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Editor's Notes

This issue of *Development Bulletin* investigates a social, political and economic issue that is seldom considered in the development debate; is overlooked in development policy; and has no place in the Millennium Development Goals or in the Australian Government's White Paper recommendations yet it seriously constrains the likelihood of achieving sustainable development goals in most Asian, and increasingly Pacific, countries.

Illicit drugs provide the seamier, more tragic and clandestine side to underdevelopment and poverty. Accurate information is hard to find and the ability of drug producers and traffickers to rapidly change the types of drugs produced and the channels for distributing them makes them hard to identify and combat. What is obvious however, is the scale of the problem and the relationship between drugs, poverty, conflict, instability and very large scale corruption. Illicit drugs impact on almost every sphere of Asian society.

Symposium and support

The papers presented in this issue were selected from those presented at the international symposium *Illicit Drugs and Development: Critical Issues for Asia and the Pacific*, which was held at the National Museum of Australia, 15-16 August 2005. The conference was attended by 120 international and regional academics, researchers and experts in drug reduction, law enforcement and HIV/AIDS together with leading Australian development policy makers and professionals involved in drug eradication and treatment of drug users.

The symposium was organised by the Development Studies Network in close collaboration with Turning Point Alcohol and Drug Centre, the Burnet Institute's Centre for Harm Reduction, the Australian National Council on Drugs and Australian Federal Police, with support from AusAID. The symposium was followed by a one-day workshop which looked at the policies needed to improve development outcomes of combating the illicit drug trade. This was sponsored by the Australian Institute of Criminology and Turning Point Alcohol and Drug Centre. The National Institute for Social Sciences and Law and the Asia Pacific Futures Research Network provided support for post graduate students to attend the symposium.

Here at the Network we would like to thank all those who supported the symposium, workshop and the production of this special issue of *Development Bulletin*.

Viewpoint

This issue also includes a paper which looks at transport patterns and economic status in Indonesia and we reproduce a paper by Rebecca Spence from the last issue on Timor-Leste, which was incorrectly attributed.

At the back

At the back of this issue we provide information on some useful websites, publications and reports.

Next issue

Our next issue of *Development Bulletin* will focus on improving the economies of Pacific Island countries. If you would like to include a paper please contact us.

Gender and Women in Development in the Pacific

We are very pleased to announce that with support from AusAID we are reproducing on our web site nearly 100 papers from those previous issues of *Development Bulletin*

that are now out of print. We had so many requests for these issues that we felt we should make them freely available to everyone. The papers are clustered into six categories: Conflict and Peacemaking; Gender Perspectives; Women, Legal Issues and Human Rights; Women and Governance; Gender, Civil Society and Political Participation; Women, Status and Social Change; and Women and Gender Mainstreaming. We would

like to invite you to download them and hope you find them useful. The website is <http://devnet.anu.edu.au/GenderPacific/index.html>.

Best wishes and interesting reading for 2006,

Pamela Thomas

Managing Editor

Introduction: Illicit drugs and development: Critical issues for Asia and the Pacific

Pamela Thomas, Development Studies Network, Australian National University

Background

Over the last decade the production, trafficking and use of illicit drugs in the Asia Pacific region has both expanded and changed dramatically. Changes have included the move from opiates to injecting drug use and amphetamine type stimulants (ATS) and from cultivating often small opium crops to large importation of precursor chemicals for ATS. Illicit drugs now impact on national and regional political economies, law enforcement and legislative systems, and the opportunities for sustainable development. As the papers in this issue show, the drug trade in the Asia Pacific region is linked to high levels of corruption and organised crime; to conflict and terrorism; to dramatic increases in drug-related health problems, most particularly HIV/AIDS, and the expansion of a black economy. Globalisation has supported the expansion of the illicit drug trade making the transboundary movement of money, drugs and precursor chemicals quicker and easier and increasingly difficult for individual countries to identify and control.

A key characteristic of the illicit drug trade is its invisibility — both politically and developmentally. There is limited recognition of the relationship between illicit drugs and poverty or sustainable development. Illicit drugs are given a cursory mention in the Millennium Development Goals, yet they impact negatively on almost all of the goals — health, life expectancy, education, employment, human rights and ability to reduce poverty. Not only do illicit drugs impact on health and family economies, they impact on national financial, legal and political credibility.

The following papers focus on the situation in the countries of Asia and the Pacific and the initiatives taken to control drug production and use and to minimise the harms caused by both drug taking and the rapid and enforced elimination of opium crops. What emerges is a vicious circle between illicit drugs, poverty and instability, and a developed country political agenda which has imposed drug control programmes on developing countries with little or no consideration for their impact. The papers highlight the need for a more broad based approach to drug reduction which incorporates international and national cooperation in law enforcement to reduce the supply and distribution of drugs, development opportunities to reduce demand, and international support to reduce the harms caused by drug taking and drug reduction programmes. In other words, what is required is a more development-oriented approach which takes into consideration the historical, social, economic and political context of drug cultivation and use, the reasons which underlie drug use and basic human rights.

The papers are organised around five major themes: current trends in illicit drug production, trafficking and use in the countries of Asia and the Pacific; the relationship between illicit drugs and development; responses to the problem and their impact; HIV/AIDS and illicit drugs; and country case studies. This issue also includes recommendations from an international workshop on illicit drugs and development which identified key issues and ways in which illicit drugs might be addressed within a development and poverty reduction agenda.

Current trends in illicit drugs

In his overview of the world illicit drug trade, Sandro Calvani of the United Nations Office on Drugs and Crime (UNODC), Colombia, indicates that the world's illicit drug trade has grown dramatically in the last decade. The global illicit drug market is thought to be worth around US\$322 a year or US\$51 per person. Its annual value exceeds the GDP of 88 per cent of the world's countries. Calvani points out that Australia has the highest annual per capita spending on illicit drugs at US\$502 per person followed by North America at US\$331. In contrast, the average in Latin America and the Caribbean is US\$22, in Africa US\$15 and US\$9 per annum in Asia.

Afghanistan and Myanmar are the major global opium and heroin producers while Colombia is the leading producer of coca leaves and cocaine. Asia supplies most of the global market for ATS. The illicit cultivation and trafficking of drugs is frequently linked to internal armed conflict, violence, terrorism and the illegal movement of arms.

Globalisation and the drug trade: Calvani and several other contributors discuss the negative impact of globalisation on the illicit drug trade. Increased transport links at reduced costs, increased global commercial exchange, unification of financial markets through electronic transfers, availability of tax havens and relaxed boundary control all facilitate the movement and trade in illicit drugs. Richard Pieper of the Australian Federal Police points to globalisation as a key factor in the proliferation of transnational crime. 'It has opened previously untapped markets and avenues for trade and exposed them to exploitation by organised crime groups. These groups readily exploit any weakness found in global law enforcement capacity to broaden their base of operations'. Large criminal organisations are able to rapidly adapt their operations to take advantage of differences in legislation and law enforcement standards and to exploit the situation in the poorer of the developing countries.

Development and the growth within the Asia Pacific region in global commerce and transportation provide an ideal conduit for transshipping a range of illicit commodities, from drugs to firearms and human beings.¹ Chris Lyttleton of Macquarie University maintains that increased engagement in a globalised culture creates new markets for synthetic drugs and demand is influenced by marketing strategies. Irwanto, using the example of Indonesia, agrees that the globalisation of a Western model of culture has led to an increase in drug taking among young people.

Drug traffickers take advantage of armed conflict to mask their operations and insurgent groups take advantage of drug trafficking to fund their operations. Calvani points out that the experience of three decades shows that peace and reconciliation are necessary components in the sustainable elimination of illicit crops.

Some Pacific Island countries, while not necessarily involved in growing illicit crops, are considered safe havens for the production or the safe transshipment of ATS and other illicit drugs. These countries have until recently had little experience with the illicit drug trade and most have inadequate legislation or law enforcement capacity to identify or deal with it.

Patterns of drug use

In a recent analysis of the situation in Asia and the Pacific, Devaney, Reid and Baldwin found a rapid increase in drug use in Asia and that Indonesia, Philippines and Thailand each had in excess of one million drug users. There is little illicit drug use in the Pacific with the exception of cannabis. A key pattern in drug use in Asia has been the shift from opium to heroin, and more recently, to ATS. Heroin is the most frequently used drug in Asia although opium is still used in Myanmar and Laos but as it becomes more difficult to access is giving way to heroin and amphetamines.

Although cannabis is still widely used in Asia and the Pacific, Devaney, Reid and Baldwin found that the use of ATS, especially ecstasy, is now well entrenched most particularly in Thailand, Philippines, Myanmar, Indonesia and Brunei and increasingly in China. Use of solvents and glue is common among street children and homeless young people throughout the region.

In his review of drug use and change in the Golden Triangle, Lyttleton outlines the transition from opiates to ATS during the 1990s — a change driven by enforced eradication of opium crops and to some extent by the quick, very large and easy profits to be made from the production of ATS. Lack of control over the legal importation and use of precursor chemicals (largely ephedrine), the small space needed to produce ATS and the flexibility as to where it can be produced, combined with the difficulties of detection and the ease with which ATS can be trafficked make it a popular choice among criminal organisations. As Proctor and Johnston point out, the equipment needed to produce synthetic drugs is much smaller than that required for heroin processing. 'Attempting to control the production and trafficking of ATS requires new and innovative responses as producers can quickly turn to alternative products, markets and distribution routes'.

In the highlands of the Golden Triangle Lyttleton provides an example of how 'modernisation' and a more globalised consumer-driven culture, together with opium reduction policies, have inadvertently encouraged changes and growth in drug use rather than reducing it. Griffiths also points to a similar situation in the move from opiates to heroin in Vietnam. Economic liberalisation and improvements in livelihoods that provide access to markets, schools and health clinics have encouraged heroin availability, use and the spread of HIV/AIDS.

This view is supported by Irwanto who maintains that Indonesia's illicit drug problem is clearly linked to economic and socio-political issues and rapid change.

Indonesia has a sophisticated illicit drug industry which produces ATS and psychotropic drugs locally and traffics heroin for local and international use. Since the 1970s it was common for poor and jobless young people to sell and consume marijuana and homemade psychotropic drugs, and for poor families to be involved in their production, but recently there has been a significant upsurge in the use of psychotropic drugs and heroin among the young, urban and well educated. Research undertaken in 2003 showed that nationally, 5.8 per cent of people between the ages of 16 and 35 had used illicit drugs — in Jakarta this rose to 23 per cent. Irwanto links the rapid increase in drug use to increased prosperity and a more liberated, 'Western' lifestyle as well as to poverty and conflict. 'Although the use of heroin disappeared during the 1980s it returned with full force in the late 1990s' and Indonesia is a key market destination of international drug cartels.

In Thailand, Aramrattana and Jinawat report a total of 3.5 million drug users and an increasing trend towards the use of ATS, especially in the north.

Illicit drugs and development

Proctor and Johnston of AusAID acknowledge that assisting developing countries to reduce poverty and achieve sustainable development are seriously threatened by the trafficking and use of illicit drugs and that much better knowledge of the relationship between drugs and development is needed to ensure that effective reduction support can be provided. This includes greater understanding of the factors that underlie drug use and how development and social forces create individual and communal vulnerability to drug use.

Lyttleton points to the importance of understanding the intersection between development policies and evolving drug use patterns and to look not just at individual drug use patterns or national policies but the impact of a range of socio-cultural and economic factors on communities and how drug use emerges as a product of forces beyond simple individual 'delinquency'. He uses the example of Laos and the way in which the newly adopted National Poverty Eradication Programme, which demands a dramatic shift from subsistence to the market economy through cash crop production allied with enforced eradication of opium crops, resulted in widespread displacement of minority ethnic groups and an epidemic of heroin use. Development-induced changes also demand new social competencies.

Poverty and conflict are the most common factors in the complex and volatile relationship between illicit drugs and social and economic development as the situation in Afghanistan, Myanmar and northern Laos illustrate. Conflict, poverty and

vulnerability lead to drug production or to trafficking and use, while drug use leads to poor health and poverty. The papers in this issue show that efforts to improve social and economic development can inadvertently encourage drug use by changing value systems, introducing markets, creating instability and uncertainty and destroying the traditional social order and patterns of land use. On the other hand, international and national programmes to reduce illicit drugs have in many cases led directly to increased poverty and displacement and to greater drug use, including injecting drug use. Ironically, 'modernisation' is leading to increased drug use among the better off and a greater involvement of the better educated in drug production.

Countries where development has been slow and/or where corruption and conflict are endemic are often those involved in illicit drug production and trafficking. On the other hand, given the massive profits involved, illicit drugs fuel corruption and exacerbate transboundary threats, including the spread of HIV/AIDS. Countries that cannot afford high levels of law enforcement or border control are those used by criminal organisations for production or transshipment.

Addressing the problem

Historically the three approaches to combating drugs have been the US-initiated 'War on Drugs', crop substitution; and alternative development/livelihoods. On their own, none have been effective in reducing drug trafficking or drug use. More recently harm minimisation or harm reduction has been added to drug policies. Harm minimisation is defined as the combination of supply reduction, demand reduction and harm reduction.

'War on Drugs': The 'War on Drugs' is a highly politicised US-initiated prohibitionist approach which includes the enforced eradication of opium crops, law enforcement and in some countries the criminalisation of drug users. It has no base in development policy and its sole aim is to stop drug availability in developed countries (the US primarily) by eliminating drugs at their source — on foreign soil, and using direct US military intervention when required (see Wodak). As examples from Laos, Myanmar, Thailand and Vietnam illustrate, eradication of opium crops and prohibition has not led to a reduction in drug production or use but to new forms of drug use most particularly the rapid increase in injecting drug users (IDUs) and among them an explosion in HIV/AIDS (see papers by Cohen, Lyttleton, Boonwaat, Aramrattana and Jinawat). It has also resulted in increased poverty among the already poor, and usually ethnic minority, populations. The impact of criminalisation and imprisonment of drug users and the very high numbers and turnover of prisoners who are IDUs has exacerbated the rapid spread of HIV from prison populations to the general public (see Dolan and Larney).

Boonwaat shows that in Laos a 93 per cent reduction in opium cultivation was achieved in seven years but access to development support is limited in previously opium-growing areas and it is unclear how 'to ensure an environment that enables opium to remain eliminated'. The ethnic minority groups involved in opium cultivation have few options other than to move to seek paid employment. While the government provided strong political commitment to the elimination of opium cultivation little has been done to stem the massive flow of illicit drugs to and through the country.

Crop substitution: These approaches focus on providing opium growers with alternative crops and livelihoods (see Aramrattana and Jinawat, Calvani, Griffiths, Proctor and Johnston). In northern Thailand crop substitution was established among minority ethnic communities in 1969 and was adapted over the years to provide improved, and sometimes subsidised, markets for substitute crops. This approach met with very limited success. It did not address demand for drugs or treatment or support for drug users and was unable to address the socio-economic conditions which led to drug use.

Alternative development: This approach is based on crop substitution and/or providing alternative livelihoods to opium growers. It is based on a more bottom up participatory approach to development which allows for greater involvement in community-based decisions and activities, including treatment for drug users and a longer time frame for eradication. Although international aid organisations support this as a more appropriate model, governments often establish policies which demand more rapid results. For example, the Thai Government as well as supporting alternative development has also employed strong enforcement policies which have included extra judicial killings and enforced treatment for drug users together with the expectation that community members will report drug users to the police (see Aramrattana and Jinawat).

Prohibitionist v alternative development: Cohen argues that the prohibitionist approach takes precedence over alternative development principles and that alternative development is often an attempt to camouflage and conceal the punitive elements of supply-side drug eradication campaigns. The major promoters of the supply-side approach have been the US and the United Nations through the United Nations Drug Control Programme (UNDCP) and currently the UNODC. While recently there has been a greater emphasis on a more balanced approach between alternative development and law enforcement this, according to Cohen, is largely illusory and development assistance is conditional on reductions in illicit crop cultivation within a specific time frame. Aid provides the incentive for farmers to 'voluntarily' enter agreements to stop growing drugs but if they fail to keep their side of the bargain, assistance will

be refused and law enforcement measures applied. In case studies on Laos and Colombia, Cohen queries the 'voluntary' nature of this type of assistance.

Harm minimisation: The papers in this issue point very clearly to the need for new, more holistic approaches to sustainable drug reduction, which address not only reductions in supply and distribution, but reductions in demand and in the harms caused by drugs. This harm minimisation approach will not be possible without cooperation between countries in the region, cooperation between those involved in law enforcement, development assistance and harm minimisation and a very clear understanding of why people cultivate and use illicit drugs, what the longer term impacts will be of crop elimination, how country policies impact on drug reduction and poverty, and how to address globalisation. Providing traditional development assistance alone is not enough — efficient and effective coordination of development assistance that considers existing ethnic and cultural diversity is needed. Development policies must support illicit drug reduction from a humanitarian and sustainable perspective, but as Lyttleton points out, they must take into consideration the fact that drug markets are created and drug epidemics emerge as a product of social relations.

Illicit drug use and HIV/AIDS

'The HIV epidemic in Asia has been largely shaped by injecting drug use and injecting drug use in Asia has been largely shaped by global drug prohibition ... the different trajectories of future AIDS spread will have considerable impact on economic growth and poverty eradication' (see Wodak). In 2004 there were 3.3 million IDUs in Asia and 8.2 million people with HIV/AIDS. While worldwide, five to ten per cent of infections are due to injecting drug use. In Asia it is responsible for 20 per cent of new HIV cases, in Myanmar up to 30 per cent and Jakarta up to 48 per cent (see Bezziccheri). Between 2003 and 2004 the number of reported Indonesian HIV/AIDS cases doubled — 80 per cent of new cases were related to injecting drugs (see Mesquita and Lorete). High HIV risk is also associated with heightened sexual drive associated with ATS use.

As illicit drug use is criminalised in most countries in Asia, a large number of IDUs can be found in prison where they can comprise half the prison population (see Dolan and Larney) and where high risk behaviour including rape, violence, injecting drug use and tattooing transform prisons into an important source of HIV infection.

Overall, only five per cent of IDUs in Asia have access to HIV prevention services, and law enforcement, which criminalises drug use, makes the provision of preventive services extremely difficult. Throughout the region fear of arrest and harassment by police has further marginalised IDUs and their ability to seek treatment or harm minimisation services, such as needle and

syringe programmes or methadone treatment. This zero tolerance approach is still strongly supported by the US, but harm reduction policies, including needle and syringe exchange, and treatment are now supported in Europe, Asia, Canada and New Zealand and by most major United Nations organisations.

Until recently it has been difficult to legitimise the prevention of HIV among drug users but in 2005 methadone and buprenorphine were added to the World Health Organization list of essential medicines and the UNAIDS Programme Coordinating Board adopted a policy position paper which recognised heroin addiction as a medical condition in need of appropriate treatment. Other encouraging developments outlined by Bezziccheri include the implementation of 'triangular clinics' which deal simultaneously with HIV prevention, drug abuse treatment and sexually transmitted infections in prisons.

Three priorities for harm reduction are outlined: an expansion of needle exchange programmes; expansion of methadone clinics; and ensuring acceptance of free and universal access for anti retroviral treatment to IDUs as well as other AIDS clients. Harm reduction requires access to resources, political action and commitment at the international and local levels.

Conclusions

As Proctor and Johnston and the different case studies show, illicit drugs exacerbate transboundary threats, encourage the spread of HIV/AIDS, support political instability and conflict (and potentially terrorism) and fuel corruption. They are inextricably linked to poverty and their spread is encouraged by economic and cultural globalisation. Experience in anti-illicit drug activities show that prohibition not only does not work, but encourages more dangerous forms of drug use. What is required is a multifaceted approach which includes the harm reduction principles of reducing supply, reducing distribution, reducing demand and reducing harm. As Wodak suggests, 'unless harm reduction programmes are rapidly established soon throughout most of Asia, a major HIV epidemic will occur, resulting in major devastation in the region, including a substantial setback to economic development and poverty eradication'.

Note

1. Also see *Development Bulletin* No.67, People Trafficking and Development in Asia and the Pacific.

Global trends and key issues on illicit drugs: Drug reduction policies and alternative development¹

Sandro Calvani, United Nations Office on Drugs and Crime, Colombia²

Globalisation and illicit drugs

The unwanted synergy between globalisation and illicit drugs has grown irreversible.

Reductions in transportation costs; proliferation of maritime, air and surface connections; increases in the world's commercial exchanges; progressive unification of financial markets through internet-based electronic transfers; use of tax havens and other offshore centres; and, in general, increasing interdependency among countries all facilitate the globalisation of the illicit drugs phenomenon. Social and economic security has also changed, with national authorities having reduced capacity to control the domestic effects of globalisation. Illicit drugs and crime have gained an undesired space in the globalisation framework

In 2003, the value of the world's drug market reached US\$322 billion, or US\$51 per person per year. The value of the illicit drugs market exceeded GDP in 88 per cent of the world's countries (163 out of 184 countries reviewed). Drug sales accounted for 14 per cent of the world's agriculture exports and exceeded the combined value of legal agriculture exports from Latin America and the Middle East (UNODC 2005a).³

Economically, the largest regional market for illicit drugs is North America — Canada, the United States and Mexico. North America accounts for 44 per cent of global retail drug sales followed by Europe with 33 per cent, Asia 11 per cent, Australia five per cent, Africa four per cent, and Latin America and the Caribbean (excluding Mexico) three per cent.

Analysis of the illicit drug market changes significantly, however, when reviewing its per capita value. Australia has the highest level of spending on illicit drugs, with US\$502 per person per year, followed by North America with US\$331, Central and West Europe US\$186, South and Southeast Europe US\$58, Latin America and the Caribbean US\$22, Africa US\$15 and Asia US\$9. The average worldwide is US\$51 per capita per year.

In relation to GDP, spending on illicit drugs in Australia amounts to 2.6 per cent of GDP, followed by South and Southeast Europe with 2.2 per cent, Africa 2.1 per cent, North America 1.1 per cent, Latin America and the Caribbean 0.9 per cent, West and Central Europe 0.8 per cent, and Asia 0.4 per cent.

As in most transnational organised criminal activities the largest profits in the drug market are obtained at the end of the chain, during the final transactions, although prices in the

production phase are also quite high. The value of the world's illicit crops to producers is around US\$13 billion, intermediary sales or wholesales total US\$94 billion and retail or final sales reach US\$322 billion. Given the global nature of drug trafficking and use, the fight against drugs should be equally global with consistent co-responsibility among countries.

Most governments have chosen the United Nations as the institution with the key responsibility to design a global strategy to address illicit drugs issues, and to lead and coordinate its implementation. As a result, the UN has gained extensive experience in all aspects of illicit drugs and now has a comprehensive capacity for policy review. During the last decades international drug control has gone through different emphases and priorities, and has changed and adjusted to the multiple historical and geographical scenarios including globalisation.

Global consensus on policies

In June 1998 the United Nations General Assembly special session on drugs reviewed the global strategy and agreed for new common action to counter the world's drug problem. The representatives of 185 countries approved a balanced anti-narcotic strategy which provides a mix of control measures at source, law enforcement against trafficking and comprehensive demand reduction strategies (UN 1998).

In their political declaration, the UN member states defined two pivotal issues for this new policy: the principle of an integrated and balanced approach, and of shared responsibility among nations. The two principles eliminated the anachronistic distinction between producer, consumer and transit countries, thus reflecting UN member states' recognition of the need to establish a transnational alliance against this transnational threat.

The UN General Assembly's decision marked a new era for UN drugs control policy as foundations were laid for more humane and evidence-based policies reflecting a greater government and civil society awareness of the multiple facets of the drug problem. The UN General Assembly established clear objectives, targets and target dates for action including legislative change, implementing national programmes against money laundering, improving judicial cooperation, setting up programmes and strategies to reduce demand, and significantly reducing illicit crops and chemical precursors for drug production (UN 1998).

Demand reduction and drug abuse prevention were recognised among the most effective policies. Public education, information and advocacy strategies were promoted as well as detox, rehabilitation services and community-based therapies and treatment for addicts, to contain the growth of drug abuse. For the past two decades, such policies have been strengthened globally with satisfactory results. Best practices have been identified and reviewed through networks of experts and practitioners.

One of the latest advances is the World Health Organization (WHO) decision in July 2005 to list methadone in the WHO complementary list of essential medicines (see Bezziccheri paper, this issue). The complementary list is used when specialised diagnostic or monitoring, specialist medical care and/or specialist training are needed. Another significant change was the introduction of a new section in the WHO essential medicines list, namely, medicines used for substance dependence programmes. This is an opening for other medicines used for treatment of substance dependence, including alcohol.

After years of fierce differences of opinion on policies for injecting drug use, at the end of June 2005 the governing body of UNAIDS agreed a new global policy on preventing HIV/AIDS. To prevent transmission of HIV through injecting drug use the global policy calls for:

comprehensive, integrated and effective systems of measures that consist of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users (UNAIDS 2005:23).

On the eradication of illicit crops, the UN General Assembly stated that alternative development methods including alternative livelihoods, make crop eradication sustainable while respecting the human and economic rights of farming communities (see Cohen, this issue). The alternative livelihood interventions would allow countries taking measures against illicit crops to achieve sustainable development, keeping the specific socio-cultural characteristics of the beneficiary communities and groups in mind.

An analysis of one regional alternative livelihoods strategy provides some insight into the drugs and development nexus.

Colombia's struggle to end its narco-trafficking

Colombia has a key role in the global drug market because, since 1998, it has been the world's leading producer of coca leaves and cocaine. Although illicit cultivations have dropped

by 51 per cent since 2000, in December 2004 the country had approximately 80,000 hectares in coca crops in 23 of its 32 departments or provinces (UNODC 2005b).

Colombia's drug problem is one of the world's most complex political and criminological puzzles. Google gives 1.1 million links for the words 'Colombia and drugs' and just 555,000 for the words 'Colombia and cocaine'. My office documentation centre has collected more than 3,000 books, studies and investigations on Colombian narco-trafficking. Colombian universities can add more than 10,000 recent documents to such a search.

Deep economic inequalities; lack of government presence in large rural areas of the country; a lengthy history of internal armed conflicts; a strategic location that serves as a gateway to South America and a connecting station to the West Indies, Europe and North America; a grave agricultural crisis during the 1990s; long-delayed agrarian reform; and chronic institutional weakness are all factors which contribute to placing Colombia at the centre of illicit drug trafficking.

The relationship between illicit cultivations and illicit armed groups is at the core of Colombia's drug problem. These groups monopolise the purchase and sale of cocaine base and poppy latex, they determine prices and the levy charged to traffickers, and they manage laboratories and landing strips. They also guarantee territorial control to facilitate drug production and trafficking. The armed groups promote illicit cultivation in their areas of influence because narco-trafficking profits provide the hard currency required in the international illicit arms market. For the two criminal adversaries — the guerrillas and the paramilitary — keeping the drug business going means securing income to finance their armed operations.

According to a study by the Colombian Department of Planning one of the extreme leftist political groups, the FARC, obtains 60 per cent of its income from drug trafficking. The extreme right group, the United Self-Defence Forces, has publicly recognised that most of its funding depends on drug trafficking. Reportedly, for each American dollar of cocaine sold in any street in the world, four to five cents ends up in the hands of Colombia's armed groups, thus financing the war.

The illicit crops/drug trafficking/violence/terrorism nexus places a heavy burden on social and economic development. Over the past decade the country has invested more resources to combat violence exacerbated by drug trafficking and its effects — such as human rights violations, large population displacements, corruption, political instability and environmental destruction — than it has in social and productive investment.

Over the last few years, large population displacements have been prompted by violence, armed conflict, drug trafficking and, in general, the pursuit of better living conditions. Approximately 1.4 million people were displaced between 2000 and 2004.

The current scenario in Colombia is not big news in the recent history of narco-trafficking: other larger narcotic-producing countries have followed the same pattern. All of them were at war or facing grave internal conflict. Drug traffickers take advantage of armed conflicts, and vice-versa, insurgent groups take advantage of drug trafficking. Over the past few years Asia's poppy and heroin production has moved towards countries on the brink of endemic war. This is the case in Afghanistan and Myanmar, where the Taliban and the Burmese ethnic guerrillas (and the national military regime) finance their operations with profits from drug sales. Another example is Peru, which in 1990 reached record levels of production with 210,000 hectares of coca, while attacks by Shining Path (*Sendero Luminoso*), financed mainly by illicit crops, also increased. Likewise, the record 163,000 hectares of coca crop in Colombia in 2000 coincided with an unprecedented number of abductions (2,840), massacres (142) and attacks on unarmed civilians.

Colombian municipalities with illicit crops have more armed groups than coca-free municipalities. Municipalities with coca or opium poppy cultivations have an average of 100 enlisted guerrillas, while armed groups in coca-free municipalities enlist an average of 40 guerrillas.

The experience of various nations over the past three decades shows that peace and reconciliation processes are necessary components of sustainable elimination of illicit crops. All countries that have recorded quick and sustainable results in this regard had designed efficient eradication and illicit crops substitution mechanisms. Countries with the best results in the fight against illicit cultivation have found that alternative livelihood strategies usually guarantee that farmers will destroy illicit crops and replace them with legal income-generating activities.

Moreover, when new rural livelihood opportunities are linked to a sustainable and profitable economy, the producer will not return to growing illicit crops in another area. Providing farmers legal and profitable alternatives, and improving the living conditions in rural areas, villages and urban centres of regions affected by illicit cultivation, reduces the scope of organised crime because potential and indirect engagement in armed conflict is eliminated. The results of alternative development are not immediate but they are indeed sustainable.

Challenges to alternative livelihoods

Alternative livelihoods take time and require consistent political will as well as dedicated technical assistance (see Boonwaat, this issue). Alternative development policies are relatively new to Colombia, compared to other countries, and are constantly being adjusted in line with changing economic policies of successive governments, and as new scenarios emerge in the internal conflicts. Depending on the security of an area, alternative livelihoods are linked to voluntary manual eradication of illicit

crops through two different strategies: the Forest Ranger Families Programme and the Alternative Production Programme.

The Colombian Government implements the ranger programme in environmental protection areas, and it comprises cash incentives to 50,000 farmer families. The programme's goal is to help keep these families' farms free of illicit crops while they carry out conservation, reforestation and environmental protection activities. UNODC constantly monitors this programme, reporting monthly on how the government and farmers are complying with the agreement, and offering social and environmental recommendations.

In other traditionally agricultural areas, mid- and long-term productive projects are financed and technically assisted to provide a legal alternative economy to participant families.

Creation and strengthening of rural organisations is the best strategy to generate regional development processes. It generates social capital, promotes effective social control mechanisms for projects, and becomes an efficient coordination mechanism between rural communities and national and local governments. A key element for the success of alternative development initiatives lies in projects' capacity to transfer know-how to the community. Positive results are owned by the empowered community because it sees itself not only as the beneficiary but also as a protagonist of change, carrying out projects and taking a leading role in the process.

Nevertheless, strengthening social rural organisations does not make much sense if these organisations do not come together to carry out profitable productive activities, which implies market access, and consequently improves quality of life for farmers. Organisational strengthening is not, and should not be funded by donations to farmer organisations. Grants are used instead to create rotating microcredit funds aimed at income-generating projects, thus ensuring sustainability of farmer organisations.

Dialogue established with producers' associations identified problems with marketing, an essential element for long-term alternative development sustainability. Former coca growers were able to produce red beans, rubber, palm hearts and grow cattle but their products were not and could not be considered commodities in the free market. For a product to become a commodity it must meet quality, sanitary, packaging and transport standards and the producing company must have basic management, marketing and business skills.

In order to meet such conditions an agreement was reached with the private sector. As a result, palm hearts and red beans from Putumayo; plantains from Meta; coconuts, lumber and tomatoes from Nariño; beans from South Bolivar; organic coffee from South Cauca; cocoa and organic honey from Sierra Nevada de Santa Marta; rubber from Caquetá; and cheese and tropical dairy products from Guaviare were all successfully placed in local markets.

Without a strong private sector able to offer both new technology and supplies to diversify production and the necessary market systems, alternative development strategies are practically impossible. Moreover, the private sector can help by identifying products that are in demand. Members of this sector often buy alternative development products before they are mass produced, thereby boosting the goodwill of farmers. My recommendation for any alternative development project is to first identify the markets, get the business contracts, and then encourage the farmers to produce.

Economic policies in general, and those directed at the agricultural sector in particular, may or may not contribute to alternative development. Foreign trade policies, for example, may affect the relative prices of agricultural products thus affecting buyers' decisions in terms of importing products promoted by alternative development. Therefore, it is necessary to sign long-term negotiation agreements with buyers to avoid price fluctuations. It is also imperative for farmer organisations to gain direct access to their final markets by avoiding intermediaries, and so maximise income for project beneficiaries.

Appropriate multilateral aid

The Colombian Government's strong political will is not matched by appropriate multilateral aid. Under Colombia's current government, alternative development practices have been progressively modified to maximise results. The Uribe administration gave a new orientation to Plan Colombia by including the concept of alternative development into agro-forestry and reforestation plans, indicating the Government understands that different kinds of interventions are more appropriate to agricultural and non-agricultural regions, and to the regions' different soil conditions.

Alternative livelihoods are now focused on forest management, productive and sustainable use of forests, large commercial plantations, and the development of lumber production chains, as much as traditional rural development interventions. If well managed, Colombia's large forest reserves may provide huge resources to combat the country's illicit crops.

After the first decade of alternative livelihoods policies, social and human capital, in areas previously affected by illicit crops, are now strong and promising. Farmer organisations and indigenous enterprise in the departments of Cauca, Nariño,

Putumayo, Caquetá, Guaviare, Meta, Bolívar and in the Sierra Nevada de Santa Marta are empowered and rarely incapable of facing criminal organisations.

Since 1996, with UN help and advice, more than 8,000 peasant families have built alternatives to illicit crops: double purpose livestock breeding (for meat and milk), forestry, and traditional crops such as coffee, cacao, plantains, fruits and palm hearts, among others. Approximately 6,000 hectares of illicit crops were eradicated and more than 50,000 hectares of legal cultivations established. Alternative development peasants have inched towards Europe's fair markets through organisations such as Fairtrade Labelling Organizations International and Haavelar. In 2004, peasant alternative development organisations generated profits in excess of US\$4 million through direct sales to supermarkets and fair trade networks.

While workable and cost effective solutions are being demonstrated, it is particularly sad to note that in the Andean region, 77 per cent of the families involved in illicit cultivation do not have access to alternative development support. UN member countries' consensus on alternative livelihoods policies has been strongly reaffirmed — in a detailed and updated recommendation approved at the UN Commission on Narcotic Drugs in November 2004 — yet no new technical assistance grant has since been disbursed.

Notes

1. The views expressed in this paper do not necessarily reflect the opinions of the United Nations and/or UNODC.
2. See website, <http://www.sandrocavani.com>, for more information.
3. All illicit drugs statistics quoted in this paper are from the *World Drug Report 2005*. See references list for details.

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Current illicit drug issues and responses in Asia and the Pacific

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Introduction

This paper is based on the report *Situational analysis of illicit drug issues and responses in Asia and the Pacific*, commissioned by the Australian National Council on Drugs Asia-Pacific Drug Issues Committee. For the purposes of the project the Asia-Pacific region involved ASEAN, China Cooperative Operations in Response to Dangerous Drugs, Timor-Leste, and six Pacific nations. Specific focus countries and administrative regions were: Myanmar, Laos, Thailand, Cambodia, Vietnam, China, Hong Kong, Macau, Brunei Darussalam, Indonesia, Malaysia, Philippines, Timor-Leste, Fiji, Papua New Guinea, Samoa, Solomon Islands, Tonga, and Vanuatu.

The situational analysis focused on the unsanctioned use of illicit drugs and directly related harms, with consideration of pharmaceutical drugs limited to their intentional misuse. The report contains detailed information for each of the 19 locations on:

- contextual information;
- historical (cultural or traditional) interactions with illicit drugs;
- current illicit drug use prevalence and drug taking behaviours;
- illicit drug production and trade;
- illicit drug policy;
- national responses to illicit drug issues (including health, law enforcement, education); and
- Australian and international involvement in relation to illicit drugs.

This paper gives a broad overview of the prevalence of drug use and national responses in Asia and the Pacific, that is, illicit drug policy, law enforcement, drug treatment and harm reduction. Findings for Asia and the Pacific are presented separately.

Illicit drug use and responses in Asia

Prevalence

As with much of the rest of the world, reliable estimates of the numbers of people in Asia using illicit drugs are rare. The review collected various official and unofficial estimates of the numbers of users, but few estimates have been derived by any reasonable systematic process. Much variation in the nature and quality of

data collection and surveillance systems for illicit drug use across the region was found. Prevalence rates should be interpreted with caution.

The numbers of people using illicit drugs in Asia has increased over the past decades (UNODC 2004b), at times, and in some places, exponentially; at other times, and elsewhere, less rapidly. At the higher end of estimations, three Asian nations are reported to have drug user populations of one million or more: Indonesia, Philippines, and Thailand. Other countries reviewed are reported to have estimates of less than 520,000. Brunei and the Pacific Island nations have no official or unofficial estimates of the number of people who use illicit drugs.

Heroin and opium

As found by previous situation assessments (Reid and Costigan 2002), the use of heroin is the drug of choice among entrants to drug treatment centres in China (NNCCC 2004), Hong Kong (NDSB 2004), Macao (SWI 2003, 2004), Indonesia (UNODC 2004a), Malaysia (UNODC 2004a), and Vietnam (UNODC 2003b); this is biased to some extent by the nature of the services offered.

Likewise, opium is still used in most of Asia, but its popularity and consumption has diminished, largely as a result of decreased availability and accessibility. Opium is still the main opiate used in Myanmar and Laos, but it is rapidly giving way to heroin and amphetamine type stimulants (ATS) (UNODC 2004a, 2004b).

Amphetamine type stimulants

The production and use of ATS is now well-entrenched throughout Asia — its use is particularly prominent in Thailand, the Philippines, Myanmar, Indonesia, Brunei and increasingly in China. Ecstasy use continues to increase throughout Asia, but its retail cost generally appears to make it more confined to urban centres among youth (UNODC 2004a, 2004b).

Cannabis, cocaine, glue and solvents

Cannabis use is generally widespread in Asia, often as the most or second most frequently consumed illicit drug. Cocaine use overall is minor in Asia, largely due to its distance from the source countries and therefore the cost. Use of solvents and

glue is common among street children and homeless youth in many parts of Asia (UNODC 2004b; Mith Samlanh-Friends 2002).

