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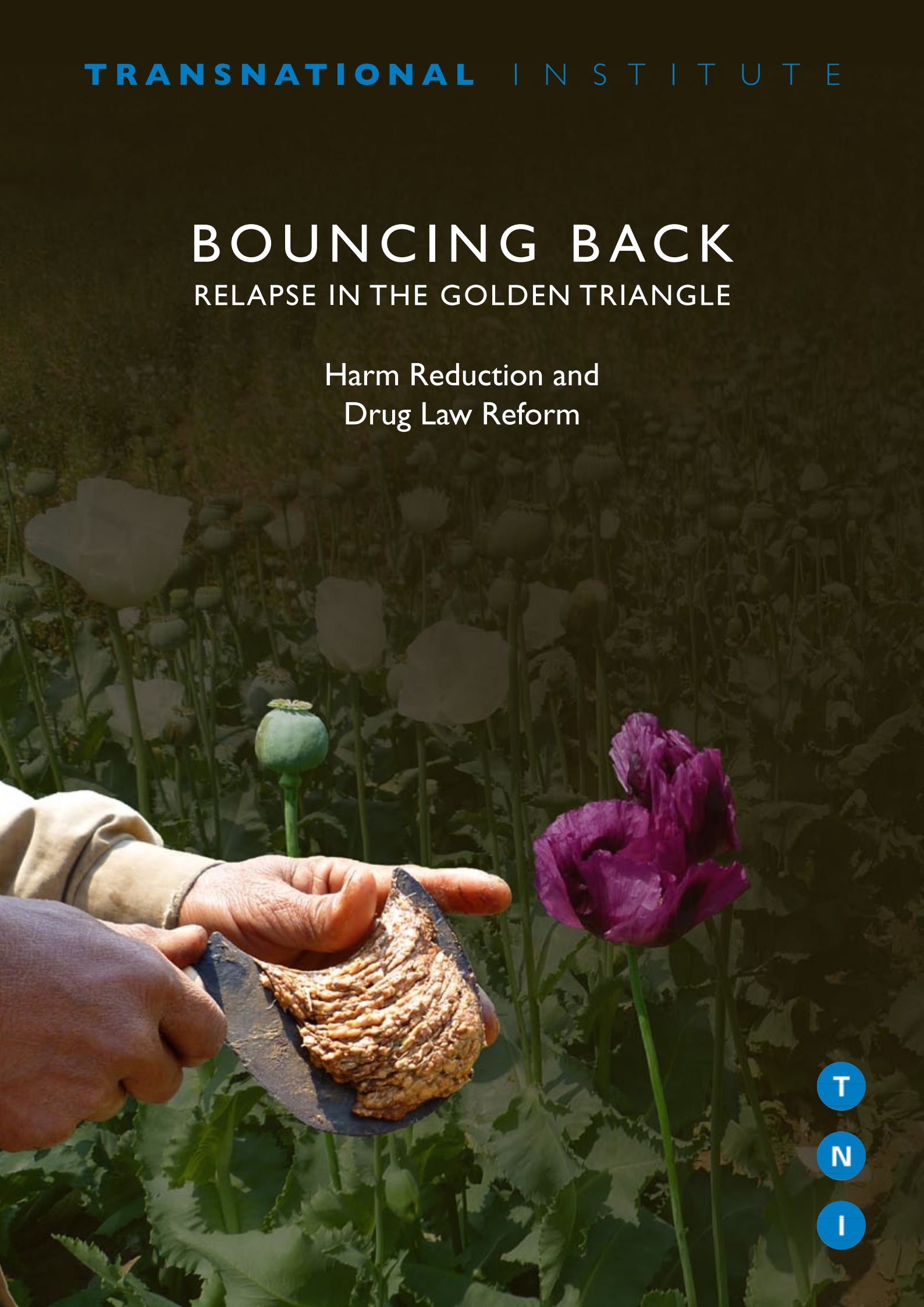
Harm Reduction and
Drug Law Reform



Harm Reduction and Drug Law Reform

"It is illegal to possess and use drugs, if you are in the company of a person caught in possession of drugs, you will be tried and convicted together. There is a place called Kyaukthapake by the riverside, we buy and use our drugs there on the spot. We can't take anything with us to use elsewhere, we are afraid to be caught by the police if we do. Sometimes the police raids Kyaukthapake but then the dealers are warned beforehand, it is a game of give and take between the police and the dealers."[1]
Taxi driver in Burma

While local and national authorities often acknowledge the scope of the problems related to drug use, policy responses tend to focus on prevention, abstinence-based 'treatment' and prison sentences. Under pressure to establish a "Drug Free ASEAN", governments in the region have favoured disproportionate sentencing in a failed effort to control the drugs market. The adoption of harm reduction policies and provision of appropriate services for drug users is lagging behind as a result of repressive drug laws and the failure to respond adequately to developments in the regional drugs market. National responses to drug related issues have often been far more harmful than the problems caused by the drugs they aim to control.

Tens of thousands of people across the region are being jailed for minor drug related offences, as drug use continues to be criminalised and sanctions for micro-trading or street dealing are severe. Harsh custodial sentences for drug related offences result in overcrowded prisons. In 2013, China, Indonesia, Malaysia and Vietnam carried out executions for drug related offences. Laos, Singapore and Thailand imposed the death penalty for drug offences, but have not carried out the executions. The limited access to life-saving harm reduction services has led to the high incidence of HIV and hepatitis C among drug users. Repressive policies are further hampering drug users' access to services.

In recent years there has been a change in how drug users are perceived, as the discourse has shifted from seeing them as 'patients' rather than 'criminals'. While it is a positive move to decriminalise drug users, the region's policy makers are increasingly adopting the false assumption that all drug users are patients who need treatment. Authorities do not distinguish between recreational and problematic drug use, and more than half a million people are undergoing compulsory 'treatment' either in a custodial setting or as out-patients. In most cases these treatment centres are run by law enforcement agencies with no medical supervision.

Across the region, the emerging response to repressive drug control policies shows an increase in poly-drug use,

including pharmaceutical drugs, and in more harmful forms of use. In order to avoid the displacement of drug related problems from one area or substance to another – the so-called 'balloon effect' – it is necessary to understand how the drug market responds to policy interventions.

At the national level, there has been a slight tendency in recent years to adopt a harm reduction approach with a stronger focus on addressing the health-related aspects of the drug problem. Burma, India, Laos, Malaysia, and Thailand all have adopted harm reduction initiatives as part of their national strategy. In practice, however, the implementation and scope of the harm reduction services leave much to be desired. There are hundreds of thousands of drug users in the region, many of whom suffer unnecessarily as a result of inadequate or unavailable services.

Much needs to be done to advance the drug-policy climate and work towards more humane and evidence-based policies. Some countries are reviewing their national drug legislation and it is hoped that this will bring some positive changes that incorporate a public health approach.

To date, the participation of civil society in the policy discussions among UN agencies and governments in the region is very limited. Civil society has hardly any influence on the design, implementation and evaluation of drug control policies and programmes, which greatly affect the lives of their communities – and this situation needs to change.

The Struggle for Harm Reduction

In response to the HIV and hepatitis C epidemic in the region, several countries have adopted and/or approved harm reduction policies and programmes. However, the quality and coverage of services for drug users in the region remain inadequate to deal with the scale and seriousness of the problems. There is an urgent need to develop more health-oriented approaches and to accept the validity of – and expand – harm reduction services. Current obstacles include strict drug laws and repressive policies that prevent drug users from obtaining access to life-saving services. Across Southeast Asia, public opinion generally favours a repressive approach, and drug users are often discriminated against and stigmatised. The fact that only a small percentage of drug use is problematic is barely recognised.

Problematic Versus Non-Problematic Drug Use

Throughout history and in many parts of the world there is substantial and growing evidence that the large majority of people who take drugs are moderate and non-problematic users. Studies on opium use in late imperial China, for instance, found it remarkable that "in a society in which opium was cheap and widely available, so many people smoked lightly or not at all".[2] While some opium users did become addicted and there were some problematic users, it is striking that most Chinese consumers were non-problematic and moderate users.[3] Other studies on opium smokers in China also show that most regulated both the quality and quantity they used. There were (and continue to be) many smokers who used limited amounts and only on occasion, and who were able to control their use, including reducing or stopping it if necessary.[4] A study on opium use in India in 1935 arrived at the same conclusion.[5]

Contemporary research shows similar trends. For example, a 1997 survey in the UK among people of between 16 and 24 years of age found that "drug use is commonplace and consumers tend to be independent, lead active lives, and do not lack self-esteem". The survey found only "a minority of problem users, who fulfilled the stereotypical Trainspotting image and took a mixture of heroin and methadone with other drugs". It concluded that "many anti-drugs campaigns and education packages are aimed at the wrong people, often falsely stereotyping young substance-abusers as friendless junkies with no ambitions".[6]

