.

India: Chennai-YRG Care (NGO)

Pakistan: Nai Zindagi (NGO)

Thailand: Chiang Mai Centre for Harm Reduction

Vietnam: HIV/STD Prevention Network Trials

Timeframe

2+ years

Percentage of project relating to drugs

100%

Project type

HIV/AIDS prevention research training

Reports to

United States Department of Health and Human Services, National Institutes of Health, Fogarty International Center

Funding source

National Institutes of Health, Fogarty International Center

Contact

Johns Hopkins University, Chris Beyrer

B5. Summary table of regional projects – Australian and international

B5.1 Australia's involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Alternative Development Cooperation in East Asia (AD/RAS/00/C96)	AusAID (partial contribution)	UNODC Regional Office	ongoing	Alternative development	2000–ongoing	Australian Government: \$315,840	NA
Annual Core Contribution to General Purpose Funds	AusAID (partial contribution)	NA	ongoing	General – core contribution	1991–ongoing	\$9,844,000 since 1991	Global
Core contribution – Regional Cooperative Mechanism to Monitor and Execute the ACCORD Plan of Action	AusAID (partial contribution)	NA	One-off contribution	General – core contribution	2003–2004	\$620,000	Global
Mekong Drugs Initiative – Alternative Development Cooperation in East Asia, Phase 1	AusAID (partial contribution)	NA	3 years (project completed)	NA	2000–2003	\$400,000	China, Laos, Myanmar, Thailand and Vietnam
Colombo Plan Drug Advisory Program to Implement the Enhancing Life Skills/Social Competence Skills in Preventative Drug Education in Southeast Asia Project	AusAID (partial contribution)	NA	2001–ongoing	NA	NA	\$100,000 to date	NA
UNODC Computer-based Law Enforcement Training Project	AusAID (partial contribution)	NA	1 year (project completed)	Law enforcement	2003–2004	\$75,000	NA
Support for MOU partnership in East Asia	AusAID (partial contribution)	Part of core contribution to UNODC	2 years	NA	2004–2006	NA	Regional Southeast Asia – Greater Mekong subregion countries
Precursor Control in East Asia (AD/RAS/01/F34)	AusAID (partial contribution)	UNODC Regional Office	NA	Law enforcement	NA	\$1,793,700	Cambodia, China, Lao PDR, Myanmar, Thailand, Vietnam, Indonesia, Malaysia, Philippines

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Asia Regional HIV/AIDS Project (ARHP)	AusAID	Burnet Institute's Centre for Harm Reduction /ACIL	3 years	Harm reduction	2002–2005	\$7,000,000	China, Myanmar and Vietnam
Maritime Security in the Pacific Project	AusAID	NA	3 years	Law enforcement	Jan 2005–2007	\$3,000,000	Pacific
Pacific Regional Policing Initiative	AusAID	NA	3 years	Law enforcement	Jan 2004–2008	\$17,000,000	Pacific
Support to drug law enforcement in East Asia and the Pacific	AusAID (partial contribution to UNODC)	UNODC	6 years	Law enforcement	1999–2005	NA	Asia and Pacific
Development of global guidelines and training resources on preventing HIV transmission among injecting drug users, Phase 3	AusAID (partial contribution to WHO)	WHO	2 years	Reduction of HIV/AIDS transmission	2003–2004 (project completed)	\$1,510,000	Asia and Pacific
A review of drug injection and HIV in prison	UNAIDS	Program of International Research and Training, Kate Dolan	8 months	Research	2005	NA	Developing and transitional countries
Assess the best documents on HIV prevention and care among IDUs	UNAIDS	Program of International Research and Training, Kate Dolan	2 months	Education Research	NA	NA	NA
IDU and HIV/AIDS risk reduction, prevention and treatment	Centre for Addiction and Mental Health, Canada	Program of International Research and Training, Kate Dolan	6 months	Research	NA	NA	NA
IDU and HIV/AIDS risk reduction, prevention and treatment measures for prison populations	Centre for Addiction and Mental Health, Canada	Program of International Research and Training, Kate Dolan	6 months	Research	NA	NA	NA
International review of methadone in prison – Document all countries with prison methadone programs	WHO	Program of International Research and Training, Kate Dolan	NA	Education Research	NA	NA	NA
International review on the effectiveness of prison-based interventions	WHO	Program of International Research and Training, Kate Dolan	6 months	Research	NA	NA	NA

B5.2 International involvement

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Reducing HIV Vulnerability from Drug Abuse (AD/RAS/02/G22)	NA	UNODC Regional Office	3 years	Reducing HIV vulnerability through regional coordination	2002–2005	\$1,400,000	NA
Taking Action against Amphetamine-Type Stimulants (ATS) Abuse in the East Asia and Pacific Region (AD/RAS/00/F15)	NA	UNODC Regional Office	5 years	Demand reduction Capacity building	2000–2005	\$5,996,700	NA
Subregional Development of Institutional Capacity for Demand Reduction among High Risk Groups (AD/RAS/97/C75)	NA	UNODC Regional Office	Ongoing	Demand reduction	1999–ongoing	NA	US\$1,889,800 (UK: \$1,780,000; Canada: \$45,000; required funds: \$64,800)
Improvement of Drug Abuse Data Collection Systems (AD/RAS/97/C73)	NA	UNODC Regional Office	NA	To improve the design and operations of drug abuse information systems within the subregion of East Asia and the Pacific	2001–2005	\$1,755,400	NA
Reducing Illicit Drug Use in the Highlands of East Asia (AD/RAS/96/B53)	NA	UNODC Regional Office	NA	Demand reduction	NA	NA	NA
Development of Cross-Border Law Enforcement Cooperation in East Asia (AD/RAS/99/D91)	Japan	UNODC Regional Office	Six years and three months	Law enforcement	1999–2005	\$2,809,100	NA
Capacity Building for Drug Use Related HIV/AIDS	USAID – Family Health International	Centre for Harm Reduction	1 year	Technical assistance and training	2005	\$30,000	Mekong Region
Reducing drug abuse and delinquency among youth in Thailand, Vietnam, Lao PDR, Yunnan Province China	US – INL	UNESCAP – Emerging Social Issues Division, Health	1 year	Drug treatment	2005	NA	Thailand, Vietnam, Lao PDR, Yunnan Province China
Regional technical cooperation promotion program	Japan International Cooperation Agency (JICA)	NA	3 years	Provision of equipment and training	June 2002	NA	Cambodia, Laos, Myanmar, Vietnam and Thailand

B5.3 Multi-country projects

Project title	Donor	Implementing agency	Duration	Project focus	Start/end year	Budget \$US	Geographical areas
Cross Cutting: Substance Abuse	NIH Fogarty International Center	Johns Hopkins University	4+ years	Prevention research training	NA	NA	India, Laos and Thailand
Substance Abuse in South and Southeast Asia	NIH Fogarty International Center	Johns Hopkins University	2+ years	HIV/AIDS prevention research training	NA	NA	India, Pakistan, Thailand, Vietnam