Country responses: Asia

Illicit drug policy

There is a general awareness among all countries in the region of the negative effects that illicit drug use, production, and trafficking 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 to direct drug supply and demand reduction efforts, such as the National Narcotics Board in Indonesia, the Dangerous Drugs Board in the Philippines, and the National Authority for Combating Drugs in Cambodia. There is generally collaboration with other related agencies and/or ministries when developing policy responses (for example, ministries of health and education and NGOs).

Each Asian country reviewed has as a major policy goal — the goal being the reduction of drug use (often to zero), 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 intensive enforcement of laws 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 varies in different countries. There is, however, a general trend in most countries towards a concentration on law enforcement (UNAIDS and UNDCP 2000).

Treatment

There are treatment approaches for drug dependent people in all countries of Asia, including medical detoxification, therapeutic communities, substitution programmes, residential dependency programmes and, in some countries, the introduction of drug treatment programmes into correctional and detention centres. Although drug treatment options are available, there are insufficient numbers of treatment and rehabilitation centres in most countries to cater for the numbers of drug users — overall it is likely that only ten per cent at best of all drug users access residential drug treatment programmes (DoH 2002).

Harm reduction

The focus of country responses to illicit drug issues has historically been supply and demand reduction oriented, however, in some places there has been the slow emergence of including harm reduction approaches to tackle the dual epidemic of injecting drug use and HIV/AIDS (see Bezzicheri, this issue).

For example, in China harm reduction was added to national policy as a third component, with equal priority to supply reduction and demand reduction, during a conference organised by the Ministry of Public Security. Another example of the emergence of harm reduction in Asia is in Indonesia (see Lorete, this issue).

Substitution therapy programmes are expanding in some Asian countries, while in others such approaches are under consideration. For example, in China the current strategic plan is to have 1,500 methadone maintenance treatment programmes in operation by the end of 2007 (Wu 2005).

Substitution therapy is available, although often limited, in China, Hong Kong, Indonesia, Macao, Malaysia, Myanmar. In countries where harm reduction services are in place they are often pilot programmes.

Illicit drug use and responses in the Pacific

Limited data is available to assist in understanding illicit drug use and the harms associated with its use in the Pacific Islands. There are no formal surveillance systems in place for illicit drug use or harms. Much of the research undertaken on substance use is anthropological in nature, principally concerned with traditional drugs such as kava, betel nut and other ritual plants, and mainly undertaken in Papua New Guinea (see, for example, Brunton 1989; Jowitt and Binihi 2001; Kava 2001). There are some exceptions (see Halvaksz, this issue). Work has been published on the consumption of alcohol and other drugs in Oceania (Marshall 1987, 1993, 2004; McDonald et al. 1997), and more recently work was undertaken on illicit drug use, predominantly cannabis, in Papua New Guinea (see, for example, Jenkins and Alpers 1996; Johnson 1990, 1994, 1998).

There has been little systematic research undertaken on heroin, cocaine and methamphetamines in Papua New Guinea, Fiji, Solomon Islands, Tonga, Samoa or Vanuatu. Regional overviews undertaken by multilateral organisations such as UNODC and the Bureau for International Narcotics Law Enforcement report on drug trafficking and seizures of heroin, cocaine and methamphetamines (see, for example, DEA-ID 2004; INC 2003). There have been four case studies examining substance use in particular settings (Johnson 1990, 1998; McMurray 2001, 2003).

Consequently, this paper can only make partial comment on the illicit drug situation in the Pacific Islands with much reliance on key informant data and regional overviews.

Cannabis

Key informants reported the most frequently used illicit drug in the Pacific is cannabis. Cannabis is mainly smoked, but it is

also chewed and sometimes baked with flour. The majority of cannabis users are young, aged between 15-20 years. Cannabis is generally consumed with alcohol, often home brewed.

Heroin, methamphetamines, cocaine and inhalants

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 (DEA-ID 2004; Nejo 2001; UNODC 2003a). However, concern has been expressed by authorities that, in the near future, methamphetamine abuse could become an issue for the six Pacific Island countries reviewed. Injecting drug use is believed to be limited in its extent. There were a number of anecdotal reports on inhalant use in the countries under investigation. The most widely used/abused inhalant is petrol.

Illicit drug consequences

A range of issues linked to drug use stem from the use of cannabis and alcohol (Cox 2000; Kick 2001; Save the Children Australia 2004). The issues fall into four main categories:

1. Domestic/family issues including adultery, disputes, family violence, family breakdown, financial stress;
2. Law and order problems: robbery, property damage, sexual violence (rape, gang rape) murder, fighting;
3. Health, such as exposure to HIV/AIDS and other sexually transmitted infections through the disinhibiting effects of alcohol and drugs, cancer (from smoking); and
4. Community, increased number of children on the streets, premature termination of schooling, fighting and related community disturbances, and impeding people's freedom of movement.

Country responses: The Pacific

In the Pacific, in contrast to Asia, there is no overall regional or country-based drug policy. There is currently a focus on developing and implementing drug control legislation to provide a common base for Pacific nation law enforcement agencies to operate from (pers. comm. Forum Secretariat 2005). 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 (DEA-ID 2004; UNODC 2003a).

The Pacific does not have programmes that specifically focus on the needs of drug users. Drug use issues are usually incorporated as part of life counselling or other programmes undertaken by

the non government community and/or the churches. In Papua New Guinea, Fiji and the Solomon Islands treatment of drug users is conducted by general or psychiatric hospitals. There is no harm reduction interventions in the six Pacific countries reviewed.

Future directions

The review noted the limited research on illicit drugs in the Pacific. Strategic alcohol and drug research and more formal research and data collection systems are required to enable an understanding of the illicit drug situation in the Pacific. Accordingly, findings from the research will inform drug policy and service development. To address the research needs, a tangible outcome is the establishment of the Pacific Drug Use Research Network. The aim of this group is to explore and develop key research priorities focusing on public health and HIV implications of substance use in the Pacific.

The final report from the situation analysis will be available at the end of 2005 from the Australian National Council on Drugs website. While this research project has collected much data it is known that the illicit drug situation is dynamic and the data becomes dated quickly. It would be useful to build on this process of data collection by establishing, perhaps in collaboration with regional multilateral offices, a continuing collection and updating of this dataset, to continually inform strategy and resource allocation.

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Trends in law enforcement and border operations in the Asia-Pacific

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Introduction

Illicit drug use has been identified as a major harm to the Australian community contributing to illness, injury, workplace concerns, violence, crime and breakdowns in families and relationships.

Australia's National Drug Strategy for 2004-2009 provides a framework for an integrated approach to both licit and illicit drug issues in the Australian community (Ministerial Council on Drug Strategy 2004:2). Supply reduction and harm minimisation are the underlying principles of the strategy's policies and programmes. The Australian Federal Police (AFP), in its efforts to detect and minimise the flow of illicit drugs into Australia, plays a significant role in the 'supply reduction' principle.

Australia places a high priority on international cooperation and promotes a holistic approach to the global drug problem (see Proctor and Johnston, this issue). Australia has made a commitment to work multilaterally in the region to deal with drug abuse and illicit drug cultivation, production, processing, distribution and trafficking (Ministerial Council on Drug Strategy 2004:13).

As Australia's principal Commonwealth law enforcement agency, the AFP has the prime responsibility for the investigation of crimes against the Commonwealth and the protection of the Commonwealth and its national interests from crime in Australia and overseas. Illicit drugs are a high priority for the AFP because:

- illicit drug use causes major physical and psychological harm; and
- drug trafficking provides funds to criminals that enable other crimes, including terrorism and people smuggling.

As well as seizing illicit drugs at the point of importation to Australia, the AFP aims to prevent them from being sent to Australia in the first place. To this end, AFP intelligence collects and assesses information to build a strategic understanding of the transnational illicit drug markets to aid law enforcement on tactical and operational levels.

International factors relevant to AFP intelligence include:

- transnational crime groups identifying the Australian market as a viable and profitable target for their drug trafficking;

- regional countries being sources of illicit drugs and distribution hubs for some of the drug types that are imported into Australia;
- trafficking routes to Australia;
- methods of importation, transport and concealment;
- socio-economic and political status of source drug production countries;
- results of research and drug signature programmes;
- findings from intelligence cooperation with foreign law enforcement agencies;
- legislative and policy changes that impact on border issues; and
- wholesale prices of drug types.

National factors include:

- activities of organised crime groups;
- customs barrier detections;
- regional or state issues that influence drug activity, for example, population, demand;
- exposed land and sea borders;
- interstate trafficking;
- laundering of funds derived from drug manufacturing and trafficking; and
- remittance of funds to criminal groups in their homelands.

Local factors include:

- street drug activity, prices, purity and availability;
- Australian-based research; and
- information sharing between state and Commonwealth law enforcement agencies and government departments.

Transnational drug manufacturers and traffickers generate billion dollar black market profits. Strong international law enforcement cooperation plays a vital role in many AFP operations undertaken to counter this market and has been integral to some of the most successful outcomes.

Under the Law Enforcement Cooperation Program the AFP's international liaison officer network facilitates the exchange of information through attendance at international conferences and seminars, promoting cooperation between law enforcement agencies and building a rapport with law enforcement officers of their host country.

Drugs

Heroin

Opium is produced in three major regions — the Golden Triangle (Burma, Laos and Thailand), the Golden Crescent (Afghanistan) and Central and South America. The Golden Triangle remains the primary source of heroin for the Australian market. Opium poppy cultivation in the Golden Triangle has steadily reduced since 2000 and the United Nations Office on Drugs and Crime has reported that the estimate of potential opium production for Burma has decreased significantly (UNODC 2004a). Opium production in Afghanistan has increased significantly during 2004 and the potential opium production continues to increase (UNODC 2004b).

Since 2000 Australia has seen a dramatic reduction in heroin availability both on the streets and detected at the border. In the same time frame a marked reduction in purity levels has been detected.

The shortage of heroin in Australia from the end of 2000 was a result of a series of collaborative international operations. Key facilitators of large heroin importations from the Golden Triangle to Australia were arrested or lost the trust of other figures in the market. So, for a time, there were no large shipments of heroin being arranged from Southeast Asia to Australia. Despite this, organised crime groups were identified still attempting to traffic large shipments of heroin to Australia.

Recent seizures of imported heroin have reflected a continuing pattern of high-frequency, low-volume importations. More than 75 per cent of seizures have involved small quantities imported through parcel post. However, most of the volume of seized heroin continues to be imported via sea cargo, with the amount from air passengers also being significant.

Although it is expected that postal importation and air passenger attempts will continue, the continued heroin importations by sea cargo are of greatest concern. While there has been a decline in sea cargo detections in recent times, sea cargo importation remains the most effective method of supplying the Australian market. Most of the Australian heroin market is apparently satisfied through such importations. Continued targeting and ongoing operations are required to ensure against a resurgence of heroin.

Cocaine

Most of the global cocaine supply originates from the Andean region, particularly Colombia, Peru and Bolivia.

Australian interceptions have generally been of cocaine imported through parcel post, airline passengers and occasional bulk cargo shipments. The majority of recent cocaine seizures have been conducted through parcel post. Analysis of the circumstances surrounding these seizures has revealed that the cocaine transited countries such as Brazil, United States, New Zealand, Greece, Jordan and the Netherlands.

West African and Asian organised crime groups have continued their involvement in cocaine trafficking, and other organised crime groups have been increasingly noticed trafficking cocaine to Australia.

Of particular interest to the region is the tenfold increase in seizures of cocaine in certain Asian countries, while the street price of the drug fell by 40 per cent. Regular reports are received about significant cocaine seizures throughout Asia. These developments, along with the existence of well established heroin trafficking routes between Asia and Australia, are the issues that may require greater attention in the near future.

It is expected that postal importation and air passenger attempts will continue. The involvement of various organised crime groups suggests that the Australian cocaine market is still evolving and that future developments or honing of current practices can be expected. The identification of various transit and staging countries will assist law enforcement in future operational activities.

Amphetamine type stimulants

Most amphetamine type stimulants (ATS) in Australia — predominantly methylamphetamine — are manufactured domestically. The higher purity forms of methylamphetamine, commonly known as ice, are imported. Almost every state jurisdiction has anecdotally reported increases in ice availability, despite the fact that seizure rates have remained relatively low.

China remains — and Burma is emerging as — a significant global producer of ice.

It is expected that in the short term ATS will continue to be manufactured domestically by crime groups operating within Australia. This manufacture is expected to be largely facilitated through the diversion of precursors and pharmaceuticals. Tighter domestic controls may prompt a greater push towards the importation of ATS precursors. It is also expected that ice will continue to be imported from Southeast Asia.

Ecstasy

Australia has seen a sudden increase in law enforcement detections of methylenedioxymethamphetamine (MDMA, commonly called ecstasy) and its precursors, both at the border and domestically. During 2004-2005, AFP and Customs seized more than three times as much MDMA or its precursors as in the previous year.

European MDMA syndicates have made moves to shift the manufacturing of MDMA away from Europe and closer to the consumption countries. This has been shown by a rise in the seizure of precursor chemicals in Australia and the identification of specialist MDMA chemists who have travelled from Europe to manufacture the drugs locally. Asia has seen similar instances, as shown by recent arrests of Dutch chemists at commercial-scale MDMA laboratories in Asia.

A recent seizure in Queensland identified a specialist Dutch chemist who had travelled to Australia for the purpose of manufacturing MDMA. The AFP has identified and interdicted the beginning of a possible trend towards large-scale importations of MDMA or its precursors and the travel of specialist chemists for domestic MDMA manufacturing.

The street price of MDMA in Australia is considerably higher than in other countries, ensuring that Australia will remain an attractive target for MDMA trafficking syndicates.

Precursors

China and India remain the primary global sources of illicit drug precursors. The main reason for the increasing profile of China and India as source countries for chemical precursors is the size of their legitimate pharmaceutical and chemical industries.

The Chinese Government has stated a commitment to tackling the trafficking of precursors for illicit purposes. This commitment and ongoing regional cooperation programs are expected in time to provide greater insight into syndicates involved in trafficking in precursor chemicals. Asian countries are reporting the seizure of large quantities of precursors used in the production of various forms of ATS.

In Australia diversion of precursors and pharmaceuticals has continued despite regulatory controls being implemented.

The diversion of precursor chemicals from countries such as China and India is unlikely to change significantly in the foreseeable future. Domestic diversion of precursors and pharmaceuticals is also unlikely to wane. The increase in precursor trafficking is likely to have a flow-on effect for Australian law enforcement, with requirements for greater technical expertise for forensic officers and a better general understanding of precursors by law enforcement agencies.

Corruption

Corruption is a pervasive issue that affects many countries in the region. In November 2004 Asia Pacific Economic Cooperation (APEC) ministers recognised it as one of the most serious threats to good governance and the proper development of economic systems in the APEC region, and globally. Fighting corruption was acknowledged as essential for developing economies and improving living conditions (APEC 2005).

Corruption creates an environment where organised crime and drug syndicates are able to conduct their activities relatively unimpeded. Over the last decade, Asian and Pacific societies have begun to realise the extent to which corruption damages their social welfare, political stability and economic growth. To date, 25 countries in the region have committed to taking action against corruption. In the framework of the Asia Development Bank Organisation for Economic Cooperation and

Development Anti-Corruption Initiative, those countries have developed the Anti-Corruption Action Plan for Asia and the Pacific and work together towards its implementation.¹

The initiative aims at supporting the establishment of effective and sustainable anti-corruption mechanisms in the region. The action plan has three pillars:

- developing effective and transparent systems for public service;
- strengthening anti-bribery actions and promoting integrity in business operations; and
- supporting active public involvement.

Globalisation and organised crime

Globalisation has emerged as a key factor in the proliferation of transnational crime, including drug trafficking, throughout the world (see Griffiths, this issue). It has opened previously untapped markets and avenues for trade and exposed them to exploitation by organised crime groups. These groups readily exploit any weakness found in global law enforcement capacity to further the scope of their drug activities and broaden their base of operations. Like many multinational companies, they are becoming more complex in response to globalisation. They have taken advantage of differences in legislation and law enforcement standards, which inhibits monitoring and controlling them. Their activities increasingly transcend physical and political boundaries, using global 'pathways' for transnational crime.

The growth in global commerce and transportation has provided an ideal conduit to transship a range of illicit commodities such as drugs, firearms and human beings within our region. Due to resource challenges and varying levels of law enforcement capabilities, the Asia-Pacific region is rapidly becoming a base for a wide range of criminal operations.

Organised crime requires money laundering capacities and services. Lack of official controls makes the region vulnerable to money laundering and associated corruption. International criminals seeking to launder money have targeted Pacific Island countries that provide offshore banking facilities. These offshore banking systems have been cloaked with secrecy provisions and have flourished due to inadequate legislation to control their transactions. Poorly regulated banking systems and cash economies provide little capacity to trace or even question suspect funds. As at February 2005 Nauru was still on the Financial Action Task Force list of non-cooperative countries and territories.

Money laundered out of the Asia-Pacific region has diverse origins. Funds emerge from national and transnational crimes such as the drug trade and people trafficking, as well as from public sector corruption, which is endemic in many states in this region. Under conditions where criminal enterprise forms

a significant portion of a nation's economy, regional stability is threatened by the vulnerability that the state itself can become an active participant in criminality.

Historically, within the region, transnational crime has been furthered by inadequate detection and disruption capabilities of police and the judiciary, weaker legislation, poor border control systems and corruption among officials. Countries within the region are actively taking steps to combat these issues through tighter internal controls and the strengthening of law enforcement cooperation. Geographical factors, such as the isolation of parts of the region, have helped to keep the activities of these groups out of the spotlight. Cooperation and capacity building across the region is providing an increased law enforcement capability to combat the threats posed by criminal groups.

Summary

There is now ample evidence that the drug situation in the region is changing rapidly. Drug trafficking is one of the most prevalent forms of transnational crime in the region, which is increasingly being used to trans-ship drugs from producer countries to markets in other parts of the world. Drug trafficking syndicates have commenced using Pacific islands for storage, production and trans-shipment locations.

Organised crime groups have greater access to drug markets as a result of globalisation. This has enabled them to more extensively exploit commodity sources, trans-shipment routes

and networks. There is a need for continuing coordinated multinational law enforcement responses.

Continuing cooperation between Asia-Pacific countries has the potential to diminish vulnerabilities to criminal attack and thus reduce the risk to the region. There are prospects for success in joint agency drug investigations, which detect and disrupt criminal organisations, at the same time increasing the levels of cooperation between various countries.

Note

1. See <<http://www1.oecd.org/daf/ASIAcom/ActionPlan.htm>> for more details.

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Opiates to amphetamines: Development and change in the Golden Triangle¹

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Introduction

Amphetamine use results to a large extent from the pressure many people feel to keep up the increasingly hectic pace of modern life, to cope with a world in which nothing seems predictable but change — constantly accelerating change ... To put it quite simply: our culture influences, encourages, and sometimes causes people to use amphetamines; and their behaviour under the influence of these drugs often constitutes a caricature of the very society that produced it (Grinspoon and Hedblom 1975:288, 291).

Although opiates retain a substantial production and consumption base in mainland Southeast Asia, amphetamine type stimulants (ATS) have recently become the drug of choice for producers in the Golden Triangle. This transition can be linked to quick and substantial financial returns, ease and flexibility in production, and lack of comprehensive control over precursor chemicals (primarily ephedrine). As a result, ATS trafficking dramatically increased in the region during the late 1990s and its consumer base swiftly expanded among urban and rural youth, students, labourers, sex workers, farmers and fishermen. Its recent and rapid uptake means that in most countries of Southeast Asia, 'ATS dependence is not widely understood and recognition of the growing problem of ATS abuse is only beginning' (Richards et al. 2003:1).

In Southeast and East Asia, ATS demand has emerged in sync with changing value systems fostered by specific development trajectories, which is to say that there are specific reasons why ATS consumption in the region at present vastly overshadows that of heroin or opium. Patterns of drug use and abuse evolve as socio-economic modernisation and increased engagement in a globalised commodity culture create new markets for synthetic drugs in lowland and highland populations. These changing patterns bear the clear imprint of trafficking and marketing strategies. At the same time, they dovetail neatly with a larger order of social change and the ongoing production of a modern subjectivity.

In the highlands of the Golden Triangle, development policies inadvertently encourage changing forms of drug abuse even as specific projects focus on opium reduction as a primary goal. Although there are improvements in livelihood strategies and road networks that provide access to markets, schools and health clinics,

in most cases development over the past several decades has been a mixed blessing for highland populations and minority ethnic groups. The emphasis on cash-crop production that serves as a push for market expansion at the national level, sedentisation at the community level and removal of opium cultivation at the household level has proved highly problematic for highland villagers throughout the Golden Triangle. For example, as opium cultivation has been successfully controlled among Thai hill tribes over the past twenty years, exploitation, heroin use and HIV/AIDS have also become prevalent in highland communities.

Across the border in Laos, opium eradication is a more recent initiative. It has become a key platform of the National Poverty Eradication Programme (GoL 2003) which dictates that, as citizens of modern-day socialist Laos, highland villagers are expected to actively engage in a newly embraced capitalist mode of life. ATS consumption is accompanying this transition for reasons that are implicit, but unplanned for, in the shift from subsistence to the market economy. My intention here is to explain differing drug-use practices by examining social changes that confront Akha highlanders living in northwest Laos as they increasingly enter a broader commodity-based economy to make the point that problems of illicit drug use are not the simple product of availability.

While it is possible to identify clandestine production networks, forces motivating a growing consumer demand are more difficult to isolate. The consumption of different forms of drugs has been embedded in social change and economic development for centuries and probably longer. Widespread sugar, coffee and tea uptake, for example, occurred in the West with the shift from circadian rhythms required by industrialisation and regimented production. Nowadays, in much of the world, ATS is a thoroughly effective symbol of a social ethos geared to increased production, cash income and a consumer culture oriented to the pursuit of pleasure through purchase. Leaving to one side the growing range of items through which desire is manifest in the highly consumerist cultures of urban Southeast Asia, it is important to consider how politicised formations of pleasure and social subjectivity underpin the transition in drug-taking practices in the first place. In turn this helps to explain why Lao Akha are not currently replicating the heroin uptake of their Thai counterparts.

Minorities, drugs and assimilation

Drug cultivation and development strategies have long been entwined in the Golden Triangle, an area whose ecology of cool hills and poor soils make it well-suited to be one of the largest opiate-producing regions in the world (see Boonwaat, this issue). Large-scale opium cultivation was introduced to Southeast Asia by minority ethnic groups (primarily Yao and Hmong, to a lesser extent Akha, Lisu and Lahu) fleeing the Opium Wars and constant fighting between warlords and bandits in southern China in the mid-nineteenth century. Once established within national borders, governments soon pressured highlanders to grow opium for national and colonial excises. While most local use among minority groups has typically been medicinal and social, the economic value of opium as a valuable trading commodity has been an adequate incentive for highlanders to cultivate poppy regardless, and at times in defiance, of warlord and state controls.

While exact timelines are murky, the Akha (of the Tibeto-Burman language group) are thought to have gradually moved southwards for several hundred years. Typically, before programmes to integrate them into centralised forms of state governance, the Akha have lived, alongside other minority groups, scattered through mountainous forested zones of the upper Mekong, practising subsistence swidden (including poppy cultivation). They reside in Burma (approximately 180,000), southern China (150,000), northern Thailand (33,000) and Vietnam (12,000). Within the past 150 years nearly half of the 60,000 Akha in Laos have settled in Luang Namtha Province which borders China and Burma. Until recently, the majority had populated hills surrounding lowland valleys, practising dry rice farming. Accompanying widespread opium production among Lao Akha communities, levels of addiction have been significant, prompting recent development programmes to focus specifically on drug rehabilitation initiatives alongside national policies of drug eradication.

Following UN prohibitionist models, in recent decades the region's highland populations have been subject to numerous state and international interventions to reverse reliance on opium production. With varying commitment from local governments, foreign development aid has supported national mandates that prohibit poppy production, which together with shifting cultivation is depicted as inherently antithetical to modernisation.

In the face of these non-negotiable components, punitive action from the State is often built around a politics of ethnic difference premised on threats that traditional minority-group practices pose to both the environment and national security through migration, potential rebellion and illicit drug production (McCaskill 1997).

The Akha, like other highland ethnic groups in the region, have been historically associated with traditional practices that

are now seen as inappropriate in modern state functioning. In Thailand, lowlanders consider the Akha to be the 'most "primitive" of the hill tribes' (Kammerer 2000:47). The confrontation between cultural difference and national development has fostered social disjunctions that cause large-scale Akha movement to towns and cities, widespread uptake of heroin, commonplace female prostitution, and epidemics of HIV/AIDS and malnutrition (Geusau 1992; Toyota 1996).

State forces seeking to control the Akha's semi-sedentary lifestyle in Laos are more recent; the impacts of crop substitution, relocation and village consolidation are still being determined. One constant is the central role that drugs play for the Akha both prior to and as a result of modernisation in Thailand and Laos. The rapid increase of ATS usage in highlands and lowlands in both countries adds a further chapter to this complex history.

Drugs and development

Examining processes of assimilation and culture change among ethnic groups also highlights the importance of understanding the intersection of development policies and evolving drug use patterns. In very general terms, it is possible to broadly characterise four different levels of approach to drug problems: firstly, the clinical or biomedical approach that might consider (among other things) neurological effects, detox treatments and the chemical toxicity of different drugs; secondly, the public health approach that examines and seeks to intervene in the specific risk practices such as mode of intake, shared paraphernalia and the use (non-use) of clean needles. The third level looks more broadly at how development and larger social forces create individual and communal vulnerability to drug use in the first place. Lastly, we have the geopolitical level that focuses on the nation-state as its unit of regulation and seeks to mobilise policies and interdiction strategies. This is not a comprehensive breakdown but the point is to highlight that a development focus looks not just at individual practices or national policies but the impact of a range of socio-cultural and economic variables of communities and how drug use emerges as a product of forces beyond simple individual 'delinquency'.

Focusing at the development level we see that the spread of liberal capitalism has played a fundamental role in the gradual (and not so gradual) evolution of social and material practices into a so-called post-traditional society in much of the world. Modernity and capitalist networks of production and control have introduced new political, economic and social relations and accompanying subjective identity formations. Contemporary Laos is no exception since it has gradually opened up to a wider world of liberalised trade and investment. While the specific forms and sensibilities promoted by modernisation are never entirely fixed, modernity's emergent generic structures and ideologies are usually considered to include: the birth of

consumer society; the spread of market relations and wage-labour along with the growth of instrumental rationality and an individualistic sensibility; the rise of national sentiment, the nation-state and racialised perceptions of identity; and the development of administrative bureaucracies and modern tax systems (Scott 2002).

These characteristics are becoming evident throughout Laos including the highlands where over the past several years, everyday livelihoods of Lao Akha (and other ethnic groups) have been radically altered by national mandates facilitated, in turn, by international aid. The Lao Government is increasingly insistent that pioneer swidden agriculture and opium cultivation be halted. Thus, the newly adopted National Poverty Eradication Programme (GoL 2003) demands of the highland population is a dramatic shift from subsistence to engagement in a market economy through sedentary cash-crop production and wage-labour relations (often accompanied by movement out of the highlands). Removal of economic and psychological reliance on opium — commonly termed ‘alternative development’ — has been a cornerstone of modernisation policies in the Golden Triangle for decades, and Laos is not a new story. However, the history of supply and demand reduction is not one of judicious substitution that cleanly removes need or compulsion. Rather, development-induced changes also demand new social competencies, the fraught achievement or demonstration of which frequently implicate new forms of drug use, as rising levels of illicit substance abuse throughout the region (and the world) testify.

Evolving patterns of drug use and abuse are deeply embedded in a broad array of changes in the social order and the individual’s sense of identity within this. In countries flanking northern Laos, opium prohibition led directly to heroin epidemics among minority groups; under similar eradication programmes Akha highlanders in Laos are currently turning to ATS rather than heroin. Examining trajectories of drug use within the region shows that while addiction and compulsion may be nothing new to highlanders (and lowlanders), its form and associated practices, even in the context of illicit substances, evolve for reasons anchored in transformations of value systems implicit in new social and productive relations.

Social production of drug use in Southeast Asia

Though opium and heroin still have a substantial number of users in Thailand (and Vietnam, Burma and China), data from Thai treatment centres suggest that in the late 1990s the scale of ATS use (locally termed *ya ba* — the crazy drug) widely overshadowed heroin. Although they are only estimates, some commentators suggest there are up to six million ATS users in Thailand, and by 2003 the number of ATS pills entering

Thailand was believed to have reached almost one billion (Bezziccheri 2003:4, 22). The recent Thai ‘War on Drugs’ has significantly lowered these figures; by how much and for how long remains to be seen (see Aramrattana and Jinawat, this issue).

Since 1997, ATS use in Laos has also become widespread — more than 1.5 million ATS tablets were destroyed in 2001–2002 (Richards et al. 2003:49). News reports indicated that in 2003, four per cent of high school students in nine provinces tested positive to ATS use (urine samples); in 2004, 11 per cent of students in six provinces showed positive test results; in 2005, the numbers of students testing positive for ATS use had risen to 28 per cent (*Vientiane Times*:6). It is not just the amount being consumed that is of importance; the social context is also central to its uptake: ‘compared to heroin, *ya ba* is a social drug taken by workers to perform longer hours and by kids to have fun in groups; heroin on the contrary, is an isolationist drug taken in lone settings’ (Bezziccheri 2003:5). This distinction is of major significance and highlights that ways in which pleasure is sought can also stand as a ‘figure for the transformation of social relations’ (Jameson 1983:14). Whereas opiate addicts are marginalised socially and economically, it can be argued that rapid ATS spread has both elevated and become symptomatic of commodity-based desire at new levels throughout mainland Southeast Asia.

ATS’s growing popularity is based both on its performance-enhancing characteristics (perfect for capitalist production), and a growing demand for ‘designer drugs’ among urban club-goers (perfect for conspicuous consumption). Production and display and pleasure are basic tenets of a consumer capitalism that has become such a paramount symbol of the vibrant Southeast Asian economies. As Grinspoon and Hedblom (1975:180) suggest: ‘Amphetamine, by its alerting effect, helps people to get on with what is regarded as the business of society — studying for examinations, driving trucks for long distances, athletic performances — so the notions of pleasure and usefulness, of feeling good and doing something right are fused’. Grinspoon and Hedblom focus on the USA of several decades ago; nevertheless, their analysis of episodic ATS epidemics is particularly relevant for present-day Southeast Asia. Here, we might usefully add to their list: labourers, women in the commercial sex industry, and highlanders, all of whom are subject to pressures to ‘perform’ in pursuit of money income.

Pursuing pleasure through drug use is not straightforward, however. It becomes problematic in several ways: the direct abuse and physio/psychological damage from excessive use, or in a more relative sense, where pleasure entails the pursuit of something better than that which is currently held (Jay 1999). Relative pleasure comes, in this second instance, from the use of ATS to actively avoid an existing unpleasant or intolerable situation and dependency begins as a product of this enforced

escapism. Labourers, for example, who are pressured to increase productivity, can be considered to be attempting to avoid 'a worse situation' through increased ATS use. We can also link 'problematic' drug-taking specifically to the intersection of development policies and highland minorities whose lives are radically changed, not always for the better. Frequently these mandates come under the guise of seeking to eradicate the 'drug problem' in the first place. For example, development enforced lifestyle changes among the Akha in Thailand suggest that 'a growing sense of despair' had direct links to heightened heroin abuse (Kammerer 2000:47).

Drug control and its consequences

In Thailand many of the state-based drug control initiatives came under the rubric of state security and 'the minority problem' in the aftermath of the Vietnam War. While international politics underpin local strategies, Lao opium eradication initiatives derive from a broader policy concern with rural poverty. In Laos, opium reduction and ATS spread are happening concurrently and it seems unlikely, for the moment at least, that heroin will gain the foothold it did in Thailand. Building on an inclusionist socialist ideology, highland villagers are being called on to become contributing Lao citizens by engaging in a more centralised market economy — opportunities unavailable to many highlanders in Thailand who have historically been denied citizenship and thereby rights to education, landholding and legal employment. In Laos, the opium reduction projects have incurred a process of substantial relocation to the lowlands in Sing and Long valleys (see Cohen, this issue) as the Akha search for alternative market opportunities, a movement which fits neatly with the Lao government's 'focal site' strategy of halting swidden and encouraging village consolidation and wet rice production.

Insofar as development is nowadays closely synonymous with capitalism, targeted manoeuvres to remove drug abuse among highlanders inevitably do so by imposing new value systems meant to take the place of drugs, not just in terms of specific crops (or prior models of enforced re-education) but through capitalist modalities that must also operate in the realm of substituted symbolic and experiential pleasure. In so doing, new material and social relations foster changing subjectivities. In Laos, opium rehabilitation is embedded in a larger modernist project which, intentionally or not, reframes the pursuit of happiness through forms of commodity exchange that are the basis of contemporary capitalism. In this respect, such programmes confront lifestyles where drugs have played a key symbolic and material role for hundreds of years. They are part of a national policy that insists there will be no opium cultivated after 2005. They also confront a situation where ATS is increasingly considered a low-cost commodity (pills sell for

around US\$0.60 each) that has resonant symbolic and use value for wide sectors of the Lao population: for urban adolescents for whom it is perhaps the cheapest way to engage in a global youth market, for labourers who seek stamina, for the growing number of women in the sex industry for whom it increases the ability to converse with prospective customers (and reduces dietary consumption), and for highlanders for whom it provides a counter to the lethargy and lassitude associated with opium use.

Of concern here is how the dual processes of opium eradication and village relocation encourage ATS uptake among the Akha. Since 2000, ATS use has increased dramatically in Namtha province. It was first introduced within enclaves of townspeople, largely comprising the lowland Tai Lue ethnic group, but its consumption is moving steadily outwards into the Akha villages in the hills. Notably ATS use is highest in villages in closer proximity to the town, but its use among the Akha is not simply a product of ready access, as local traders market *ya ba* in nearby villages. It is also actively purchased by those seeking its social and/or physical effects. Akha labourers at the small port on the Mekong river bordering Burma regularly consume ATS to expedite contract work loading and unloading Thai and Chinese cargo: those working as contract labourers in rice, watermelon or sugarcane fields sometimes smoke it.

Villagers undertaking new economic ventures use it to maximise their output. For example, palm fruit has recently become a valuable commodity traded to Thailand: villagers collecting and lugging the fruits to the sales points take ATS to expedite their lengthy night-time journeys through forest trails. Methods of spreading its uptake can be insidious. Landowners reportedly offer ATS on occasion instead of, or alongside, cash or opium as wages for Akha labour in lowland rice fields, or on road construction projects. As in Thailand, a primary market is young people who want to follow big city trends and labourers who want to extend their physical capabilities. To date, virtually everything Akha hear about ATS is positive — it doubles energy for work, it offers new exciting ways of thinking, it creates a good mood for hours and should a partner be available, men report that one can have sex all night.

Significantly, ATS's appeal is not limited to marginalised opium addicts; its uptake is broadly encouraged by those selling their labour regardless of prior history with opium and its marketability is reinforced as a packaged, refined commodity. Due to the pejorative association of opiates with highland traditions, heroin use by minority groups deeply inscribes the bounds of ethnicity; ATS, on the other hand, currently offers the Lao Akha the timely opportunity to consume a product associated both materially and affectively with the wider world of market enterprise and commodity exchange.

Conclusion

It might be argued that ATS is a consummate postmodern commodity: small mobile factories use imported substances to synthesise pills by the million and market them through transnational flows tailored specifically to target communities. But when we consider demand, it becomes clear that increasing ATS use among Southeast Asian highland and lowland populations is closely embedded in the social production of a modern subject. In the Golden Triangle, changing patterns of drug use offer us a clear indication of the complex interrelation of social, psychic and material relations in a changing arena of individual choice and heightened governmentality.

Laos has begun similar opium prohibition initiatives to those carried out in Thailand over the past 30 years. While there are important distinctions in the way the Lao government handles issues of ethnic politics and nation-building, there are nonetheless many similarities in drug control both in urban (clinic-based) and rural (crop eradication) sectors. But even as urban Lao youth emulate Thai youth culture's fascination with the pleasures offered by ATS and its direct links with the wider world of accessible, cheap and fashionable commodities, Lao highland communities differ from their Thai counterparts.

Rather than heroin, highlanders in northwest Laos are at present increasingly using ATS. The distinctions can be explained by the different trajectories into capitalist markets. In Laos, with relatively low population density, opium eradication is accompanied by policies that encourage highlanders to move to the lowlands and become active members of a Lao citizenry engaging in a free market economy. In Thailand, relocation projects were rarely successful and development was more typically marked not by movement but by commercial exploitation within the highlands, and increasingly enforced legal strictures on forest protection and national security. Conversely, as the Lao highlanders move geographically and culturally into new material and social relations of production they attempt to negotiate their positions within a new capitalist order and mitigate the potential threats induced by such social upheaval. ATS is being used by the Akha, a population intimately familiar with taking drugs, as a ready-made foil to assist in the transition to new forms of subjectivity required by the adoption of sedentary market trade and wage-labour.

Markets for drugs do not exist *sui generis* — they are created. So too drug epidemics emerge as a product of social relations. Many Akha wish to embrace capitalist forms of accumulation; the opportunity to do so invests life in the lowlands, access to markets, commodities and trade with enormous appeal. Recent

government policies remove a large degree of choice as traditional lifestyles are deemed unsustainable. But, as numerous studies show, the transition to (frequently) inequitable relations of production carries its own threats to integrity and well-being. Dramatic increases in ATS use are logical in the sense that they facilitate new and desirable forms of subjectivity in which the traits associated with tradition, such as opium addiction, lethargy and 'primitiveness', are exchanged for a new entrepreneurial labourer/trader identity. At the same time, ATS use fosters new forms of psycho/physiological damage, criminality, social exploitation and marginalisation as the Akha maintain drug dependency on the way to new life in the lowlands (Lyttleton 2005).

Note

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Illicit drugs and development: AusAID's efforts to combat illicit drugs

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Introduction: The drugs/development link

The Australian Government has a wide range of measures in place to combat illicit drugs, from domestic policies and legislation to the provision of technical assistance to other countries. The Australian Federal Police in particular has a network of cooperative relationships and overseas liaison offices throughout the region that assist in combating illicit drugs (see Pieper, this issue).

The primary purpose of Australia's aid programme is to assist developing countries to reduce poverty and achieve sustainable development. This purpose is threatened by a number of development threats, including illicit drugs.