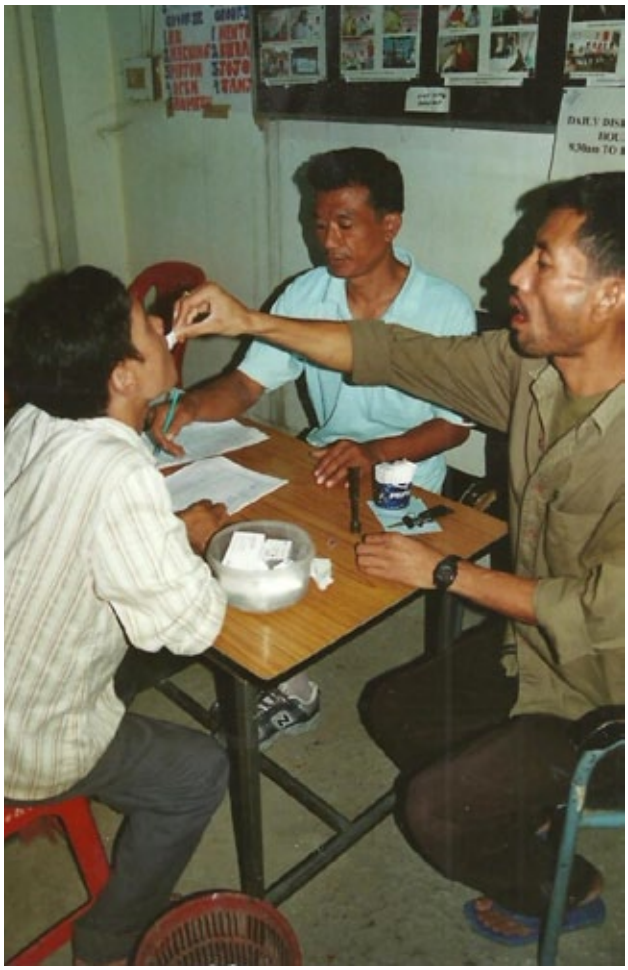
This is not to deny the existence of serious problems related to drug use. In absolute numbers, there are many problematic drug users in the region who are in urgent need of more and better services. However, these constitute only a minority of all drug users in the region, and to be most effective, services should be geared to this group of vulnerable people.

The European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) defines problematic drugs use as "injecting drug use or long-duration/regular use of opiates, cocaine and/or amphetamines".[7] According to

the UK agency Drugscope: "Problem or problematic drug use tends to refer to drug use which could either be dependent or recreational. In other words, it is not necessarily the frequency of drug use which is the primary 'problem' but the effects that drug taking have on the user's life (i.e. they may experience social, financial, psychological, physical or legal problems as a result of their drug use)."[8]

There is a high incidence of HIV and hepatitis C (a progressive liver disease) among injecting drug users in the region. According to UNAIDS, the HIV prevalence among people who inject drugs is estimated to be over 18% in Thailand and Burma,[9] compared to the prevalence among the general population of 1.2 % and 0.6% respectively. Recent years show a reduction in new infections in most countries in the region. The high HIV prevalence and related immuno-suppression in turn results in a high incidence of tuberculosis among injecting drug users.[10]

The hepatitis C virus among injecting drug users has now overtaken HIV as the most serious health threat. As mentioned earlier in this report, the prevalence among injecting drug users is up to 90% in Thailand[11] and Northeast India.[12] Estimates are that between 80% and 85% of users will develop chronic hepatitis C.[13] The treatment with Peginterferon and Ribavirin is costly and not provided by existing services for drug users. The treatment also causes side effects such as nausea, influenza, weight loss and depression. Depending on the type of hepatitis C, patients are required to take these medicines for a period of several months up to a year. Hepatitis C is difficult to treat, especially if there is co-infection with HIV. The cure rate among mono-infected hepatitis C patients depends on the genotype of the virus; for co-infected patients the cure rate is lower than in the case of only one infection.[14] To address the high prevalence of hepatitis C UNAIDS is advocating for the joint prevention and treatment of hepatitis C and HIV.

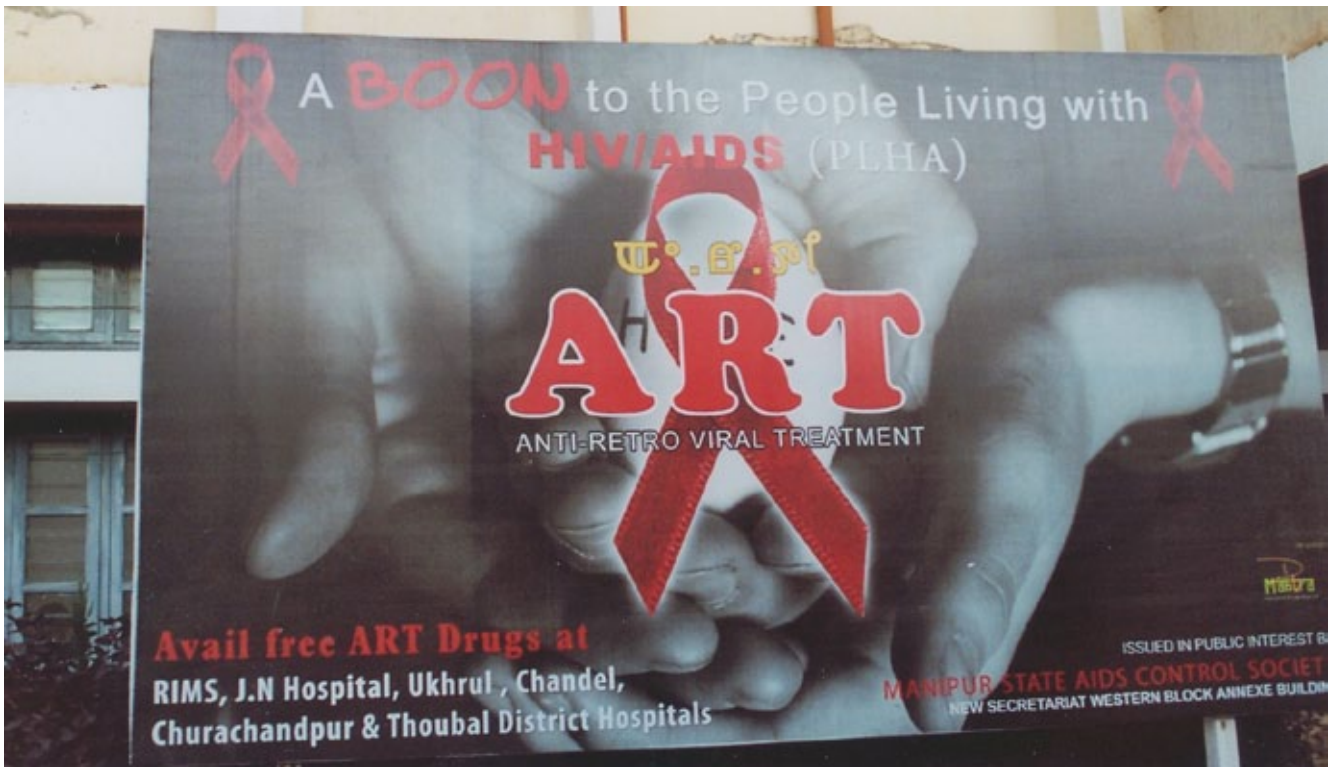


Providing Buprenorphine at local NGO in Northeast India

Burma adopted its first National Strategic Plan on HIV and AIDS in 2006, and this already included harm reduction services. In 2011 the second National Strategic Plan was adopted with the aim of achieving the HIV-related Millennium Development Goals (MDGs) to be achieved by 2015. Initially there was resistance to a harm reduction approach, but such services were piloted in Lashio, northern Shan State in December 2004.[15] Since then drug users in Burma have had a growing number of services available to them. There have also been more awareness and prevention programmes about drug use and associated health risks. Drop-in centres (DICs) for drug users along with needle-exchange programmes and condom distribution are now becoming more accepted, although there remains some resistance. At the DICs the clients' names remain confidential and codes are used in day-to-day management. Harm reduction services are slowly expanding across the country, although their quality and quantity are still inadequate to address the scope of the problem.

There is only limited Methadone Maintenance Therapy (MMT) in Burma, currently reaching about 3,000 people. Only government-run centres (mostly based in hospitals) can prescribe and supply methadone, and users are obliged to register in order to be eligible for it. A hospital psychiatrist decides on the dose, which usually starts at 25 ml but can be as much as 120 ml. According to outreach workers, some patients need up to 180 ml a day, and most users will revert to illegal drugs to avoid withdrawal symptoms. Drug user organisations in Burma recommend making methadone more widely available, and not only at state hospitals from 9am to mid-day as is currently the case.[16] They also recommend easing procedures for being allowed to travel while on MMT. At the moment it is still a complicated bureaucratic procedure to receive methadone elsewhere, and there are also restrictions on carrying methadone locally and out of the country. The government plans to have 8,000 people on MMT by 2015,[17] which is low compared to the estimated 60,000 to 90,000 injecting heroin users.[18] In certain regions where there are no government facilities to provide methadone, NGOs are allowed to offer maintenance treatment.