Contrary to popular belief, the threat of illicit drugs to development is not new. Australia's aid programme has been working to combat illicit drugs for many years. It is a changing phenomenon, however, and AusAID is committed to continuing to develop its understanding of illicit drugs issues as they change over time, including how the issue overlaps and intersects with traditional development issues.

In September 2004, three AusAID officers undertook a three-week mission to Southeast Asia to meet with country and United Nations Office on Drugs and Crime (UNODC) officers to discuss the illicit drugs threat in the region from a development perspective. This led to a draft report that examined the linkages between drugs and development, and outlined a wide variety of options that could be considered for future support. The Prime Minister subsequently announced the development of a new regional initiative to address drugs issues in Southeast Asia.

Need for a multifaceted approach

It is clear from AusAID's studies and experience in anti-illicit drugs activities that combating illicit drugs requires a multifaceted approach. For example, law enforcement activities do not provide alternative livelihoods for farmers currently reliant on opium crops. Conversely, alternative development projects have no impact on the demand for illicit drugs. Anti-illicit drugs activities must also recognise the negative consequences of illicit drug use on the wider community, including the spread of disease, anti-social behaviour and crime.

Research has also shown that illicit drugs exacerbate other transboundary threats, including encouraging the spread of HIV/AIDS, funding conflict and potentially, terrorism, and fuelling corruption. AusAID's activities to combat illicit drugs reflect the need for a variety of approaches, including indirect means such as public health and agriculture interventions.

Current illicit drugs trends in Asia

Over the last decade, the production, distribution and consumption of illicit drugs in East and Southeast Asia has changed significantly.

One of these changes has been increased production and consumption of a range of synthetic drugs most commonly known as amphetamine type substances (ATS; see Lyttleton, this issue). The Asia region is now the largest global source of ATS. To provide an indication of scale, Thai seizures of ATS in 2002 amounted to over 100 million tablets. In China in 2000, 21 tonnes of methamphetamine were seized, the equivalent of around 200 million tablets. While these seizures have been an indicator of some success in law enforcement efforts, it is widely agreed that such seizures account for only a small proportion of the total production. Informal reports suggest that the industry is able to respond with some flexibility to law enforcement efforts, turning to alternative products, markets and distribution routes.

The nature of ATS production and use is very different to traditional illicit drugs such as opium production. For example, ATS laboratories are much smaller than poppy fields, and require only running water, electricity and precursor chemicals to operate. This makes them much harder to detect. The equipment required to produce methamphetamines and other synthetic drugs is also much smaller than that required for heroin refining. As this makes it harder to locate ATS laboratories, producers regard ATS production as entailing lower risks. The changing demographic of drug producers from poor farmers to more affluent middle class ATS producers means that traditional responses are no longer appropriate. Responding to ATS will therefore require new and innovative responses.

Even though ATS is becoming an increasing concern in the region, the production of refined heroin and raw opium in

Burma is still a significant problem. Drugs from Burma are transported in small and large amounts via land, sea and air and are destined for most of the countries throughout East Asia before moving to the West. The illicit drugs threat in one country can therefore also threaten stability in a number of nearby countries in the region.

Both of these trends are of serious concern, which is why AusAID is considering appropriate ways to combat them.

Some anti-illicit drugs activities

AusAID implements a wide range of anti-illicit drugs activities. The following summaries of a few of AusAID's project illustrate the variety of activities currently being funded.

Demand reduction in Burma

The Australian Government has fully funded the A\$490,000 Community-based Demand Reduction Project in Burma, which aimed to reduce the incidence of drug abuse. Using community-based offices, the project provided and monitored revolving loans for community-based demand reduction and social development activities to villages. The project also provided health education; implemented detoxification programmes; and conducted training in community management, financial management and gender awareness.

The project worked directly with the police, and was successful in highlighting the role of police in detoxification and the social side of drug abuse. This improved community confidence and trust in police over time.

AusAID considered this project to be a necessary measure as it was clear that while law enforcement measures were impacting on opium production, they were having minimal impact on reducing demand for illicit drugs. This is due to the complex and multi-dimensional nature of addiction. AusAID considers that longer-term investment in sustainable community development is required to address this problem. For example, support to sectors such as health care, water supply and sanitation and small-scale agro-based economic development is appropriate, alongside continued community capacity building and demand reduction efforts.

The project's relapse rates were far lower than other detoxification programmes. This was primarily due to the high commitment of the communities in supporting the addicts through the programme.

Alternative development in Afghanistan

The Seeds of Strength project is an alternative development activity in Afghanistan. It is currently in its second phase and Australian contributions are now valued at A\$2 million.

Phase I was implemented over two years from June 2002 to June 2004, at a cost of A\$1 million. Phase I focused on

improving seed distribution and quality in Afghanistan, and developing and distributing stress-tolerant wheat and maize varieties. While Phase I achieved some real progress, Phase II was implemented to address a perceived lack of trained personnel and learning materials.

Phase II is being implemented over three years from July 2004 to July 2007, at a cost of A\$1 million and is jointly funded by AusAID and the Australian Centre for International Agriculture Research. Phase II aims to improve the productivity of wheat and maize in Afghanistan through identification and dissemination of improved varieties and improved ways of growing these crops.

Improving food security is a key priority for Afghanistan where years of conflict and drought have impacted negatively on local agricultural production. Improving farmer's agricultural livelihoods is also important from the perspective of providing viable alternatives to the illegal production of opium in agricultural regions.

While a vital part of any illicit drugs response, alternative development faces many challenges, including the problem that wheat and maize will never be able to compete with the returns for opium. This is why alternative development responses must be accompanied by other efforts to reduce the demand, supply and harm aspects of illicit drugs.

HIV/AIDS prevention in China

The Xinjiang HIV/AIDS Prevention and Care Project operates in the Xinjiang Uygur Autonomous Region, which has the fourth highest number of HIV-positive people in China, most of whom are intravenous drug users. There is evidence that HIV is expanding into the general population.

The project aims to reduce the economic and social impact of HIV/AIDS on the region by assisting regional, prefecture and county-level governments to develop and implement an effective multi-sectoral approach to HIV. There are three technical components: planning and coordination, including leadership and advocacy; health promotion, including anti-discrimination; and direct and indirect care, including acute and palliative care in hospitals and community-based preventative and palliative care.

The project has been described by UNAIDS country representative in Beijing as 'world class' and has generated high praise from senior Chinese health officials, including the Deputy Director General of the China Centre for Disease Control. The project has also won a series of regional government awards, including the Tianshan Cup in two successive years — the highest award for foreign experts in Xinjiang.

At a strategic level, the project is working with agencies involved in the Xinjiang Regional Working Group for HIV/AIDS and sub-regional working groups to raise HIV awareness

across government and to improve the institutional capacity to plan and coordinate an effective multi-sectoral response to the epidemic. This reflects the fact that HIV/AIDS is not just a health issue, nor is it just an issue for health agencies.

At a local level, the project is facilitating a range of innovative initiatives designed and implemented by state and community partners with the support of Australian technical expertise. The project began at a time when there was great local resistance and national policy constraints to developing and implementing prevention and care strategies to target the most vulnerable and already affected groups. The project has established partnerships spanning regional, prefecture and county levels of government and various non government organisations.

The importance of regional approaches

AusAID's bilateral activities such as those outlined above are a vital element in its fight against illicit drugs. However, the transboundary implications of illicit drugs must be addressed beyond country-specific activities. No country, including Australia, can address illicit drugs alone.

AusAID supports a variety of regional approaches, including through regional activities and through participating at regional fora.

The Asia Regional HIV/AIDS Project

One of AusAID's major regional activities is the A\$10.7 million Asia Regional HIV/AIDS Project (ARHP), 2002–2006, which aims to contribute to the reduction of HIV-related harm associated with injecting drug use in Burma, China and Vietnam (also see Birgin, following).

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 HIV harm reduction. Activities under the project began with advocacy among senior officials to gain political support, and then progressed to providing awareness and training among health and public security officers to increase their understanding and knowledge of HIV and harm reduction approaches.

The project also introduced trials at local levels, and then used lessons learned from these trials to inform policy decisions for the expansion of harm reduction approaches across the countries in which ARHP operates. The ARHP has performed excellently at the local technical level. The project is widely recognised as having introduced a logical and systematic approach to harm reduction.

AusAID is in the process of designing a new regional HIV/AIDS project and intends to mobilise this project in May/June 2006.

Illicit Drugs Initiative

AusAID is implementing a new two-year regional activity, the Illicit Drugs Initiative (IDI) announced by the Prime Minister late 2004. The IDI will work as a grants scheme to support projects to build regional cooperation and to support national drug control strategies. IDI focus areas include expanding treatment and rehabilitation approaches, improving data collection capabilities, and supporting ATS precursor control across the region. The IDI will consider proposals from Burma, Cambodia, Laos, Thailand and Vietnam. Proposals may also address enhancing regional cooperation with China.

International and national fora

AusAID is actively involved in a wide range of national and international bodies to discuss illicit drugs and best practice approaches.

AusAID has supported the Colombo Plan since its inception in 1951, and currently provides an annual contribution of A\$56,000. The Colombo Plan is a loose knit network of donor and recipient countries which meet to discuss development issues, focusing on technical cooperation and human resource development. More than half of AusAID's contribution supports the Colombo Plan's Drug Advisory Programme which implements demand reduction activities, including regional workshops on drug abuse and drug education manuals for schools in Southeast Asia.

Through its participation in UNODC's major donors' meeting, Australia supports the UNODC in enhancing international awareness and the development of best practices and key partnerships.

AusAID participates in the Asia Pacific Drugs Issues Committee convened by the Australian National Council on Drugs. Australia also attends the annual sessions of the Commission on Narcotic Drugs, the Standing Interdepartmental Committee on International Narcotics Issues, and the Dublin group meetings in Burma, Cambodia, China, Laos, Thailand, and Vietnam.

Donor harmonisation

AusAID is committed to improving donor harmonisation, and continues to seek opportunities to harmonise with other donors, as part of our obligation to ensure our aid is as effective as possible, including in the area of illicit drugs.

For example, AusAID has provided core funding to the UNODC since 1993. Its current contribution is A\$1 million per year. In 2004–2005, 50 per cent of AusAID's core contribution was provided for general purpose funds through the Geneva central office, and 50 per cent for activities from the regional office in Bangkok where it is used to support the

ASEAN and China Cooperative Operations in Response to Dangerous Drugs. This strategy of earmarking funds for activities in our region helps raise the profile of the region in UNODC's overall focus.

Conclusion

AusAID is dedicated to constantly deepening its understanding of the issues hampering development in the regions we work in. The organisation considers that the only way to achieve a

sustainable impact is to address the problem through a multifaceted approach. Further, while bilateral projects are necessary for implementing country-specific activities, regional approaches are also vital when working in an issue with significant transboundary implications.

Through collaboration with national and international bodies, and efforts towards improving donor harmonisation, AusAID is committed to securing developing countries against the destabilising effects of illicit drugs.

Help as a threat: Alternative development and the 'War on Drugs' in Bolivia and Laos

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Introduction

The origins of the 'War on Drugs' can be traced back to international drug treaties promoted by the United States, such as the Hague Convention (1912) and the Geneva Convention (1925), and to Harry Anslinger's campaign, as director of the US Federal Bureau of Narcotics, to demonise marijuana in the US in the 1920s and 1930s. After World War Two, Anslinger also played a dominant role in the United Nations Commission on Narcotic Drugs and in the development of the so-called prohibitionist paradigm of international drug legislation (Bewley-Taylor 1999).

President Nixon initiated the modern 'War on Drugs' when he declared drugs to be a national threat. He expanded the punitive approach to illicit drugs and the anti-drug bureaucracy at home. He also extended the drug war abroad to strike at foreign drug traffickers (who were labelled national enemies) and at sources of supply. Subsequently the major protagonists in the modern 'War on Drugs' and promoters of supply-side policies have been the US and the UN, first through the United Nations Drug Control Programme (UNDCP) established in 1991 and currently the United Nations Office on Drugs and Crime (UNODC; see Calvani, this issue).

The aim of supply reduction is to eliminate illicit drugs at their source, to destroy refining facilities, to intercept and confiscate drugs en route from the source countries to Western markets, and to locate, arrest and prosecute drug dealers and seize drug supplies. The underlying assumption of this strategy is that reduced supply will force up prices in the Western markets and reduce drug consumption.

At the same time the UN and other international organisations have come under the influence of other philosophies and policies that emphasise poverty reduction, bottom-up development, the mobilisation of social capital, and grassroots participation. In the field of illicit drug reduction, alternative development has been the UN catch-phrase since the early 1990s, replacing rural integrated development of the 1980s and crop substitution of the 1970s.

Despite often-repeated pronouncements of the need for a balanced approach between alternative development and law enforcement such a balance is elusive, even illusory. It is not

just that grossly unequal resources are invested in law enforcement measures to reduce supply. One should also consider that the 'War on Drugs' is a 'war about emotional imagery and contested symbols' (Manderson 1995:799). As such, the drug war is waged with a passion and intensity that contributes to an overriding, even obsessive, concern with meeting supply reduction targets as evidence of battles won in the war.

The paramount goal of the 'War on Drugs' is to eradicate supply on foreign soil — a goal regularly supported by US certification policy¹ and even, on occasions, by direct US military intervention (as in South America). In short, I argue in this paper that the prohibitionist paradigm takes precedence over, and dominates, alternative development principles and programmes. The latter may consequently take on a political function that conspires to camouflage and conceal the punitive elements of supply-side drug campaigns. In support of this argument I draw upon anthropological research in the Chapare region of Bolivia and in Sing and Long districts of Luang Namtha province, northwestern Laos.²

Help as a threat

In a perceptive article, Marianne Gronemeyer compares the early Christian idea of help as unconditional help based on the concept of *misericordia* — pity in the face of the need of another. By contrast modern help, she argues, is self-interested and calculating and the boundaries between giving and receiving become blurred. Help is not only calculating, it is also threatening. Help is no longer help to someone in need but help in response to a deficit as diagnosed by the helper and according to some external standard of normality. Thus help 'has been transformed into an instrument through which one can impose upon others the obligation of good conduct' (1992:54). Help becomes a means to discipline and to conceal.

Alternative development is the international aid component of supply-side policies and provides wide-ranging development incentives (substitute crops, education, health, infrastructure development, and social services) for the reduction of illicit drug crops. Alternative development should be participatory in a way which involves 'encouraging direct participation by the farmers

and communities in the design, planning and implementation of alternative development activities' (UNODC 2001: 8-9). Indeed the term participatory alternative development is sometimes used interchangeably with alternative development. Other UN documents emphasise that alternative development should be 'people centred', promote 'democratic values' and be based on 'dialogue and persuasion' (CND 1998). Implicit in this discourse is that alternative development is voluntary and consensual.

But there is a catch, which is the conditionality of aid. That is, development assistance is conditional on reductions in illicit crop cultivation within a specified time-frame. Aid provides the incentive for farmers to voluntarily enter agreements, but if they fail to keep their side of the bargain, assistance may be refused or withdrawn and law enforcement measures applied (Farrell 1998). In short, alternative development is implicitly punitive. It also fits well Gronemeyer's definition of modern help as conditional, calculating and self-interested, involving the 'yoking together of help and threat' (1992: 53).

Alternative development and 'voluntary' eradication in Bolivia

Bolivia is one of the three largest producers of coca in the world, along with Peru and Colombia. Coca production in Bolivia declined from 53,000 hectares (77,000 tonnes) in 1990 to a low 14,600 hectares (13,400 tonnes) in 2000 but there has been an upsurge in recent years to 27,000 hectares (25,000 tonnes) in 2004, including 12,000 hectares in the Yungas region of legal cultivation for 'traditional' consumption (UNODC 2005). The Chapare has been the most important coca cultivating region, producing as much as 55,000 hectares in 1987 but reduced to 10,100 hectares in 2004.

Anthropologist Harry Sanabria describes the vigorous campaign against coca cultivation in the Chapare, due largely to pressure on the Bolivian government of US threats of decertification. The campaign combined alternative development programmes (financed by USAID) with repressive policies by US-backed state agencies to forcefully eradicate coca cultivation. He notes that Law 1008 provided for the 'voluntary' eradication of coca planted prior to the enactment of the law in 1988. 'Voluntary' eradication was to go hand-in-hand with alternative development with a financial incentive equivalent to US\$2,000 offered to switch to alternative crops.³

According to Sanabria, the 'public transcript' (a term coined by James Scott) focused on peasants as willing participants in the destruction of their own coca. He cites a state document that 'the reduction of coca plantings will take place with economic compensation and with the agreement and free and voluntary participation of the (coca) producers' and adds: 'Yet official claims of widespread 'voluntary' eradication in the

Chapare and elsewhere are deceiving at least, concealing an array of repressive and coercive acts and contexts that force peasants to 'voluntarily' destroy their coca' (Sanabria 1997:176).⁴ These acts ranged from the use of violence, arbitrary arrests, verbal threats and other forms of intimidation to more subtle forms of coercion, such as claims by officials of the Coca Eradication Bureau that compensation funds were being rapidly depleted and that unless growers quickly 'volunteered' to destroy their coca shrubs the officials would do it instead without compensation.

Furthermore, in such climate of concealed repression peasants often felt obliged to offer officials various 'services' such as good meals, beer, and even money for petrol. This 'forced generosity' was aimed at minimising the harm of official eradication efforts (Sanabria 1997:180).

Behind the 'public transcript' of the willing complicity of Bolivian peasants in coca eradication was a 'hidden transcript' of rage and anger at the abuses perpetrated by the state (Sanabria 1997:181). Resistance took many forms varying from organised, public protests, road blocks, and armed clashes with officials of the coca eradication bureau and with security forces to less militant forms of non-compliance such as uprooting coca shrubs in one area and planting new ones in other areas.

Alternative development and 'voluntary' eradication in Laos

Lao PDR has been the third largest producer of illicit opium in the world, with production reaching a peak of an estimated 380 tonnes in 1989 and with maximum production in the 1990s of 275 tonnes in 1990 and 167 tonnes in 2000 (see Boonwaat, this issue). Opium cultivation is concentrated in the north and is grown in 11 out of 17 provinces. In 1997-1998 in Sing and Long districts, highlanders, mostly Akha, cultivated approximately 1,500 hectares of poppy yielding about 12 tonnes of opium. Until a few years ago about 90 per cent of highland villages in Sing district cultivated opium but most did not grow enough for their own consumption. In Long district only about 60 per cent of highland villages grew opium, though two Hmong villages cultivated opium extensively, much of it for export. In the 1990s the Akha had high rates of opium addiction — on average about nine per cent of total population — though rates of addiction varied considerably from village to village.

The UNDCP formulated a Comprehensive Drug Control Programme (known as the Masterplan) for Lao PDR for the period 1994-2000. In 1996 the Lao Government revised its drug control law (Article 135 of the Criminal Code on Drug Trafficking and Possession) and officially prohibited the production of opium. In December 2000 the Prime Minister issued Decree 14 mandating the total elimination of opium by 2006. The deadline was later brought forward to 2005. The

Lao National Commission for Drug Control Policy and Supervision (LCDC), set up in 1990, is the government agency responsible for drug control policy and implementation. LCDC oversees provincial and district drug-control committees established in 2001. UN documents have proclaimed the need for a 'balanced approach' to opium elimination in Laos between alternative development, community-based drug demand reduction, and law enforcement. The Masterplan also stipulated the need for 'gradual elimination' (UNDCP 2000:26), though the 2005 deadline dictates an even shorter period than the quite stringent UN definition of 'gradual' (that is, six to ten years) (UNDCP 1998).

Following the Prime Minister's decree of 2000 it took a while for the opium eradication campaign to get underway in Sing and Long districts. In August 2002 local officials ventured into the hills to collect poppy seeds from all highland households. This did not cause great concern as villagers handed over only a small part of their stockpiled seeds. However, one village in Sing district did decide to cease growing opium 'because the project/district staff said they would stop all help for the village if the village does not become drug-free' (Mumm 2002:28). In December 2002 and January 2003 the eradication campaign became even more threatening and punitive. In Sing and Long districts numerous state officials spent a month in the highlands visiting each opium-growing village. They insisted the villagers 'volunteer' (*samak*) to destroy their crops of poppy and to sign agreements to cease growing opium, with the threat of fines if they did not comply. One report laments that the authorities were excessively 'output oriented' and were only concerned with 'figures' (for example, how many hectares of poppy destroyed) (GTZ 2003a:14). By January 2003 the area of poppy cultivated had been reduced to 28 hectares in Sing district and 54 hectares in Long district. Officials turned a deaf ear to many villagers' pleas to delay eradication so they could use the opium crop to buy rice, due to rice shortages from the poor harvest of the previous year. Furthermore, villagers were expected to provide meals to officials charged with destroying their opium crops — a practice that resembles the 'forced generosity' of Bolivian peasants noted above.⁵

The UNDCP's Long Alternative Development Project document proclaims: 'communities are able to analyse their own solutions, constraints, potentials, priorities and solutions' (UNDCP 2002:22). However, it is obvious that the problems and solutions had already been dictated by the Lao state and the UN and agencies charged with implementing their mandate. There is not much scope for dialogue, choice and voluntary participation in this context.

The rigorous and uncompromising eradication activities imposed a heavy burden on highlanders, not just on addicts but on almost all households that used opium as a major source

of income. In a situation of declining upland rice yields and government restrictions on shifting cultivation, opium was crucial to highlanders as an item of barter and/or to generate cash income to make up for rice deficits. The eradication campaign caused considerable dismay and anger but the response was generally not as militant as in the case of the Bolivian coca growers. In desperate attempts to survive, highlanders resorted to various forms of disobedience and recidivism. Some migrated to more remote highland areas to grow opium in the hope of escaping official surveillance; others stayed put but persevered with opium cultivation, forcing officials to destroy their poppy fields as many as three times. Another response, in Sing district, has been the spontaneous and uncontrolled migration of Akha to the lowlands in the hope that the local government would allocate them paddy land there. In 2003 one sub-district was virtually depopulated in this way, despite attempts by district officials to stop the exodus.

In accordance with UNODC and Lao Government policy, alternative development should go hand-in-hand with opium eradication. In Sing district alternative development is embedded in the Integrated Rural Development Programme, established in 2001, of the German aid agency, GTZ. GTZ has acknowledged that, at the 'agro-commercial level ... finding an alternative is proving a daunting task' (2003b:7). The project has been experimenting with maize, cotton, sugar cane, sunflower and rattan shoots and claims that cardamom and sapan wood 'look promising'. District authorities in Sing have promoted sugar cane and rubber in recent years but there has been considerable conflict between Akha cane growers and Chinese buyers and rubber growing is still at a trial stage.

Norwegian Church Aid (NCA), as part of its Long Alternative Development Project, reached agreement in 2003 with a private company to supply corn and ginger with a contract to buy at stipulated prices for sale in China. The company also planned to introduce the cultivation of sesame and soybean. These are important initiatives with, in some cases, appropriate attention to securing markets and guaranteeing prices. However, there is little chance of these new crops providing viable, alternative sources of income to highlanders in the near future and, in Sing district, of stemming the migration of highlanders to eke out a precarious livelihood as wage labourers in the lowlands (see Lyttleton, this issue).

In his foreword to the *Lao Opium Survey of 2004* the Executive Director of UNODC, Antonio Costa, praises the Government of Lao for the 'historical achievement' of reducing opium production by 75 per cent in six years. At the same time he rebukes aid agencies as follows: 'The donor community must match this achievement by helping Laos to provide poor farmers, who are now giving up their income from opium, with sustainable alternative sources of livelihood. Not enough has

been done in this respect. In many areas, opium elimination has been achieved without the farmers having the opportunity to develop other sources of income'. What is disconcerting about this statement is that it betrays a lack of appreciation of the obvious connection between the rapidity of opium eradication in Laos and the failure of the donor community to achieve viable alternative development.

Conclusion

In this paper I have emphasised the powerfully symbolic character of the global 'War on Drugs'. The emotional and negative imagery and enduring virulence of the war underpins the prohibitionist paradigm and engenders an obsessive concern with achieving supply reduction targets. I have also argued that the prohibitionist paradigm, with its privileging of law enforcement, takes precedence over and dominates the participatory and consensual principles of alternative development. Consequently, alternative development, irrespective of the success or failure of its economic goals, may prove politically useful as a smokescreen that conceals the punitive elements of the drug war. 'Help as a threat' is reflected in the conditionality of alternative development — a 'carrot and stick' strategy that uses development aid to entice voluntary agreements to reduce illicit crops but resorts to law enforcement if farmers fail to comply.

In the Bolivian and Lao examples above I have shown how mounting political pressure to meet eradication targets for illicit drug crops, in the absence of viable alternative economic opportunities, results in the increasing use of threats (including force) and the progressive stripping away of the façade of the participatory and consensual nature of alternative development. Bolivian peasants and Lao highlanders have expressed anger at the deception unveiled and the hardships endured and have responded in ways that range from militant armed resistance and public protests to less confrontationalist forms of disobedience.

What are the alternatives to alternative development in the current global drug war? There are advocates of drug law reform who argue that the 'War on Drugs' is tragically flawed and that prohibition itself has stimulated the global trafficking in illicit drugs (McCoy 2004). Others recommend alternative legal markets for illicit coca and opium (Hellin 2001; Senlis Council 2005). However, even if one accepts the necessity of the supply-side drug war there are policies that can be adopted to minimise the punitive aspects of alternative development and realise the participatory ideals enshrined in UN proclamations.

One option is to adopt a more gradualist approach to illicit drug crop reduction that sets realistic eradication deadlines and allows adequate time for the growth of viable alternative

sources of income. Indeed, why not even reformulate the 'conditionality' of alternative development in a way that requires alternative development to precede and succeed prior to illicit crop eradication, as has been advocated by some peasant unions in Bolivia (Leons 1997), and some development specialists in Laos who have argued that 'UNODC has put the cart before the horse, and that development must come before, not after, the cutting back of opium cultivation' (Fawthrop 2004).

Notes

1. A policy that threatens major illicit drug producing and/or drug transit countries with the withdrawal of US, foreign assistance for failure to fully cooperate with US anti-narcotics efforts.
2. In Laos I conducted fieldwork independently from 1995-2000 and thereafter jointly with Dr Chris Lyttleton.
3. During the 1990s the alternative crops introduced included bananas, pineapple, palmheart, passion fruit and black pepper. Hellin (2001) cites reports that only a small minority of ex-coca farmers were likely to succeed.
4. With regards to the UN Agroyungas project in the coca-growing Yungas region of Bolivia, Leons also notes that peasant organisations were wary of alternative development because 'they suspected it of being simply a code for eradication' (1997: 154).⁵ For example, in one Akha village officials from various departments stayed in the village for 11 days. The food provided free amounted to 144 kg of milled rice, 25 kg of meat, 90 kg of vegetables and ten bottles of whiskey.

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Drugs, development and the media: How has the media performed? Can it perform better?

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Those engaged in policy making about both drugs and development and those engaged in crime prevention and enforcement share one thing in common — they all operate within a context where public opinion impacts upon their room for manoeuvre.

Public opinion is the outcome of a complex symbiotic relationship between journalists, public relations officers and policy makers. The relationship between these three sets of actors constructs a 'picture of the world' that is disseminated in the mass media. Therefore public opinion could be seen as the outcome of how the mass media choose to report various issues. These 'pictures of the world' influence all of us, even policy makers.

The question is what happens if the mass media construct 'pictures' that are in some way distorted? What happens if the 'pictures' are simplistic or naïve because journalists did not quite understand the complexity of the issues? What happens if the 'pictures' are simplified, skewed or hyped up because of editorial decisions geared to attract larger audiences? What happens if the 'pictures' are sanitised so as not to offend vested interests or to be politically correct? And what happens when television becomes the dominant storyteller in society, because television is a vehicle that tends to inherently sensationalise and simplify a story?

The answer is that the public receives a picture of the world that is distorted. This can produce a misguided public opinion, which in turn can impact on policy makers who are themselves not immune from the effects of distorted mass media portrayals of the world. For this reason an understanding of the media's role in constructing 'helpful' and 'unhelpful' public opinion should be seen as of central concern to policy makers.

Undoubtedly, for policy makers, development agencies and policy agencies it would be useful if public opinion could be better informed about the complexity of the problems being confronted. For this reason it is useful to consider:

1. How the mass media is performing in its reportage of drug use and drug production;
2. How the mass media is performing in its reportage of the 'criminalisation' of drug use and/or the 'normalisation' of drug use;
3. How the mass media is performing in its reportage of law enforcement in the drug arena;

4. How the mass media is performing in its reportage of development issues;
5. Whether the mass media has successfully sketched out the links between the issue of drug supply and development;
6. Whether journalists are adequately trained to cover the complexity of many policy issues;
7. Whether a mass media driven by audience ratings is the right vehicle to try and explain complex policy issues to the public;
8. Whether spin doctoring has become an endemic problem that inherently skews media images of the world;
9. Whether policy makers pay too much attention to public opinion; and
10. Whether policy makers are also influenced by distorted media presentations.

A key problem is that 'distorted' world views can sometimes become entrenched because the media constructs a skewed picture which is not only internalised by the public, but also by the next generation of journalists and politicians. This means unhelpful 'pictures of the world' tend to be recirculated again and again because so many people are 'trapped' inside what has become a 'commonsensical' way of understanding the world; and those who are not are often too afraid to speak out and question the dominant story being circulated in society.

Drugs and the Australian media

If we examine the Australian media in the context of communication for development and social change we find that the reporting of drugs has generally operated within a culture of blame. The 'drug problem' is blamed upon 'bad people' (bad individuals and organised crime). Within this logic, if these 'bad people' are taken out of the system the 'problem' will go away. Law enforcement is also blamed for not rooting out the problem.

Two commonly related sub-themes within the media are that drug users are vulnerable victims or adults with the right to inflict self-harm. Vulnerable victims are, for example, children preyed upon and led astray by the 'bad people'; or people who have 'gone off the rails' because of 'unfortunate circumstances' in their lives. This view is often tied to the notion that society

needs to protect the vulnerable from the bad people. When this is not done the police are blamed. In the case of adults, it is precisely because they are adults that they have a right to use recreational drugs (responsibly) if they wish. This media theme blames poor policy making and/or overzealous policing for creating the drug problem. Within this view the problem is the criminalisation of something (drug taking) which ought not to be considered a crime in the first place.

Both of these shift the blame away from drug users. Many in the media seem reluctant to seriously examine the issue of drug use in a way which might imply drug users are in any way blameworthy. This is tied to a view that society is to blame for 'creating' criminals, rather than that individuals are personally blameworthy — this is, in turn, tied to an interpretation of the nature-nurture debate wherein nurture (not nature) is seen as blameworthy. Of course, if drug users are not to blame then the media has no alternative but to lay the blame at the feet of policy makers, the police or criminals. The media's narrative about drugs consequently tends to revolve around shifting blame between these three. This, in turn, produces a public relations game in which public relations officers working for policy makers and/or the police engage in a never ending exercise defending themselves, blame shifting and spin doctoring. It is a media spin game that does little to fix the problems.

What the mass media has failed to do in its reporting is seriously examine the complexity of the drug problem. For example, what about the relationship between drug supply and issues of underdevelopment? How many journalists have the necessary training to be able to understand these issues? How many editors would be interested in reporting such issues? Is it true (as many editors would say) that their audiences just do not care?

What about the existence of politically and economically marginalised groups in Asian, African and Latin American societies; or insurgency struggles fought by marginalised groups against their governments? Such groups often resort to the production of drugs to fund their wars. Is reporting such issues too difficult? Is the lack of reporting of such issues due to mass media staffers not understanding these issues themselves; or is it because editors have decided their audiences do not care? Or perhaps it is because no one wants to talk about such issues since they are too 'sensitive' — after all how did these situations develop in the first place? How many First World governments and agencies have been involved in creating the conditions that gave rise to these problems? And where were the journalists who should have been reporting these problems as they grew, instead of averting their gaze, or writing spin-doctored stories?

We also see little coverage of the growth of warlordism in Asia and Africa and the way in which intelligence agencies sometimes encourage warlords and insurgency struggles. There

are few stories about how warlords and crime bosses can sometimes become part of the political establishment of a country; or the way in which warlords and crime bosses develop symbiotic relationships with government agencies and officials in some countries. Sometimes they even develop relationships with overseas development agencies. Again, perhaps the silence is because no one wants to talk about such issues. Are they are too 'sensitive'? Have too many First World governments and agencies helped create the conditions for warlordism to arise? Have such stories not been written because journalists were not well enough trained to produce such stories; or did they deliberately avert their gaze to avoid writing 'sensitive' stories? Or have journalists simply chosen to see what they wanted to see instead of what was actually going on? Perhaps too many people were trapped inside a 'commonsensical' way of understanding the world that precluded them from asking the right questions?

Why are there no stories about the way in which globalised free trade is improving conditions for drug trading (see Calvani, Pieper and Lyttleton, this issue)? Globalisation is enmeshed with economic growth. This is premised upon an efficient global transport system and an efficient communication system (for example, the internet). These infrastructures can also be used to organise drug movements. Are such stories ignored because they may offend some powerful interests?

Why no stories about the relationship between economic growth, migration and drugs? Policies that are focussed on economic growth encourage migration (especially the migration of entrepreneurs and skilled people who are good organisers). This has produced diasporic communities across North America, Europe and Australasia that can (and do) serve as 'bases' for organised crime (and terror groups). Do the mass media fudge such issues because they are too 'sensitive' or because they make some people 'uncomfortable'?

In other words, the media has failed to examine how a certain type of development (based on globalised free trade) can have, and does have, negative spin-offs. In short, the media, by focusing on skewed 'blame-game' reporting, has failed to grapple with the complexity of the drug issue and failed to examine the linkages between drugs and wider issues of development, underdevelopment, insurgency wars, and government policies on trade, migration and foreign relations. This failure has produced an unsophisticated public opinion that is unhelpful to policy making and policy execution. Perhaps, for some of the vested interests in our society such an uninformed public opinion may be helpful? But for anyone seriously concerned about our society's drug problem, the failure to report on complex and unpleasant issues can be deemed socially irresponsible. Sanitising the news by design, or default, means we are all short changed.

The question is, does anyone have a vested interest in challenging this skewed reporting? Are their government agencies (development or otherwise) who are game enough to draw attention to such issues? Are there any politicians willing to speak up? Are there any senior bureaucrats (or their public relations officers) prepared to challenge the 'commonsensical'? Are there any editors willing to carry stories their audiences do not want to hear about? Are there any journalists with the skills or inclination to step outside the 'normal' paradigm of reporting and rattle some cages, or are we stuck with a form of 'sunshine journalism' (and 'sunshine public relations') that sidesteps the 'uncomfortable'?

A way forward

It would be helpful if media reporting of the relationship between drugs and development could be improved. The question is, what can be done to improve this reporting? The following could be suggested as ways forward:

1. Systematically research the reasons for the poor media coverage of the drugs-development nexus with a view to identifying ways to create better journalistic coverage of the issues. This also involves examining the problem of journalistic stereotyping and the way journalistic values and preferred readings inhibit accurate reporting;
2. Systematically research the failure of public relations/public affairs officers to effectively communicate with journalists about the true nature of the problems being confronted;
3. Find ways to replace spin doctoring with good information flows and good public discussion;
4. Identify ways to make journalists more self-reflexive about the poor quality of their work with a view to improving this work, possibly through running workshops and seminars;
5. Identify ways to make journalists more aware of the complexities of the relationship between drugs and underdevelopment; weak states and warlordism; poor governance and corruption. This might be achieved by running workshops, seminars and conferences where journalists, law enforcement officers and development workers are brought together;
6. Identify ways to create better journalistic coverage of the globalised drugs trade system and the role good foreign policy (and foreign aid policy) can play in disrupting this trading network. This might be achieved by commissioning discussion papers to stimulate discussion of these issues; and
7. Create an awareness of the negative impacts of sanitising the news.

The current status of harm minimisation in Australia

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Introduction

A generation ago, Westermeyer (1976) studied the effects of opium prohibition in Hong Kong, Thailand and Laos. He titled his prophetic paper *The pro-heroin effects of anti-opium policies* because treatment records in these three countries showed that within a decade of opium prohibition, heroin injecting in young, sexually active men replaced opium smoking among elderly men, preparing the way for a public health catastrophe of apocalyptic proportions. What we can see today in Asia is the inadvertent 'pro-HIV effects of anti-heroin policies'. To understand this situation, it is necessary to review the origins of the development of the global policy of drug prohibition.

Global drug prohibition was implemented with ever-increasing intensity during the course of the twentieth century (Bewley-Taylor 1999). Resources provided to drug law enforcement increased steadily and penalties were made increasingly severe. While the world relied increasingly on drug law enforcement to control illicit drugs, consumption of these drugs grew inexorably.

In the first half of the twentieth century, the United States was the only country with a sizeable illicit drug problem. In the second half of the twentieth century, the illicit drug problem in the United States continued to grow with increasing drug consumption, and rising drug-related deaths, disease, crime, corruption and growing numbers of correctional inmates serving sentences for drug-related offences (Drucker 1999). No nation was more critical to the international initiation, expansion and implementation of a drug law enforcement-based approach than the United States (Bewley-Taylor 1999). The United States played a seminal role in the initiation of global drug prohibition by convening the Shanghai Opium Commission of 1909 and assisting the subsequent development of the three major international drug treaties (1961, 1971, 1988) and the creation and growth of a complex United Nations apparatus to monitor and implement global drug prohibition (Bewley-Taylor 1999).

There were two major developments in drug policy in the third quarter of the twentieth century. Firstly, substantial illicit drug use and consequent drug problems spread to virtually all developed countries. Secondly, President Nixon launched a 'War on Drugs' in 1971 as part of his re-election strategy (Baum 1996; see Cohen, this issue). This was the first time that a

punitive drug policy had been exploited for political purposes. The apparent success of this political strategy was noted and subsequently copied by politicians in many other countries. The wisdom of acting in defiance of powerful market forces, and consequently the effectiveness of the 'War on Drugs' as public policy has, however, been increasingly questioned in recent years (Birt 2005).

There were two major developments in drug policy in the final quarter of the twentieth century. Firstly, illicit drug use and drug problems spread to most developing countries (outside Africa). Secondly, the AIDS pandemic was recognised in 1981 and the sharing of needles and syringes among injecting drug users was identified soon afterwards as a major transmission factor for HIV infection.

Harm minimisation, also sometimes referred to as harm reduction, is a well-established principle of public health policy and has also been widely adopted for some time in public health approaches to alcohol and drugs (see Birgin, this issue). The distinguishing feature of harm reduction is the paramount focus on reducing adverse outcomes when it is recognised that problematic behaviours can be reduced but not eliminated. Compulsory car safety belts, first introduced in Australia in the 1960s to reduce road crash deaths and serious injury are a good example of an effective, harm reduction approach to road trauma. Vigorous efforts to reduce road crashes due to factors such as alcohol intoxication or speeding continued, and some crashes still occurred, but car safety belts substantially reduced deaths and serious injuries.

In the last decades of the twentieth century the AIDS epidemic stimulated a reappraisal of illicit drug policy in many countries. Many realised that the 'business-as-usual' approach to illicit drugs of relying heavily on the criminal justice system would not slow the spread of HIV among and from injecting drug users, and this would have catastrophic health, social, economic and national security consequences for a number of communities. Consequently, support for a more pragmatic approach grew. This emphasised the paramount need to control HIV infection, resulting in growing support for harm reduction. However, after several decades spent politically exploiting the 'War on Drugs', harm reduction has been a difficult issue for politicians in many countries (Baum 1996; see Mesquita, this issue).

Harm minimisation, illicit drugs, HIV and development in Australia

Did Australia adopt harm minimisation as its official national drug policy?

The Prime Minister, all six Premiers and both Chief Ministers adopted harm minimisation as Australia's official national drug policy at the Special Premiers Conference (commonly referred to as The Drug Summit) in Canberra in April 1985 (Fitzgerald and Sowards 2002). These nine Governments represented all the major political parties. The importance of bipartisan support for a harm minimisation drug policy was well recognised and widely respected at the time and lasted for the next 12 years.

Is harm minimisation still Australia's official national drug policy?

The Ministerial Council on Drug Strategy (MCDS) has been the paramount official national drug policy-making body in Australia since 1985 (Fitzgerald and Sowards 2002). MCDS endorsed harm minimisation after each of the several independent reviews of Australia's response to drugs since 1985 and recommended continuation of this approach as Australia's official national drug policy. Consequently, harm minimisation is still Australia's official national drug policy.

What does harm minimisation mean?

Harm minimisation was not defined when adopted as Australia's drug policy in 1985 but has since been defined officially on several occasions. The most recent definition stipulates, notwithstanding an evident circularity, that harm minimisation is a combination of supply reduction, demand reduction and harm reduction. The International Harm Reduction Association (2005) defines harm reduction as policies and programmes intending to reduce the health, social and economic costs of psychoactive drug use for individuals, families and communities without *necessarily* reducing drug consumption. This means that reducing the adverse consequences of drug use is regarded as even more important than reducing drug consumption. It also means that an intention to reduce drug consumption can still be consistent with a harm reduction approach, provided that reducing drug consumption is regarded as a means to an end and not merely considered an end in itself.

Is 'Tough on Drugs' now Australia's official national drug policy?

'Tough on Drugs' is not Australia's present official national drug policy, but the brand name chosen by the Commonwealth Government to communicate to its constituency a 'War on Drugs' approach. Thus 'Tough on Drugs' is more an exercise in political product differentiation than a drug policy. Some time after the Federal Cabinet rejected the proposed prescription

heroin trial in August 1997, the Government responded to the substantial public and private criticism received by launching its 'Tough on Drugs' policy although it had previously cut drug law enforcement funding in its 1996/97 and 1997/98 federal budgets. Under the 'Tough on Drugs' banner, the Government substantially intensified its drugs rhetoric, dropped the agreed bipartisan approach to drug policy and increased funding, especially for drug law enforcement, but also slightly increased funding for some drug-free health initiatives. Although several major drug law enforcement leaders have made only modest claims for the contribution of supply control to the heroin shortage which developed in Australia from 2001, some Government ministers have claimed the heroin shortage was entirely due to drug law enforcement and the 'War on Drugs'. Since 1996, heroin production has declined by 80-90 per cent in Burma, source of almost all the heroin reaching Australia.

As part of their 'Tough on Drugs' strategy, the Prime Minister and several senior ministers began to vehemently attack the more controversial symbols of harm reduction, especially prescription heroin trials and medically supervised injecting centres. However, other forms of harm reduction, such as needle syringe programmes and methadone treatment were not attacked, perhaps because of the now unassailable supporting evidence and consistent majority support for these measures demonstrated in community surveys. In the most recent survey, 58 per cent of respondents supported methadone treatment while 55 per cent supported needle syringe programmes (Australian Institute of Health and Welfare 2005).

The rhetoric used by the present and previous Commonwealth Governments is now substantially different although their policies are virtually indistinguishable. Both Governments have been 'soft' on the legal drugs (alcohol and tobacco), responsible for 97 per cent of drug-related deaths in Australia. While claiming to be tough on drugs, the federal Liberal Party still accepts donations of millions of dollars from the tobacco industry to fund its party conventions every few years although tobacco is responsible for 71 per cent of drug-related deaths in Australia.

Explicit support for harm reduction and drug law reform divides rather than separates the major Australian political parties. Many prominent Liberal Party politicians have publicly supported harm reduction and drug law reform. New South Wales (NSW) opposition leader Nick Greiner supported a prescription heroin trial in June 1984 as did Kate Carnell, while Chief Minister of the Australian Capital Territory. Both of these Commonwealth Ministers voted for the heroin trial at MCDS in 1997. NSW opposition leader John Brogden publicly supported medically supervised injecting centres in 1999. Other prominent Liberal Party politicians who have supported drug law reform include the late Rupert Hamer, the late John Gorton

and former Senators Peter Baume and Chris Puplick. A Country Liberal Party Government liberalised cannabis policy in the Northern Territory.

In practical terms, what does the present Commonwealth Government do regarding illicit drugs?

The present Commonwealth Government relies heavily on drug law enforcement measures to control problems associated with illicit drugs. There is little emphasis on drug treatment and harm reduction; this is not very different from the previous Government.

The best indication of what governments do, as opposed to what they claim to do, is to identify the allocation of government expenditure. However, data on the breakdown of total government expenditure on illicit drugs is difficult to find, possibly intentionally so. The most recent available data on the response to illicit drugs indicates that the Commonwealth and State Governments in 1992 allocated 84 per cent of expenditure to drug law enforcement, six per cent to drug treatment and ten per cent to prevention and research (UNDCP 1997). This represents a solid core of drug law enforcement expenditure with a thin veneer of harm reduction spending. The previous and the present Government often refer to their approach to illicit drugs as 'the balanced approach' despite the disproportionate spending on measures supported by limited evidence of benefit which, not surprisingly, provide a poor return on investment. In contrast, there is evidence of considerable benefit from health measures, such as methadone maintenance treatment and needle syringe programmes, and also impressive evidence of a remarkable return on investment. The disproportionate allocation of Government expenditure to drug law enforcement in Australia is similar to allocations in many other developed countries such as the United States, Canada and the members of the European Union including the United Kingdom.

Is there a significant difference between the drug policy of the present and the previous Commonwealth Government?

The most significant difference between the present and the previous Commonwealth Government in regard to drug policy is the abandonment of a bipartisan approach by the present Government and the more strident rhetoric used.

Notwithstanding its public position on harm minimisation, the present Government deserves praise for its consistent, but private, support for harm minimisation. This includes: discreet financial support for needle syringe programmes run by the states and territories; A\$200 million funding over some years for programmes to divert selected offenders from the criminal

justice system to drug treatment; recognition that reduction of harm is a central principle of the HIV prevention work conducted by AusAID in Asia (see Proctor and Johnston, this issue); and strong advocacy for harm reduction by Australia in major international drug policy meetings. Though never publicised, the Commonwealth Government has provided A\$10 million per year to the states and territories to support their needle syringe programmes for the last seven years. The decision to support needle syringe programmes was taken at a high Government level following a review of the substantial evidence supporting the effectiveness and safety of needle syringe programmes. This funding allocation has never been publicised. The AusAID programme to allocate A\$600 million over a number of years to support HIV-related activities in Asia includes explicit support for reduction of harm due to illicit drugs (see Birgin, this issue).

For many years Australia has been a strong supporter of harm reduction at meetings convened by the United Nations Commission on Narcotic Drugs (CND), the World Health Organization and UNAIDS. Australia was one of 17 countries to strongly defend harm reduction at the CND meeting in Vienna in March 2005 against the forceful opposition of the United States, Russia and Japan. The Australian delegation was one of 21 countries to vociferously support harm reduction at the Geneva meeting of the Programme Coordinating Body of UNAIDS in June 2005 against the (now) lone opposition of the United States. At the 2005 UNAIDS meeting, convened to approve a policy document on HIV prevention, unlike the CND meeting three months earlier, the United States failed in its attempt to exclude explicit reference and endorsement for harm reduction and needle syringe programmes.

What have been the major global and regional changes in drug policy in the last decade?

In the last decade, harm reduction has become the mainstream drug policy in many parts of the world and among many major UN and other international organisations. In contrast, support for zero tolerance is diminishing rapidly.

The evidence available for the effectiveness and safety of harm reduction measures, such as needle syringe programmes and methadone and buprenorphine treatment for heroin dependence, is compelling and continues to improve. Consequently, political support for harm reduction is strong and increasing. In contrast, evidence to support drug law enforcement is weak and this is being increasingly acknowledged. International support for the 'War on Drugs' is declining though support from the Government of the United States remains strong for the time being. Harm reduction is now supported strongly in Europe, Asia, Canada, New Zealand and by most major United Nations and other international organisations such

as the International Federation of Red Cross and Red Crescent Societies. Twenty-four of the 25 European Union countries now provide methadone maintenance treatment and needle syringe programmes and it is expected that all 25 European Union countries will provide these programmes by 2006.

Sweden, previously the strongest supporter of a restrictive drug policy in Europe, recently announced its intention to establish a national needle syringe programme and substantially expand methadone and buprenorphine treatment. Sweden did not support the criticism of harm reduction by the United States at the UNAIDS meeting in June 2005. Authorities in China, Vietnam, Malaysia, Indonesia and Burma have announced support for harm reduction policies and have begun implementing methadone treatment and needle syringe programmes (see, for example, Lorete, this issue). Apart from the United States, other vigorous critics of harm reduction and supporters of a 'War against Drugs' have included Japan, Russia, Thailand (see Aramrattana and Jinawat, this issue), some countries in Eastern Europe, Central Asia, the Middle East and North Africa.

What is the significance of harm minimisation or zero tolerance for development in Asia?

Injecting drug use is now the major mode of HIV spread in Asia (see Bezziccheri, this issue), home to 56 per cent of the world's population. Rampant HIV spreading from injecting drug users to the general population threatens the health, well-being, prosperity, stability and national security of the region. Harm reduction measures are the only effective way known to control HIV among and from injecting drug users. Zero tolerance, by delaying and preventing effective HIV prevention among injecting drug users, accelerates HIV spread and, therefore, increases mortality, weakens economic development and threatens national security.

The HIV epidemic in Asia has been largely shaped by injecting drug use and injecting drug use in Asia has been largely shaped by global drug prohibition. HIV spread in some African countries has dramatically increased poverty. It has been shown that different trajectories of future HIV spread will have considerable impact on economic growth and poverty eradication in Asia (ADB and UNAIDS 2004; Sachs 2005).

One third of HIV infections outside Sub-Saharan Africa are now associated with injecting drug use. The only Millennium Development Goal Malaysia failed to achieve, number six, was HIV control and that was because Malaysia had not adopted harm reduction. Injecting drug use has been and continues to be a major factor in several populous Asian countries where HIV has become established including China, Vietnam, Malaysia, Indonesia, Burma, Taiwan and the north east of India. In the four major Indian cities with populations exceeding ten

million, there are large populations of HIV-infected injecting drug users. It is now clear that HIV epidemics among injecting drug users have preceded generalised epidemics in a number of countries, although generalised epidemics are not an inevitable consequence of HIV epidemics among injecting drug users.

A recent report to the Council of Foreign Relations in New York demonstrates that the epidemic spread of HIV among injecting drug users in Burma has been the major driver of HIV spread in Asia and that this epidemic threatens economic development and national security in the region (Garrett 2005). AIDS was compared to only two events in human history: the Black Plague of the 1340s which resulted in the deaths of a third of the population of Europe, and the Spanish flu of 1918 which killed 50 million people world wide. It has been shown that pragmatic, harm reduction approaches to HIV prevention among injecting drug users can avert, stabilise or reverse HIV epidemics inexpensively and safely. Yet many countries still resist harm reduction despite the threat of serious consequences from epidemic spread of HIV among injecting drug users. The main obstacle has been a perceived irreconcilable incompatibility between harm reduction and the previous entrenched commitment to a drug law enforcement based approach to illicit drugs.

Unless most Asian countries decide soon that HIV control for injecting drug users and the general population is the paramount priority, and that high programme coverage must be achieved promptly, the most populous region of the world will soon experience a major HIV epidemic with declining life expectancy, social upheaval, economic contraction and major threats to national security. At present, most major countries in the region accept this in principle but HIV is still spreading faster than harm reduction programmes are being established. Thailand is the only major country in the region to still support a war on drugs and reject harm reduction (see Aramrattana and Jinawat).

Conclusions

Australian Governments from 1985 have supported and continue to support harm minimisation as the official national drug policy. Harm minimisation is presently defined, in somewhat circular fashion, as the combination of supply reduction, demand reduction and harm reduction. The essence of the International Harm Reduction Association definition of harm reduction is the intention to reduce the costs of drug use without *necessarily* reducing drug consumption. 'Tough on Drugs' is a brand name used by the present government for its drug policy but the official national drug policy has not changed. Like the previous government, the present Commonwealth Government allocates most funding to drug law enforcement with a small proportion allocated to drug treatment, prevention, research and harm

reduction. The Commonwealth has discreetly allocated A\$10 million for the last seven years to needle syringe programmes run by the states and territories. The Commonwealth Government strongly advocates for harm reduction regionally and internationally but is quiet about this with the Australian public. Government attacks on prescription heroin trials and medically supervised injecting rooms are only political product differentiation and should not be confused with policy. The most significant difference between the drug policy of the present and the previous Commonwealth Government is the rhetoric used and the abandonment of a bipartisan approach.

The major global and regional change in drug policy in recent years has been the steady growth in support for harm reduction and the declining support for a 'War on Drugs' approach. Unless harm reduction programmes are rapidly established soon throughout most of Asia, a major HIV epidemic will occur, resulting in major devastation in the region including a substantial setback to economic development and poverty eradication.

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Indonesia: Facing illicit drug abuse challenges

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Vulnerability

Geographically, Indonesia is highly vulnerable to illicit drug trafficking. It is an archipelago consisting of 17,000 islands of which 13,000 are inhabited. The number of islands with existing major and small ports — including fishing villages — is a nightmare for security and drug control operations.

Historically and culturally, drug use is not a foreign habit. Indonesians learned the charms and consequences of drugs, especially opiates and stimulants, including alcohol, many centuries ago. Records show that as early as 689AD an Act was passed in the Kingdom of Srivijaya (Sumatra) against the use of opiates. During the fourteenth to the nineteenth centuries, kingdoms in Java and Sumatra cooperated with the colonial government and private companies to create an opium monopoly and, in 1894, the first Opium Regie, as the system came to be called, was opened on the Indonesian island of Madura. Although earlier use was limited to certain communities, especially the economically and culturally privileged, over the years all socio-cultural levels in the community were affected (Yatim 1986). In 1912, Java was also known to have cultivated and exported coca leaves — over one million kilogrammes annually — although there was no evidence of local use (Musto 1999).

Other factors which contribute to Indonesia's vulnerability come from a combination of the economy, welfare and political instability.¹ The period after the declaration of independence in 1945 to the mid-1960s was marked by absolute poverty, national institutional bankruptcy at all levels, and continuous political struggle against existing colonial forces including local insurgencies in major islands. Extreme destitution and political instability, however, did not become a fertile ground for an observable increase in illicit drug use and abuse due to the absence of buying power, and to the existence of a common enemy — colonial rule.

The 1960s brought an important political and social transition marked by political struggles within the military and among political parties, a reflection of the Cold War period. For the first time, a larger portion of Indonesian society, especially the young and educated, were exposed to Western pop culture. Economically, however, Indonesia was collapsing with a GDP per capita growth lower than in 1913 (Booth 1999).

The New Order

The New Order regime, as it was called, took power in 1968 and was able to attract foreign investment; it also vigorously fought inflation and budget deficits. Medium range objectives were spelled out in a five-year economic development plan (REPELITA). As a result of a concerted effort, the economy grew on average seven per cent from 1968 to 1981. This miraculous change was possible partly due to an increase in the price of crude oil in 1974 (Booth 1999).

During the first decade of national development, priority was given to the rural economy and the agriculture sector. Infrastructure such as roads, canals and other transport systems were developed very rapidly. Hugo (1997), for example, noticed that in the 1970s most people in the rural areas, especially in Java, had access to some sort of modern transport and many of them eventually owned motorbikes. The percentage of people living below the poverty line fell from more than 40 per cent to 13 per cent by 1997 (Sutyastie and Tjiptoherijanto 2002), allowing Indonesia to experience a flourishing of wealthy middle and upper classes.

Improvement in any economy brings changes in lifestyle. The 1970s witnessed a boom of hard rock music bands, influenced by a similar genre of Western music, along with the use of psychedelic drugs and heroin. More educated Indonesian youths found this type of music spiritually and culturally liberating. Discotheques and bars were very popular within this segment of the population in all the country's major cities. The New Order regime, led by Soeharto, did not forbid these bands or their fans. He knew too well that after such trauma in previous years Indonesians, especially the young, needed diversions and recreation. For the first time in the post-colonial history of Indonesia we observed a significant upsurge in the use of lifestyle drugs, especially phencyclidine (Angel Dust) or PCP, mushrooms, marijuana, all kinds of psychotropic pills, especially hypnotics/sedatives, and heroin (Joewana 1987). The users were mostly high school and college students.

Economic development, however, does not resolve the problem of extreme poverty. Before the monetary crisis in 1998, the Gini ratio (a measure of inequality) was 0.36 worse than a decade earlier (0.32 in 1990). In late 1997, 20 per cent of the poorest of the poor consumed only nine per cent of the country's total output of goods and services while the richest 20 per cent consumed 45 per cent (Sutyastie and Tjiptoherijanto 2002; ILO 1998).

The financial crisis of 1998-2000 delivered a fatal blow to Indonesia. Almost all sectors experienced negative growth and the country was squeezed by a foreign debt of approximately US\$162 billion. In addition, the Government had to deal with insurgencies in Aceh, Papua, and Maluku. The proportion of people living below the poverty line rose from 13 per cent in 1997 to more than 35 per cent in 1999-2000. Many people were out of a job, many children had to leave school early, and the health status of children and adolescents became frail. Sixty per cent of all available financial resources was used to pay national debts.

Indonesia is projected to become one of the world's largest democracies, however Governments succeeding Soeharto have had a hard time fighting corruption and establishing the rule of law. As a result, basic services remain neglected. For example, although most of the country's leaders have realised the importance of education, the average number of years of schooling in 2002 was only 7.1 years. This is due to lack of political commitment (Irwanto 1998; Bappenas 2004). It is understandable, therefore, that many people can only find jobs in the informal sector, and find selling drugs an interesting option. Since the 1970s marijuana, cheap alcohol,² and homemade psychotropic pills have been widely consumed by jobless youths and manual workers. The situation worsened after the monetary crises. Many of them, including non-drug user family members, were involved in the sale, distribution and production of illicit drugs (Irwanto 2004; Irwanto and Sarasvita 2004). On the other hand, however, middle- and upper-class youths have continued to enjoy economic prosperity, which provides them with the capacity to access and experiment with different lifestyles and leisure activities, some involving the use of drugs, especially amphetamine type substances (ATS). Although the use of heroin temporarily disappeared during the 1980s it is not surprising that it returned in full force in the late 1990s.

Current situation: Illicit drug use

It is difficult to precisely assess the magnitude and severity of illicit drug use in Indonesia due to a lack of systematically collected information. Sketchy evidence from arrest and drug seizure data seems to suggest that serious problems already exist and are tending to get worse. Arrest data from the National Narcotics Board (NNB) suggest that in the seven-year period to 2004, the number of arrests increased almost tenfold, from 964 to 8,395.

Information from the NNB also indicates that Indonesia has been, for some time, considered the market destination of international drug cartels.³ Arrest data in the past five years suggests that 351 foreign nationals, mostly Nigerians, were detained in Indonesia. From 1999 to 2002 there were also 15

Indonesian men and 21 women arrested on drug courier charges in different countries (Irwanto and Sarasvita 2004; NNB 2004a).

The severity of the problem may also be measured by the fact that users are typically young, with the majority being in senior or junior high school; many are young children. In 2004, for instance, there were 4,715 drug-related arrests of people in the 30-plus age category, 5,774 people aged between 20-29 years, and 834 who were under 19 years of age (NNB 2004a).

In the absence of a national system for monitoring illicit drug abuse, a number of surveys and other studies have been conducted. Small surveys by the Ministry of Health in Jakarta in 2002 indicated that approximately 1.8 per cent of school children aged 11-14, and 5.8 per cent of 15-18 year olds have experimented with illicit drugs such as marijuana and psychotropic pills (Pusdatin Depkes 2004). A 2004 survey of 1,310 senior high school students in Jakarta, conducted by the youth foundation YCAB, revealed more than one quarter had consumed alcohol and 8.3 per cent had at some point used illicit drugs. Since both of these studies were conducted in Jakarta, the results are not surprising. A rapid assessment in 2003 easily identified 74 residential areas in the capital where retailers and medium-sized drug distributors were found (Irwanto and Sarasvita 2004). According to the police source within the Jakarta Metropolitan Narcotic Board, no sub-district in Jakarta is drug-free. To what extent do the nature and magnitude of the problem in Jakarta reflect what is happening nationwide?

Unfortunately, we do not have enough reliable data and information to answer this question. A rapid assessment in eight cities (Jakarta, Bandung, Yogyakarta, Surabaya, Denpasar, Medan, Ujung Pandang, and Manado) in 2000, however, indicated that most residents had increasing awareness of illicit drug problems, especially ATS and heroin. Most informants in those cities were aware of growing numbers of injecting heroin users, especially among high school and college students (Irwanto 2001). A national survey in 2003, involving 13,710 respondents aged 16 to 35 plus in 26 cities, found that 5.8 per cent admitted to having used illicit drugs at some point (Pranata Sosial UI and NNB 2005). The highest percentage was found in Jakarta (23 per cent), followed by Medan (15 per cent), and Bandung (14.1 per cent). This survey also found drug users in cities in remote areas such as Maluku (5.9 per cent) and Kendari in Sulawesi (five per cent). Marijuana and homemade hypnotics/sedatives, followed by ATS and heroin, were the most commonly used drugs. Another survey of 8,000 workers who were regular customers of entertainment establishments in 15 cities found that over 90 per cent had tried alcohol, marijuana and ATS (Matrix and NNB 2005).

In addition, a study involving 2,979 senior high school students in different cities found that 2.5 per cent of girls and 13 per cent of boys had experimented with illicit drugs (HRC-UI and NNB 2004). The study also estimated that at least 3.2 million Indonesians or 1.5 per cent of the population, mostly young and male (79 per cent), are currently using one or more kinds of illicit drugs. The most popular drugs are marijuana or hypnotic/sedatives, followed by ATS and heroin (*putaw*). The number of injecting drug users (IDUs) is estimated to be 572,000, much higher than a 2003 estimate of 160,000 (Pisani et al. 2003).

Double jeopardy

Since the turn of the millennium, Indonesia has had to accept the fact that it faces not only the problem of drug use but also the consequences of those who use injecting drugs. While cases of HIV/AIDS infection among IDUs were rarely found in 1999 and earlier periods, at present infection among IDUs comprises 50-80 per cent of all reported new cases (Riono and Jazant 2004; Pisani et al. 2003; MOH 2002). Alarming rates of infection among IDUs are being reported: *Kios Informasi Atmajaya* reported a 76 per cent incidence rate among voluntary counselling and testing clients (Swandari 2004); the Drug Dependence Hospital in Jakarta reported more than half of its in- and out-patients tested positive; and, in state prisons the infection rates are currently estimated at 15-40 per cent. One 2004 assessment concluded that approximately 229,000 IDUs may have become infected with HIV, and 15,000 drug users may have died of AIDS in 2004 (HRC-UI 2004). This is much higher than an earlier estimate of 160,000 total infections in 2002 (Riono and Jazant 2004). The total cost of illicit drug abuse to be borne by the country was estimated at IDR23.6 trillion in 2004 (around AU\$3.4 million), and may increase. External costs to the country are not accounted for in this study.

This is a serious blow to the economy and the development agenda in general as the country is facing a serious lack of resources for basic needs such as education and health. Many of us who keenly observe HIV infection among IDUs believe that the highest mortality and morbidity in this population due to HIV and hepatitis C will appear in the years 2007-2015. That is despite whatever we are doing today since the current infection rate is above 50 per cent for HIV and above 80 per cent for hepatitis C among IDUs, and more than ten per cent in various commercial sex populations. If the current policies on HIV and injecting drug use do not improve in terms of programmes and coverage, the country will face very serious problems for the next decade (Pisani et al. 2003; Riono and Jazant 2004).

Current policy developments

Over the years, the response to the problem of drug use and abuse has been changing in terms of state support, coverage,

and players involved. When the problem was acknowledged by the new regime in 1970, the response was coordinated through Presidential Instruction 6/1971 which was used as a statutory basis to establish a Coordinating Board to oversee implementation. The instruction specifically designated psychiatric hospitals as the main service providers for detoxification and rehabilitation, and also ordered the Board to coordinate state and other agencies dealing with drugs issues. In addition, the board was tasked with looking after issues of drug-related money laundering and fraud.

In 1972 Jakarta's Drug Dependence Hospital was established as an expansion of Fatmawati Public Hospital, and is the only specialised hospital in the country to date. In 1976 the government ratified the Single Convention on Narcotics through Law 8/1976; and, in the same year, Narcotic Law 9/1976 was enacted. Following the issuance of the laws, the Minister of Health issued a decree and three regulations, all concerned with the control of often-abused substances.

In 1996 the Indonesian Government, through Act 8/1996, ratified the Convention on Psychotropic Substances. The national law on psychotropic substances came later as Act 5/1997. In 1997 the Government also ratified the UN Convention Against Illicit Traffic of Narcotics Drugs and Psychotropic Substances through Law 7/1997, followed by the enactment of the Narcotic Act 22/1997, an update of Act 9/1976. In 1999, after a long debate over improved coordination, the President issued Decree 116/1999 for the establishment of the National Narcotic Coordinating Board (NNCB), which replaced the Presidential Instruction.

The police spearheaded the implementation of the Presidential Instruction in 1971, as well as the 1999 Decree. They soon realised the new decree did not enable the unit to push into further action. In March 2002, President Megawati issued Decree 17/2002 on the formation of a National Narcotic Board (NNB), which allowed the police to devote a special unit to fighting drug trafficking. The Decree provides articles on coordination, and specific roles of other public sectors including health, education, and social welfare. NNB receives strong support from the People's Assembly and a significant state budget has been earmarked for fighting illicit drug abuse in sectors such as education, health and social welfare, and a structure similar to the NNB has been established down to provincial level.

NNB's national strategy is called P4GN which stands for *Pencegahan* (prevention), *Pemberantasan* (eradication), *Penyalahgunaan* (abuse), *Peredaran Gelap* (trafficking), and *Narkoba* (illicit substances). Although existing laws and regulations criminalise illicit drug use, the strategy clearly states that drug users be referred for treatment and rehabilitation by court order, rather than be imprisoned. On the issue of injecting drug use, HIV/AIDS and hepatitis C infections, the strategy prioritises community information education and

communication (NNB 2004b:18). In all programmes, the current policy also recognises the need for the government to build partnerships with community organisations, regional and international organisations, and drug enforcement agencies in the region and worldwide.

Prevention of HIV/AIDS infection, on the other hand, is coordinated by the National AIDS Commission (NAC), established by Presidential Decree 36/1994. The need to address HIV infection among IDUs was recognised by policy makers in 2000 and eventually discussed in a special cabinet session on HIV/AIDS in March 2002. This session concluded that infection among IDUs posed a serious threat to the country and should thus be handled seriously (MOH 2002). After concerted meetings and discussions involving international experts, especially from the Burnet Institute in Australia, strategies to prevent the further spread of HIV infection from the injecting drug user community were incorporated into the renewed, 2003-2007 National Strategy to Prevent HIV/AIDS.

In 2003 it was observed that 83 per cent of all reported cases of HIV infection came from the provinces of Papua, Bali, East Java, West Java, DKI Jakarta, and Riau. In January 2004, the Coordinating Ministry for People's Welfare called a meeting of those six provinces' governors who brought with them decision makers from sectors such as education, health, religious affairs, home affairs and family planning as well as Members of Parliament. This meeting, held in Sentani, Papua, produced the Sentani Commitment to step up government action in a more concerted, coordinated and comprehensive manner. Fourteen provinces have now joined the Sentani Commitment. Issues covered include budgetary and legal environment, care and support, stigma and discrimination, establishment and operation of local AIDS Commissions, and strategies to prevent HIV transmission through sexual contact and drug injection (Mboi 2005).

The Cabinet's special session on HIV/AIDS in March 2002 was a very important turning point. Recommendations from the session include the need to develop pilot projects for harm reduction (MOH 2002:23; see Lorete, this issue). This allowed the World Health Organization in 2003 to set up a methadone maintenance therapy programme in government hospitals in south Jakarta and Bali. The coverage of this programme is to be enlarged significantly in 2005-2006. AusAID and Family Health International (sponsored by USAID) support harm reduction programmes in several cities. Multiple coordination meetings and workshops involving the NNB and the police have been held, resulting in a positive response from the NNB. The NNB joined the NAC in sponsoring the first National Harm Reduction Conference in Jakarta in February 2005, thereby lending further support to the Sentani Commitment. Early in 2005, three locations (two in Jakarta and one in Bali) were

appointed by the government, through an NAC-NNB Joint Decree, as pilot projects for providing clean needles to IDUs. Policy development and implementation in Indonesia, it seems, is going in the right direction.

Future challenges

Indonesia's illicit drug problem is clearly linked to economic and socio-political issues. As the country with the world's largest Muslim population, we could expect religion to help most Indonesians be more resilient to illicit drug use. Unfortunately, poverty and continuous social and political conflicts may play greater roles in eliciting the need to use and trade illicit drugs. Fighting poverty and resolving existing conflicts should be part of a comprehensive approach to fight illicit drug trafficking (see Calvani, this issue).

Although the NNB is improving its capacity to fight drug production and trafficking, all kinds of drugs are still easily accessible in most of the country's urban communities. Undoubtedly the NNB has to keep up with the increasing sophistication of the illicit drug industry; the use of marijuana, ATS, heroin and homemade psychotropic pills is rampant, and all except heroin are produced locally. These should be a number one priority for interdiction and police operations, especially given that the consumers of marijuana and ATS are children and young adults, and that consumption of these drugs usually leads to the use of heroin.

NNB or related sectors in the government should soon establish a systematic monitoring mechanism. The mechanism should include choices of data, such as hospital or community health clinic data, school-based data and other drug-specific data. Existing mechanisms such as behavioural sentinel surveillance, which is currently conducted in a limited fashion, HIV case reports, police arrest and seizure data, and the NNB's national surveys should be maintained and improved in their coordination, scope, and quality.

Illicit drug use has become a deadly epidemic due to HIV infection. Current efforts are simply not enough to stop the epidemic. As more than half of IDUs are infected, community education will not do justice to the problem. Indonesia needs more radical intervention, such as needle exchange programmes. There are currently pilot projects but, considering the magnitude of the spread of infection, policy makers will soon have to significantly enlarge investment and coverage. Otherwise, we may receive a false impression that harm reduction does not add value to stopping the epidemic. As Indonesia's president Susilo Bambang Yudhoyono (2005) declared on International Day Against Illicit Drug Trafficking, illicit drug use is not about the numbers alone but, more importantly, the lost lives of our children, our sisters and brothers, and our beloved ones; that is, the country's human capital.

Notes

1. Analysis in this section is anecdotal.
2. Many communities in Indonesia are familiar with alcoholic beverages (*arak*, *tuak*, *saguer*, *chiu*, and so on) which were used for religious and socio-cultural purposes.

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Law enforcement and crop substitution in the Golden Triangle

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Introduction

The Golden Triangle is a mountainous area of Southeast Asia covering parts of Myanmar, Laos and Thailand and is home to numerous ethnic hill tribe groups. In Thailand alone there are 11 hill tribe groups and a few other minorities living in the area (Labour and Social Welfare Ministry 1993). Some hill tribes grow opium and have traditionally used the drug to alleviate illness, greet special guests and as an exchange for labour; some also sell it to merchants to generate income.

Illicit drugs from the Golden Triangle

The Golden Triangle was the world's main opium production centre until 2003. In 2004, Afghanistan became the world's leading opium producer, followed by Myanmar and Laos (UNODC 2005). Opium cultivation started to decrease on the Thai side of the Triangle in 1986, and by 2004 production had dropped to the lowest-ever levels at 129 hectares (ONCB 2005a). Reductions were observed on the Myanmar and Lao sides in 1999, when each country's opium cultivation area was around 110,000 hectares, one-third lower than the previous year. In 2004, this figure dropped further to about 50,000 hectares. Myanmar's Shan State is now the highest opium production area in the Golden Triangle (UNODC 2005). Since Shan State leader Khun Sa surrendered to Myanmar's military government in the mid-1990s, the area's illicit drug trade has been controlled by the United Wa State Army. While opium production in this area has been declining, methamphetamine production has increased rapidly. Large amounts of the drug have been seized en route to Thailand. At present, the methamphetamine epidemic in Thailand is slowing down while other countries in the region are experiencing an epidemic of this drug (APAIC 2005).

Law enforcement and opium in Thailand

Opium trade suppression in Thailand can be traced back to the 1820s, when heavy military suppression against the Chinese opium trade lasted for more than ten years with many lives lost. In the late 1800s, King Rama IV revived legal opium trade and introduced a tax on opium; revenue from this tax soon became

the kingdom's fifth leading income source with corresponding chronic opium addiction. From the early 1940s, the opium tax income decreased steadily, replaced by income from the then new and widely-available substance, tobacco. In 1958, the Thai military government revived a legal ban on opium use and trade, registering opium users and establishing treatment facilities. In the same year, heroin addiction was identified among previous opium addicts and heroin addiction, refining and trafficking became a major problem in Thailand (Poshyachinda 1980:1-22).

Crop substitution

Crop substitution efforts were initiated in Thailand when His Majesty the King visited hill tribe villages in Chiang Mai Province's mountainous areas in 1969. This first project established several small activities offering villagers agricultural development. With the additional involvement of experts, government agencies, and other bodies interested in development issues, the activities expanded significantly. As the project grew and became more coordinated, and international organisations and foreign government bodies chose to play a part, it was inaugurated as the 'Royal Project' (Office of the Permanent Secretary Ministry of Agriculture and Cooperatives n.d).

The evolution of the Royal Project comprised three phases. During the 1970s, initiatives were established to replace opium poppy with other crops. When the difficulty of this became clear, a second phase of rural integrated development projects began. The final phase began in the 1990s when demand reduction and community-based participatory (alternative development) approaches were recognised as being essential to the process.

Alongside the evolution of alternative development projects in the highland areas, law enforcement activities were stepped up. In 1984, the Office of the Narcotic Control Board (ONCB) began cooperating with the border patrol police and the army to engage in a poppy destruction programme. The coordinated use of satellite imagery, aerial surveys and ground inspection started to be used to control the cultivation of poppies in the face of growers' ingenious evasion detection tactics, resulting in

a drop in opium production areas on Thai soil from more than 8,000 hectares in 1984 to less than 200 hectares in 2004 (ONCB 2005a).

During these phases, a number of development projects were being carried out in northern Thailand supported by donors from North America, Europe, Japan, Australia and New Zealand, as well as various UN agencies (Renard 2001:69-71). These projects started by experimenting and promoting a variety of highland cash and food crops, followed by marketing development (see Calvani, this issue). Based on lessons learned from these projects, subsequent development initiatives were aimed at integrated highland rural development for improving quality of life and preserving natural resources and environments. These projects also passed through periods of misunderstanding, failure, loss and harsh criticism to periods of community participatory sustainable development.

After 30 years of continuous efforts, those activities served as a successive model for alternative development in the region. It is a model of a balanced approach, combining people's participation, demand reduction, law enforcement, ample long-term investment and national unity (Renard 2001:113-119). Similar development projects for reducing opium production and promoting sustainable development have been implemented in other areas of the Golden Triangle by the United Nations Office on Drugs and Crime and the Thai government.

Amphetamine type stimulants and the 'War on Drugs'

Since 1977, treatment statistics in Thailand have shown an increasing trend towards amphetamine patients, especially in the northeast areas (Poshyachinda 1980:23-24), and in the late 1990s, Thailand experienced a methamphetamine epidemic. In 1994, it was estimated that the trade in heroin and amphetamine (*ya ba*) in Thailand was each worth almost THB13-15 billion (about A\$422-487 according to current rates) (Phongpaichit, Piriyaangsan and Treerat 1998:86-111).

The first national household survey on drug abuse in 2001 revealed that of a total population of around 60 million about 900,000 people had ever used opium, 270,000 had ever used heroin and 3.5 million had ever used amphetamines (ONCB 2002). In addition to policing and treatment attempts, the Thai government launched new community participatory policies to curb the problems. In February 2003, the Thai Rak Thai Government announced a 'War on Drugs' policy and mobilised all available resources to fight drugs, aiming to control the situation within ten months. More than 200,000 drug users were registered and treated in boot camps all over the country. And, more than 2,000 people (allegedly involved in the drugs trade) were killed during the campaign's first three months, attracting strong criticism from some circles who

believed some of these deaths were extra-judicial. The war stirred fear among drugs users and traffickers around the country and markedly reduced drug accessibility (Vongchak et al. 2005:115-121). The majority of injecting heroin users reported ceasing intravenous use, many switching to other modes of administering the drug (though the war impacted upon rural more than urban injecting drug users). The Government declared a victory in early December 2003, then reactivated its 'War on Drugs' operations in 2004 and 2005. Seizure statistics during 1998-2004 showed decreasing trends of amphetamine but increasing amounts of inhalants, ecstasy, ketamine, cocaine and crystal methamphetamine (also known as ice); heroin seizures also increased markedly in 2004 (ONCB 2005).