The lack of access to methadone or other substances to help opiate users deal with withdrawal symptoms has led to the exploration of various alternatives on the market.



Billboard in Imphal in Northeast India

Reportedly, opiate users in the China–Burma border region use Compound Diphenoxylate tablets, locally known as 'CDO', which they use to ease their pain and stop withdrawal symptoms. CDO pills contain diphenoxylate hydrochloride (2.5mg per pill) and atropin (0.025 mg per pill). This opioid agonist was widely used in China to treat diarrhoea. "I smoke heroin three times per day and two caps per time", says a 53-year-old Kachin woman: "I use CDO when I do not have heroin. It costs 6 Yuan for one bottle, which contains 100 tablets. I take seven tablets for each time, and if I take it in the morning right after breakfast it controls my desperate urge to use heroin until the afternoon."[19]

According to a 22-year-old Kachin man: "I tried to stop using heroin twice. During that time, I was suffering a lot, my nose was bleeding, I felt painful in the whole body, and I felt hot and cold. I used CDO pills to kill and reduce those feelings. It has a white colour and has 100 tablets in a bottle and costs only 6 Yuan per a bottle. I took 10 tablets at once, and I felt much better. There is also another drug called Ma-tau-hpyen. The colour and bottle are similar to the CDO bottle. It has 10 tablets in one card and it costs 8 Yuan a card. It is not so effective compare to CDO so it has fewer users. We can easily buy both of them in any Chinese pharmacy."[20]

After 2009 when CDO became difficult to find on the market, drug users approached a harm reduction project in Kachin State near the China border to help them to get access to it. "We tried really had to get methadone for users but we could not during that time", says a former project coordinator. "We had a shelter for the drug users and many of them came with no money, no clothes and no drugs. Some of them were willing to stop using heroin and this was the only legal medicine that we could find to help them when they were suffering from the withdrawal syndromes. It actually works really well, and the drug users liked it very much." The CDO pills were used in combination with Tramadol, and the treatment was a temporary solution as no other legal substitute could be bought in the area.

Although there are no reliable data, HIV rates among injecting drug users in Laos are thought to be low compared to neighbouring countries. However, as the country is a major heroin-trafficking route and heroin is easy to obtain, and there is high HIV prevalence among populations along its borders, the government set up a task force to address HIV and drug use, and to develop harm reduction policies and programmes. The country's 2011–2015 National Strategic Plan for HIV and AIDS includes promoting clean needles and other harm reduction services, but implementation so far is limited to information and counselling for injecting drug users. A study on harm reduction focused on government officials in Laos found that "law enforcement officers in particular had limited understanding about harm reduction and the feasibility and appropriateness of harm reduction services in the Lao context".[21]

Thailand is still developing a comprehensive harm reduction policy. The government rejected legalising needle and syringe programmes, as it is convinced that these would stimulate drug use, and thus contravene the Thai narcotics law. This position has slowed down the implementation of harm reduction interventions.[22] As a compromise the government is now allowing NGOs to carry out needle and syringe programmes. Population Services International (PSI) has partnered with various local NGOs and support groups for people living with

HIV to distribute clean needles to the country's estimated 40,000 injecting drug users, 20% of whom share needles, according to 2010 government figures. The Global Fund has granted funds to "facilitate an urgently-needed roll-out of needle and syringe programs for injecting drug users and condoms for the most at risk populations such as drug users and sex workers. These populations remain a major gap in the HIV prevention interventions in Thailand".[23] In November 2010, the Thai government decided to launch ten pilot programmes to test whether needle and syringe programmes reduce the harmful aspects of drug use. But the authorities clearly felt more comfortable with prevention programmes, and most of the resources were spent on capacity-building and anti-drug exhibitions. In February 2014, the Thai Office of the Narcotics Control Board announced the launch of the new harm reduction strategy, which will also include needle and syringe programmes. The strategy will be piloted in 19 provinces across the country (four in the central region, six in the north and nine in the south) and run through to September 2015.

Methadone maintenance therapy is provided only in a small number of health centres in Bangkok, whereas in other cities only short-term methadone treatment is available. The National Health Security Office is providing the MMT but the capacity is low and only 7% of users are enrolled in a programme.[24] The programmes are strict: failure to produce a negative urine test results in two-week suspension of MMT. Some users reported that they needed to have a job in order to be allowed to participate in the programme.

The distribution of Naloxone to prevent overdose is very challenging in Thailand, despite being on the WHO Model List of Essential Medicines that should be available in all health-care facilities. Only after concerted efforts did PSI manage to make Naloxone available in 19 DICs in Bangkok.[25] There is a need for more pressure to allow all drop-in centres in the country to do the same. In Burma, the overdose rate among users is also reported to be high, although there are no exact figures. Unfortunately, neither the Global Fund nor the Three Millennium Development Goal Fund covers the costs of Naloxone in Burma, which are now met by international NGOs. The Asian Harm Reduction Network in Burma has trained peer educators to administer Naloxone.

Nagaland and Manipur, two sparsely populated states in Northeast India that border Burma, have the highest prevalence of injecting drug users in India. Unsafe practices, especially needle sharing, have been the main reason for the epidemic of HIV/AIDS and hepatitis C in these states, illnesses that have spread to the general population. The seriousness of the situation brought unconventional responses, and in 1996 Manipur was the first state in India to adopt a policy that included a harm reduction approach aimed at vulnerable groups such as injecting drug users. The government set up the National Aids Coordination Organisation (NACO) to coordinate programme implementation. Nevertheless, the new policies and services have proved inadequate to deal with the scale of the problems. Between 2000 and 2010, HIV prevalence among the adult population in Manipur was estimated to be 1.4%, compared to the average prevalence in India of around 0.4%.[26] Local NGOs and drug user self-help groups complain that NACO does not work.[27] At the same time NACO claimed a huge decline in the number of HIV infections among drug users as a result of its harm reduction strategy.[28]

In China, the government also responded to the HIV/AIDS epidemic, caused largely by injecting drug users as in the rest of the region, by introducing MMT and needle and syringe programmes. MMT was first introduced in 1993, but only for in-patients in specific medical contexts. Since 2004, MMT clinics were set up in five provinces, which soon expanded, and MMT is mainly used as a detoxification method. NGOs and international donors set up needle and syringe programmes because the government believed that they would stimulate drug use. As evidence of their success grew, in 1999 the government introduced needle and syringe programmes in Quanxi and Yunnan provinces, bordering Southeast Asia. These programmes have now been extended to other provinces.[29]

While the government has expanded MMT, it has accorded less funding and political support to needle and syringe programmes, which remain controversial among government officials.[30] Though it is accepted that these programmes reduce HIV infection rates, they are seen as condoning illicit drug use. This is also reflected in different opinions within government departments on the issue: "Whereas public health practitioners prioritise reducing risk of infection from blood borne diseases amongst injecting drug users, public security authorities are charged with enforcing the laws against the sale and use of illicit drugs."[31] While the central government strategy includes MMT, implementation varies. And as long as China continues to make drug use illegal, services for current drug users will remain limited. This means that harm reduction policies and services in China remain inadequate.

Malaysia adopted harm reduction policies in 2006, and subsequently expanded MMT and needle and syringe programmes throughout the country. According to UNAIDS, Malaysia reports the highest coverage in the region with 200 syringes a year per injecting drug user and 26% coverage of opioid-substitution treatment.[32] However, the prevalence of HIV among drug users remains at around 19%, and there is a need to extend harm reduction services as "coverage remains too low, police harassment prevents effective implementation, and broad political or public support for these controversial policies is lacking".[33]

Voluntary drug treatment center in Kachin State

In recent years, the funding provided by the Global Fund – and the 3 Millennium Development Goal Fund in the case of Burma – has played a very important role in the expansion of harm reduction services and practices in the region. Domestic funding accounts for only a small percentage of the costs.[34]

In 2008, WHO, UNODC and UNAIDS published a technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.[35] The guide identifies a comprehensive package of nine interventions[36] that have proved effective in preventing the spread of HIV, in addition to reducing other harmful side-effects of drug use. The guide has been endorsed by the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, and the UNAIDS Programme Coordinating Board and serves as a tool to enhance the implementation of harm reduction strategies. But the reality is that still much remains to be done to achieve comprehensive harm reduction programmes in Southeast Asia.

Compulsory 'Treatment'

In addition to causing considerable health and social harm, repressive drug policies in Southeast Asia have resulted in a very large number of drug users undergoing forced treatment in closed settings. The number of compulsory 'drug treatment' centres has grown from 750 in 2005 to over 1,000 in 2010 in East and Southeast Asia.[37] For a while, Cambodia, China, Laos, Malaysia, Thailand and Vietnam viewed compulsory centres as the answer to the drug problem. There are, however, many complaints about the treatment in these centres, where it is claimed that human rights violations are rampant.[38] Although treatment differs from one centre to another, in 2009 WHO concluded that "generally the approach provided in China, Malaysia, Vietnam and Cambodia needs much improvement".[39] The detainees receive little or no medical care, and beatings, forced labour and compulsory exercises are part of the "treatment" in the centres. Often people are sent to these centres without due process, and with no right to appeal.[40] Relapse rates from the compulsory centres are high, ranging from 60% in China to close to 100% in Cambodia.[41]

In Thailand, the courts decide whether to sentence a person found guilty of drug related offences to prison or to compulsory treatment. Sentencing is based on the person's history of drug use and a urine test. After reviewing the evidence and the reports of the inquiry officer, the relevant Sub-Committee will order compulsory drug treatment in either custodial or non-custodial programmes. In practice, the decisions of the Sub-Committees are also influenced by whether there is prison space. The Sub-Committee does not distinguish between recreational or problematic drug use. Once a person is confined for treatment the Sub-Committee has the authority to extend treatment for periods of up to six months at a time to a maximum of three years, and the detainee cannot appeal against an extension. Custodial treatment programmes initially involve four months in treatment centres, followed by a two-month 're-entry' programme. Between 1 October 2008 and 1 June 2009 nearly 40,000 convicted

Methadone Maintainance Therapy programme in China

drug users were held in compulsory centres, and over 7,000 were held in detention.[42] These numbers have increased exponentially since then (see the Thai wars on drugs section below).

In 2010, Cambodia had 11 temporary centres for drug education and rehabilitation, treating over 1,100 people. The centres are run by various ministries, NGOs, and the civilian and military police. However, even government agencies have admitted that these centres have failed to provide the treatment intended.[43] In 2012, the Cambodian government made the commitment to expand community based treatment to 350 communes by 2016. Recent research by Human Rights Watch found that in the eight remaining Cambodian drug detention centres torture, physical abuse and forced labour still continue with impunity.[44]

In Laos, there is only one treatment centre in the capital Vientiane, which is heavily overcrowded with 1,000 people. So far Laos has focused on abstinence-oriented treatment, and other forms of treatment and services for drug users, based on harm reduction principles. It is crucial to apply international standards. "We can treat about 10 percent of drug addicts each year. But compared to the actual need, we are nowhere close to providing sufficient assistance", according to the Acting Chairman of the Lao National Commission for Drug Control and Supervision (LCDC) in September 2013.[45] The Lao government is seeking funding from international agencies to extend these services. Several donors are supporting a community-based project on opium addiction and civic awareness and a pilot project on community-based treatment for ATS users. [46]

Malaysia's narcotic addiction rehabilitation centres (PUSPEN in Bahasa Malaysia) have been criticised over the years for "providing little medical care to the patients and resorting to corporal punishment verging on physical abuse" and for high relapse rates ranging between 70% and 90%.[47] However, since the introduction of harm reduction policies in 2005, the population of these centres dropped from an average occupation rate of 10,000 people to less than 7,000 by early 2010. The treatment practised in these compulsory centres used to consist of forced labour and sometimes 'water treatment',[48] both in violation of human rights and harmful to the patients. In 2010 the government decided to transform part of the compulsory centres into 'Cure and Care Centres', although some compulsory centres remain. At these Cure and Care Centres people can receive methadone treatment for three years, but the centres do not offer needle and syringe exchange. The urine sample must be clear of heroin in order to be admitted, and the centres have full waiting lists. The state runs methadone clinics, and the coverage in Malaysia is highest in the region after China: in 2012, some 52,000 people across 674 sites were enrolled. These clinics have to be registered, so private practitioners care for those who want to remain anonymous. Heroin arrests have been increasing in Malaysia in 2013 – although this is not necessarily due to increasing use but could also be because of more police arrests.[49]

In 1990, the Chinese government issued a regulation stipulating that drug users who were caught would be fined and encouraged to receive treatment at a government-run voluntary detoxification centre. Those who relapsed were sent to compulsory centres, which include forced labour. Anyone who was arrested and still using drugs after having gone through the two previous stages would be sent to labour camps for two or three years of re-education.[50] In 2006 the government issued a new policy to send drug users immediately to compulsory detoxification centres, while relapsed drug users would go to re-education labour camps. A few months after the policy was introduced large numbers of drug users were sent directly to these closed facilities. According to one study, "in June 2006 alone, 269,000 drug users were incarcerated and 71,000 of them were sent to reeducation labor camps. At the end of 2006, there were about 1000 incarceration sites in China". [51]

Joint UN Statement on Compulsory Treatment

In March 2012, 12 UN agencies released a joint statement calling for the immediate closure of compulsory drug detention and rehabilitation centres and for the establishment of voluntary, evidence- and rights-based health and social services in the community.[52] The statement reads:

The UN entities which have signed on to this statement call on States that operate compulsory drug detention and rehabilitation centres to close them without delay and to release the individuals detained. Upon release, appropriate health care services should be provided to those in need of such services, on a voluntary basis, at community level. These services should include evidence-informed drug dependence treatment; HIV and TB prevention, treatment, care and support; as well as health, legal and social services to address physical and sexual violence and enable reintegration.

The UN stands ready to work with States as they take steps to close compulsory drug detention and rehabilitation centres and to implement voluntary, ambulatory, residential and evidence-informed alternatives in the community.

In a 2012 UNODC survey on compulsory centres in Southeast Asia, six countries reported their existence, four reported anticipating a reduction in their number, and five reported that the number of people in the centres would decline over the next two years. This picture has been confirmed by UNAIDS: "Countries, including Malaysia, Vietnam, Cambodia and Myanmar, are moving away from compulsory detention for people who use drugs and investing in evidence-informed, community-based treatment approaches. Such efforts promote and protect human rights and produce higher quality public health outcomes, including for HIV."[53] This shift to voluntary treatment has to be scrutinised, however, because in some cases it is not as voluntary as it sounds. In Thailand, for example, drug users are offered 'voluntary treatment', but in fact they are offered the choice between prison or treatment – which means that many users who do not want or need it are being treated all the same.

Given prison overcrowding and human rights violations in the compulsory centres, and yet increasing drug use, governments need to invest in alternative and more effective interventions, such as community-based voluntary treatment. Problematic drug users should have a choice of whether and how they are treated; this is a fundamental human right as defined in the Right to Health.[54] There should not be preconditions or consequences tied to treatment, and relapse needs to be acknowledged as part of the process. People do not attend if they feel there are obstacles or conditions in place, or if they feel the treatment on offer is poor or ineffective. Drug enforcement agencies have to be informed about such services and should cooperate to ensure that they are successful and offer free access for drug users. Very few people actually need in-residence treatment, as most can be treated in their communities with support from their family and community. But most importantly it has to be acknowledged that most drug users do not need treatment at all – it has been estimated that only 10-20% of users become problematic, depending on their drug of choice.[55]

Law Enforcement and Prison

Law enforcement and police arrests of drug users have a negative impact on access to harm reduction services. Drug users in Burma, India and Thailand complain about police harassment. Police officers are reported to have falsely accused people of using and dealing drugs, including planting drugs on suspects – often in order to extract bribes. Excessive force is used to compel users to inform on other people in the drug-using community. One drop-in centre in Bangkok, for example, reported that sometimes police officers visit and demand urine tests from all their clients. Despite the efforts of the DIC staff it proved impossible to establish a good professional relationship with the police.[56]

This harassment not only hampers access to life-saving services but also can also result in the use of more dangerous substances and riskier methods of using them. In the same DIC in Bangkok, drug users started taking a mix of Dormicum and Midazolam to avoid the detection of ATS in their urine. In Burma, the mere possession of needles can lead to arrest unless the suspect is carrying an MMT registration card. As a result, users stop carrying needles on them and stash them away or run the risk of sharing needles.

Members of the National Drug User Network Myanmar (NDNM) report that they are under police surveillance,

and on some occasions people attending NDNM meetings have been searched. Clearly police practices have a large influence on the success of harm reduction services and it is therefore imperative for law enforcement officials to be supportive.

Law Enforcement and Corruption in Burma

"At the age of 22 I used to peek through the door of my brother when he used heroin. I stole his drugs and tried it myself, then got addicted. I smoked heroin the first two years, then my brother and I started injecting. It is illegal to possess and use drugs, if you are in the company of a person caught in possession of drugs, you will be tried and convicted together.
There is a place called Kyaukthapake by the riverside, we buy and use our drugs there on the spot. We can't take anything with us to use elsewhere, we are afraid to be caught by the police if we do. Sometimes the police raids Kyaukthapake but then the dealers are warned beforehand, it is a game of give and take between the police and the dealers. Now the price of heroin has gone up, before it was only US$2 for a bottle of penicillin, but now it is up to about 7.50 US$. The traffickers are caught and convicted, and heroin is difficult to transport. The quality of the drugs has gone down, it looks dirty and mixed."
Taxi driver in Mandalay

"I am worried about my security but I would like to discuss with you about my experiences of our police force. Because of our country's political situation everyone is doing their own things. Most of the police are becoming thieves, and they are using many ways to get money from the local people. They bribe a lot and I am also doing that, because we do not have enough salary. I would like to say that we can only solve this problem when we have honest policeman to run a strong police organization."
Police officer in northern Shan State

"Generally we can buy drugs in the border area. Most of drugs are couriered by women and I have received a lot of bribes from them. Often when we check families, they already have prepared a bribe for us. Each side - China and Burma - knows what we are doing, and my colleagues in China are doing the same. I would like to say the truth, we are doing special narcotic work, but we cannot stop receiving bribes because it is our income. We do not accept bribes always but it depends on the situation. I know there are not many Kachins who become rich by selling drugs. They do little business in drugs and are often arrested. When they are arrested they cannot pay the fine, so they have to carry enough drugs to pay for the fine: one kilogram of drugs pays for carrying two kilograms. I also carry drugs from Mandalay to Muse. Sometimes I spend a lot of money on the way, then the costs are higher than the benefits, it is very dangerous work."
Police officer in Laukhai township in the Kokang region

Drugs and Prisons

Drug offences account for a large number of prisoners in Southeast Asia, largely as a result of the focus on law enforcement in drug control policies. The enforcement of harsh penalties for small-scale drug offences or simple possession has thus not only been ineffective in curbing the production, trafficking, and consumption of illicit substances, but has also had enormous negative consequences, including overwhelming caseloads in the courts, overcrowding in the prisons, and the suffering of tens of thousands of persons behind bars on minor drug related offences.