Regional cooperation

The heavy suppression of drug trafficking in Thailand, especially along Thai-Myanmar border in the north, has made life more difficult for drug dealers. Drugs are now entering Thailand from Myanmar via Laos and Cambodia. A large volume of drugs has also been intercepted in the Andaman Sea heading to the country's south from Myanmar. Therefore, close collaboration between ASEAN nations and China was recently established with joint meetings and workshops in the region (ONCB 2005).

Conclusion

The Golden Triangle remains a major producer of the world's opium, heroin and methamphetamine. While opium production has declined, methamphetamine production has increased and markets for this drug have spread rapidly around the region (see Lyttleton, this issue). Drug problems are multi-faceted and very dynamic. To solve drug-related problems, balanced approaches would yield more promising results than a single, rigid approach. It is too early to conclude whether the successive Thai experiences on alternative development for opium control can or cannot be replicated in other areas and with other drugs. Thailand still struggles with a changing pattern of drug-related issues (see Bezziccheri, this issue). With globalisation, problem solving can be more effective with regional and international cooperation.

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Opium elimination in Laos: Poverty alleviation and development challenges

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Introduction

Opium monopolies were responsible for a major part of French colonial revenues, and cropping expanded until Laos was labelled as part of the notorious Golden Triangle in the early 1970s. Laos once ranked as the world's third largest producer of illicit opium. Committed to its obligation to national policies, as well as international conventions, the Government of the Lao People's Democratic Republic (PDR) is determined to eliminate illicit opium poppy cultivation in the country by 2006. Opium, as part of the shifting cultivation system, is mostly grown by ethnic minorities in some of the most remote, poor and least accessible regions of northern Laos.

The national programme strategy to eliminate opium balances three key components: alternative development, demand reduction and law enforcement. A 93 per cent reduction in opium poppy cultivation has been achieved over the last seven years. As Laos gets closer to becoming an opium production-free nation the question remains how to ensure an environment that enables opium to remain eliminated. Access to development support is still limited in many areas. Recently, methamphetamine transit trafficking and abuse along with corruption, crime, human trafficking, and HIV/AIDS have emerged as extremely serious threats to the country. A critical juncture has been reached. Without sufficient and appropriate assistance the development, economy, and stability of the country and possibly the region could be undermined.

Background

Opium has been known for its medicinal properties for hundreds of years in Laos and it was only recently that opium poppy started to be cultivated as a cash crop. After the French annexed Tonkin in Vietnam in 1884, and Laos in 1893, opium monopolies were founded to finance the heavy initial expenses of colonial rule (McCoy 1991). Sixty tonnes of opium was imported from Iran and Turkey for this enterprise. World War Two caused Indochina to be cut off from the poppy fields of the Middle East, and French officials embarked on a massive poppy production campaign to induce the Hmong and other ethnic minorities to expand their opium production. Indochina's opium production jumped from seven tonnes in 1940 to more than 60 tonnes in 1944.

Arabian merchants are reputed to have introduced opium poppy into China more than a thousand years ago during the Tang dynasty (618-907 AD). There were an estimated two million addicts before the Opium Wars of 1839. By 1932, China was importing up to 6,000 tonnes annually. During the years 1929-1934 an estimated 6.1 per cent of the arable land in the country was used for opium poppy cultivation, producing an estimated 50,000 tons of opium annually, with up to 80 million addicts in China (Zhou 1999).

During the early years of the People's Republic of China, opium poppy cultivation was virtually eliminated. To replace the opium lost on the world market, production of opium in Southeast Asian countries such as Laos, Burma and Thailand increased. Opium was taken over by various paramilitary forces to finance covert operations in the region. The region was first called the Golden Triangle in 1971 by Marshall Green, an American Assistant Secretary of State, to draw attention to the fact that Thailand, Burma and Laos were major producers of opium while China had successfully been able to eliminate opium (see Aramrattana and Jinawat, this issue). This was at the time President Richard Nixon took the initiative to restore relations with China.

After the Pathet Lao came into power in 1975, opium continued to be produced and exported to the Soviet Union for pharmaceutical purposes to repay debts incurred by Laos and Vietnam for arms and war supplies during the long wars fought in the region as part of a barter trade agreement (Boonwaat 2001).

Lao PDR is one of the United Nations' least developed countries and one of the world's poorest nations. It ranked 135th out of the 177 countries in the 2004 human development index with a GDP per capita of US\$304 (UNDP 2005). The country is landlocked with a population of about 5.6 million, consisting of 49 officially recognised ethnic groups. Before 2003, it ranked as the third largest producer of illicit opium after Afghanistan and Burma with an estimated 11 per cent of the world's opium poppy cultivation in terms of area but only about four per cent of its production. This reflects the very low yield of 4.6 kilograms per hectare compared to the world average of 15.8 (UNODC/LCDC 2000a). Opium has been produced in ten of the country's 17 provinces.

Opium poppy, as part of the shifting cultivation upland farming system, is cultivated mainly by ethnic minority semi-subsistence farmers in some of the most remote, mountainous and least accessible regions of northern Laos. These regions have some of the highest levels of poverty in the country. Some areas have sensitive situations that could affect national security and stability, and these places lack the socio-economic and physical infrastructure that are pre-requisites for development. Many villages are accessed only by several days walking and are characterised by lack of access to health, education and water. Many ethnic families do not speak the Lao language.

Opium is sold or bartered for rice and other basic essentials. In the absence of health care services, it is used to relieve pain and alleviate respiratory problems. It is also used for social and recreational purposes. Easy availability and frequent use leads to widespread addiction with long-term negative consequences for health and productivity. Opium addiction is closely associated with household social and economic problems including increased household and village poverty, heavy workloads for women and a lack of rice for up to four months of the year.

Laos has one of the highest rates of opium addiction in the world. The 1999-2000 national opium survey documented 63,000 opium users in the country, with an estimated 70,000 households in 2,056 villages cultivating opium poppy (UNODC/LNDC 2000b). This equates to nine in ten opium-producing households having an addict among its family members. Opium consumption is concentrated in the opium-producing provinces of the north and closely associated with cultivation. Of the 123 tonnes produced domestically, it is estimated that 70 tonnes, or more than half of the domestic production, is consumed locally, leaving some 53 tons (five tonnes of heroin) for sale on the illicit market.

In the remote highland areas, the main advantages of opium production are its low volume, high value and non-perishable quality. An entire year's production can be easily carried in a backpack over the mountains to markets. In many cases traders come directly to the villages to buy the opium. The advantages are, however, offset by the fact that opium has been illicit since 1996, as well as the economic and social problems caused by addiction including increased labour demands on women.

Laos lacks the resources to effectively police and control the flow of drugs within the country and along its long and porous borders with Vietnam (1,957 km), Thailand (1,736 km), Cambodia (492 km), China (416 km) and Myanmar (230 km). Most drug smuggling takes place in the northern region and across the Mekong River, in transit from Burma on its way to other countries. Sources estimate that only 35 per cent of trafficked opium was produced domestically. Since the mid-1990s, heroin transit trafficking, methamphetamine trafficking and abuse have become an increasingly serious problem (see Lyttleton, this issue).

Opium elimination policies and action

Laos is party to the three major international drug control treaties currently in force: the 1961 Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and in 2004 it ratified the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. National responsibility lies with the Lao National Commission for Drug Control and Supervision, established in 1990. In that year, an Article concerning trade or possession of narcotic drugs was included in the Penal Code.

In 1994, the Lao Government launched the comprehensive National Drug Control Programme. It called for a gradual, balanced approach to the elimination of opium poppy cultivation with an emphasis on alternative development. In 1996, the Government revised its drug control law (Article 135 of the Criminal Code on Drug Trafficking or Possession) and for the first time prohibited the production of opium. Penalties for illicit trafficking were increased and dispositions introduced for precursor control.

In November 1999, the Government and the United Nations Office on Drugs and Crime (UNODC) jointly prepared the national programme strategy for 2000-2006. The strategy comprises three main components: accelerated rural development, community-based treatment of opium addicts, and law enforcement. A special unit was jointly established in 2000 to be the key supporting backbone responsible for planning, coordinating, monitoring and implementing the national opium elimination programme.

The Government further reinforced this with a Prime Ministerial order in November 2000, stipulating measures against cultivation, abuse, production, and all kinds of illicit trafficking of drugs. In March 2001, the Seventh Party Congress set as a national priority the elimination of opium poppy by 2005, linking this with poverty reduction. The goal is for Laos to eradicate mass poverty and to emerge from least developed country status by 2020.

In October 2001, the President appointed the Prime Minister chair of a new national steering committee to combat drugs. Drug control organisations exist at the national, provincial, district and village levels.

This strong political commitment has provided a legal framework through which authorities can enforce the reduction and eventual elimination of opium poppy cultivation. Between 1982 and 1988, the Government received no assistance for drug control activities. In 1989, opium cultivated areas in Laos totalled 42,130 hectares and the addictive habits of tens of thousands of opium addicts were depriving communities of otherwise potentially productive members.

The UNODC-funded Palaveck Highland Integrated Rural Development Project commenced in late 1989 and was the first

project to directly address the problems of opium cultivation and consumption in Laos. The project demonstrated that a strong supportive clan leadership, together with community based planning processes, and appropriate alternative development interventions can reduce opium without the need for punitive measures or forced eradication (see Cohen, this issue).

Important lessons in eliminating opium, community-based treatment of opium addicts, and community-based law enforcement paved the way for a series of alternative development projects initiated with support from various donors.

Since 2001, the Government has launched nationwide civic awareness campaigns. Opium elimination contracts were agreed to with opium farming communities. Many of these contracts came with the promise of alternative development assistance together with the threat of law enforcement for violations. This approach has resulted in significant reductions. In many areas, however, opium elimination outpaced the provision of sufficient development assistance. Abiding by the law was offered as the main reason for not cultivating opium poppy by half of one survey's respondents.

Annual opium surveys indicate that opium poppy cultivation has decreased from 28,837 in 1998 to 1,800 hectares in 2005. In 2003, so-called voluntary eradication of poppy was used for the first time in fields where farmers violated opium elimination contracts.

The post-opium scenario

Opium poppy cultivation has been reduced by more than 93 per cent over the last seven years, and Laos is practically in a post-opium setting. This very significant achievement should be measured not only by reductions in area cultivated but also by the impact elimination has had on former opium poppy cultivating communities.

The Government's strong political commitment to eliminate illicit drugs, especially illicit opium, is achieving significant results. An increasingly supportive physical as well as socio-economic environment to enable the elimination of opium is being created. Over the course of the ten years between 1992 and 2003, the proportion of people living in poverty fell from 46 per cent to 32.7 per cent. Official development assistance increased from US\$171.8 million in 1997 to US\$372 million in 2004. Conditions for economic growth in Laos have improved. This applies even to the northern highlands where the road network has been extended and schools and health centres have been established.

Many obstacles remain, however. The country's highest rates of poverty and the worst human development indicators are found in the north of Laos. Increasing population pressure on decreasing arable land makes sustainable livelihoods more difficult to establish. The key questions are:

1. How to enable an environment that ensures illicit opium remains eliminated and at the same time provide a sustainable human development process for former opium farmers?
2. How can treatment be provided to all existing addicts, and relapse be prevented?
3. How can other drugs such as ATS be prevented from replacing opium as a major health and social problem?

Opium poppy farmers are among the poorest communities in the country. The annual national opium poppy cultivation survey of 2003 estimated the average opium farmer receives US\$88 from opium poppy cultivation out of an annual income of about US\$205. This is roughly equivalent to income that could be generated from the sale of a calf, or one tonne of rice, or a couple of pigs, or five goats, or fifty chickens, or two pieces of woven silk. Replacing lost opium income is more easily achievable once a certain level of development has been reached. The challenge is how to lift these communities out of poverty. Opium is mainly a supplementary crop in Laos. In 2003 the average opium poppy farmer's opium income constituted only 42 per cent and in 2004, only 12 per cent of the total family annual cash income (UNODC/LCDC 2003; UNODC/LCDC 2004).

Women do most of the work involved in producing opium, but men usually control the proceeds. Given a choice, nearly all women would give up opium cultivation voluntarily, making them key players in the success of opium elimination.

A study undertaken as part of the annual opium survey for 2005 indicated that villagers grew more rice and maize, sold livestock, collected more non-timber forest products, and took up off-farm labour as part of coping strategies after elimination of opium poppy. In areas where assistance to villages and treatment to addicts was provided, women said opium elimination meant more time to tend to other livelihood opportunities closer to home, that brought them more direct income and satisfaction as well as less domestic abuse. Survey results indicate that at least half of former opium-producing communities lack assistance (UNODC/LCDC 2005).

The success and sustainability of the opium elimination programme is dependant on the timing and quality of alternative development assistance. The Government, with UNODC, has developed a national programme strategy for the post-opium scenario. The first three-year phase of the programme is estimated at US\$8.3 million. It aims to provide special targeted assistance in the transition period before all former opium poppy cultivating areas are fully integrated within the National Growth and Poverty Eradication Strategy and national socio-economic processes.

The national programme strategy has four key components:

- civic awareness to mobilise communities against drugs;
- sustainable alternative development to replace the socio-economic incentive to produce opium;
- demand reduction to eliminate the need of addicts for opium; and
- law enforcement to stop trafficking for internal and external markets.

The main objective of the programme is to enable an environment that will ensure opium remains eliminated by stabilising the situation in the immediate post-opium setting. It would address the need to ensure food security and provision of alternative development assistance in needy areas, continue treatment for over 20,000 remaining addicts, and prevent new addictions.

Conclusion

Laos is at a critical junction. The risk of not providing sufficient and appropriate assistance at this stage could easily reverse successes already achieved. The possible scenario of farmers and addicts breaking the law in order to survive could affect national peace, stability and security — all prerequisites for development and alleviation of poverty — as well as threaten the development and economy of the region.

Laos is a relatively peaceful country and currently does not have warlords who finance their armies with illicit drugs. Other concerns, however, remain related to corruption and crime, money laundering, human trafficking, HIV/AIDS as well as unsustainable coping strategies leading to environmental degradation and greater poverty.

To address these concerns, efforts focusing on building local capacity need to be based on self help. Ensuring the rule of law and good governance is important, as are steps to ensure food security, improved access to water, health, education, affordable microcredit, markets, and sustainable livelihoods. Affected highland communities must be ensured of the prospect of better futures without opium through continued improvements to living conditions and family incomes. This must contribute to sustained human development processes that ensure dignity and respect.

The elimination of opium and poverty requires a long-term approach that cannot stop after farmers have ceased opium

poppy cultivation. Elimination of opium poppy cultivation and poverty as well as the stabilisation of shifting cultivation are ranked as national policy priorities. The Government has the political will but lacks necessary financial and human resources, and has requested that the international community support its fight against poverty, illicit drugs and transnational crime.

Efficient and effective coordination of development assistance that considers existing ethnic and cultural diversity is needed. Complementary as well as synergistic development partnerships must be formed. Providing traditional development assistance alone is not enough, and revision of relevant legislation including strengthening of the judiciary system is required. Assistance has been requested to develop a national strategy for drug law enforcement with regional cooperative support to establish a firewall against the trafficking of illicit substances across the region. All of these critical issues need addressing now.

Note

1. This is not an official document of the United Nations.

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Marijuana in Papua New Guinea: Understanding rural drug consumption and production

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In spite of a growing trade, the production and circulation of marijuana in Papua New Guinea (PNG) has only received tangential research attention. In part, this reflects its status as an illicit substance, circulating in a hidden market that is difficult to track. The few research articles that do exist focus on published accounts in the media (Iamo et al. 1991), rely heavily on a combination of police and media accounts (Ivarature 2000), or speak of it generally in relation to other licit drugs (Chen et al. 1999). Only McDonald (2005) has done any significant interviews with users, mostly relying on urban areas for his sample. Other studies briefly mention marijuana as it intersects with violence in the Highlands (Ketan 2004), small arms trade (Alpers and Twyford 2003; Capie 2003), urban gang activities (Dinnen 2001; Harris 1988), or assessments of corruption (Pitts 2002).

The picture painted by such studies overly emphasises connections between marijuana and violence and/or broader criminal activity. And the reaction to its presence is equally exaggerated. For example, the *Post-Courier* (2005:10), in a lead editorial declared: 'People caught trafficking drugs and guns should face a mandatory death penalty'. Furthermore, the editorial claimed: 'This view has been strongly expressed to the guns committee by people throughout PNG' (ibid). But as Chen et al. point out, use of cannabis and other criminal behaviour is not necessary related, but may 'simply represent the activity of a criminal who happens to smoke cannabis' (1999:98). If public sentiment is set against marijuana in this way, how many of today's youth would survive? That marijuana poses harm to communities is not in question here, but how are we to develop policies that will best reduce harm on society in such a climate? We need a better understanding of marijuana's consumption and production in PNG, one that is not limited to the worst instances as seems to be the case at present. To date, we do not have an accurate picture of cannabis in rural PNG, and only a brief idea of its use in urban areas (McDonald and Winmarang 1999; McDonald 2005).

Here, I review existing literature on marijuana in PNG, examine some of the motivations for use in rural areas along the Bulolo river, and provide discussion with an eye towards a national drug policy. Central to my argument is that marijuana is seen by many as a strategy for development even if they are not currently participating in its production. Therefore we need

to develop an understanding of the motivations for marijuana production in PNG, and its link with local development aspirations. Policies that focus on its link to violence, international trafficking, and other crimes will overlook its wider circulation.

Literature review

There is no research on the production of marijuana in PNG or on almost any other aspect of it. This is true of most other Pacific Island countries (see Adinkrah 1995; Larson 1987; Marshall 1987, 1993, 2004; Oneisom 1987; Pinhey 1997a, 1997b). McDonald's (2005) study of drug use in PNG is significant in that he presents a summary of a much larger account published for internal use by the National Narcotics Bureau (McDonald and Winmarang 1999). Iamo's and Ivarature's works are largely from the perspective of media representations and interviews with members of the drug enforcement community. Both conclude the crop is being produced in large quantities and they find evidence that its circulation is being encouraged by much larger drug cartels based in Australia and Asia. Others have raised questions about this assessment (Capie 2003), suggesting that earlier accounts are not typical in today's trade. As I argue here, it is certainly not typical of all growers in PNG, ignoring the degree of growing for personal consumption and local circulation.

This lack of research is surprising, especially in light of the wide circulation of cannabis production among the inland valleys and coastal port communities of PNG (Ivarature 2000). In the Highlands, for example, social scientists often outnumber linguistic groups, but none report on the large crops of marijuana detailed in the national media. According to media accounts reviewed by Iamo (1991), Ivarature (2000), and Halvaksz and Lipset (n.d.), large quantities are produced in the Highland valleys of the country. Most of the initial impetus for growing marijuana in this region reportedly comes from inter-tribal warfare, with marijuana financing the purchase of guns and ammunition (Ketan 2004:186). While some marijuana enters the local market, much is bundled and sent to the coast where it is consumed by urban youth. Less frequently, it is flown into Australia creating the perception that the drug is primarily an export crop. While there is a great deal of debate about both

the extent to which this is an ongoing problem and the scale of such trade (Capie 2003), few doubt that such trade exists, or could exist at some level. As this is wrongly conceptualised as typical of marijuana production in a Pacific 'War on Drugs', the wider impact on rural PNG is overlooked.

This is apparent in some Australian-based policy research in which PNG is viewed as a security concern, or part of what some have dubbed the 'arc of instability' (Windybank and Manning 2003). While largely focused on the fear of a failed state, drug trafficking is taken as a sign of PNG's impending demise (for counter argument, see May 2003). Furthermore, the reported involvement of PNG drug traffickers in international syndicates and the flow of marijuana across the Torres Straits are often cited as evidence of the real threat 'PNG gold' has for its neighbours.

Marijuana in rural Papua New Guinea

The production and consumption of marijuana in PNG is both overstated, and understated, especially in the media. It is overstated in terms of the degree to which it is trafficked across international borders. It is a situation where the worst cases are made typical by the media (see Louw et al., this issue) and politicians (seeking political leverage) in a developing discourse of a 'War on Drugs' (see Wodak, this issue). Certainly, there are instances of large scale production in PNG (Iamo et al. 1991 and Ivarature 2000) and evidence of past and ongoing international trafficking. However, this overlooks most local production and consumption practices.

At the same time, the degree of local use is understated and not well understood. Marijuana is increasingly a fact of life in rural communities where it grows readily and provides a cheap substitute for beer. Young men smoke marijuana purchased in nearby towns, or grown for their own personal use. For most, smoking is not an everyday event, but is done opportunistically. In a 2001 study that my research assistants and I conducted with all men between the ages of 18 and 35 in two rural communities around Wau, 65.4 per cent had tried marijuana at some point. As with alcohol, women in these rural communities did not use marijuana at the time of my research in 2001. The high percentage of men is not too surprising, given the novelty of the substance in the area. However, 25 per cent of the entire sample described themselves as intermittent users, meaning that they would smoke once a week, if the opportunity arises. Only a few individuals in the sample described themselves as more regular users (for further discussion of this survey, see Halvaksz n.d., 2005).

In many ways, the local consumption of marijuana mimics other licit drugs, such as betel nut and tobacco (Marshall 2004), which are individually consumed, but often willingly shared among like-minded consumers to facilitate sociality. Informants

described this as typical of most local production and consumption practices. Typically, a young male will grow a few plants for his own use and that of his friends. However, even at such a small scale, the practices are not separated from resource management and development strategies. Among a few of the regular smokers, marijuana is consumed in association with work, acting as a 'labour enhancer' (Jankowiak and Bradburd 1996). In this, one could argue that smoking facilitates the repetitive tasks associated with coffee growing and subsistence gardens.

While such practices reflect one of the intersections between illicit drugs and development, informants also spoke of the potential for expanding their crop. A number of informants considered marijuana a real development option, and they were enticed by the possibility of selling or trading it for desired items. This was true of those with access to cash through work opportunities as well as those on the margins of current development options (in particular gold mining, forestry and ecotourism). A number of informants spoke of past involvement, either growing it themselves or participating as middlemen. The former had found it quite easy, fondly recalling stories of selling and smoking in and around Wau and Bulolo. Those who had once functioned as middlemen had similar experiences, selling on behalf of distant relatives in other villages in exchange for a share of the profits.

However, most had stopped participating in the trade following efforts by community and church leaders. In one community, a public ceremony in the late 1990s saw youth hand in their current crop and sign a formal statement vowing not to participate in its trade. Like other group surrenders (Dinnen 2001), those participating seek prestige and equal status with other community leaders. The success of these practices depends on the ability of leaders to address wider concerns, including assistance in education and development opportunities. Of those who signed the document, only a few admitted to currently smoking and/or growing. While some have returned, the majority continues to abstain or smoke opportunistically at large social events (such as regional sports competitions).

Even as these rural communities continuously debate marijuana consumption, as it is not completely eradicated from village life, many still see it as an opportunity. In this, the overstated case of an international guns-for-drugs trade figures prominently in local imaginaries of a successful marijuana trade. Small scale growers and even a few non-smokers believe there is a large and lucrative market, as described in the media, into which they can easily enter and acquire money and guns. Given this perception, the overstated case for international and large scale production might not be so overstated in the near future. While there are certainly a few large scale operations in PNG right now, the potential is certainly there for the problem to grow in the current development context.

Conclusion

PNG does not face the same problems of illicit drug consumption found in other areas of the world. And perhaps marijuana should be less of a concern than licit drugs such as alcohol and nicotine. But the potential for a growing drug trade and for using the country as a trans-shipment point is there, requiring attention to the problem across all levels of society. How PNG responds to the current illicit drug problem will help set the stage for future interventions, and it is important that the current problem is thoughtfully engaged.

Priority should be given to strategies that reduce demand through education while continuing to police large scale production. As suggested in the example of a youth surrender of marijuana above, much greater effort needs to be directed towards community involvement in education and control. Informants' uncertainties about the effects of marijuana on their health and community life suggest that there is room for reducing intermittent demand through education. This is not a novel idea for rural PNG. The Foundation for Law, Order and Justice in PNG (1992:17) concluded:

anti-drug campaigns stand a greater chance of success if they stress the health, rather than legal, implications of drug abuse. Education and information about the harmful physiological effects of both legal (alcohol, cigarettes and betel nut) and illegal drugs must be disseminated as widely as possible.

This point is echoed elsewhere (McDonald and Winmarang 1999). The call for a wide ranging educational campaign about drug use would be most effective at the community level, where internal family and group structures still prove effective. While police efforts should be directed towards large scale activities, community efforts should be encouraged and enabled with the information and resources they need to develop their own discussions about drug use including marijuana, tobacco and alcohol.

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A shot in the arm: Transboundary flows and opiate transition in Vietnam

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Introduction

Alarming HIV sub-epidemics among injecting drug consumers in transition economies have highlighted the need to investigate the changing structures that produce risk environments. Transboundary trade and transportation flows, migration, political change, specific drug consumption practices and authorities' tolerance of them are among the key overlapping factors that frame risk environments. These processes are usually outside an individual's sphere of influence, and are shaped by the course of globalisation (Rhodes, Singer et al. 2005; see Pieper, this issue). This paper examines these processes in the context of changing illicit drug consumption patterns in Vietnam.

Opiate-HIV nexus

A central question in globalisation discourse is whether the degree and impacts of contemporary transboundary flows are new (Held, McGrew et al. 1999). It was recently observed that HIV was closely linked to Sino-Vietnamese micro-level heroin exchanges around 1996 (Kato, Shiino et al. 1999) however the relationship between heroin use and the spread of a transboundary disease is not new.

Following British opium marketing to the Chinese in the 1800s (Baker 1896), Yunnan province became an opium production and export locale (AJIL 1911). Yunnan opium crossed the Sino-Vietnamese border into international markets, including the United States (Benedict 1996). Coinciding with mid-nineteenth century globalisation assisted by shipping innovations (Held, McGrew et al. 1999), Yunnan opiate flows carried rats accompanied by fleas. The movement of opiates and fleas diffused bubonic plague from the Yunnan reservoir into Vietnam and then into global pathways (Benedict 1996), arriving by ship to San Francisco in 1900, coincidentally the Year of the Rat (May 1952). As evident in Bombay (Klein 1986), the simultaneous travel of opiates and zoonotic blood borne disease was inextricably linked to global economic development that had uneven, sometimes negative, consequences in many local environments.

By overlaying the nineteenth century Yunnan opiate-bubonic plague maps with recent molecular mapping of heroin-HIV routes in the Mekong sub-region, it becomes evident that many

of the pathways are the same, including points of intersection across the Chinese-Vietnamese border (see Benedict 1996; Beyrer, Razak et al. 2000). The underlying association between globalisation, transboundary opiate mobility and blood borne illness remains constant. The product and its consequences have been modernised, however, and its travelling speed dramatically increased.

From opium to heroin

The first International Opium Conference was held in Shanghai nine years after the 'Yunnan plague' hit the US west coast. It was predicted that, with US State Department leadership, 'the world will shortly see the obliteration of the Indo-Chinese opium trade' and regulation of 'legitimate opium trade and allied traffics' (Wright 1912:867). Rather than obliteration, post-World War 2 geopolitics contributed to heroin proliferation dependent on extremely vulnerable farmers in the sub-region. These marginal farmers supplied primary materials to chemists who, through molecular reconfiguration, cooked some of the highest quality heroin since it was created in 1898 (Stares 1996). This sophisticated heroin comprises fine particles which, unlike a Mexican variety known as 'black tar', enable it to become highly viscose and thus pass efficiently through a syringe (Ciccarone and Bourgois 2003).

In its production locales, however, Mekong heroin was facing stiff competition — opium was maintaining market dominance within source communities. Heroin was emanating from and transiting opium smoking zones, and was not being consumed en route. Therefore, as the HIV-1 virus gradually entered global pathways (Chitnis, Rawls and Moore 2000) the maintenance of opium-smoking practices posed no direct HIV risk to users in Vietnam.

In Thailand in the 1970s it was observed that heroin was making inroads into local opium consumption markets (Poshyachinda 1993). The subsequent HIV crisis highlighted that as poppy fields were being eradicated, heroin was superseding opium smoking (Celentano 2003). Despite evidence that anti-opium policies potentially create harm (Westermeyer 1976), in 1998 the United Nations committed itself to the eradication of illicit opium by 2008 (Jelsma 2003). Laos is striving for an even earlier timeline so can be used as a case

study to observe whether rapid opium eradication in heroin transit zones introduces HIV to rural communities. This makes lessons from neighbouring Vietnam pertinent.

Vietnam: HIV risk transition

Economic liberalisation deemed essential for globalisation, particularly trade facilitation, improves conditions for narcotics flows because illicit goods accompany licit trade (Stares 1996). Vietnam provides an opportunity to critique this paradoxical nexus because Cold War boundary rigidities had isolated it from the early Mekong sub-regional heroin-HIV crisis.

While Vietnam is considered a case of successful 'new globalisers' by prominent economists such as David Dollar (Labonte, Schrecker et al. 2005) it simultaneously recorded one of the world's most impressive HIV sub-epidemics among injecting drug consumers (Pisani 2004). The first HIV case was detected in 1990. From an injecting drug consumer seroprevalence rate of 21 per cent in 1994, it declined steadily until 1997 when an explosive escalation began (Nguyen, Long et al. 1999). For example, sentinel surveillance data for Quang Ninh province, through which opium was traded globally in the nineteenth century, reveals that from 0.76 per cent in 1996, injecting drug consumers' seroprevalence reached 73 per cent in 1999. In 2002, 89.9 per cent of 1,435 injecting drug consumers tested in Quang Ninh were HIV positive (MoH 2003).¹ Compared to 1996, national detections doubled by late 1998 and had risen tenfold by 2002. By mid-2005 almost 100,000 cases had been detected.

A mounting body of research provides insights into individual-level risk factors that account for the HIV explosion, but there is far less information on the association between the timing of economic transition and the escalation. The following section briefly touches on trade, transportation, migration and drug diffusion transition to suggest that an interplay of development-driven factors overlapped to vastly improve the social and physical environment for narcotics and HIV flows.

Trade and transportation

The official value of imports to Vietnam almost tripled between 1994 and 2000 and the total value of exports increased almost sixfold between 1991-2000 and doubled between 1994-1997 (ADB 2004a). Export tonnage through the main points increased 128 per cent between 1995 and 2001. In the case of Hai Phong, export tonnage increased 171 per cent between 1995 and 2001. Importantly, since the 2004 upgrading of Highway Two directly north to the Chinese border, containerised Yunnan exports pass through Ha Giang province en route to Hai Phong port. Similarly, trucks from southern Quy Nhon transport bales of Yunnanese tobacco south to cigarette factories

in Ho Chi Minh City. At the macro-level, the integration of Yunnan export flows into Vietnam's transportation infrastructure formally reconnects historic opiate routes.

Intensification of port throughput is reflected in the increased number of seagoing entrants to Vietnam.² In 1995, the official number of foreigners entering Vietnam by sea was 21,745; a year later the figure jumped to almost 162,000 and rose steadily to more than 256,000 in 2000. The seaboard became more porous as shipping catered for licit trade requirements.

Domestic freight transportation tonnage increased 82 per cent between 1995 and 2002, the largest increase (153 per cent) being maritime. Road freight tonnage increased 77 per cent (GSO 2005). Freight flows have been enabled by unprecedented, and ongoing, road construction that includes highways linking Vietnam to Lao, Cambodia, China and, indirectly, Thailand and Myanmar.

An important element of the trade environment was the flow of foreign direct investment (FDI). Annual registered transboundary investment flows rose from approximately US\$2.1 billion in 1993 to US\$9.2 billion in 1996 before it crashed spectacularly. In 1999, FDI commitments were almost back to 1993 levels at US\$2.15 billion (Le 2002). This investment collapse overlaps with a post-1996 GDP growth downturn, most evident in the industrial sector where annual growth moderated from 14.5 per cent in 1996 to 7.7 per cent in 1999 (ADB 2004a). With far more youths entering the labour force than jobs created, unemployment and under-employment emerged as a major social problem, especially in rural areas. This is predicted to intensify with forecasts of job losses through state sector reform, which will include privatisation (NCSSH/UNDP 2001).

Migration

Post-1988 agricultural reform introduced a monetised labour market which later benefited from relaxation of strict internal migration controls coinciding with the transition toward a market economy (Dang, Tacoli et al. 2003). Despite strong overall economic growth throughout the decade, income inequalities increased significantly, 'especially between 1996 and 1999' (NCSSH/UNDP 2001:46). In 1993 and 1998, 11 per cent and 15 per cent of household heads migrated, respectively; families with migration experience increased from 29 per cent to 64 per cent (Gallop 2002). The urbanisation rate rose from 20 per cent in 1990 to 24 per cent in 2000 and continues to increase. Passenger flows in the Red River delta almost doubled from 1995 to 2002 (GSO 2005), reflecting circular mobility increases.

It is now possible to gauge elements of foreigners' migration across Vietnam's land boundaries during transition. China officially sealed the land border in July 1978 in response to

mass migration of Chinese Vietnamese. China started the Sino-Vietnamese border war in February 1979. The militarised boundary was impenetrable until Vietnam's withdrawal from Cambodia; the Sino-Vietnamese normalisation communiqué of 1991; the dissolution of the USSR; and the announcement of the resurrection of severed transport links and expansion of emergent cross-border trade (Xinhua 1995; Womack 1996). In 1995 US-Vietnam relations were normalised and Vietnam joined ASEAN. The timing is significant because by this stage heroin injection was reported in Yunnan and Guangxi provinces, which border northern Vietnam.

Government data does not capture the non-official border crossings, a feature of illicit trafficking. Nevertheless, the data reveals China-to-Vietnam flows increased dramatically mid-decade. In 1993, officially recorded entries to Vietnam by foreigners across land borders totalled just 33,335, and only 2,738 Chinese nationals were recorded as entering. In 1995, total land entrants rose to almost 123,000; Chinese entries to 62,640. By 1996, land entries had reached 505,653 and Chinese entries were 377,555. Between 1993 and 1997, land entrants increased 94 per cent, sea entrants 73 per cent, air entrants 42 per cent and officially recorded visits by Chinese 99 per cent.

From 1992-2002 the total number of entrants increased from 217,410 to more than 2.6 million, close to a tenfold increase. Less than 4,000 Australians entered Vietnam in 1991, but in 1999 it was more than 63,000 and 128,661 in 2004 (GSO 2005).

The magnitude of transboundary flows suggests that from the perspective of risk-averse narcotics traders, Vietnam's increased human mobility, trade and transportation flows overlapped to improve trafficking environments from the mid-1990s onwards. The Sino-Vietnamese border reopening signalled the potential resurrection of historic opium trafficking pathways.

Drug diffusion

Highland opium cultivation in Vietnam derived from nineteenth century migration flows out of Yunnan. Promoted under French colonial rule, cultivation continued and was later integrated into Vietnam's post-1975 commerce with the east European pharmaceutical trade. An estimated 18,000 hectares were under cultivation at the beginning of the 1990s, and state-sanctioned licit trade of the product was overseen by 'Special Company' (Rapin 2003).

Vietnam has had injection sub-cultures in the past, but the product consumed post-1975 and pre-regionalisation was not heroin. In the early 1990s, heroin injection had appeared in Myanmar, China and Thailand, but in Vietnam cooked liquid opium was the injecting substance of choice. Awareness of this opiate preparation process, which was at odds with practices

elsewhere in the sub-region, was possibly due to technology transfer enabled by migration. More than 200,000 Vietnamese workers were exported to former eastern European states where liquid opium injection had evolved and diffused in the absence of modern heroin (Carnwarth and Smith 2002; Dang, Tacoli et al. 2003:12). It is feasible that socialist-to-socialist migration patterns facilitated knowledge flows that, in Vietnam, were used to exploit domestic opium in the absence of viscose heroin.

Significantly, opiate liquid preparation involved cooking and administration by 'professional' injectors in shooting galleries. Although liquid was extracted from a common jar, reports suggest that the generally glass syringes were rinsed between refills (Power 1993). Evidence particularly from the US west coast indicates that rinsing syringes with water reduces viral load that reduces the likelihood of HIV passing between needle sharers (Ciccarone and Bourgois 2003).

Eradicating heroin's competition

Forced opium eradication corresponded with Vietnam's economic regionalisation. Overlapping with increased trade inflows from west of the Mekong, poppy cultivation was reduced to an estimated 340 hectares by 1997. In north central Nghe An province, for example, in a district bordering Lao, cultivation was reduced from 3,000 to 99 hectares between 1993 and 1996. This reduction coincided with a doubling of Lao-to-Vietnam vehicle crossings at the main provincial borders (Griffiths 2001). The transboundary road, highway seven, is an historic opium route.

As it was gradually paved, highway seven emerged as one of the main heroin arteries into Vietnam. Road re-construction was, quite literally, narcotic flow facilitation through some of Vietnam's poorest ethnic minority communities. Despite the presence of a multi-million dollar UN drug control project in Ky Son since 1996, a transition from opium smoking to heroin injection has occurred (UNODC/MARD 2003). The transition period was 1996 and is viewed locally as heavily structured by poppy eradication (Griffiths 2001).

At the national level, although some heroin consumption began to emerge beforehand, in Hanoi it was not until around 1996-1997 that heroin overtook and then replaced opium as the main illicit narcotic injected (Torode 1996). Unlike cigarettes, heroin crossed the gender divide. This transition coincides with important deregulation: 'private pharmacies increased from none in 1986 to more than 6,000 in 1996' (Chuc, Larsson et al. 2002:1148). Domestically-produced plastic disposable syringes and new drugs entered the market. The introduction of heroin and availability of disposables negated the need to have designated opiate cookers or injectors. Liquefied black opium water, which seems to have involved some rinsing between customers, was replaced by low viscosity heroin which requires no rinsing between applications.

Furthermore, police crackdowns in Hanoi smashed many urban spaces where injection could occur safely, in one case, to make way for a theme park and expensive housing. Injection became much more individualised, although obviously still conducted in subgroup and subcultural contexts involving shared consumption. Significantly, appearance of do-it-yourself heroin was at the expense of prepared liquid opium which had included at least some rinsing between refills. The discernable transition in the molecular typology of available opiates, in a period of rapid social transition and wealth inequality, was followed by the blow-outs in HIV seroprevalence rates.

Despite several unsustainable pilot projects, harm reduction was only officially incorporated in the national HIV framework in 2004. Enormous advocacy challenges remain in order to translate policy into structural interventions, especially in non-metropolitan settings where the problem is acute.

Conclusion

Transboundary opiate-illness traverses familiar pathways, and opiate prohibition discourse has not been matched by reality. A confluence of flows in the mid-1990s may account for why former opium producing Vietnam rapidly became a viable heroin transit zone. Around 1996, opium production declined, trade with Myanmar, Lao and Thailand increased, land borders became more porous, and international exports and internal migration increased. Formerly (relatively) restricted boundaries became more permeable just as foreign investment crashed and relative wealth inequality rose. In some senses, this interplay of macro-level factors engendered conditions for a perfect HIV storm. These structural transitions were exogenous to individuals; as a nation was becoming modernised and individualised, so was the opiate scene. Both the transition and the consequences were extremely rapid.

Although this discussion has tended to be retrospective in order to discuss a transition period, we are certainly not dealing with the past. Heroin's marketing success story continues to unfold throughout urban and rural Vietnamese communities. Social dislocation and rising inequality continues in the face of an overall successful economic transition, and greater unemployment is a distinct possibility due to imminent reform of the state-owned enterprise sector. Improved transport links will make drug flows even less viscous.

Injecting drug consumers' seroprevalence rates provide virological indicators that transboundary harms can be created with far more alacrity than transconceptual responses. Harm prevention programmes require reversal of this unfortunate paradox.

Notes

1. Sentinel surveillance data records 34 per cent injecting drug consumer seroprevalence in Ho Chi Minh City in 1994 and 18.62 per cent in 1998. By 2001 it was 81 per cent. In Hanoi, the injecting drug consumer rate was 0.56 per cent in 1996, 3.25 per cent in 1998 and 22.25 per cent in 2001. In Hai Phong, it was 1.35 per cent in 1997, 32.8 per cent in 1999 and 81 per cent in 2001. Nationally, the injecting drug consumer seroprevalence rate recorded through surveillance was 21 per cent in 1994, 9 per cent in 1997, 19 per cent in 1998 and 30 per cent by 2000.
2. Ocean-going tourism only commenced in Vietnam in recent years, so for the period 1990-2000 sea-faring entrants are almost certainly a measure of sailors on trading vessels.

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The health and social impacts of drugs in Brazil and Indonesia: What it means for development

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Introduction

This paper compares the health and social impacts of drugs in Brazil and Indonesia. It looks at the developmental impacts of these issues in the two locations from the perspective of a public health professional. As a result of the relationship between economics, policy, and illicit drugs, public health services all over the world face tremendous challenges in dealing with the social and health consequences of drugs misuse.

Discussions on drugs should be placed in a context of an annual increase of illicit drug consumption of ten per cent per year, and a trade market of US\$322 billion per year. By the middle of 2005, injecting drug use was reported by more than 130 countries (UNODC 2005). Rushed national policies on illegal drugs, based on the 'War on Drugs' strategy (see Cohen, this issue) and misinterpretations of the United Nations Conventions on drugs, are common tools used by developing nations to face this mega problem.

Despite international efforts, supply of and demand for drugs globally has not been reduced in recent years, though there have been changes in production and consumption trends; these efforts may, however, have contributed to regional changes in drug supply and demand. This paper will examine the cocaine market in Brazil and Indonesia's heroin market (see Irwanto, this issue).

Cocaine and heroin

Cocaine use became clearly evident in Latin America at the beginning of the 1980s, though the drug has been used in the region for centuries. Coca production in South America's Andean region is focused in Bolivia, Peru and Colombia. Over the last 25 years combined coca output from these three countries has remained steady, although production inside each individual country has varied greatly.

Cocaine is the world's most profitable illegal drug, with an annual market of around US\$70 billion (UNODC 2005). From the Andes the drug is exported to North America and Europe; it is also very popular in Latin America. In the last few years cocaine use has been reported all over the planet at least on a small scale, including in some African countries. It can be sniffed, smoked (crack cocaine) or injected. The injection of cocaine is being reported mainly in North America and Europe, but is also a popular practice in Argentina, Uruguay, Paraguay, Chile

and Brazil. The HIV/AIDS crisis in Brazil in the 1990s was directly related to the injection of cocaine and was the cause of transmission in 30 per cent of Brazilian AIDS cases in the 1990s. In Argentina today it accounts for more than half of AIDS cases.

The popularity of heroin soared after the second world war and skyrocketed after the Vietnam war. Traditional use of opium has a similar history to the use of cocaine, and began centuries ago in the Middle East and Asia. In the case of opium there is evidence of a prehistory existence in the Mediterranean region. Nowadays, however, there are many centres of heroin production, the main ones being Afghanistan, the Golden Triangle and Colombia.

The beginning of this century marked a critical juncture in the movement and production of heroin around the world. After the Taliban's intervention in opium production in 2000 and 2001, production levels dropped dramatically in Afghanistan. At the same time, the Taliban heroin ban had strong social consequences for poor Afghani farmers from the rural heartland of heroin production. That market recovered its high capacity for heroin production immediately following United States intervention in the country.

When Afghani production slumped, Colombia improved its heroin production capacity and gained a foothold in the North American market. Over a five-year period, Colombian drug lords managed to capture 80 per cent of North America's heroin market – the biggest and most profitable in the world. With so much shake-up of the Middle East and North American markets, it seems that the production of heroin in Asia's Golden Triangle is being consumed mainly in Asia, instead of being exported to overseas markets (see Griffiths, this issue).

Heroin is the world's second most profitable illegal drug, with an annual market of around US\$65 billion. Heroin is exported from Latin American and Asia to its main markets in North America and Europe (UNODC 2005). It is very popular in Asia and Eastern Europe, and in the last few years its use has been reported in other countries as well. Heroin can be sniffed or injected. The injection of heroin is being reported mainly in North America, Europe, Eastern Europe and Asia; however the injectable use of heroin occurs in many countries. The HIV/AIDS crises in China and Indonesia, and parts of India, are directly related to the injection of heroin (see, for example, Bezzicheri, this issue).

Brazil

The first AIDS case detected in an injecting drug user (IDU) in Brazil was reported in 1982 in the state of Sao Paulo. Thereafter, injecting drug users (IDUs) played a key role in the spread of the HIV/AIDS epidemic in Brazil, and soon became a target group for control of the epidemic. The epidemic brought with it a contradiction: the suffering of thousands of young Brazilians affected by HIV/AIDS as well as an awareness of a previously unknown public health problem. By the end of 2000, the National STD/AIDS Control Programme estimated that around a quarter of AIDS cases in Brazil directly or indirectly stemmed from IDUs. In the 2004 annual Brazilian Government report on the epidemic, they account for 12 per cent of total AIDS cases in Brazil.

In 1989, the Health Department of the city of Santos conducted the first proposed Brazilian response to control of HIV/AIDS transmission among and from IDUs. Santos, a coastal city of Sao Paulo, had at that time a reputation as the Brazilian AIDS capital, based on the number of AIDS cases per capita. In 1989, health authorities, guided by international experience, announced the launch of Brazil's first needle exchange programme. Public attorneys, however, decided to sue health authorities over the move, based on an interpretation of the existing Brazilian Law on Drugs. The attorneys argued that health authorities were facilitating the use of illicit drugs and tried to prosecute them as drug dealers. The city of Santos, the state of Sao Paulo and the Federal Government supported the needle and syringe exchange initiative and assisted health authorities in the trial.

This episode marked the start of an intense fight for human and civil rights for IDUs in Brazil, and preceded a long and interesting history of delay. In 1991, the Santos Health Department was the first in Brazil to buy the AIDS anti-viral Zidovudine, and IDUs were given access to treatment like any other AIDS client. Following this, the State of Sao Paulo and the Federal Government introduced a specific policy on the provision of anti-retroviral therapy.

In 1993, the *Instituto de Estudos e Pesquisas em AIDS de Santos*, a health professional-led NGO in Santos, initiated the first outreach project in Brazil with support from the Government through the National STD/AIDS Control Programme. In the city of Salvador in 1995, the University of Bahia started the nation's first tolerated needle and syringe programme. After that, projects were launched in many other cities.

In 1996, after the international AIDS Conference in Vancouver, universal and free highly active anti-retroviral therapy (HAART) was launched in Santos. By the end of the same year, former President and current Senator Jose Sarney proposed and approved a law that guaranteed access to HAART for all Brazilians affected by AIDS, under standards defined by the Ministry of Health.

In 1998, during the opening ceremony of the Ninth International Conference on Drug Related Harm in Sao Paulo,

State Governor Mario Covas announced Brazil's first harm reduction law. This legislation authorised the purchase and distribution of sterile needles and syringes by the Sao Paulo Health Department as a way of controlling the HIV/AIDS epidemic. This opened the door for many legislative amendments, culminating in changes to the Brazilian Law on Drugs in January 2002 authorising the Ministry of Health to implement harm reduction projects nationally. In 2005, the Ministry signed a decree regulating this national law, thereby guaranteeing its application across Brazil.

The Universal Policy of Free Health Care is a key element facilitating Brazil's response to the HIV/AIDS crisis. Universal free access to health care and necessary medication was stipulated in Brazil's Constitution of 1988, which emerged during the country's democratisation following 20 years of military dictatorship. In 1990, the Organic Health Law was proposed by Congress as the tool to implement constitutional policy. The constitutional commitment and the health law became the legislative platforms that supported the 1991 initiative to provide Zidovudine to AIDS clients in Brazil.

In 1996, the same legislative basis was used to argue that AIDS clients be given access to HAART; rights to the therapy were later reinforced under federal law. Since then, the federal Government has been battling the multinational pharmaceuticals industry for treatment cost reductions; the Government also supports national production of generic drugs to make feasible the provision of HAART to every patient who needs it. This stance has led to some dramatic fights on the international arena, the most important of which played out within the World Trade Organization (WTO) and resulted in an expression of victory for the Brazilian approach. In another Brazilian victory, the General Assembly of the World Health Organization (WHO) declared the right to HAART a fundamental human right. Brazil's stand on anti-retrovirals is supported globally by most at the forefront of the fight for control of the epidemic including researchers, health professionals, government staff, media, activists and people living with AIDS. By mid-2005, 170,000 Brazilians were receiving HAART, supported by the Federal Government. The Government is also running a Bill through Congress which would allow them to contravene patent law in case of a need to lower medication prices and save more lives.

Brazilian policies on drugs are generally flexible, given the acceptance of harm reduction strategies and despite the main thrust of national policy being focused on supply reduction. Internationally, Brazil openly supports harm reduction approaches in international forums and in that sense, the technical alliance between the Ministry of Health and the Foreign Affairs Department could be considered progressive and successful.

The Indonesian case

Indonesia's first reported AIDS case was reported in 1987; and in 1995 came the report of the first Indonesian infected as a result of sharing needles. The spread of the virus reached epidemic proportions at the beginning of this century. Between 2003 and 2004, the number of reported Indonesian AIDS cases doubled. In these two years, 80 per cent of new cases were related to the injection of drugs (see Lorete, this issue). The Ministry of Health estimates that up to 150,000 Indonesians are now living with HIV/AIDS. Heroin is by far the main drug injected in Indonesia, and there is also a growing market for meta-amphetamines. The country's harsh drug approach criminalises use, possession or trafficking, and this makes gaining access to IDUs difficult.

Anti-retrovirals have been provided for free since 2004, and national production guarantees the local provision of three anti-retroviral drugs. Two other drugs are imported, giving AIDS clients five treatment possibilities. AIDS treatment is available, however, some doctors find it difficult to accept the practice of treating IDUs like any other AIDS client. In addition, the CD4 count, which tests the strength of a client's immune response, is not available free of charge and therefore poses a barrier for many AIDS clients including drug users who wish to access anti-retroviral treatment. In mid-2005, 1,346 people were receiving anti-retroviral treatment in Indonesia.

In 1999, Balinese NGO Hati-hati, in cooperation with public health center Kampung Bali in Jakarta, introduced Indonesia's first harm reduction project with needle exchange. Currently, around 32 NGOs do harm reduction work across the country. Indonesia HIV/AIDS Prevention Care Project (IHPCP), an AusAID project, is the main supporter of Indonesia's harm reduction projects. The work of NGOs is a great initiative, however it is estimated that the rates of coverage are around nine per cent of the target population. Based on that coverage, efforts are now focused on increasing coverage by involving the public health system in needle exchange projects.

Since 2003 two methadone clinic pilot projects were initiated with support from WHO. The project's very successful experience was supported in 2005 by IHPCP as well. The coverage is not significant, however, as over two years only 400 people attended the two methadone clinics, one in Jakarta and the other in Bali.

Harm reduction is part of Indonesia's national strategy to control the HIV/AIDS crisis. It is supported by the National Narcotics Board, the National AIDS Commission, the Ministry of Justice (which has jurisdiction over the prison system), the National Police and the Ministry of Health, among other institutions. The key element of Indonesia's current strategy is how to scale up the current projects to match the size of the country's epidemic, and that is a big challenge. While harm reduction is a commendable strategy closely connected to controlling the HIV/AIDS crisis, in Indonesia it appears

alongside a national policy that criminalises drug use, with the death penalty in some trafficking cases.

In a public speech on 26 June, 2005 (International Day Against Illicit Drug Trafficking), at Jakarta's drug dependence hospital RSKO, the President of Indonesia Dr Susilo Bambang Yudhoyono voiced support for the expansion of methadone clinics around the country. He supported the allocation of money from the national budget, and demanded that the National Narcotics Board implement his decision. This was the most important political declaration in the fight against the HIV/AIDS epidemic in Indonesia since the introduction of free anti-retrovirals in 2004.

Three priorities are being developed to help control the HIV/AIDS epidemic among Indonesian IDUs:

- expansion of needle exchange programme coverage;
- expansion of methadone clinics; and
- ensuring acceptance of free and universal access for anti-retroviral treatment to IDUs as well as for every other AIDS client.

The Indonesian response to the HIV/AIDS epidemic is under construction. A promising series of initiatives have helped to build the basis of this response. In order to really face the magnitude of the epidemic, we are hoping and working for better coordination of efforts and a scaling up of the response.

Conclusion

The developing world is extremely affected by the health and social impacts of the illicit drugs market. The huge profits and organised nature of the drugs market, and the ineffective drug policies passed down from the UN and interpreted by national governments, punish developing world populations with many crises including HIV/AIDS. Many diseases can affect a nation's development, however, at the end of last century and the beginning of this one, AIDS has impacted like no other.

HIV/AIDS is a condition which affects the productive population, and it is becoming a global crisis with enormous relevance in the developing world where around 80 per cent of new cases appear every year. With a broader response and political will, there is a possibility of facing the epidemic even in the developing world. So far, Brazil may be considered a good example of this possibility. Our hope is that Indonesia, and every other developing country, can limit the impact of the HIV/AIDS epidemic, one of the undesirable consequences of drug misuse.

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Scale up responses or scale up the epidemics?*

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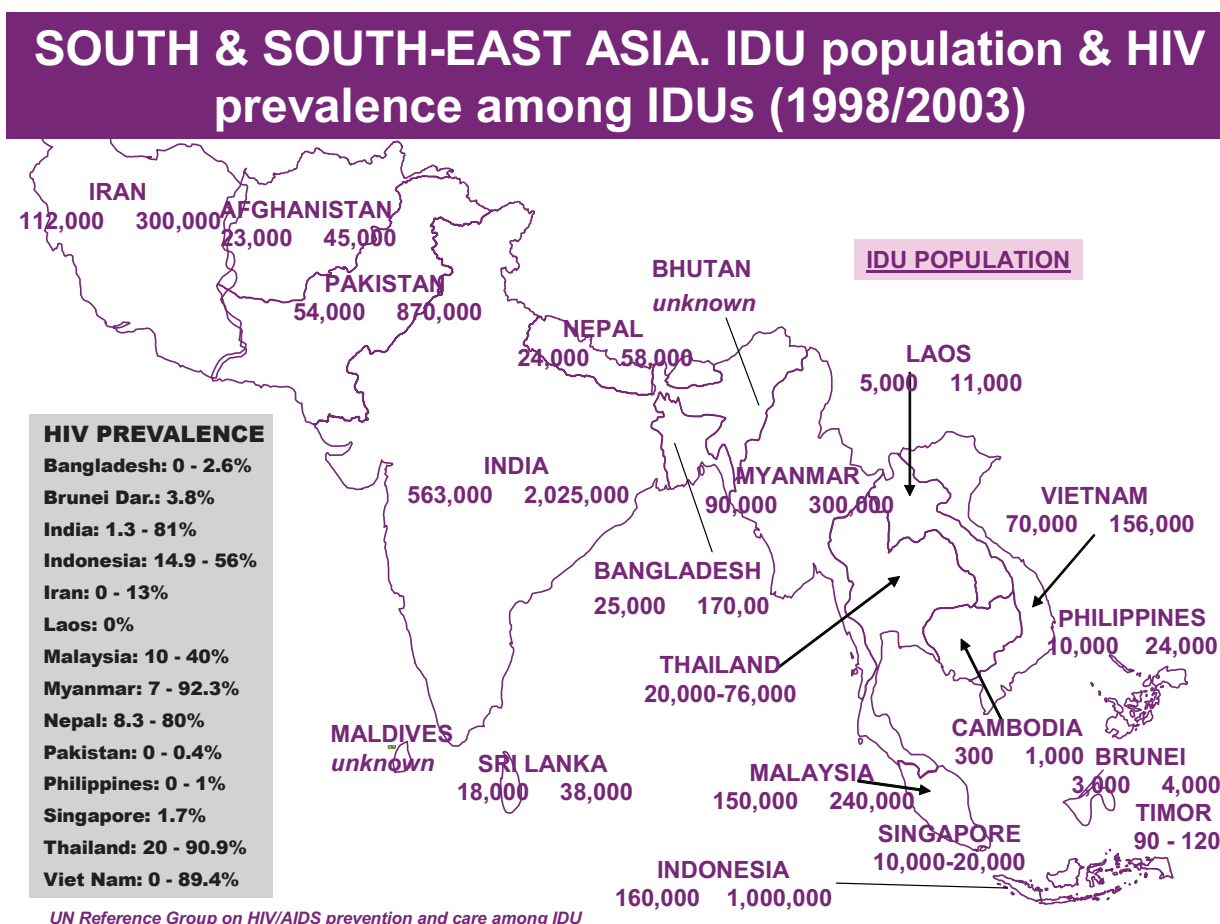
Introduction

In 2004, Asia was home to 3.3 million injecting drug users (IDUs) and 8.2 million people with HIV or AIDS, while more than half a million people in Asia died of AIDS-related complications. More than one million new infections — accounting for 24 per cent of new infections worldwide — are contracted in Asia each year, and this rate is likely to increase. Worldwide, five to ten per cent of infections are due to injecting drug use through sharing of needles and syringes, and commercial and non commercial sexual contact. In Asia, however, injecting drug use is responsible for 20-30 per cent of new HIV infections. In Thailand, for example,

injecting drug use accounts for 20 per cent of new HIV cases, while in Myanmar it contributes to 30 per cent (Aceijas et al. 2004).²

In general, injecting drug use is a very effective route for HIV transmission; in Asia, it is a key transmission mode, as depicted in Figure 1. The reasons for this are multifaceted, and will be explored in the course of this paper. Projection models designed to anticipate the course of HIV epidemics over the coming decades strongly suggest IDUs will be the predominant vulnerable group for initiating a dramatic increase of HIV across all levels of society in a number of Asian countries, in most cases via accelerating sex work epidemics.

Figure 1



Source: Aceijas et al. 2004

Only five per cent of IDUs in Asia have access to HIV prevention services, however. In Southeast Asia, only around one per cent can access such services. Often facing double public stigma for both HIV and drug addiction, IDUs are usually not considered part of mainstream society. Heavy crackdowns by police around the region have intensified users' marginalisation through fear of arrest and harassment.

Most regional authorities understand the importance of intensifying HIV prevention and access to treatment to curb the disastrous effects of the disease. The issue is addressed at various levels of governance including the economy and social stability. Commitments made by governments still require much to be honoured in practise to have any real impact on the course of the concentrated epidemics in Asia, however. And, if there is no concrete impact, the HIV epidemics will continue to scale up.

Overview

The nature of the HIV epidemic in Asia is different from the one found in the Sub-Saharan region. In Asia, there is not one epidemic but numerous, diversified and concentrated ones that affect the most vulnerable groups of society specifically IDUs, men who have sex with men, sex workers and their clients as well as mobile populations. HIV has spread through high risk behaviour associated with unprotected sex and sharing of injecting equipment among such vulnerable groups. This explains why the epidemics in Asia have a tendency to stay concentrated among these groups rather than make their way into the general population. For these very reasons, only a few countries show HIV prevalence greater than one per cent among adult population including Cambodia, Myanmar and Thailand (UNAIDS 2005a).

Despite successful condom campaigns that considerably slowed the epidemic in the 1990s, Cambodia and Thailand face a threat of a resurgence of cases due to complacency regarding prevention as well as an underlying disregard for targeting specific populations such as injecting and other drug users. Thailand is a case in point. An acclaimed best practice model for past efforts, the country still reports about 50 per cent HIV prevalence among its injecting drug user population.

In Cambodia, sentinel surveillance results showed 1.9 per cent HIV prevalence among its adult population in 2003. At the same time, the country is also experiencing a steep increase in drug abuse, particularly amphetamine type stimulants (ATS) and injecting of heroin. In 2004, nearly one million ATS pills were seized, a fourfold increase from 2003. Furthermore, injecting drug use is rising, and sharing of needles and syringes is common practice among IDUs (UNODC et al. 2005). High HIV risk is also associated with heightened sexual drive caused by ATS use. For example, 40 per cent of illicit drug users reported irregular use of condoms or none at all when engaging in sex

under the influence of drugs. They also reported that they were selling blood for money to buy drugs. A recent report by NGO Mith Samlanh/Friends (2004) shows that HIV among drug users in Cambodia is rising.

The HIV epidemic in Myanmar has shifted from being concentrated among high risk groups such as IDUs and sex workers to, unfortunately, a general epidemic. The Government has committed to providing a response to the epidemic through the Joint Programme to Fight AIDS in Myanmar, a United Nations collaborative initiative which provides a framework for cooperative planning, resource mobilisation and advancing the 'Three Ones' principles. However, limited implementation infringes on coverage. Specific geographical pockets may show 50-90 per cent HIV prevalence amongst IDUs.

It is unfortunate that despite early and clear warning signs these countries had to experience a 'spill-over effect' — from initial concentrated infections among vulnerable groups to a generalised spread, thereby placing millions of people at risk of disease and death — at a time when we all have the right to the maximum standards of health. Is this not a violation of basic human rights condoned by government complacency and inaction?

The lucky ones

Opportunities still exist for other parties to avert concentrated epidemics from scaling up to the general population. Laos, Bangladesh, Timor-Leste, Japan, Pakistan and the Philippines 'have golden opportunities to prevent serious outbreaks' (Rao 2005). These countries should quickly review the experience of their neighbours, then act to avert the detrimental consequences of the epidemics on their social and political fabric by adopting clear and concerted political commitment and adequate implementation of evidence-based health models for those most in need.

Sex and drugs: China, Indonesia and Vietnam

The concentrated epidemic amongst IDUs in Indonesia, Vietnam and China have 'kick started' the epidemic among sex workers and their clients, and national infection rates have skyrocketed. In Jakarta, current HIV prevalence amongst IDUs is 48 per cent. It is estimated that more than 100,000 new infections could occur by 2010 due to high risk behaviour — unprotected sex among IDUs, sex workers and their clients, and sharing of contaminated equipment — if nothing is done to circumvent this (UNAIDS 2005a).

In China, reports show unsafe injecting is common practice among IDUs who also have multiple partners, and often buy and sell sex without a condom. In 2002, HIV was found among

drug users in all 31 provinces; in 2001, 70 per cent of HIV infections were observed among IDUs. Compared to other countries in the region, the Government has reacted relatively urgently through a national multi-sectoral task force comprised of various ministries at decision-making levels, formalised under the Prime Minister. As a result, 34 methadone maintenance clinics and 50 needle and syringe programmes were set up nationwide following preliminary pilot programmes. The Government plans to have 100 such clinics and 130 needle and syringe programmes by the end of 2005 and in the next three years it will have scaled up such programmes to 1,500 methadone maintenance clinics and 1,400 needle and syringe programmes nationwide.

Similarly, in Vietnam the nexus of injecting drug use and sex work skyrocketed HIV infection rate to above 80 per cent among IDUs in 2003-2004, and 50 per cent among sex workers especially in the country's north. Hence the Government responded to the problem and AIDS spending is being increased from US\$7-8 million in 2003 to a projected US\$50 million in 2006. One development has been the gradual replacement of the highly stigmatising 'social evil' approach to substance abuse and sex work in favour of prevention efforts based on sound and effective public health practices (UNAIDS 2005a).

The message here is very clear: any intervention to prevent HIV among IDUs and other drug users has to take into consideration the need to raise awareness about sexual protection. Indonesia, like China and Vietnam, has now committed to scaling up comprehensive prevention and treatment approaches at all levels; these commitments now need to be adequately monitored and guided (see Irwanto, this issue).

Breakthroughs

In 2005, two important breakthroughs took place in legitimising the fight against HIV. Firstly, methadone and buprenorphine were added to the World Health Organization model (complementary) list of essential medicines. Secondly, in mid-2005, UNAIDS' Programme Coordinating Board adopted the policy position paper 'Intensifying HIV Prevention'.

Both of these recent developments recognise heroin addiction as a medical condition in need of appropriate treatment, such as drug substitution therapies. The UNAIDS position paper sends a strong signal that access to treatment is central to prevention, especially for the most vulnerable, and that only when these interventions are simultaneously provided are results most effective. Together these developments should allow wider access to treatment for HIV and drug abuse. Structural impediments at policy levels should also be rethought accordingly to provide the necessary enabling environment to increase access to services.

Other encouraging developments occurred at country level in Iran and Malaysia. In Iran, the implementation of the so

called 'triangular clinics' — dealing simultaneously with HIV prevention, drug abuse treatment and sexually transmitted infection (STI) in and out of prisons — has helped that country curb the epidemic. Iran is now considered a best practice model proving a Muslim country can successfully adopt a comprehensive package to prevent HIV among drug users in and out of the prison system. Other Muslim countries are considering adopting the model.

In Malaysia, the government realised punishing and locking up drug dependents was not constructive, neither for the users nor for the state, after HIV rates increased — estimates indicated that 75 per cent of infections were attributed to injecting drug use. Subsequently, the Government, under pressure from NGOs, adopted a health approach and gradually introduced the comprehensive HIV prevention from drug abuse package. In 2003, after pilot methadone and buprenorphine programmes showed good results, the Government provided US\$10.3 million of support to scale up interventions. An additional US\$1.5 million was allocated to NGOs last year to continue such activities.

Similarly, in Bangladesh there exists a striking association between adherence to needle and syringe programmes and a decrease in needle sharing, as well as an increase in reporting and seeking treatment for STI. In three rounds of serological surveillance carried out at the needle and syringe programmes sites in 1999-2000, not one of more than 400 IDUs tested positive for HIV (MAP 2005:11). These results show Bangladesh has successfully responded to the concentrated epidemics, due in part to pressure from NGOs. If the Government had stood by idly, HIV prevalence could have reached ten per cent among sex workers and two per cent among their clients in 2005, considerably higher than the one per cent currently reported in each group.

Understanding injecting drug users

Injecting drug use is high risk behaviour that has proven to be a very effective vector of HIV transmission. This is due to the sharing of needles and syringes, viraemia, a significant overlap with commercial sex work, incarceration and punishment, and the low priority given by IDUs to HIV compared with other immediate life-threatening risks.

Viraemia is a condition, common among IDUs, describing a high level of viruses in the blood that prevents early detection of HIV. This means when IDUs are infected with HIV it is often not immediately detected (if they are tested) and so continue their sexual and sharing practices as normal. Given that HIV is transmitted very efficiently through direct blood contact via shared syringes, HIV among IDUs is often described as 'explosive'.

Illicit drug use in most Asian countries is criminalised. As a consequence, a large number of IDUs can be found in confined

settings including juvenile and adult prisons, where drug users can comprise half the population (see Dolan and Larney, this issue). High risk behaviour — rape, violence, injecting drug use, tattooing, men who have unprotected sex with men — in such settings is well documented and a source of international concern. UNODC estimates ten million prisoners worldwide, while the annual prison turnover is about 30 million individuals a year.

Throughout Asia, IDUs report more sexual activity than any other population group, much of which includes commercial sex work. For example, a 2000 behavioural surveillance in the northern Vietnam port city of Haiphong revealed 40 per cent of sex workers injected illicit drugs. In China, 20 per cent of street sex workers in the Sichuan province reported drug injection. In Asia, drug injectors usually buy and sell unprotected sex, except in Thailand (MAP 2005:8). The nexus between sex and drugs is clear and any HIV prevention programmes directed at injecting and other drug users has to target this crucial component. IDUs and other drug users are young and sexually active, hence they are probably experimenting and in need of protection and guidance through their peers and through their own networks.

Risk of HIV infection is often not an overwhelming concern of IDUs, who perceive that they face other more immediate life threatening situations on the street. This may help explain why in Kathmandu Valley, Nepal, 37 per cent of male drug injectors acquired HIV in one year or less of their injecting career, while 70 per cent became HIV positive within two to five years. By the time users have injected for five or more years, it is estimated that 81 per cent will be infected with the HIV virus. In 'high-prevalence settings, drug injectors need to adopt very high levels of safe injecting practices right from the start of their injecting careers if they are to be confident of avoiding infection' (MAP 2005:7).

Yet what real incentives and chances do drug users, or for that matter, vulnerable people, have to protect themselves against HIV when they are the prey of structural disadvantages stemming from in-egalitarian societies? As President of the AIDS Society of Asia and the Pacific, Dennis Altman (2005) said at a recent conference:

Imagine a child, living on the streets in the slums of Rio or Dacca or Lagos [or Phnom Penh, Kunming or Bangkok], forced to survive through prostitution and petty crime, often turning to drugs to numb the pain, the fear, the hunger and cold of everyday survival. Telling such a child to use condoms or not to share the needles to ward off an illness that may strike many years hence is meaningless.

Imagine a woman, forced by family and community pressure to marry at 13 and have sexual relations with a man older than her father, whom she has never properly met, and the possibility of her insisting on his using a condom — if indeed, she even knows the dangers of unprotected sex.

Imagine a young man, forced into an army or militia, having to flee his family and home to survive, perhaps in prison or makeshift camp, introduced to drugs as a means of escape, and then imagine the chances that he will have the means or the incentive to reject the short term euphoria of a hit because the needle may not be clean.

It is indeed hard to imagine. 'For many ... choices both large and small are limited by racism, sexism, political violence and grinding poverty ... Both HIV transmission and human rights abuses are social processes and are embedded, most often, in the in-egalitarian social structures I have called structural violence' (Altman 2005).

Money talks, or does it?

The social costs of the HIV epidemic translate into a plethora of difficulties for the state including loss of human life, family break up, millions of children without guardians — all burdens a health system should carry. An epidemic is a great societal stress and infringes all other human, social and political fabric of the state. Other costs involved in an epidemic include national security concerns that may range from excessive 'youth bulge' and its consequences, to resentment and violence (Laurie 2005).

Then there is the economic loss. In 2001, Asia was down an estimated US\$7.3 billion through productivity losses as a result of the epidemic. If Asia simultaneously brings HIV treatment and prevention to scale as soon as possible, the region could save annual AIDS-related costs of US\$4 billion by 2010, and over US\$10 billion by 2015 (ADB and UNAIDS 2004:1). Notwithstanding donors' increased pledges from US\$300 million in 1996 to US\$6.1 billion in 2004, Asian nations must show intent and willingness to address the epidemic in order to gain much needed confidence from donors.

The experience from other regions, namely Africa, shows that the HIV epidemic creates a negative impact not only on ongoing business but also on local and international private investors who shy away from placing funds in countries with generalised HIV epidemics, thus further jeopardising social and economic development opportunities.

Where do we go from here?

Except for Papua New Guinea, which shows signs of a generalised epidemic, the Asian HIV epidemics are concentrated among so-called high risk groups such as IDUs, migrants, sex workers, men who have sex with men, prisoners, as well as other populations at the margins like women and girls, refugees and people living in conflict and post-conflict situations. Increasing coverage of these marginalised population groups as well as men in general must become a priority for prevention.

Removal of the causes of stigma and discrimination and of human rights violations of drug-dependent people is essential. The 2005 UNAIDS policy paper places respect for

human rights at the top of the list of both the Principles of Effective HIV Prevention and the Essential Policy Actions for HIV Prevention. Fear of arrest and harassment by the police has been recognised as an obstacle for effective HIV prevention for IDUs. Police should be trained in public health approaches and encouraged to view drug addiction as a mental and physical condition that needs medical care and appropriate 'structural interventions'.

Access to treatment, especially by the populations at the margins of society, must be considered as a valuable opportunity to reach such groups also for prevention initiatives. Modelling by Salomon et al. (cited in UNAIDS 2005b:10), for example, demonstrated that successful HIV treatment can enable more effective HIV prevention.³ Furthermore, the essential principles determining the success of any effective HIV prevention initiative rest on the requirements that all prevention and treatment programmes be comprehensive, based on sound scientific evidence, and nationally owned and led, as well as to up-scale and be inclusive of the effected community.

Furthermore, programmes require adequate access to resources, policy action and commitment at the international and local levels, an increase in investment in capacity building and technical support and the provision of an enabling environment, an essential component for all of the above to work. Additionally, in order for countries to implement adequate responses, international organisations must be aligned in their approach to AIDS; they must harmonise and coordinate their policy, planning, action and financing through a clear agreement on the division of labour and by building on one another's competitive advantage. Similarly, country-centred alignment tools to channel and oversee all external support must also be in place. Finally, there must be a considerable strengthening of monitoring and evaluation mechanisms and structures to facilitate oversight at country level (UNAIDS 2005c). Undoubtedly, what needs to be done is widely known.

Projections provided by experts in Asia and the Pacific deliver a clear message. The choice now is a simple one: scale up the response or scale up the epidemics?

Notes

- * This is an internal document of the UNODC Regional Centre for East Asia and the Pacific. The views expressed in this paper are those of the author and do not necessarily reflect the views of the United Nations and UNODC. The designations employed and presentation of the material in this work do not imply the expression of any opinion whatsoever on the part of UNODC concerning the legal status of any country, territory, city or area of its authorities, or concerning the delimitation of its frontiers and boundaries. Quoted statistics are not UNODC-based.

1. Thanks to Burkhard Dammann, UNODC and Swarup Sarkar, UNAIDS, for their advice on and revisions of this paper.
2. This data is from the United Nations Reference Group on HIV/AIDS Prevention and Care among injecting drug use in Developing and Transitional Countries, which seeks to advise on the international epidemiology of HIV transmission associated with injecting drug use and on effective HIV prevention and care interventions targeting IDUs. The Reference Group is steered by UNAIDS, WHO and UNODC. Its objective is to enhance an evidence-based approach to HIV prevention among IDUs. The Secretariat team of the Reference Group is based at The Centre for Research on Drugs and Health Behaviour in the Department of Social Science and Medicine, Imperial College London. Background papers can be accessed at <http://www.idurefgroup.org>.
3. At the same time, the global attention to AIDS treatment has caused some neglect of HIV prevention, a problem which can be addressed best if HIV treatment and prevention are recognised as equally important and supportive of each other and their synergies are harnessed programmatically, in policy as well as in advocacy (UNAIDS 2005b).

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HIV in prison in Asia and the Pacific

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Introduction

Elevated levels of HIV infection and the over-representation of injecting drug users (IDUs) in prisons, combined with HIV risk behaviour, create a crucial public health issue for prisons and the surrounding communities. Most research on these topics has occurred in developed countries, therefore the extent of the problem in the Asia and Pacific regions is largely unknown. This paper reviews data on imprisonment rates, the proportion of IDUs, and the prevalence and incidence of HIV in prison in Asia and the Pacific.

HIV is identified as a major health problem for prison settings around the world (UNAIDS and WHO 2002). Prison environments are characterised by certain attributes that can elevate the risk of HIV transmission. For example, HIV, hepatitis B, hepatitis C and tuberculosis are often much more prevalent in prison populations than in the surrounding community (UNAIDS 1997). What is more, drug injectors are vastly over-represented in prison populations. This is in stark contrast to the community where IDUs typically account for less than two per cent of the general population (Aceijas et al. 2004). In the community, there has been significant progress in reducing HIV transmission among IDUs (Wodak and Cooney 2004), but this will be undermined if efforts to prevent HIV transmission in prison are insufficient.

Imprisonment is a common and reoccurring event for most IDUs. More than 60 per cent of IDUs in a 12 city study reported a history of imprisonment (Ball et al. 1994), and IDUs report an average of five imprisonments (Dolan et al. 2003). Furthermore, prison populations are dynamic with a vast number of movements of prisoners, prison staff and visitors around and through the prison setting. These two attributes of prison populations — a high proportion of IDUs and a high turnover of inmates — will facilitate the spread of blood borne viral infections among prisoners and the broader community (Dolan 1998; Dolan, Wodak and Hall 1999).

Documented cases of HIV transmission in prison have been uncommon in the developed world (see, for example, CDC 1986; Brewer et al. 1988). This lack of research is probably due to the difficulties in gaining access to prison populations rather than transmission being an insignificant problem. Internationally, HIV prevention efforts in prisons have lagged behind those in surrounding communities. HIV education is provided to prisoners in at least 20 countries, condoms in 26,

bleach in 18, methadone maintenance programmes in 20 and needle and syringe programmes in eight countries (Jurgen 2004).

It is unclear whether the situation with HIV and IDUs in prisons in the developed world reflects that in Asia and the Pacific. There are indications the situation may be more serious in Asia. Often HIV prevalence is higher in the general community in developing countries than in developed countries (UNAIDS 2001). In addition, three-quarters of the estimated 13 million IDUs live in developing and transitional countries. By 2003, the estimated minimum number of IDUs was 1.3 million in South and Southeast Asia and 600,000 in East Asia and the Pacific (Aceijas et al. 2004).

To gain a better understanding of this situation in Asia and the Pacific, a thorough and systematic assessment is required. This overview is the first step in that assessment. It is hoped this paper will indicate the countries where research is most needed and assist countries in their response to this public health problem.

Data were sought for each of the 20 countries in South and Southeast Asia and nine in East Asia and the Pacific. The five types of data sought were:

1. imprisonment rates per 100,000 of the adult population;
2. HIV prevalence among general prisoners;
3. proportion of IDUs in the prison population;
4. HIV prevalence among prisoners who inject drugs; and
5. HIV transmission in prison.