As in other parts of the world, a high percentage of prisoners have committed only minor offences for which they are serving disproportionately long sentences. These are often poor people with low levels of education, who are unemployed or have only temporary jobs. As argued earlier, very few major traffickers end up in jail (see Chapter 2). But the judicial systems in the region do not appear to differentiate between different levels of involvement in the drugs trade and make no distinctions between violent and non-violent offences. Many people serve lengthy jail terms just for possession or small-scale trading, with no other offences. TNI research in Burma also found that several female drug users and female small-scale traffickers have been jailed. Their number is still far less than the male prison population, but seems to be increasing.

Furthermore, the prison systems in the region fall short of meeting international human rights standards, and more often than not fail to provide for basic needs, such as access to sufficient and nutritious food and health services. The overcrowding of prisons – mainly due to the large number of drug related cases – also causes other problems. In such settings, incarceration has many negative health effects, such as STDs, including syphilis, herpes and HIV, mental health problems, skin infections, tuberculosis, and hepatitis B and C. AIDS and tuberculosis are reportedly the major cause of death among prisoners.

Research into prison conditions undertaken in 2012 by Chiang Mai University showed that 64% of the total prison population of over 246,000 were convicted on drug related offences.[57] The same study found high rates of HIV and tuberculosis; supply of drugs in prisons; injecting drug use with high infection risks; and high-risk sexual behaviour, especially among men having sex with men. Combined with stigmatisation and discrimination of HIV-positive people, which makes it difficult for this vulnerable group to obtain access to the necessary services (only 10% of HIV-positive people choose to undergo medical check-ups because of fear of discrimination), there are high health risks for drug users in Thai prisons.[58] Of those convicted of drug related offences, over 95% used ATS and 2.7% opium or heroin. The high percentage of ATS-related offences is because the police urine tests detect only ATS use and not

other substances.[59] The prison population in Thailand has continued to increase, especially among youth, causing more overcrowding and further reducing adequate access to health services. By early 2014, the Thai national prison administration reported that the prison population had risen to 290,000.

In Burma, sentences for drug related crimes can be very harsh.[60] In 2012, UNODC reported 5,740 drug related arrests in Burma.[61] Most are drug users and very few dealers are arrested. Once convicted of drug related crimes people are sent to one of the country's 42 prisons or 100 labour camps.[62] Burma's total prison population is estimated at some 60,000.[63] Compared to Thailand, whose population is some 10-15% larger than Burma's, this is a much lower incarceration rate.[64] As in Thailand, however, Burma's prisons are overcrowded, and a high percentage of people are jailed for small drug related offences. This includes people arrested simply for possession and use. TNI research undertaken in 2013 among drug users from different areas of the country showed that a large majority had at least been arrested once, mostly for failing to be registered (section 15 of the narcotics law) and possession (section 16). They estimated that over 60% of the prison population is there because of drug related offences, citing sentences varying from two months to 35 years. Some also reported to they had been forced to do agricultural work and mining while in prison.[65]

In Burma, even the suspicion of drug use is enough to lead to an arrest, and a positive drug urine test can result in conviction. However, the application of drug laws is heavily dependent on those who enforce the law and can therefore be quite arbitrary. Informal arrangements with police have in some cases prevented the arrest of drug users going to drop-in centres, even though the law formally requires law-enforcement interventions. This collaboration between public health and law enforcement operates through the township harm reduction coordination committees but has no a legal basis.

According to a 2011 study, Malaysia's prison population stands at some 36,000 people, including people held in drug treatment centres, detention facilities for illegal immigrants and juvenile institutions. Data from 2007 showed that 40% of the prison population was incarcerated for drug related offences.[66]

Information in India on the percentage of the prison population on drug related offences was elusive. Using the Indian Right of Information Act, one TNI researcher tried to gather information on the nature of the arrests made under the Narcotic Drugs and Psychotropic Substances Act (NDPS Act) in India between January 2001 and December 2011. Only the state of Punjab sent the requested overview of all persons arrested under the NDPS Act during those 10 years. All drug related arrests in the state of Punjab were of drug users or small peddlers, and one major trafficker or

Compulsorary drug treatment center in KIO territory

'kingpin' was arrested. Drug use in prison is widespread, and according to local research the riot in Punjab's Kapurthala jail in November 2011 was caused by the fact that a new superintendent had stopped the supply of drugs, facilitated by police. After the riot, in which one user was killed and 13 injured, the superintendent was transferred and all went back to normal.[67]

With over 2,3 million people in jail and detention centres in 2013, China has the second highest per capita incarceration rates in the world, after the USA.[68] There are no available data on the number of drug related prison sentences. Those convicted for drug use are not sent to ordinary prisons but to compulsory detoxification centres and labour camps, which are also closed settings.

Unfortunately, we can be brief about harm reduction services in prisons in the region: they are virtually non-existent. According to the Global State of harm reduction Report not one country in Southeast Asia is offering needle and syringe programmes and only India and Malaysia offer limited substitution treatment to prisoners. In India, the only prison in the country that runs an opoid-substitution programme is Tihar Jail in New Delhi, where drug users can receive Buprenorphine. There is no opioid-substitution therapy available in any other detention facility. Only two

Drug Related Arrests and Prison

"I am a member of Kachin Independence Organisation [KIO – ethnic armed opposition group] but at the moment I am on official leave; I have already served KIO for 15 years. The past three years I have been selling drugs. In my home village most families used to sell drugs though at the moment not that many. In August 2008 I was arrested but I paid a bribe of about 10,000 US$ so I was released in December 2008. The police did not find drugs in my house but they knew I was involved in drug dealing. I hid all the drugs in the jungle so that they would not find them. They also knew I am a KIO member so they did not ask too many questions but in the end they did find some drugs on my body. I told them that I was not a drug user but the drugs were for my friends. First I went to Muse jail and then to Kutkai jail. I am not a drug user but the police checked my blood to be sure. However, I still needed to bribe them to ensure that the test result was negative. In the end they sentenced me with article 15, 17 and 21 [failure to register, possession and providing financing assistance to commit an offence], but after that I spent only seven months in jail and I was released.

If you have money you can get everything in jail. If you want to use drugs, you can buy it from the police, you can have alcohol and play cards. The police even provide security when you use drugs in jail, and they warn you when the director comes. Outside of jail we give US$1 for one cap of a penicillin bottle of heroin, but in jail we have to give US$2. We can also get good curries in jail with our own money.

I lost all the money I got from selling drugs, I just have my house left. I paid many people who helped me, and I am still paying them. If I continue to sell drugs they will kill me so I am not interested in doing this job again. I was just released from jail so I have not decided what to do in the future. It is very difficult to get money if we live in Burma. I have no peace."
Former KIO member in Kachin State

"I went to jail in 1993 because of drugs and was released in 2003. The police arrested me at a checkpoint together with a friend. I carried drugs for other people, and the owner of the drugs followed in another car. When we got arrested she fled immediately. My friend who I was travelling with was only 16 years old then, she is very beautiful, but she has no education and cannot speak Burmese very well. As I felt sorry for her, I told the police that all the drugs belonged to me. I carried a lot of drugs on my body, but my friend had not that much. She carried drugs only two times, but I did it ten times already. She also has financial problems in her house. We carried drugs from Muse to Mandalay. I know the owner, she is also from our village, but I confessed to the police that all drugs belonged to me. They sentenced me to 15 years in jail.

I faced many difficulties in jail. We need to stay in good health in jail. When I was in jail, my husband became a drug addict. My eldest son also went to Hpa-kant jade mine area. My youngest son is also a drug user, so I am very sad at this moment. My husband died in 2004 as a result of his drug use. My youngest son has stopped to use drug this moment, he lives with his older brother in Hpa-kant.

Now I face financial problems again so I would like to be a drug carrier again. My daughter also carried drugs from northern Shan State to Maja Yang in Kachin State via China, but she was arrested in 2006 on the China side, so she is in a Chinese jail. I do not know when she will come back. When I was in jail the lady who owned the drugs I trafficked was also arrested. They sentenced her to 18 years in jail but she only spent five years, and then she was released. She is a very brave and clever woman. After her release, she became involved in drug business on the China side. Two years later she was arrested in China. She caused many problems to our village. Many women were trained by her and many women are in Burmese and Chinese jail. Her daughter is also in drug business, and she has HIV. I lost everything in my family because of drugs. I lost my daughter, son and husband. Now I serve at the children's school, I will live here and help the community."
52-year-old Kachin woman from Northern Shan State

of the prisons in Malaysia offer care clinics for inmates. Elsewhere, prisoners have to be sent outside to obtain the care they need, but this depends on the warden's discretion. There is no condom distribution in prisons.

Thai Wars on Drugs

The provisions of the Narcotic Addict Rehabilitation Act (2002) stipulate that people who use or are dependent on drugs should be "treated as patients, not criminals". However, the arrest and charging of drug users continue to take place under the Psychotropic Substances and Narcotic Control Acts (1975, 1976, 1979). In 2003, the populist Prime Minister Shinawatra Thaksin started an aggressive 'war on drugs', which aimed to eradicate drug use, trade and production within three months. The campaign resulted in the arbitrary inclusion of drug suspects in poorly-prepared government 'blacklists' or 'watchlists', the intimidation of human rights defenders, violence, arbitrary arrest and other breaches of due process by Thai police, coerced or mandatory drug treatment, and the extra-judicial killing of over 2,800 people. The government blamed these murders largely on gangs involved in the drug trade, but human right organisations blamed them on the endorsement of a policy of extreme violence by government officials at the highest level.[69]

After Thaksin was overthrown in a coup in September 2006, an independent special committee formed by the

temporary military government investigated the unlawful deaths. According to this committee, almost half of the victims were unrelated to drug dealing or were killed for no apparent reason. According to one newspaper report: "Senior public prosecutor Kunlapon Ponlawan said it was not difficult to investigate extra-judicial killings carried out by police officers as the trigger-pullers usually confessed."[70] With the elections in January 2008 Thaksin's People's Power Party was returned to power, and the final report presented to the cabinet only contained statistical data and no senior officials were linked to the killings.[71] Despite many promises to bring those responsible to justice, to date not a single high-ranking military or police officer involved in the atrocities has been formally charged.

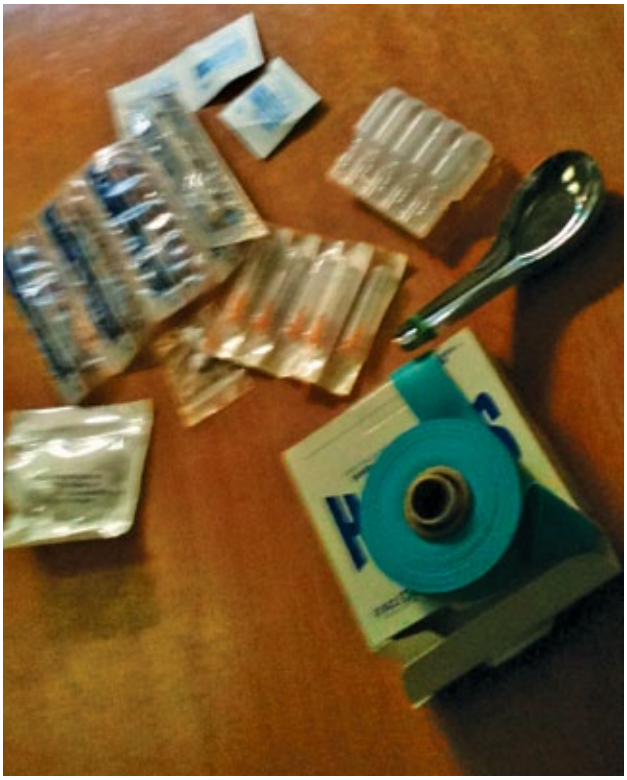
Opinion polls throughout the drug war showed support for the government's violent tactics. However, the violent outcome did not curb Thailand's illegal drug trade, use or production, but simply made it more dangerous. Most drug users continued to take heroin or methamphetamine, albeit at a higher cost and less frequently. Treatment experts also noted that many people who started drug treatment in early 2003 were not drug users at all, but were people who feared for their lives because they were suspected of using drugs. The Thai war on drugs targeted only petty traders (often drug users themselves, dealing in order to sustain their habit) and did not lead to the arrest of major drug traffickers, nor did it investigate corruption among government officials related to the drug trade.

Shortly after her election in 2011, Prime Minister Yingluck (sister of former Prime Minister Shinawatra Thaksin) announced another war on drugs. Immediately several human rights organisations voiced their concerns about the potential consequences.[72] Deputy Prime Minister Chalerm Yoobamrung presented ruthless plans to take on this war, and proposed to cut the time on death row for those convicted of drug related offences to 15 days and halved the threshold for handing down a death sentence from possession of 20,000 to 10,000 methamphetamine tablets.[73] Currently 45% of the almost 700 people on death row in Thailand are convicted on drug related offences, but there has been no execution since 2009. In this second war on drugs judges have been ordered to cooperate with police and anti-narcotics officials to speed up the procedures for issuing arrest warrants. As a result, the number of drug related trials increased by 30% to over 8,700 in 2011. Chalerm is reported to have said that "the Ministry of Justice needs to prioritise narcotics over human rights"[74] and warned of "collateral damage".[75]

In September 2012, the Office of the Narcotics Control Board (ONCB) reported over 500,000 drug users had entered its rehabilitation programme, over 100,000 more than the original target. In 2011, there were over 247,000 drug related arrests in Thailand, of which some 192,000 were linked to methamphetamine tablets.[76] The number of people arrested on drug related offences in 2012 reached over 360,000. The number of confiscated methamphetamine tablets is enormous: 76 million between August 2011 and September 2012. Yet the purity and the market price remain more or less constant, a sign that these large seizures have not affected its availability.

Drug users represent a large proportion of Thailand's prison population.[77] In February 2002 this amounted to two-thirds, or well over 100,000 people.[78] In August 2013, Thailand's prison population had risen to nearly 280,000,

ONCB leaflet



Safe injecting kit at DIC in Bangkok

Billboards at Yangon airport

and occupancy was estimated at 133.9%,[79] which means that the prisons are housing nearly 34% more inmates than they are built for. To solve the problem of overcrowding the Thai Minister of Justice announced in October 2013 that the government would seek 30 billion Thai baht (US$92 million) to build 42 new prisons nationwide.[80] The ministry was also considering suspending the remaining sentences of elderly inmates and of prisoners who have served at least two-thirds of their terms. By April 2014, however, the number of prisoners had risen to over 292,000.

Despite the massive number of drug users in prison and compulsory centres, as well as the huge confiscation of pills, in 2012 the Drugs Abuse Information Network for Asia and the Pacific (DAINAP) reported an increase in the use of all drugs in Thailand.[81]

Death Penalty

China, Indonesia, Laos, Malaysia, Singapore, Thailand and Vietnam still impose the death penalty for drug offences. In 2013, China, Indonesia, Malaysia and Vietnam carried out executions for drug offences. Because China and Vietnam classify data on the death penalty as a state secret, it is impossible to know the precise number of executions for drug related offences in the region.

Handing down the death penalty for drug offences fails to meet the threshold of 'most serious crimes' permitted under the International Covenant on Civil and Political Rights (ICCPR). UNODC, the UN Human Rights Commission, the UN Secretary-General and most recently the International Narcotics Control Board (INCB)[82] have all called for the abolition of the death penalty for drug related offences. At the 2013 High Level Segment of the annual meeting of the UN Commission on Narcotic Drugs, the death penalty for drug offences was heavily debated. Several member states wanted the Ministerial Statement to acknowledge that the INCB has announced that it encourages abolition of the death penalty for drug related offences. However, it was impossible to reach a consensus on a text and as a result the Ministerial Statement made no reference to the death penalty. Representatives of a number of member states said that this was a missed opportunity,[83] although others claimed that to express a view on the death penalty would exceed the mandate of the CND.[84]

The Thai government is considering abolishing the death penalty and has announced a review.[85] India has recently

amended its national drug law and no longer applies a mandatory death penalty for drug related offences.[86] Though this is a step in the right direction, even the discretionary death penalty for drug offences is in contravention of human rights standards.

Drug Policies of Armed Groups

The armed groups in the Northeast India have an ambivalent position on drugs. They are believed to use drug production to earn money and influence in the region, but are also known for their violence towards drug users. According to a representative of a local NGO in Imphal, drug users used to be chained to the benches in 'treatment' centres to prevent them from escaping. No medical care was available at these centres and drug users were often physically abused. "They used to kill drug users and traders. Instead of killing them, they started shooting their leg, and putting them in low small cages", says a Naga NGO worker in Kohima. "After some advocacy and dialogue they brought it down to forced labour. They call it work therapy."