In general the amount of data located was limited and old, except for imprisonment rates. No information on any of the five types of data listed above was located for Afghanistan and Bhutan. No information, apart from rates of imprisonment, was found for Brunei Darussalam (127 per 100,000 adult population), Fiji (128), Macau (197), the Maldives (414), Mongolia (246), Myanmar (120), Papua New Guinea (66), Sri Lanka (110), and Timor-Leste (41) (ICPS 2005).

South and Southeast Asia

Imprisonment rates were found for 17 of the 20 countries in the region. Rates ranged from less than 30 per 100,000 people for both India and Nepal to approximately 400 for the Maldives and Singapore. HIV levels below one per cent among general inmates were reported for some prisons in Bangladesh,

Indonesia, Iran and Pakistan. HIV levels above ten per cent among general prisoners were reported for some prisons in India, Indonesia, Iran, Malaysia and Vietnam.

Data on the proportion of IDUs in prison populations were located for India, Iran, Nepal and Singapore, with the highest proportion for Nepal with 19 per cent (Paul et al. 2002). Reports of extremely high levels of HIV infection among IDUs came from Manipur Central Jail in India with 80 per cent (Sarkar et al. 1995), Indonesia 50–53 per cent (Costigan, Crofts and Reid 2003; Juniarta 2003; Anwar 2003), and an Iranian prison 63 per cent (UNAIDS 2002).

Evidence of HIV transmission in prison was located for Iran, Indonesia and Thailand. There were outbreaks of HIV in prisons in Iran (pers. Comm. Nassirimanesh), and Indonesia. In Thailand, a HIV outbreak occurred in prison and spread to the community (Choopanya et al. 2002).

East Asia and the Pacific

Rates of imprisonment were found for all nine countries and ranged from 66 per 100,000 of the adult population in Papua New Guinea to 301 in American Samoa. Only four reports of HIV among general prisoners were located and all were below five per cent. The only reports of the proportion of IDUs in prison populations came from Hong Kong with 25 per cent and South Korea with three per cent (pers. comm. Wong; South Korean Department of Corrections 2003). The only information located on HIV among prisoners who inject drugs was from China with 42 per cent (USAID 2003). In Taiwan, seven HIV positive prisoners were believed to be IDUs (Chen et al. 1994). No information was located on HIV transmission in prison for this region.

A reasonable amount of data was found on imprisonment rates and HIV prevalence among general prisoners. There were enormous differences in the rates of imprisonment — less than 30 per 100,000 adults for India and Nepal to approximately 400 for the Maldives and Singapore. HIV prevalence among general prisoners was below five per cent for all countries with data in East Asia and the Pacific and above ten per cent for some prisons in India, Indonesia, Iran, Malaysia and Vietnam.

Although little information was found on the proportion of IDUs in prison populations and the related prevalence of HIV, what information was located revealed a disturbing situation. Outbreaks of HIV in prison were reported to have occurred in Iran, Indonesia and Thailand.

Apart from imprisonment rates, most data referred to one or two individual prisons, making it unwise to generalise for each country's prison population. Much of the data were old and unlikely to reflect the current situation, but presumably the situation has deteriorated with time. Nevertheless there were two disturbing aspects to this overview. Firstly, there were huge gaps

in the data sought, meaning the data do not exist or were not accessible, or both. This lack of data meant no real assessment of the situation of HIV infection in prison in Asia and the Pacific could be made. Secondly, when data were located, HIV prevalence and transmission among prisoners who inject drugs was extremely high. It is very highly likely that HIV transmission in prison is a serious public health problem for many countries.

Conclusion

This paper appears to be the first attempt to collate information on HIV prevalence and incidence and the proportion of drug injectors in prison in Asia and the Pacific (Dolan et al. 2004). Similar papers have examined the global diffusion of injecting drug use (Stimson 1993) and HIV infection among IDUs in community settings (Aceijas et al. 2004). Prisons have often been neglected in the global response to the threat of HIV infection (Jurgen 2004).

A number of problems were experienced with data collection, including a general paucity of data, language barriers, a lack of detailed web-based information and official reluctance to release data on HIV and drug use in prisons. Some experts indicated that very little data were available on health and drug issues within their prisons and that many Asian and Pacific countries do not have surveillance system for HIV infection in prison. Even where data was collected through surveillance or scientific studies, they were not always readily accessible. Organisations or governments in developing countries are unlikely to maintain detailed websites or to publish this type of information given its sensitive nature. Some information was available only in languages other than English. Modest funding for this review precluded the extensive use of translators, although native speakers of Farsi, Mandarin and Korean were employed.

For governments wanting to tackle the issue of HIV transmission in prison, there are a number of strategies to consider. In order of priority, these strategies will most likely include:

- access funding from international donors especially for HIV prevention in prison;
- reduce the size of the prison population;
- train prison staff and educate inmates about HIV;
- provide methadone maintenance treatment for at least half of drug injecting inmates;
- provide bleach, condoms and sterile needles and syringes; and
- evaluate these strategies (Black, Dolan and Wodak 2004).

Anonymous HIV surveillance of prisoners should also be conducted where no recent data exist.

HIV is an increasing problem for many countries, especially where drug injecting occurs, but due to the paucity of data available on the subject the contribution of HIV within prison

settings is difficult to determine at present in Asia and the Pacific. Nevertheless it is known that HIV is present in prison populations in most of the countries reviewed here and poses a serious threat. The paucity of data is one of the major challenges and the systematic collection and release of data are urgently needed.

Note

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Harm reduction strategies in Indonesia

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Introduction

HIV, AIDS and injecting drug use are closely linked in Indonesia. Currently, nearly 200,000 Indonesians are HIV positive and in total, it is estimated that 3.2 million people (1.5 per cent of the total population) have developed AIDS.¹ Sexual contact is the main mode of transmission especially among sex workers and men having sex with men, however HIV is spreading rapidly among thousands of young injecting drug users (IDUs). At least 150,000 IDUs have died from AIDS-related diseases, accounting for the majority of virus-related deaths.

In Jakarta, half of the injecting drug user population have HIV, while in far-flung cities such as Pontianak in West Kalimantan, more than 70 per cent of those who request HIV testing are already infected (MAP 2005). Together with China and Vietnam, the spread of HIV/AIDS in Indonesia is the fastest in the Asia-Pacific region. To date, targeted HIV prevention programmes have reached only nine per cent of IDUs, not including those in prisons.

This paper briefly outlines the progression of HIV/AIDS among Indonesia's IDUs (also see Irwanto, this issue), and the harm reduction strategies adopted by Indonesia's narcotics and law enforcement agencies to try to curb the spread of the epidemic.

The progression of HIV/AIDS

The number of IDUs appearing in Indonesia's HIV profile has increased rapidly over the past decade, representing around one per cent of cases in 1988 to an estimated 80 per cent of all new HIV infections in 2003. At least 300,000 drug users are currently estimated to be injecting drugs with around 90 per cent of them sharing needles. In 1997, for example, Jakarta's drug dependence hospital, RSKO Fatmawati, registered no cases of HIV among its patients; four years later, a prevalence rate of 48 per cent was recorded.

HIV infection rates are particularly high in Jakarta, West Java, East Java and Bali. In 2000, half of all drug users in one Balinese prison tested HIV positive.

Research into HIV prevalence in the Indonesian capital forecasts a very rapid expansion in Jakarta within the next decade, with drug users accounting for around one-third of all HIV infections in the city by the end of 2010 (MAP 2005:5). International evidence indicates that IDUs and sex workers

function as a bridge to the spread of HIV to the general population (UNAIDS et al. 2003; see Bezziccheri, this issue).

There is clearly an urgent need to tackle HIV among IDUs. While awareness campaigns to the general population are to be applauded, investments in containing the epidemic in vulnerable groups will be the most cost-effective way to curb the rapid explosion of HIV in Indonesia and other Asian countries.

Major areas of concern that should guide HIV prevention strategies targeting injecting drug user networks include needle sharing, drug users' sexual behaviour, the confinement and incarceration of IDUs, and the relationship between HIV and these other issues.

Harm reduction

Effective approaches to preventing the spread of HIV among IDUs are well documented and focus on the prevention of harm surrounding drug use, rather than on the immediate reduction of drug use itself. As HIV is spread through unsafe injecting practice, including the sharing of needles, harm reduction approaches focus on educating users on safe injecting and safer drug use. Like any behaviour change campaign, however, education by itself is not enough.

The provision of comprehensive and integrated services that directly target the needs of IDUs and also support behaviour change is essential. This includes, among other services, the provision of sterile injecting equipment to IDUs and substitution treatment. Outreach work and drop-in centres are effective strategies for running needle and syringe programmes. Safe injecting kits have been developed as part of a comprehensive programme of information and services to encourage harm reduction among drug users. Such programmes have the added benefit of providing a focal point that directs users to other essential services such as drug treatment, primary health care services, voluntary counselling and testing.

A variety of interventions are needed to effectively reduce the harms of HIV/AIDS and drug use. Appropriate interventions endorsed by the World Health Organization (WHO) have been listed by Indonesia's Department of Health in their guidelines for health service providers. They include:

- outreach;
- information, education, and communication;
- risk reduction counselling;

- voluntary HIV/AIDS counselling and testing;
- disinfection programme (bleaching);
- provision of sterile needles, syringes and other injecting paraphernalia;
- safe disposal of used needles and syringes;
- drug treatment and rehabilitation services;
- pharmacotherapy services;
- HIV treatment and care;
- primary healthcare; and
- peer education.

These integrated services work together to prevent the transmission of HIV, hepatitis B and hepatitis C as well as other blood borne viruses among IDUs, their sexual partners and children, and from them to the non-injecting community. While these approaches have been successful in many Western countries, Indonesia is only beginning to embark on them.

Political commitment

In December 2003, in the presence of her Excellency the President of Indonesia, Mrs Megawati Sukarno Putri, a Memorandum of Understanding was signed by General Da'I Bachtiar, National Police Chief and Chair of the National Narcotics Board, and Mr Yusuf Kalla, Coordinating Minister for People's Welfare and Chair of the National AIDS Commission.

The Memorandum provides a framework for cooperation to control the spread of HIV among IDUs. A national implementation team on HIV and drug use, comprising technical experts in the fields of health, social welfare and law enforcement, was established to oversee integrated efforts. This is one of the platforms the Government is using to stage a campaign against the spread of HIV. The Government's commitments to reducing HIV among IDUs incorporates the establishment of the following:

1. National HIV/AIDS strategy (2003-2007);
2. Memorandum of Understanding (Dec 2003);
3. National harm reduction strategy (2003-2007) drafted by national implementation team on HIV and drug use (ongoing);
4. National pilot programme to reduce HIV/AIDS and drug related harm, needle exchange programme (July 2004);
5. Guidelines for harm reduction implementation, Department of Health (ongoing);
6. Sentani Commitment, signed by six priority provinces, recommended expansion of harm reduction programmes;
7. National working group for the prevention of HIV in prisons, Department of Justice and Human Rights;

8. National strategy for the prevention and control of HIV/AIDS and injecting drug use in Indonesian prisons, 2005-2009;
9. Legal review of Narcotics (22/1997) and Psychotropics Laws (5/1997); and
10. National harm reduction conference (2005), recommended expansion of harm reduction programmes to 14 provinces.

Asian Harm Reduction Network in Indonesia

The Asian Harm Reduction Network (AHRN) was established in 1996 to provide peer support to organisations and individuals in Asia working in hostile conditions while trying to introduce scientifically-based, practical concepts and practices for the prevention of HIV transmission from and among IDUs. In 2002, AHRN and the Centre for Harm Reduction were contracted by Family Health International's Aksi Stop AIDS Project, supported by USAID, to support and facilitate a range of advocacy activities to the police, religious leaders, the media, parliament and NGOs.

Working in close collaboration with the Centre for Harm Reduction, the main purpose of AHRN's advocacy was to promote supportive and enabling political, 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 practices.

AHRN's main focus in Indonesia is harm reduction advocacy targeting the criminal justice system, the police and law enforcement agencies at national and regional levels, as well as the national parliament; and to support the creation of a network of Indonesian NGOs implementing harm reduction programmes.

Law enforcement and HIV/AIDS

Narcotics and law enforcement officials are of central importance when implementing harm reduction programmes. They often misunderstand the purpose of harm reduction programmes, frequently associating them with the promotion of drug use or drug legalisation, instead of the promotion of public health.

The controversy often lies within two very essential harm reduction strategies: needle and syringe exchange, and substitution (or pharmacotherapy). Despite such misunderstandings, and their role in reducing the supply of illicit drugs and the enforcement of laws which criminalise drug use, police are important allies in responses to the twin epidemics of HIV/AIDS and drug use, and should be consulted and involved. By effecting positive change in the specific knowledge, skills and attitudes of law enforcers, they will be able to play a valuable role in reducing HIV/AIDS.

Harm reduction advocacy to the narcotics and law enforcement

The positive involvement of the narcotics and law enforcement agencies is crucial to the creation of a supportive environment so that health interventions can effectively respond to drug use and HIV/AIDS. Advocating the harm reduction principles to narcotics and law enforcement agencies as effective approaches against injecting drug use and HIV/AIDS can lead to police engagement to:

- reduce the harms associated with injecting drug use;
- ensure the personal safety of law enforcers in searching for and handling needles and syringes; and
- create an environment for collaboration between the law enforcement agencies, the community, and other stakeholders (such as NGOs, National AIDS Commission, criminal justice, religious leaders).

There is no centralised mandate from the Indonesian police to support harm reduction at the national level, however. Nor is there centralised advocacy within the national police as advocacy and training efforts have so far been focused at provincial level.

A lack of strategic intervention with the police was a key issue arising from one recent NGO-police workshop. Twenty-five police officers from seven provinces and 31 NGOs from 14 provinces raised the following problems:

- police are restricted to supply and demand reduction, such as detention of outreach workers and their injecting drug clients, causing the disruption of NGO work;
- fear by IDUs to freely access health services available to them;
- police harassment of IDUs (verbal, physical and sexual);
- general negative attitude of the police towards people with HIV/AIDS; and
- very limited knowledge and understanding of HIV/AIDS and harm reduction among field police.

Legal environment and harm reduction

The policies, practices and procedures of law enforcement agencies have a direct effect on the risk behaviours of IDUs. Access to clean needles and syringes is often not enough. In several countries, injectors have indicated that being subjected to fines, arrest and imprisonment is a very real problem. If a country is serious about tackling HIV among IDUs, it must ensure that drug users can safely access and utilise HIV risk reduction services.

In Indonesia, harm reduction programme implementation is affected by the following laws:

- Narcotics Act (22/1997);
- Psychotropics Law (5/1997);
- Health Law (23/1992);
- Child Protection Law (23/2002);
- Presidential Decree establishing the National Narcotics Board (17/2002);
- Presidential Instruction concerning drug abuse and trafficking (3/2002);
- Regulations related to syringes and injecting equipment (229/1978); and
- National Police Law (2/002).

There are three major legal obstacles to implementing harm reduction strategies in Indonesia.

1. The Narcotics Act states that parents or guardians of underage narcotic dependents and adult narcotic dependents are obliged to report themselves (or have their family report them), or are obliged to report the dependent to the responsible body to receive medication and/or treatment. Failure to do so may lead to a prison term.
2. The Psychotropics Law states that a community member must report to the responsible body if s/he knows about the abuse or illegal possession of psychotropics. Failure to do so may result in a prison term.
3. IDUs' right to an optimum degree of health is recognised by law, and this would logically include the right to use clean needles and syringes to avoid disease. However, under the terms of the Narcotics Law, tools and equipment related to narcotics are to be confiscated by the state. What is more, by law, needles and syringes may only be provided or distributed with a government permit thereby further limiting IDUs' access to clean needles and syringes.

The Narcotics Board and National Police: In transition

Indonesia's National Narcotics Board and National Police play an important role in the effective implementation of the 12 harm reduction interventions endorsed by both the WHO and the Ministry of Health. The police chief also chairs the Narcotics Board, and both agencies report directly to the Indonesian President. The Board's day-to-day operations are under the auspices of its executive director, and AHRN's advocacies to date have primarily been directed at him.

The Board is the focal point for drug prevention and control in Indonesia. Its national operations consist of prevention, law

enforcement, therapy and rehabilitation, informatics and research. Support from these bodies for AHRN has waned in past years. Nonetheless, in September 2003, a Board position paper officially recognised the twin epidemic of injecting drug use and HIV/AIDS, identified its capacity to respond to these epidemics (including needle and syringe exchange programmes, and substitution therapy), and recommended a joint response with the National AIDS Commission.

Donor agencies organised a policy orientation study visit to the Netherlands in October 2003. The delegation was led by a former minister of religion and included a Member of Parliament, the director of the Narcotics Board, head of the prison department, head of disease control and prevention, an ASEAN representative, some former IDUs and regional media representatives. Although Indonesian officials have participated in other study visits, this one catalysed the signing of the landmark 2003 Memorandum of Understanding. Yet, several years passed before the board explicitly endorsed needle and syringe exchange and substitution therapy.

Indonesia's police force continues to undergo reform to create a new image distinct from the military after they split in 1999. Police reform programmes, such as community policing, are meant to eradicate the perception of the police as bullies and bandits who are unaccountable to the law. Recent successive changes of the Board's executive director were, in a way, motivated by changes at national police headquarters. Along with these politically-motivated transitions went the evolution of AHRN's programme, from advocacy to police training.

Fortunately, with the transitions came the gradual acceptance of needle and syringe exchange, and substitution therapy. General Sutanto, the second Board executive director, visited methadone programmes and NGOs providing harm reduction services. During the international illicit drug trafficking day, in mid-2005, he was instrumental in the visit of the Indonesian President to methadone programmes and also announced a scaling up of such programmes. This was in addition to the usual rhetoric about eradicating illicit drugs and ensuring the death penalty for anyone who commits a drug crime.

Less than six months after his appointment to the board, in July 2005, General Sutanto was appointed as national police chief which, in a way, is fortunate for harm reduction advocates and programme implementers.

The acting executive director of the Board recently expressed support for both needle syringe exchange programmes and substitution. AHRN has also received Board endorsement to conduct police training and develop a harm reduction curriculum for the national police. Endorsement from the police will also be sought.

Harm reduction and police transitions

The law enforcement agencies' policies, practices and procedures have a direct influence on the risk behaviours of IDUs. AHRN anticipates a carry-over in the acceptance of harm reduction principles onto the police agenda, and along with it a re-focusing of its advocacy from the Board to the police.

The level of interaction with police at national, provincial, district and community levels also depends on the degree of interaction and cooperation that NGOs require. But the recurring day-to-day incidents involving field-level police officers and NGOs implementing harm reduction programmes indicates a clear need to keep police informed about NGO activities involving IDUs. In many cases, police are usually an afterthought within harm reduction programmes when they should be informed, and where necessary, engaged from the outset to minimise, if not avoid, recurring incidents between police, NGOs and IDUs.

Along with a coordinated programme response within the national HIV/AIDS operational plan, a strategic engagement of the Indonesian police at national, provincial, district and community levels will be crucial and significant in impacting the country's HIV/AIDS epidemic.

Note

1. Ministry of Health in 2004 and the National Narcotics Board in 2005.

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Ingredients for success: AusAID's Asia Regional HIV/AIDS Project experience in Viet Nam, China and Myanmar

Ruth Birgin, AusAID Asia Regional HIV/AIDS Project

Introduction

AIDS epidemics can have a devastating impact on economic development, due to working hours lost through illness, spiralling health care costs, orphanage and a myriad of other issues. In the developing nations of Asia, HIV/AIDS is spreading at an alarming rate among injecting drug users (IDUs) who are sexually active and often mobile.

Effective approaches to reducing HIV transmission among IDUs do not conflict with abstinence as one strategy for reducing drug-related harm, and give priority to the more urgent and practical aim of reducing harm for people who cannot be expected to stop using drugs at the present time. Harm reduction approaches acknowledge that no method to eliminate drug use has been successfully demonstrated to date, and that HIV/AIDS now represents a more serious global threat than drug use itself (Des Jarlais 1995).

Where local data regarding HIV/AIDS and risk behaviours is insufficient, rapid assessment response (RAR) activities can lead to the implementation of pilot programmes that can produce clear evidence and inform national health policies. Successful activities and models can then be adapted and transferred to a national and potentially regional scale. However, changing health policies alone will have limited impact if law enforcement authorities are not involved in overseeing and supporting the operation of harm reduction interventions.

This paper describes the regional context and the experience of AusAID's Asia Regional HIV/AIDS Project (ARHP) in working towards strengthened policy and practice for harm reduction at regional, national and local levels.

Background

In Asia, around 7.4 million people (estimates range from 5 to 10.5 million) are living with HIV/AIDS. These include more than half of those who inject drugs in parts of Thailand, Nepal, Indonesia, Myanmar and the state of Manipur in India (see Di Natale, this issue). Localised HIV/AIDS epidemics are occurring among IDUs in various provinces of China and Viet Nam (Quan et al. 2000).

It is evident that existing approaches across the region have failed to address HIV/AIDS epidemics among IDUs. Effective evidence-based approaches have been implemented at a very limited scale and coverage and, with only a small minority of IDUs accessing harm reduction information, services and commodities, are unable to address the scale of the problem.

Closed settings

In Myanmar, China and Viet Nam, along with most countries in the region, drug use has largely been seen not as a health issue, but purely as a criminal matter addressed through mandatory long-term 'rehabilitation' or severe prison terms including the death penalty.

These approaches have not had an impact on reducing the numbers of drug users in society, nor on the amount of drugs consumed. They have had the combined effect of removing people from their communities into punitive institutions. This practice also has the effect of forcing other drug users and sex workers 'underground', afraid to access mainstream public health services. Conditions within 'closed setting' environments frequently exacerbate HIV transmission (Thaisri et al. 2003; Grund 2002). These settings are also characterised by extremely high relapse rates, often upwards of 90 per cent (Kumar 1998). Detainees will return home with the attendant risk of transmission to partners, families and communities (WHO 2004c). The failure of these approaches is increasingly recognised, and the urgency for change is heightened by the spread of HIV.

However, some governments, or sectors within them, are yet to be convinced that harm reduction approaches will be effective and culturally appropriate for their nation. Some law enforcement authorities have reported concerns that harm reduction represents a threat to their attempts to reduce drug supply and drug use, while some health authorities believe needle and syringe programmes (NSP) will encourage drug use. None of these concerns can be substantiated — in fact, studies have disproved any connection between needle and syringe programmes or outreach work with increasing drug use (WHO 2004a, 2004b, 2004c). Police in countries providing

comprehensive harm reduction services, including diversion to treatment programmes, frequently find their work less devoted to processing petty crime and more dedicated to serious community policing.

Drug legislation

Drug laws across the region respond to the 1961, 1971 and 1983 United Nations Narcotic Drug Conventions. As signatories to such conventions, most countries around the world are obliged to prohibit drug use and enforce severe penalties for traffickers.

In Myanmar, the mere suspicion of drug use (without possession) is sufficient to require someone to undergo urine testing; a positive result will lead to imprisonment. Drug users are otherwise required by law to report for registration and compulsory detoxification with long term rehabilitation of up to five years. The conventions have been similarly interpreted through drug laws in Vietnam and China.

Unfortunately, all of these conventions and responsive laws were designed before HIV/AIDS emerged as a global threat, and fail to accommodate the current reality of HIV transmission among and from IDUs in the Asia region. However, within these documents there is considerable scope for diversion to treatment and rehabilitation, as well as clear references to reducing human suffering.

Myanmar, for example, has already explored some flexibility in interpretation as reflected by the practice of using a tincture of opium for drug treatment purposes (Birgin 2004). Similarly, the New South Wales Government in Australia has trialled a medically supervised injecting room in Sydney which has proved successful in averting and managing overdose, providing safer injecting supplies and information, and referral to other health services (WHO 2004c). It appears that much is to be learned in the region about the nature and effects of various types of substance use and dependence, and new drugs are reaching the market at a significant rate. National laws and the interpretation of international drug conventions need revision to reflect the health, social and economic realities of drug use and dependency if people who inject drugs, and indeed the wider community, are to be protected from HIV/AIDS and other harms associated with injecting drug use.

Key international declarations

Despite the regional context of punitive approaches towards drug use, a number of key declarations further endorse and promote harm reduction as the effective and recommended response to HIV/AIDS among IDUs. They are:

- The United Nations General Assembly Special Session on HIV/AIDS (2001);
- World Health Organization (WHO) adding methadone to the essential medicines list (2005);

- WHO's Evidence for Action series and Harm Reduction Toolkit, available online;
- The WHO-led initiative to provide anti-retrovirals to three million people by 2005, which triggered a review of access to anti-retrovirals for IDUs; and
- Warsaw Declaration of 2003 which provided a framework for effective action on HIV/AIDS and injecting drug use.

Governments across the region are becoming aware of the dual increases in drug use and HIV/AIDS prevalence, and are increasingly acknowledging the failure of traditional approaches to manage these issues. National HIV/AIDS strategies in China, Vietnam and Myanmar now support the implementation of harm reduction approaches, however capacity and leadership require strengthening.

Asia Regional HIV/AIDS Project

The ARHP aims to help prevent HIV transmission among and from IDUs by generating regional action to strengthen national responses. The project operates in 20 sites in Viet Nam, China (Yunnan province and Guangxi Zhuang autonomous region) and Myanmar, and employs more than 220 people. Funded by the Australian Government through AusAID, and managed by ACIL Australia with the Burnet Institute as the technical partner, ARHP will run for four years from 2002.

Counterparts from law enforcement and the health sectors in each of the four locations agreed to work with AusAID to support ARHP. Regular national and regional project coordination committee meetings are held with the active participation of these counterparts. They also routinely receive reports on progress and findings and general project updates. Without active counterpart support, much of the ARHP work would not be possible.

A key project objective is to provide the evidence that leadership requires to demonstrate to stakeholders that harm reduction is necessary and should be expanded country-wide. The key approaches implemented by ARHP are expanding effective approaches and institutional capacity building.

Expanding evidence-based approaches has been undertaken strategically. The initial phase entailed recruitment and training of local researchers to implement rapid assessment and response RAR, following best practice methods outlined in the WHO RAR guide on injecting drug use (IDU-RAR). This process resulted in the development of the ARHP IDU-RAR training guide for those agencies and governments implementing RARs among IDUs. It is hoped this training guide will assist with the scaling up of HIV prevention programmes in the region.

Advocacy workshops tailored to respond to the varying requirements of health, law enforcement and community sectors were conducted with senior, high and local level officials.

RAR results were collated, presented in targeted reports and disseminated to stakeholders. Researchers went on to design and assist in the establishment of sustainable, responsive, evidence-based interventions to prevent HIV transmission among people who inject drugs. This process provided an important base for subsequent harm reduction project implementation, viability and sustainability.

Institutional capacity building, particularly targeting health and law enforcement sectors, is conducted with the aim of developing and adopting harm reduction training materials within existing training institution curricula. A comprehensive train the trainer package has been developed, delivered and expanded (where trainers design and deliver harm reduction training in their own institutions) in all locations since commencement of the project. A curriculum detailing effective approaches for law enforcement has been developed and is currently being adapted for adoption by the Yunnan Police Academy, which also trains cadets from Myanmar, Laos and parts of Central Asia. The Indonesian National Narcotics Body has indicated interest in the use of the ARHP law enforcement curriculum. Training for police and other stakeholders has been undertaken at local level. Such efforts have delivered significant outcomes in terms of both building capacity and creating supportive environments for harm reduction.

The figure below summarises the project objectives and methods.

Counterpart relationship-building together with systematic and methodical advocacy has been critical to the establishment of the 15 Effective Approaches Projects (EAPs) across three countries/provinces. This has been augmented by institution-based expansion of training of trainers and the RAR process. Given the pre-existing policy and practice regarding drug use in the Mekong region, the groundwork discussed above has been an essential ingredient for the establishment and operation of harm reduction services.

The ARHP EAPs primarily provide education and information through outreach workers and drop-in centres. They also provide needles and syringe programmes. The EAPs build capacity directly, through systematic training and support for managers, supervisors and outreach workers. All 15 projects are being evaluated as pilot programmes with the objective of providing evidence to inform national and regional policies. When national policy supports scaling-up effective approaches to HIV prevention among IDUs, the EAPs also have the potential to serve as demonstration or learning sites.

At local level, the creation of steering committees or coordination groups has been pivotal in the ongoing operation of the EAPs in an otherwise frequently forbidding policy environment. Formed to coordinate and monitor the EAPs, and for rapid resolution of disputes, these committees are comprised

of representatives from police and health departments, and other local government and relevant NGO representatives. They meet every one to three months, and on a needs basis (that is, in the event of any incidents in the field or in connection with the services provided by the EAPs).

In Myanmar, these committees have expanded their scope over time to accommodate additional agencies implementing harm reduction projects, as well as representatives from the expanding referral network (for example from sexually transmitted infections clinics, and voluntary HIV/AIDS counselling and testing centres). Without this local level coordination mechanism, the EAPs would function sub-optimally, if at all. Through the work of the steering committee in Yanshan county, Yunnan province, outreach worker identity badges are now recognised by local police. This affords better access to outreach services for Yanshan clients.

In Viet Nam, while there is a supportive national HIV/AIDS strategy, there is also a conflicting approach of mass processing drug users through rehabilitation centres. The National Assembly has taken interest in reviewing legislation to allow harm reduction interventions to function. Existing harm reduction efforts of short-term and/or small scale remain scattered, however. Due to its public security counterpart arrangements, ARHP has been afforded unique access to provide harm reduction training to rehabilitation centre staff and inmates. It is envisaged that this model will be replicated in other centres, providing a bridge between closed settings and harm reduction services as they become available.

Drug users in Myanmar, being at constant risk of arrest, discard used needles and syringes quickly, and are wary of government provided services. EAPs have responded by establishing small, part-time drop-in centres in outlying rice fields and in areas where drug users tend to congregate. Some have been so successful in their local level advocacy efforts that the community actively supports EAP activity. In Lashio, one large tea shop was observed to be catering to neighbourhood customers while an outreach worker talked with a client at the other end of the table. A box of EAP condoms was on offer on the tabletop while a needle and syringe disposal container lay underneath. In Tacheleik, a border town, local community members assist EAP staff with translation during interface with clients from a variety of ethnic backgrounds.

The Myanmar implementing agency, Myanmar Anti-Narcotics Association has a long history of work in the area of demand reduction and abstinence based approaches. Following more than 12 months of training and experience, project managers understand and actively promote harm reduction. Experienced staff commented that they have observed detoxification and rehabilitation resulting mainly in relapse, and it is time to focus on preventing HIV/AIDS.

In China, central authorities delivered substantial funding to provinces in order to crack down on drug use. This means IDUs fear accessing drop-in centres, and outreach workers must be discreet. In order to maximise relevance to the target group, China EAPs have responded creatively by, for example: encouraging village clinics and pharmacies to participate in needle exchange programmes through a free coupon system; targeting Islamic IDUs through the involvement of Imams; and delivering harm reduction education in detoxification centres.

At regional level, ARHP conducted various activities including a regional police seminar on harm reduction in Thailand. This attracted senior regional law enforcement representatives from countries such as Viet Nam, China, Myanmar, India, Indonesia and Malaysia. It is anticipated that outcomes from this seminar will be presented at the United Nations Office on Drugs and Crime's regional event, Heads of National Law Enforcement Association. ARHP is consistently represented at WHO harm reduction bi-regional partners meetings, and International Harm Reduction Association conferences. ARHP also conducts regular meetings with regional counterparts. The objective of these efforts has been to advocate for harm reduction and supportive policy generally, and specifically to share the successes and products of the holistic and systematic approach implemented by ARHP.

Conclusion

ARHP has progressed through a programme of regional, national and local level capacity building, leading to the creation of a range of advocacy and training materials, available in four languages, and demonstrations of effective approaches and sharing of results and lessons learned. The project is assisting in the development of a supportive policy environment for capacity building and for scaling up effective regional approaches particularly in Myanmar, Viet Nam and China.

ARHP has developed various tools and resources including: effective approaches presentations for local and high level officials; a comprehensive IDU-RAR training guide; the ARHP RAR findings report; train the trainer kits (including videos) for law enforcement, health, community and outreach workers; a police training curriculum; and other advocacy materials.¹

Note

1. The products are available in English, Chinese, Myanmar and Vietnamese languages at <http://www.arhp.org.vn>, or by contacting the project at arhp@fpt.vn

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Project ORCHID and beyond: Responding to intravenous drug use and HIV transmission in Northeast India

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Introduction

Manipur and Nagaland are two of seven Indian states in India's Northeast region. Both states have a long and complex history of insurgent and separatist movements that challenge control of the Indian State. Their proximity to the Golden Triangle has meant they have become a major route for heroin distribution. In both states ongoing conflict has hampered development, infrastructure remains inadequate, and corruption is widespread. These factors have contributed to high rates of intravenous drug use and a rapid escalation in the transmission of HIV. Project ORCHID (Organised Response for Comprehensive HIV Interventions in the Districts of Nagaland and Manipur) is a five-year HIV prevention project in Manipur and Nagaland that aims to tackle HIV transmission by building capacity of local NGOs to deliver services to injecting drug users (IDUs), sex workers, and their sexual partners.

The Northeast region

India's Northeast is joined to mainland India by a corridor just 20 kilometres wide at its narrowest point, and is wedged in between Myanmar, Bangladesh and the Himalayan foothills. Less than one per cent of the region's external boundaries are contiguous with the rest of India, and the remaining 99 per cent form international borders (Kamboj 2005). It is rich in natural resources such as oil reserves and coal, and its position makes it an important strategic buffer between China and India.

The region is made up of over 200 ethnic groups and is much less densely populated than the rest of India. The population of Nagaland is approximately two million and the population of Manipur is approximately 2.4 million (Office of the Registrar General 2001). Its people share a common origin and their local languages stem from the Tibeto-Burmese group of languages.

In Nagaland the major ethnic group is the Nagas, comprised of 17 large tribes all of whom speak different languages. Nagaland is a devoutly Christian state, with the church being the most influential institution in Naga civil society. Manipur has a different ethnic mix with the Meiteis, a Hindu tribe, the major ethnic group comprising of almost half of the population.

The work force in both states is mainly agricultural, and shifting cultivation is the main form of employment. There has been significant migratory pressure from Bangladesh, other parts of India, and Myanmar with hundreds of thousands of migrants settling in recent decades. Migration has been a significant cause of local unrest and 'non-tribal' groups have restricted access to land ownership, trading licenses and to elected office. Mass migration has also impacted adversely upon the indigenous agrarian sector through cheap immigrant labour.

As with many other parts of India, basic infrastructure is severely compromised. There is no reticulated water supply in most rural areas, the appalling road conditions are exacerbated by frequent landslides, power outages occur frequently and telecommunications are limited. Health services infrastructure is poor and government run facilities often do not function because doctors who are employed within the public sector commonly work only in private practice. Similarly, government schools are often understaffed and private schools are expensive, so many children are unable to complete their education. Despite this, literacy rates are appreciably higher than the national average.

Both states have a long history of political instability and insurgent movements, variously described as 'the underground' or 'freedom fighters'. These groups have arisen predominantly as a result of the considerable tensions between different ethnic groups and the central government. Many indigenous people feel a strong sense of cultural isolation from mainland India and many of their grievances are grounded in the history of the formation of the Indian postcolonial constitutional order.

In Nagaland several factions exist among the insurgent groups and while there is fighting between these groups, the aim of both groups remains an autonomous Naga state. In Manipur the situation is more complex as there are also conflicting demands for independent homelands between various ethnic groups in the region. As a result, some of the insurgent groups in Manipur clash not only with Indian government forces but also with each other. The central government has used military force to quash these rebellions and the 1958 Armed Forces (Special Powers) Act grants security forces broad powers to use lethal force in the region, providing

near immunity from prosecution. A number of human rights abuses have been documented by various international NGOs and it is estimated that more than half a million people have lost their lives in the area as a result of this conflict since Indian independence in 1947.

Some insurgent groups are now substantially criminalised and are involved in gun-running and drug trafficking, as well as extortion and abduction. They regularly call general strikes or *bandhs*, the authenticity of which are impossible to determine, but which are disruptive and further contribute to the climate of fear. The insurgent movements have also created an alternative but formalised *de facto* structure of government and taxation with some insurgent groups appointing their own ministers for various portfolios and imposing a system of progressive tax collection. Although the states of the Northeast are ascribed a 'special category' status by the Government of India, ensuring a financial flow to the region, there is overwhelming evidence that revenues are distributed to an entrenched nexus of politicians, bureaucrats and insurgent organisations with only a small proportion of funds reaching the local community (Baruah 2005).

Twin epidemics in the region

Drugs such as cannabis and opium have been used in the region for centuries. However, until relatively recently there was little preference for heroin among local drug users. As production from Myanmar increased, the Northeast became a major supply route for the rest of India and Nepal, with opium and heroin transported via two main drug trafficking routes through Nagaland and Manipur (Chouvy 2002). Initially, heroin smoking occurred alongside these routes, and this was followed by a wave of heroin injection during the mid-1980s. A second wave of injection prevalence was reported in the 1990s with a number of pharmaceutical preparations used alongside heroin, including drugs such as buprenorphine, dextropropoxyphene, diazepam, and promethazine. In Manipur and Nagaland, buprenorphine injecting is relatively uncommon and heroin and dextropropoxyphene (Spasmo Proxyvon or SP) are the drugs injected most frequently. Current estimates indicate that there are approximately 20,000 IDUs in Manipur and approaching 15,000 in Nagaland (FHI 2003). IDUs in Manipur and Nagaland are more likely to be better educated and of higher socio-economic status than in other parts of India (Panda 2003).

Many insurgent groups publicly denounce drug users and the illicit drug trade, the consequences of which has been to drive users underground thus increasing the chance of high risk behaviour. Although publicly denouncing drugs, many groups rely on the drug trade to finance their operations and to purchase weapons. This link between the drugs and weapons trade has been well documented in the Northeast and elsewhere (Centre

for International Cooperation and Security 2005). It is not uncommon for prominent insurgent groups to raid known drug dealers and publicly destroy a quantity of fake drugs while profiting from the sale of the substituted product.