Organisations such as the All Manipur Anti-Drug Association (AMADA) and the Coalition Against Alcohol and Drugs (CADA), which are allegedly working closely with the government and rumoured to be secretly backed by the armed groups, are also aggressive toward drug users, dealers and producers, although this seems to have declined of late.[87] In the first half of 2010 AMADA "hauled up and reprimanded" 412 persons dealing in drugs or alcohol.[88] Local newspapers regularly publish articles naming and shaming people either reprimanded by AMADA or arrested by the police on suspicion of drug offences.

In Burma, various ethnic armed opposition groups have sought to respond to drug-related problems in their areas. A number of them have implemented strict opium bans, such as the UWSA in the Wa region, the MNDAA in Kokang and the NDAA in Mongla region. These regions remain opium-free, but cultivation has spread to other areas in the country. These groups also have strict policies against drug users. "When we know that people use drugs, we arrest them and they have to do three years of hard labour", says a UWSA representative. A representative of the MNDAA reported that there are two prisons for drug users in Kokang. "At one place we have about 70 people, and at the other about 100 people. These places are only for drug users. In the daytime we make them work on building roads and planting trees, which is hard work. In the night we put them in prison."[89]

The KIO has also adopted strict policies on opium cultivation and drug use. It has carried out several eradication campaigns in areas under its control. It has a compulsory drug-treatment centre in its capital, Laiza, where drug users – most of them injecting heroin users – are forced to undergo detoxification. The KIO has launched a campaign to make Kachin State opium free. The Shan State Army-South (SSA-South) has included the drug issue in its ceasefire talks with the Thein Sein government. Initially, the SSA-South wanted to establish special anti-drug squads to eradicate opium and arrest drug users, but lately the organisation has made public statements that it will aim for a more development-led approach to controlling opium cultivation.[90]

Drug Laws in Reform?

Several countries in the region are discussing the possibility of reforming their drugs laws. This interest is being driven, among other things, by prison overcrowding, the high burden on the judicial system, and the recognition that punitive and repressive approaches have not worked and may even have made things worse. Imprisonment has been shown to have damaging implications for individual and public health, including STDs, mental health problems, tuberculosis, hepatitis, as well as many other damaging effects – children who miss their parents, lack of family income, job loss, and forgone education.

The Burmese narcotics law dates back to British colonial rule. The Thein Sein government, elected in 2011, is reviewing all criminal and civil laws and intends to redraft the narcotics law. The stated aim is to bring all national laws

Buddhist monk speaking at drug use awareness forum in Lashio

Harm reduction programme in China near Burma border

into line with international conventions and human rights principles. Under the Global Fund, the Ministry of Health has agreed to a review of the HIV law with the assistance of civil society organisations (CSOs). The existing narcotics law still demands capital punishment and makes the possession of needles a criminal offence. Drug users call for the removal of section 15 (failure to register as drug user) and section 16 (possession). To abolish these laws would be a significant improvement, as it would end the criminalisation of drug users and provide a legal basis for harm reduction interventions. A draft proposal for a reform of part of the law has been completed, but has not yet been submitted to Parliament.

The Lao government amended the penal code in January 2013, so that a person who consumes, purchases or possesses less than 2g of heroin, morphine, cocaine, amphetamines or other psychotropic substances can be sent for treatment instead of prison. Unfortunately, this has not led to an improvement in the services offered to drug users, nor has there been any improvement in the care offered in the drug treatment centres.[91] Cambodia amended its drug law in 2012 and legislation now includes provisions for harm reduction including needle and syringe programmes. People caught using drugs or possessing a small amount for personal consumption now have a choice between imprisonment for up to six months or drug treatment.

India's Narcotic Drugs and Psychotropic Substances Act dates back to 1985 and has been amended twice, in 2011 and in February 2014. The positive amendments are: language to accommodate harm reduction, provisions to regulate private drug treatment centres, changes to ensure the availability of opiates for medicinal use, including the introduction of a new category of 'essential narcotic drugs', and making the death penalty discretionary rather than mandatory in certain cases. The increased access to essential medicines and treatment is a definite improvement since access to essential painkillers in India ranked among the lowest in the world.[92] Although the abolition of the mandatory death sentence is a welcome change, even the discretionary death sentence for drug related crimes contravenes human rights principles. It is also worrying that the amendments double the punishment for the possession of a small quantity of drugs from a maximum prison sentence of six months to one year. This will lead to an increase of prisoners in India's already overcrowded India.[93] In addition, the sentencing is based on the quantity of drugs in a person's possession, which carries the risk of wrongful conviction because not all the circumstances of an offence are taken into account.[94] Overall, the reform of India's drug laws has been ad hoc rather than being part of a clear direction or long-term strategy. There is some sympathy but no legal backing for the push to decriminalise drug use. There is also a sense that drug users and poppy farmers are victims, but this recognition is not translated into the reformed legislation.

As mentioned in Chapter 3, the Thai government is currently reviewing the ban on kratom. Kratom accounted for over 13,000 arrests in 2011,[95] and decriminalisation of its use would be a very welcome step. It would also open up possibilities for the use of kratom as a substitute for methamphetamine. It is expected that the outcome of this review will be presented in 2014. In regard to the possible abolition of the death penalty, the Third National Human Rights Plan (2014–2018) outlines a procedure that includes research on required legal and constitutional amendments,

plans for public consultation, and a parliamentary debate. The Rights and Liberties Protection Department in the Ministry of Justice announced in August 2013 that it will conduct the study and will also seek public consultation on the possibility of abolishing the death penalty.[96]

The Global Fund programmes have helped to advocate for the reform of drug laws in the region to facilitate the implementation of the HIV-prevention and treatment programmes. Other UN agencies are also pressing for reforms that would allow harm reduction and alternatives to forced treatment. Over the past decades several indicators have been established, which will help in developing evidence-based alternatives to current policies. What is needed is a shift in targets: it does not help to aim for high arrest and seizure rates; we know these do not have any impact on the drugs market. The illegal market will always be one step ahead of enforcement. Instead, we should aim to reduce the harm of drug use to the individual user and the community; setting targets for an increase in the accessibility of services; the lowering of the overdose rate and the infection rates of blood-borne diseases; and the reduction of drug related violence. The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has identified five epidemiological indicators.[97] To assess the impact of the national drug strategies the focal points of the centre are carrying out general population surveys and gathering information on prevalence of high-risk drug use, drug related deaths, treatment demand and drug related infectious diseases. Governments in the region could usefully adopt these indicators.

Involvement of Affected Communities

There are several reasons why it is crucial to involve drug users in drug policy-making. First, to adhere to the principle of 'nothing about us without us' implies that no policy should be decided without the meaningful and direct participation of those affected by it, especially marginalised population groups. According to a 2008 "manifesto by people who use illegal drugs ": "as organizations of people who use drugs, our organizations have an important role to play in advocating for our rights and for our health and well-being."[98]

Drug users are well placed to understand their own needs and problems, and to help to develop appropriate and effective services and programmes. According to one study: "People who use illegal drugs have demonstrated they can organize themselves and make valuable contributions to their community, including: expanding the reach and effectiveness of HIV prevention and harm reduction services by making contact with those at greatest risk; providing much needed care and support; and advocating for their rights and the recognition of their dignity."[99]

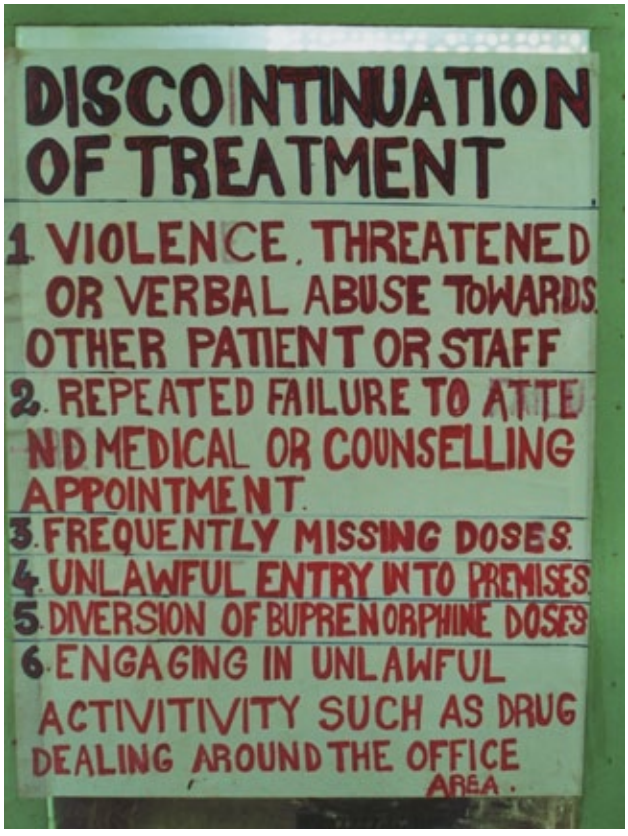
The stigma associated with drug use has been shown to have many negative consequences. Drug users have demanded to "be supported in fighting the fear, shame and stigma that keep us from fully participating in our communities and from accessing health services, and that contribute to health problems like HIV and hepatitis C".[100] It is not uncommon for drug users to be banned from their community once their habit has been discovered.

Billboard against drug use in northern Shan State

The stigma associated with drug use can affect the whole family. The media are contributing to these sentiments, and in some places in the region it is not uncommon to find newspapers publishing the full names and places of residence of arrested drug users published, together with exaggerated and unsubstantiated stories about the behaviour of drug users.

Services such as needle and syringe programmes and drop-in centres for drug users are viewed with great suspicion, although these can greatly improve quality of life of the users as well as of their community. It can take a long time for communities to accept such services. According to workers at the Mitsampan drop-in centre in Bangkok, for example, it took at least 10 years before it was accepted in the neighbourhood. In Cambodia, the community-based treatment programmes have helped to improve the way in which communities perceive drug use. The reduction of stigma made it possible to provide services in the community, a more humane and effective alternative. Peer educators and outreach workers have also proved to be very effective in providing harm reduction services. Outreach workers know the places where drug users go and can provide support on the spot.

In Manipur and Nagaland in Northeast India, NGOs have played a major role in implementing the prevention and care programmes for drug users, especially in remote areas. "Since the late 1980s NGOs are mushrooming in Manipur because there was a lack of government services", says a local NGO worker. People from the drug-using community decided to start self-help groups. "People from the community felt we needed to do this work better, and do it ourselves. That is why most leading NGOs in the field of drugs and HIV and AIDS here are community based", say the founders of the Care Foundation and the Social Awareness Service Organisation (SASO). "Our friends were dying; we had no choice and needed to do something. We started buying anti-retroviral therapy in bulk and the price went down by 30 percent."[101] In the 1990s, NGOs such as SASO, CARE Foundation and the Nagaland Users Network pioneered harm reduction methods. The organisations learned by doing. "In the beginning we felt everybody had to be completely abstinent. It took us a long time to accept not everybody is able to completely stop taking drugs", says one of the founders of SASO. The NGOs are run by volunteers, most of them with a background in injecting drug use. Home-based care has proved to be very effective, and this is now a priority for SASO. Often people who inject drugs are unable to visit a doctor. Service providers point out that the "conflict situation in Manipur, the everyday fighting, the frequent strikes and the curfews make the intervention programmes very challenging". In Manipur and Nagaland all oral drug-substitution programmes are run by NGOs.



Signboard at drop-in-center for drug users in Northeast India

There are several self-help groups and drug-user networks in the region. These include, for instance, the National Drug User Network Myanmar (NDNM) and the Thai Drug User Network. There is also the umbrella Asian Network of People Who Use Drugs (ANPUD), which was formally registered in 2010. Most of the members tend to be male opiate users. There are very few female drug users and ATS users represented in these networks, as women who use drugs face even more stigmatisation and discrimination than do their male counterparts. Some of these organisations have gained access to decision-making platforms, mostly in UN and international donors' forums related to addressing HIV and AIDS. Many obstacles remain, however, including the fact that drug use is still illegal in many countries in the region.

ATS and Harm Reduction

The use of ATS has become a significant health and social problem in East and Southeast Asia, in particular the use of methamphetamine – known as 'yaba' or 'yama', the most potent amphetamine derivative and most widely used substance in the region. ATS use is associated with a range of communicable diseases such as HIV, hepatitis B and C and STDs, tuberculosis, sleeplessness and mental health problems.

Most methamphetamine is consumed by non-dependent users who do not require treatment, although they are exposed to the harmful consequences of methamphetamine use mentioned above. So while it is estimated that about 11% of ATS users become dependent,[102] there remains an urgent need to scale up prevention, treatment and harm reduction services for ATS users. Most drug treatment and

Speakers at 'Drug Abuse and Addiction Awareness Forum' in Kachin State

harm reduction services in the region continue to be aimed at injecting heroin users and have little to offer for ATS users. ATS users rarely use harm reduction services, largely because they do not identify with opioid users. Those who have been sentenced to attend compulsory facilities receive no specific treatment. In general there exist very few services to reduce the risks of ATS use or treat problematic use in the region.

There have been some promising indications in the region of a willingness to embark on new approaches, at least on paper. The Sub-Regional Action Plan on Drug Control 2011–2013 recognises that "while there are internationally tested drug prevention approaches and psychosocial interventions for ATS use and dependence, these have not yet been fully validated in Southeast Asia, where ATS use is on an upward trend and represents a majority of treatment demand in several countries in the region".[103] The Action Plan recognises the need to scale up public health-oriented policies, as well as to develop alternatives to compulsory drug treatment and detention centres, and to implement a community-based approach based on prevention, early intervention, treatment and care that is integrated into the health system. But to date very little has been done to develop services aimed at including ATS users, a Thai policy official said of methamphetamine users: "We think they can be treated with ordinary methods, we encourage them to go to treatment to change their behaviour."[104]

The WHO Regional Office for the Western Pacific recommends that "policy makers must aim to reduce the harms from ineffective drug policies which allow for undifferentiated punishment and detention of all drug users, and find common ground between law enforcement and public health, thus enabling appropriate interventions to assist all ATS users". The Office published a series of four technical briefings laying out the latest available evidence on patterns and consequences of ATS use; harm reduction and brief intervention; guiding principles of prevention and treatment; and therapeutic interventions.[105] To date there are no approved pharmaco-therapeutic or substitution treatments for ATS use. Research into the use of kratom as a possible substitute for methamphetamine should be encouraged. Also further research is needed to better understand prevalence and patterns of use nationwide (urban versus rural settings in different geographical regions, work-related versus recreational use, different means of administration, age and sex).

Resources are urgently needed to begin to address the escalating ATS problem in the region. Community-based services and peer education can help make harm reduction, prevention and treatment interventions available for ATS users. Practical measures could include equipping drop-in centres with inexpensive preventive measures in response to specific ATS-use problems (e.g. information leaflets, drinking water, fresh fruits, dental care, condoms) and find sponsors for these.

Endnotes

Harm Reduction and Drug Law Reform

1 Interview with a taxi driver in Mandalay, November 2011.
2 Newman (1995), p.794.
3 Newman (1995), p.794.
4 Dikötter (2003).
5 Ray et al.(2005).
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The illicit drug market in the Golden Triangle – Burma, Thailand and Laos – and in neighbouring India and China has undergone profound changes. This report documents those changes in great detail, based on information gathered on the ground in difficult circumstances by a group of dedicated local researchers. After a decade of decline, opium cultivation has doubled again and there has also been a rise in the production and consumption of ATS – especially methamphetamines. Drug control agencies are under constant pressure to apply policies based on the unachievable goal to make the region drug free by 2015.

This report argues for drug policy changes towards a focus on health, development, peace building and human rights. Reforms to decriminalise the most vulnerable people involved could make the region's drug policies far more sustainable and cost-effective. Such measures should include abandoning disproportionate criminal sanctions, rescheduling mild substances, prioritising access to essential medicines, shifting resources from law enforcement to social services, alternative development and harm reduction, and providing evidence-based voluntary treatment services for those who need them.

The aspiration of a drug free ASEAN in 2015 is not realistic and the policy goals and resources should be redirectedtowards a harm reduction strategy for managing – instead of eliminating – the illicit drug market in the least harmful way. In view of all the evidence this report presents about the bouncing back of the opium economy and the expanding ATS market, plus all the negative consequences of the repressive drug control approaches applied so far, making any other choice would be irresponsible.

The Transnational Institute (TNI) was founded in 1974 as an independent, international research and policy advocacy institute. It has strong connections with transnational social movements and associated intellectuals who want to steer the world in a democratic, equitable, environmentally sustainable and peaceful direction. Its point of departure is a belief that solutions to global problems require global co-operation. TNI carries out radical informed analysis on critical global issues, builds alliances with social movements, and develops proposals for a more sustainable, just and democratic world.

TNI's Drugs & Democracy programme analyses trends in the illicit drugs market and in drug policies globally, looking at the underlying causes and the effects on development, conflict situations and democracy. The programme promotes evidence-based policies guided by the principles of harm reduction and human rights for users and producers. Since 1996, the programme has maintained its focus on developments in drug policy and their implications for countries in the South. The strategic objective is to contribute to a more integrated and coherent policy – also at the UN level – where drugs are regarded as a cross-cutting issue within the broader goals of poverty reduction, public health promotion, human rights protection, peace building and good governance.

TNI's Burma Project stimulates strategic thinking on addressing ethnic conflict in Burma and gives a voice to ethnic nationality groups. Burma has been exposed to some of the longest running armed conflicts in the world. Ethnic nationality peoples have felt marginalised and discriminated against. Addressing ethnic conflict in the country is a prerequisite to achieving democracy, development and peace. TNI believes it is crucial to formulate alternative policy options and define concrete benchmarks on progress. The project aims to achieve greater support for a different Burma policy, which is pragmatic, engaged and grounded in reality. It also builds capacity of local actors on key policy issues, including natural resource management with emphasis on land and water, and drug policy.