Illicit drug use is associated with an alarming HIV epidemic in the region, with HIV prevalence rising to 50 per cent among IDUs in less than six months after detection of the first case in Manipur in 1989 (Ray 2000). HIV prevalence among IDUs approached 80 per cent in Manipur and 39 per cent in Nagaland during the late 1990s, and although there has been a decrease in HIV prevalence reported over the past two years there are concerns that surveillance data does not accurately reflect current prevalence (NACO 2005). Illicit drug use is often associated with high risk behaviour such as commercial sex work, with the very high potential of transmission to both injecting and non-injecting groups.

Project ORCHID

Project ORCHID commenced in April 2004 in the states of Nagaland and Manipur with the aim of reducing the transmission of HIV among IDUs, sex workers and their sexual partners. It is a five-year initiative, implemented through a partnership between the Australian International Health Institute and the Emmanuel Hospital Association in India. It is funded by Avahan, the India AIDS Initiative of the Bill and Melinda Gates Foundation. Project ORCHID endeavours to strengthen the capacity of local NGOs and the state AIDS control societies to expand the current HIV response within the framework of the National AIDS Control Programme (NACP). Given that many local NGOs are inexperienced in delivering HIV interventions and that a successful response to the epidemic will necessarily involve the delivery of services beyond the life of the project, capacity building is central to the project.

By recruiting and training local NGOs, the project aims to provide a core package of activities and services to 80 per cent of all IDUs, sex workers, and their sexual partners. These services include:

- a peer outreach and drop-in centre for distribution and disposal of needle/syringe and other paraphernalia;
- peer worker based condom distribution;
- community education and action;
- support groups for IDUs;
- drug counselling;
- abscess and overdose management provided through project nurses, outreach workers and peer educators;
- screening by nurses of all IDUs for sexually transmitted infections and injection related infections, that is, pre-abscess formation;

- treatment of sexually transmitted infections by project nurses;
- data collection and documentation; and
- referral systems for drug treatment, crisis management and other preventative health care management.

The absence of substitution therapy is recognised as a significant gap in the programme response, particularly as it is the most effective option for opioid dependence treatment related to HIV transmission and care (WHO 2004). A programme of buprenorphine based drug substitution through local NGOs has now been proposed but is as yet unfunded.

Discussion

While Project ORCHID provides a much needed crisis response to the HIV epidemic it is only a small component of Avahan's main programme, and one of a number of drug related services implemented in the region. Avahan's mechanistic approach of centrally coordinating a number of agencies to deliver a range of services has a number of practical implications. Firstly, in many cases referral options (such as detoxification, rehabilitation, HIV counselling, HIV testing and care and support) are simply non-existent or are not accessed due to stigma and discrimination. Secondly, the absence of care and support initiatives risks undermining community support for the project, which is desperately needed given that the project delivers challenging interventions, such as needle and syringe exchange, within a conservative environment. Thirdly, there is little scope to respond to emerging needs, and little flexibility to adapt the project to local conditions. Finally, and perhaps most importantly, the focus on delivering services means that the project has no mandate to address the underlying factors that contribute to high levels of IDU and HIV transmission in the region.

Project ORCHID's response is strictly determined by the parameters set by the project funders. Avahan's overall programme is driven by the epidemiology of HIV transmission; hence its focus on those most at risk of contracting and spreading HIV in India's six highest prevalence states. It is a traditional public health response that is consistent with the overall direction of the Gates foundation. The foundation unapologetically overlooks the contribution of economic, social and political factors in the HIV epidemic, instead focusing on technical responses and scientific solutions. The foundation's 'Grand Challenges in Global Health', launched in 2003, reflect this approach. In a recent response to criticism of these grand challenges Bill Gates (2005) responded by stating,

Some point to the better health in the developed world and say we can only improve health when we eliminate poverty. And eliminating poverty is an important goal. But we have a

different view. The world didn't have to eliminate poverty in order to eliminate smallpox — and we don't have to eliminate poverty before we reduce malaria.

Conclusion

There is no doubt that conventional public health responses to combat the transmission of HIV have brought about significant change. Needle and syringe exchange, drug substitution treatment and condom distribution have all had a significant impact in different global settings. The prospect of an HIV vaccine also offers tremendous hope. However, when delivered in isolation and outside the framework of a broader response, their impact is necessarily limited. The distribution of needle and syringes through Project ORCHID outreach workers, for example, is often restricted by *bandhs*, blockages to supply routes and crackdowns on drug use by insurgent groups. Similarly, an HIV vaccine would have limited success unless the structural barriers restricting access to health care were addressed.

A more comprehensive response is therefore necessary. While the work of Avahan in the Northeast is a valuable contribution, the overall response must move beyond the current public health response delivered through Project ORCHID to encompass local development initiatives and a broader geopolitical response. Community development initiatives such as local employment projects, youth development programmes and microcredit schemes are almost non-existent and desperately needed to combat unemployment and the lack of recreational opportunities. Given Avahan's reluctance to work beyond a public health framework, more international development investment is necessary for this to occur.

To their credit, Avahan have indicated willingness to convene a forum involving Indian Government representatives and international donors to attempt to fill the large gaps existing in the current response. There may also be other opportunities for international development agencies to deliver programmes alongside Project ORCHID in the implementation of new initiatives such as drug substitution therapy. Achieving a geopolitical response that addresses conflict, insurgency, corruption and issues of sovereignty will be much more difficult but is just as critical because these are significant barriers to the development of new industries and international investment.

While Project ORCHID is performing a crucial role in tackling the transmission of HIV, it is only by broadening the response to address the range of underlying factors that impact upon the twin epidemics of illicit drug use and HIV transmission that lasting change will be possible. Issues such as conflict and insurgency, systemic corruption, migration, lack of economic opportunities (both wage and non-wage), lack of international

development finance and investment are but some of the many interrelated factors that contribute to illicit drug use in the Northeast. The response must inevitably involve culturally appropriate local development initiatives and a substantial geopolitical response to deal with these issues. These are the truly grand challenges.

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Drug use, treatment and development in Northeast India: Case study of female drug use in Manipur

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Introduction

When the injecting heroin epidemic began in Northeast India in the late 1980s it caught the states unprepared. In Manipur, parents and the wider community were bewildered, confused and frightened by the enormity of illicit drug use and its rapid spread. They resorted to punitive measures to try to halt the epidemic; drug users were incarcerated in jail and special hospital wards were set aside for injecting drug users (IDUs). Initially, drug use was confined to young males, but by the mid-1990s it had spread to girlfriends and partners, although the number of female IDUs remains small — five to seven per cent of the population (estimates vary from 20,000 to 40,000).

In Manipur drug trafficking is difficult to control as the state's geographic, political and economic situations facilitate drug trafficking and drug use. It shares a largely unpoliced border with Myanmar, a major drug producing country, there are very limited legal or law enforcement mechanisms to stop trafficking, there are high levels of internal inter-ethnic conflict, high levels of poverty with limited opportunities or employment for young people.

The Indo-Myanmar border is 1,643 kilometres long and extends across four states of the northeast region — Arunachal Pradesh (520 kilometres), Nagaland (215), Manipur (398) and Mizoram (510). The terrain along the border belt is densely forested and the border is virtually open with numerous jungle routes utilised by smugglers, drug traffickers and others without fear of detection by the security forces or other enforcement agencies. There are villages on both sides of the border which are interconnected by jungle tracks. The population along the Indo-Myanmar border is largely tribal, with almost all tribes having trans-border ethnic contiguity. Due to ethnic similarities and mutual interdependence, the tribal people residing on the Myanmar side wield considerable influence and control over smuggling activities.

Illegal drug trafficking and use and the accompanying high levels of corruption and contempt for the law are devastating the social fabric of the community and the credibility of the state.

The lack of development and employment opportunities are important contributing factors in escalating drug use, because it provides relief from the harsh realities of life. A

number of people have lost jobs in Manipur due to government downsizing; public sector units have been closed and public sector recruitment has been on hold since 2002 because the state has been unable to pay existing employees' salaries. Registers maintained at the nine district employment exchanges in Manipur recorded 174,863 unemployed persons for Imphal West, 39,999 for Imphal East, 45,357 for Bishenpur, 45,257 for Churachanpur, 17,873 for Ukhrul, 12,795 for Tamenglong, 3,063 for Chandel and 3,663 for Senapati. Moreover, 1,772 unemployed persons including 562 women have registered at the handicapped exchange. Another 19,111 young people including 922 women are registered at the University Employment and Information Guidance Bureau.

High rates of unemployment has bred immense frustration and discontent among young people who are now creating problems for society. The lack of development and economic prosperity compared to other Indian states has generated ill-will, and young people are taking up arms and using drugs. Female drug users are usually in the productive/reproductive age group. The strain of the ongoing armed conflict is evident from the reaction of women, many of whom are well acquainted with drugs, guns, bullets and death. Human security, particularly for women, is a major concern. Women fear that taking action against an addicted family member or spouse will cause more harm and could likely lead to a criminal sentence.

Years of national neglect and armed conflict have compounded the state's socio-economic and political problems and left the state open to drug trafficking and the corruption and disregard for the law that accompanies it. The atmosphere is not conducive to entrepreneurship and crucial areas such as education, health and employment have been neglected, particularly affecting women and youth.

Alcohol consumption appears to be decreasing while drug use is increasing, though the number of women users is still small. Most young women experiment or take drugs after being introduced to it by their boyfriends/partners, or due to peer pressure, curiosity or the thrill of chasing a high. Many young women from the mountain areas come to the Imphal valley for work, and in their search look for a 'happening place'. Unable to find employment, they often wind up as sex workers and to

blunt the realities surrounding their work, they take to injecting drugs. Others peddle drugs to eke out a livelihood, but also ingest drugs. Ethnic violence which results in homelessness and migration fuel the drug epidemic.

Women and development

Historically, the women of Manipur have been at the forefront of most of the state's social and political movements. Today, they enjoy some degree of decision-making with respect to social disputes. They hold high and honoured positions in family and society and have the power to be effective agents for positive change. But in Manipur, a dichotomy exists between the status of women in public and private spheres; in the former they are vocal, aggressive and independent, while in the latter they are dormant and submissive. This impacts on their ability to deal with growing drug use among young people and its underlying causes. Very few women work in the formal sector or in positions of power, and most work in the informal sector, where they are deprived of health insurance and pension benefits.

Drug use among women

A 1997 study found female drug users in Manipur to be at high risk for HIV with a prevalence of HIV among the female IDUs of 57 per cent compared to 20 per cent among the non-IDUs. Although the number of female IDUs is small, they can contribute disproportionately to an HIV/AIDS epidemic.

Female sex workers form perhaps the largest group of injecting women users. There is no recognised sex industry but there are an estimated 1500 female sex workers in Manipur of whom 1,131 are targeted by an NGO project in the state. A sentinel surveillance report in 2005 indicated that 14 per cent of those targeted tested positive for HIV. The attitude towards female sex workers is the same as that of IDUs — punitive measures followed by care, treatment, counselling and vocational training. Those accessing care in Imphal have formed two self-help groups, one for HIV positive women focusing on safe sex and prevention of the spread of HIV, and the other for women not infected with HIV. It is difficult for female sex workers in rural areas to access care and treatment in Imphal.

The age of initiation for female drug users is decreasing. A decade ago, it was between 20 and 24 years of age but in the last three years schoolgirls from respectable, affluent families have also started taking drugs, most of these in tablet form — Spasma Proxixon or Nitrocin. This is mainly for kicks and out of curiosity. However, most drug users are from the lower socio-economic groups.

Only a few NGOs cater to the needs of female drug users, and Manipur's AIDS Control Society has only two or three

targeted interventions aimed at this group. As a result, if a user becomes infected with HIV she passes it on to a chain of people including her family, clients, their spouses, and children and so on. Recently, a toll-free AIDS telephone helpline was installed providing counselling and maintaining caller confidentiality.

Harm reduction and rehabilitation for women

Harm reduction is a term understood more by male IDUs than female, even though the latter may be actually practising harm reduction. The most widely practised form of harm reduction for women users is detoxification followed by rehabilitation in a residential facility. There are only a few such facilities, but they are doing exemplary work. There are also drop-in centres, where women users can access needle and syringe programmes, condoms, care and treatment.

During a mid-2005 visit to a women's rehabilitation center, which has provided treatment to approximately 300 clients, all the inmates were positive about the actual and potential benefits of rehabilitation. In the first place, it provided them with security, which is hard to come by in conditions of disorder and strife in Manipur. It provided them with a space to heal holistically, and to deepen the quality of resilience within them, which is brought to the fore by spiritual therapy and the ability to actually pray. As one inmate put it, 'We are born again'. They learn to manage time efficiently, to discipline their lives, to keep busy (they want to be busy so that they would have not time to think of drugs or sex work), and they receive vocational training which is geared towards a sustainable livelihood.

Some NGOs who do not run rehab centers believe, however, that women users come to these centres as a last resort because they are financially broke, physically weak and infirm, alone and insecure, and they remain in rehabilitation only until such time as they regain their strength, after which time they exit and take to drug use again. Others also pointed out the revolving door syndrome, where women users enter and exit from the doors of different centres, using them as convenient short-stay homes. Even if this is the case, and many inmates admitted that they had been in rehabilitation before, rehabilitation centres provide a halfway home, desired and necessary for distressed women users.

It is believed that rehabilitation works better for women than for men. Women are generally more desirous than men to kick the drug habit, and are therefore more amenable to discipline. Above all, they need to rehabilitate themselves in order to stand on their own two feet when they leave the center, as they usually have no family support system to fall back upon. As users, they have been ostracised, marginalised and discriminated against.

Drug users, the economy and development

Although there is a prescribed fee for treatment in rehabilitation centres, which is sometimes so high as to be prohibitive to a potential client, a leading well-known women's rehabilitation centre, Sneha Bhavan, has in the past waived fees for those who are in need and unable to pay. Women are provided treatment and care, and also equipped with life skills. They are admitted along with their children, when there is no husband/partner/family to take care of offspring. These children, ranging from toddlers to adolescents, are provided a loving home, free board, and education in nearby schools. An interesting sidelight is that these young children act as teachers to the smaller children living at an AIDS hospice run by the same NGO. This instils in mothers and children a sense of independence and self esteem. On the day I visited the centre, the children had been paid a nominal wage for teaching, and they subsequently spent this money on a shopping spree to buy what they wanted. This stands in striking contrast to the treatment meted out to users by law enforcement agencies, non state actors and social organisations which frown upon drug use and believe in punitive measures to cure the evil.

Although there is a clear link between illicit drugs and development, most workers in the field of drug treatment, as well as the users, are usually unable to perceive this link. Those I have spoken to admit that the two impinge on one another. Economic development which does not give due care to the needs of local residents and future generations can lead to disastrous results. But the economy would definitely be negatively impacted if, at any given time, 30-40,000 drug users in their productive years were withdrawn from the workforce. There are, however, other more 'real' factors that impinge on development. In one drop-in centre which had registered 79 female drug users, 18 of these were daily wage earners, three were government employees, two were NGO workers, 28 were sex workers, 23 were unemployed, five were students, 25 were literate and 54 illiterate.

Users have few resources and even fewer advantages. They often do not think of what they themselves might be able to do to solve a problem — they assume it is the job of the government, NGOs or the AIDS control society. They tend to blame them for not doing enough. But this is not peculiar to drug users only. In the past, people in Manipur have worked together to accomplish the most difficult tasks, but now they have become dependent on outside help. Solving every issue calls for the establishment of a project. People seem to have no faith in their own abilities.

Young people suffer from a lack of employment opportunities. Vocational training in rehabilitation centres enables women drug users to earn a sustainable livelihood, however. Some are engaged

in weaving traditional cloths like shawls and *phaneks*, which are sold in nearby institutions and the market in Shillong; supply keeps pace with the demand. Others knit woollen sweaters required by the missionaries and school students; some are given a plot of land to till and when they harvest the produce it is calculated at the market value, and this amount is set aside for the women when they leave the centre. Piglets or broiler chicks are sometimes provided for rearing, and these are sold at Christmas when they fetch a high price (Rs.20,000 for a pig). After deducting the cost of the piglet, the women retain the rest of the money from the profitable transaction. Other women sew garments, like school uniforms or first communion dresses which are sold, the profit is accumulated to meet the cost of a sewing machine, which is then given to the woman when she completes her treatment. There have been cases of women selling the machines to finance their drug habit.

At drop-in centres, however, women are encouraged to form self-help groups but they are not equipped with vocational skills. The relapse rate in rehabilitation centres remains high — estimates vary between 30 and 80 per cent, and many women users display reluctance to approach drop-in centres. Those I interviewed cited three main reasons: unwillingness to be identified as users; reluctance to spend money on transport to and from the centres; and being deterred by the periodic strikes and blockades which impede free movement.

Conclusion

In Manipur women have the ability to make timely interventions to prevent further transmission of HIV through injecting drug use. They can assist women and adolescent girls to access counselling services as well as provide correct information and knowledge on a range of choices. Information can be a powerful tool to effect behavioural change but it must be provided not only by grass root workers, but also by women who command respect in society. Women can better ensure that predictable health and social service needs related to drug use and HIV/AIDS are anticipated and met. They can facilitate the removal of barriers to personal empowerment of women IDUs. Women can work towards creating a better situation for the very poor — those who are more likely to become drug users.

During a visit to Manipur in 2004, the National Commission of Women recommended a number of strategies for encouraging the growth of entrepreneurialism among poor women. Capacity building and training in resource mobilisation was highlighted as a way to provide appropriate, affordable rural technology to poor women. They also recommended checks on the displacement of women due to job seeking; the promotion of self-help groups in the hill areas (a key point as most drug users are from Christian hill tribe groups); and revitalise and expand the microcredit schemes of the Grameen Banks.

Drug use in Cambodia

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Introduction

Over recent years, an increasing number of governmental and NGO entities in Cambodia have become involved in the issue of drug use and associated health and social issues. Although only very limited data is available, there continues to be increasing drug use in the urban areas of Cambodia by a range of population groups, particularly youth aged 18-25 years; with approximately 60 per cent of the total 13 million population of Cambodia under 25 years of age, there is great concern as to the future socio-economic impact of increasing illicit drug dependence. Other key at-risk groups include brothel and non brothel-based sex workers, people of all ages involved in labour intensive activities requiring long working hours to maximise potential income, and other groups such as middle-class urban 'moneyed', as well as school-based, youth.

The situation

Intravenous drug use has been increasingly reported in the Cambodian capital Phnom Penh over the past 24 months, such as through an assessment conducted by CDC/UNAIDS/WHO in 2004.¹ Virtually no data exists as to the prevalence of HIV among drug users in Cambodia; initial indications associated with street-living youth in Phnom Penh indicate that the prevalence could be as high as 35 per cent among this extremely high-risk group.² Methamphetamine is by far the most prevalent drug of choice,³ at around US\$1.50 per tablet, followed by heroin with a street price as low as US\$1.25 per dose, putting both substances within the economic grasp of many people including those living close to, or on, the poverty line.

From assessments undertaken to date, there is virtually no knowledge among the drug using communities of Cambodia as to:

- the health risks associated with drug consumption;
- the social impact of drug usage; nor,
- the risk of HIV transmission through behaviours resulting from the consumption of illicit drugs or the misuse of licit substances.

Furthermore, drug use interventions are currently limited in geographic scope, often do not incorporate HIV prevention, and are not part of an organised and systematic referral system for counselling, treatment, rehabilitation and reintegration at national, provincial or district levels. There is virtually no governmental or NGO health or social service provision for

people with problematic or habitual drug use, with the exception of children and youth living or working on the streets of Phnom Penh who can receive symptomatic treatment and some counselling through the services provided by the NGO Mith Samlanh. One private clinic for treatment and rehabilitation exists in Phnom Penh but costs are beyond the means of most people or their sponsors. A newly formed NGO, called Korsang, has begun outreach to other drug using communities in Phnom Penh that will hopefully better inform policy makers as to the nature and extent of drug dependence in non street-living youth populations of the capital. While more than 100 Voluntary and Confidential Counselling and Testing (VCCT) centres are operated by the Cambodian Government throughout the country, it appears that very few people who have drug use issues are aware of their risks of contracting HIV and/or are unwilling to enter such facilities so as to learn of their HIV status and receive referral to appropriate services. Staff at such VCCT centres have not received specific training in drug use issues and associated risks.

Consequently, Cambodia is facing a potentially explosive cocktail in that 60 per cent of the population are aged under 25 years; Cambodia has the highest HIV prevalence rate in Asia; illicit drugs are relatively cheap and widely available; there is virtually no knowledge of drug dangers among the general or at-risk population; there is evidence of the sharing of injecting equipment and also of high-risk sexual behaviours; and, very limited availability of services for drug users. All these risk factors could contribute to a significant increase in the transmission of HIV in Cambodia if a multisectoral, coordinated and quality-based range of interventions are not developed rapidly by the Government and its NGO partners.

Drug policy and legislation

The policy and legislative environment is very supportive of HIV prevention through drug use and drug dependence. Harm reduction is an explicitly accepted methodology for prevention of HIV through drug use in Cambodia as part of the first five-year national drug control strategy (2006-2010). One pilot harm reduction project has been formally authorised by the Cambodian Government for implementation by Mith Samlanh in Phnom Penh with a two-year extension also approved; the authorities have indicated a keenness to scale up the geographic coverage of such services in the future in partnership with NGOs.

The National AIDS Authority, as part of its new national strategic plan for 2006-2010, has included prevention through drug use for the first time. Public statements by senior government officials, including the Prime Minister, since 2003 have repeatedly supported the use of harm reduction as an appropriate intervention.

In order to assist the Government and its partners in developing a complete portfolio of quality-based interventions, there also needs to be a clear vision vis-à-vis drug-related HIV/AIDS awareness, prevention, treatment and care in Cambodia.

The vision: To prevent HIV transmission through illicit drug and substance abuse among at-risk population groups and its subsequent spread among to the general population in Cambodia.

The objective: To develop a coordinated system of health and social services for the prevention, treatment and care of victims of problematic and habitual illicit drug use and the associated risks of HIV transmission and other blood-borne diseases regardless as to their socio-economic background through a multidisciplinary partnership between Government and NGOs in Cambodia using internationally recognised norms and standards to provide quality services based on best practices.

The principles: (1) Policy and legislative environment; (2) Knowledge; (3) Quality norms and standards; (4) Coordinated operational framework based on existing structures.

The components: (1) Awareness; (2) Prevention; (3) Counselling; (4) Treatment Services for HIV-positive illicit drug users; (5) Rehabilitation; (6) Reintegration; (7) After care; (8) Surveillance / Monitoring; (9) Multisectoral coordination and collaboration through referral.

The challenge for Cambodia is to put policy into practical service provision using international best quality standards and norms through the integration of drug use awareness, prevention, treatment and care services with those already established for HIV and AIDS. There is currently a range of gaps in the provision of a continuum of interventions for drug users, especially those who are HIV positive. A comprehensive and integrated approach to these issues will need to comprise the following key components:

1. *Legislative and policy environment:* The existing policy environment is well developed. However, clarity needs to be brought to the drug control law with the objective of making harm reduction activities legal and, thereby, clarifying Article 5 of the 1997 Drug Control Law of Cambodia concerning incitement to use illicit drugs;
2. *Surveillance data and qualitative knowledge:* To develop an institutionalised portfolio of quantitative and qualitative data sources and related human resources from the Government

and NGO sectors and the incorporation of injecting drug users (IDUs) and non-IDUs into HIV Sentinel Surveillance to direct the allocation of human and financial resources in the drug-related HIV/AIDS sector in Cambodia;

3. *Norms and standards:* The development, establishment and periodic review of a range of written guidelines, norms and internationally recognised best practice standards for aspects of drug use prevention, counselling, treatment, rehabilitation, reintegration, after care and, in particular, for the provision of services to HIV positive drug users; such norms and standards will be periodically reviewed and updated to include new methodologies, protocols and guidelines, as appropriate;
4. *Linkages/Synergies:* Drug use and dependence, HIV/AIDS, mental health, social care, education and law enforcement policies and relevant legislation need to be linked, as appropriate, in order to allow for cost effective service provision through a clearly understood policy and legal framework and operational environment. Governmental and NGO agencies undertaking activities in such sectors must cooperate and collaborate in the provision of services to the drug using community at national, provincial, district, commune and village levels, especially for such people who do not wish to engage with organised service provision that has linkages with local authorities. In particular, a comprehensive referral mechanism must be operationally established at appropriate local levels to allow for relevant service providers to focus upon their specific areas of expertise as part of a broad portfolio of service provision. Linkages and synergies, together with service provision, will provide an operational framework for the drug and HIV sector in Cambodia.
5. *Provision of Services:* Services need to part of a continuum of interventions and form an operational framework driven by internationally recognised good practices of norms and standards that take place within a conducive legislative, policy and law enforcement environment. Operational linkages between key partner agencies at district and provincial level will allow for specialised quality service provision at a localised level at relatively low cost through the integration or adaptation of existing services that are part of a

broad referral mechanism to synergies all aspects of prevention, treatment and care to the community, including outreach to 'hidden' sub-populations.

Furthermore, a simple — but comprehensive — strategic implementation plan of interventions must be developed for which potential and existing service providers, as well as technical agencies and donors, can base their inputs in the coming years with a detailed work plan to then be developed to identify specific roles and responsibilities of governmental and NGO entities and the operational mechanisms for such a framework at all levels.

Notes

1. *Drug Use and Sexual HIV Risk Patterns among Non-Injecting and Injecting Drug Users in Phnom Penh and Poipet, Cambodia*, International Rapid Assessment Response and Evaluation (I-RARE), WHO, Phnom Penh, January 2005.
2. *Pre-Test Counselling and HIV Test of Drug Users Amongst Street Youth, January-September 2004*, Mith Samlanh/Friends, from a presentation made to the Drug and HIV/AIDS (DHA) Technical Working Group (TWG), November 5, 2004, Phnom Penh, Cambodia; *Harm Reduction Monitoring Report 2005, January-June*, Mith Samlanh, Phnom Penh, Cambodia, October 2005.
3. Monthly reports of the Drug Information Centre (DIC), Secretariat-General, National Authority for Combating Drugs (NACD), Phnom Penh, Cambodia.

Situational Analysis of Drug Issues and Responses¹: Executive Summary

Australian National Council on Drugs, Asia Pacific Drug Issues Committee

Context

In October 2003 the Australian Prime Minister John Howard announced that the Australian National Council on Drugs (ANCD) had been asked to increase the nation'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 made up of individuals with a broad range of experience and expertise in drug policy and in Asia and the Pacific. The Asia-Pacific Drug Issues Committee's (APDIC) mission 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.

In order to provide a foundation for its work, in November 2004, APDIC contracted the Centre for Harm Reduction, Burnet Institute, 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 Australia and international involvement in relation to illicit drugs for each country. More detailed analysis about each country, complete with referencing, is contained within Appendix A and Australia 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 amounts 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 runs into the millions across the region. Issues of these magnitudes challenge the capacity of developed nations, let alone those which are attempting to hasten social and economic development, often from a low base.

Secondly, there is the 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.

Thirdly, that policy development around 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 which promise more impact. This in general happens against a backdrop of inadequate public debate, around a subject which 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 have been in existence, often short-lived, 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. Much reliance is 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.

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

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

Note

1. The full report is available for download at: <<http://www.ancd.org.au/publications/index.htm#>>.

Illicit drugs and development policy round table discussions and recommendations

Pamela Thomas, Australian National University and Judy Putt, Australian Institute of Criminology

The three-day symposium, 'Illicit Drugs and Development: Critical Issues for Asia and the Pacific', convened by the Development Studies Network at the Australian National University in Canberra in August, enabled a multi-disciplinary exploration of the relationship between illicit drugs and development in the Asia Pacific region. The symposium concluded with a policy round table that highlighted the need for incorporating discussion on the impact and amelioration of illicit drugs within the national and international development agenda and of the need for continuing interdisciplinary dialogue. The policy workshop was facilitated by Nick Crofts of Turningpoint Alcohol and Drug Centre, Australia.

Key recommendations

Round table participants proposed a number of recommendations, including that:

- greater focus be given to protection of human life in programmes addressing illicit drugs and harm reduction, and that this be incorporated into the discussion on addressing poverty in the Millennium Development Goals (MDGs);
- in addressing illicit drugs donor organisations give greater consideration to reducing vulnerability among the very poor, the displaced, dispossessed and internal or international migrants;
- the negative impacts of social and economic development and their relationship to drug use be recognised and ameliorated. Prevention programmes must address the fact that development is about change and that better and more attractive alternatives to drugs are needed to help people deal with change;
- a whole of government approach be adopted to include public health, legislation, law enforcement, and education, taking into consideration human rights and governance issues. It was strongly recommended that police and health officials work together to provide better understanding of harm reduction, how to prevent the spread of HIV/AIDS among intravenous drug users, and to provide greater clarity of their roles;
- national drug reduction networks be established among different government and non government organisations working in different aspects of drug reduction and development and that the responsibility for addressing illicit drugs and demand reduction incorporate health, education, development organisations and civil society in addition to law enforcement;
- donors expand their economic emphasis on illicit drugs to include the social aspects of illicit drugs and the intersection between development, social behaviour and drugs;
- programmes adopt a multi-faceted approach that deal in an integrated way with reducing drug supply, providing attractive livelihood alternatives, reducing drug use and demand, reducing the harms caused by drug use and the provision of treatment and support for existing drug users;
- any programmes dealing with drug reduction incorporate an advocacy component to increase understanding of drug use, drug treatment and harm minimisation; and
- appropriate research, monitoring and evaluation of illicit drug impacts in development programming/projects should be promoted and results made widely known.

Main discussion topics

- How development and social and economic transition create vulnerability and opportunities for drugs. The need to create opportunities for people to deal with change.
- How to ensure that prevention programmes address the fact that development is about change.
- The time frame for drug reduction programmes and the need for a long term view to prevention and alternative development.
- Participatory approaches to reducing drug use and improving treatment.
- How best to deal with the 'balloon effect' in drug production and trafficking.

- Whose agenda are we following? The neo liberal capitalistic modernisation model embraced by countries but people do not participate in decision making?
- The relationship between the local and global contexts and the way local actions and their consequences are influenced by the global situation.
- Lack of development exacerbates drug use but development can also lead to an expansion in drug use.
- How to catch up with ill effects of social and economic development
- How to deal with Amphetamine type stimulants (ATS) which are taking over from heroin.
- How to provide a greater focus on human rights and the decriminalisation of drug use.

Roundtable discussion

Illicit drugs and development — making the link

The Millenium Development Goals: The roundtable participants highlighted the negative impact of illicit drugs on achieving the MDGs and the absence or any discussion on illicit drugs within the MDGs' recommendations. Widespread production, trafficking and use of illicit drugs not only have negative impacts on health, livelihoods, and governance but impinge on national and regional economies, legislation, basic human rights, morbidity and mortality.

In Asia and the Pacific, illicit and licit drugs are shown to have a disproportionately negative impact on the poor and vulnerable.

Participants agreed that a greater focus needs to be given to protection of human life in programmes addressing illicit drugs and harm reduction, and that this be incorporated into the discussion on addressing poverty in the MDGs and in the policies of national and multilateral development agencies.

Underlying development issues: The conference highlighted the ways in which individual and community vulnerability were key factors underlying drug use. They resulted from poverty and lack of opportunities or displacement, migration or disenfranchisement often associated with modernisation and/or rapid change. Lack of development and lack of education and employment opportunities exacerbate drug use and drug trafficking while rapid development and accompanying social and economic change can also lead to greater involvement with drugs. The countries of Asia, and increasingly the Pacific, provide examples of the relationship between rapid change, dislocation, displacement, disenfranchisement, poverty, migration and involvement in illicit drugs.

Many of the reasons for increased drug use in Malaysia are very much related to economic development — whether this is truck drivers having to take drugs to drive all night or those who need energy for three jobs to survive, or those forced into sex work who need to take drugs to deal with their situation, or those who need to feel better about themselves, or children working in the streets (PN).

We have to create opportunities for people to deal with change as social transition creates vulnerability and economic transition creates opportunities for drugs. But this is something we ignore, we forget that prevention programmes must address the fact that development is about change. We also need to consider whose agenda we are following and in whose benefit (FM).

Development causes increased differences in access to resources. With cash in the local economy, traffickers focus on villages with cash. Villages along main roads usually have more money and these are trafficking routes so they are highlighted by the traffickers. Those in areas where there is a moving population are more likely to have trafficking as people don't know one another and have no community spirit and social control. It's the same problem as moving to town (PC).

Drugs are closely linked to both development and under-development. What is clear is that they have a much greater negative impact on the poor. Illicit drugs must be part of any developing planning, just as improved social and economic opportunities for the poor must be fundamental to any approaches to reducing drug production and drug use (RP).

Discussion then focused on the need for prevention programmes to address the fact that development is about change and that better and more attractive alternatives to drugs are needed to help people deal with change.

Approaches to reducing drug production

A key area of discussion was the effectiveness of different approaches to drug reduction and prevention. It was agreed that the 'War on Drugs' was ineffective and that alternative development approaches could only be effective if a very long time frame was allowed and if they were integrated with prevention, treatment and harm minimisation strategies. The examples given showed that alternative development projects were often based on the enforced destruction or outlawing of opium crops with little consideration of impact and without ensuring there were markets for the alternative crops.

No country has won the war against drugs, unfortunately this warrior approach to drugs makes us who work in the field also victims. Only the police and gangsters have guns. We only have empathy towards our clients — and clean needles. Our governments devote large budgets to law enforcement without consideration of why people use drugs. Governments would do better to invest in basic services such as health and education (II).

The relationship between development policies, drug use and poverty is exemplified by the situation in Laos.

The Lao government's answer to development was to move the poor ethnic minority groups from the mountainous highlands down to the lowlands. These groups traditionally planted and used opium. Then the government pledged to eradicate all opium growing within five years. When officials demanded that poppies were eradicated there was a rapid movement of highland people to lowlands. Sometimes 19-20 villages moved down together. The harm caused is now greater than in the past. Locals can't handle it. They are now dependent on wage labour and often women have to take up prostitution. When traditional communities controlled opium use, its use was not harmful. But today when communities are fragmented there is no control. There has been the creation of an addict identity. These people are criminalised and marginalised. It is so different from the past (LB).

Aid can be used as a big stick by local officials — 'if you don't reduce opium use the aid will be withdrawn'. So opium-free model villages were developed to get aid. There was a high level of social control in them — including monetary fines, or people being thrown out of the villages. The village headman served as a police surrogate. Aid and land were withdrawn if people in village using drugs or relapses (PC).

Alternative development should come before eradication but usually doesn't. EU pays \$2 a day per cow where agriculture is heavily subsidised. There's more spent on agricultural subsidies in Europe than spent on development in the world (SC).

Addressing drug trafficking

Discussion on how to deal with powerful international drug syndicates focused on the need for international collaboration in addition to national drug control efforts. The very high levels of corruption involved at all levels of governments and other organisations pose considerable problems as do the ability of crime organisations to benefit from globalisation and to ignore national boundaries. The workshop provided a number of examples of the benefits of international cooperation in addressing illicit drug production and trafficking.

Fiji has strategic location for trafficking — transnational syndicates use the country as a staging point, so it has been a joint effort between many countries to bring about successful arrests in Fiji. The AFP and NZ police have worked with us. They bring new knowledge and understanding on dealing with international syndicates. We are regionally fighting together. In this drug problem it is really important to cooperate regionally (MD).

In Yunnan, location is very special, with 4000 km shared border with Laos and Vietnam, and the Mekong river connection with Cambodia and Vietnam. We find that drug control is no one country's problem. We need international cooperation. From 2002-2004, Yunnan Province cooperated with Laos and Burma, and along with NGOs we destroyed 18 drug factories along the border. Got 2.3 tonnes of drugs and 50 tonnes chemical drugs. But we also need experts to study and work in China to help us in training and science research (YY).

Collaboration between illicit drug reduction organisations and development planning

A key point emerging from the discussion was that most individuals and organisations working in the different aspects of drug reduction work in isolation from other organisations — a situation that is reflected in national drug policies and legislation. Very few participants working in law enforcement had had the opportunity to consult or collaborate with those working in treatment or harm minimisation and vice versa. Those working in treatment or HIV/AIDS prevention were seldom involved in development policy formation or in law enforcement. The discussion highlighted the difficulty law enforcement officers face in countries where drug taking is a criminal offence punishable by imprisonment but where harm minimisation programmes operate. For many, the workshop provided the first opportunity to discuss the different aspects of dealing with illicit drugs and the increased effectiveness of collaborative drug reduction policies and practices.

I work in law enforcement: This conference has been a learning experience as it brings understanding to me that we need to know more before we can determine the best measures to fight the problem. In Fiji, we have a new drug act with more police powers in search, arrest and intelligence gathering and there is now a more realistic penalty — life imprisonment as against eight years for trafficking. But I see now that we need to also address supply and demand through public education about harm of drugs and to understand what needs to be done to reduce the harm. We need greater understanding of the problem among our officers (MD).

The Cambodian government is committed to policy related to fighting drugs — the five year national master plan includes demand and supply reduction and also harm reduction but in 2005 the government amended the law to increase punishment for drug users and suppliers. Harm reduction is not legalised, so we face difficulties. We have the right to arrest any person using drugs, but we know through NGOs that we have to help drug users to avoid getting HIV, but police officers do not know how to deal with this problem. So we need to learn more about this concept as it is very new to Cambodia. Police chiefs don't understand what harm reduction is. We require closer cooperation between law enforcement team and health institutions, as maybe this can show us the way forward (LK).

I see MPs, police, researchers, academics at this conference, talking together and would like to see that in my own country. We need to strengthen this networking and I would like to learn more on this. Not only in this type of context but at mid and low levels also, and nationally (AA).

Workshop participants discussed ways that a more integrated, collaborative approach could be introduced and what such an approach would look like.

The Vietnamese government has given concrete guidance to launch campaigns in a synchronised way with ministry authority at central level guiding implementation of drug

control laws. The capacity of local authorities has been step by step advanced, and a master plan up to 2010 has been made with clear roles and responsibilities. The roles are split into five sections: information and communication; poppy eradication; law enforcement; rehabilitation and international cooperation (NCD).

If we look at development, there are so many aspects to it: health, poverty, law enforcement, education. It is important that our plan for economic development incorporates a national drug reduction plan that takes into consideration, education, health, law enforcement, customs, not just law enforcement. We need to take total responsibility for dealing with drugs away from law enforcement, as that is where it rests presently. This will then give us opportunities to work at supply reduction, harm reduction, and not just the 'War on Drugs' because so long as the sole responsibility of drugs policy is on the law, it will always be seen as fight. And this is a bloody fight (PN).

It was agreed that national drug reduction programmes adopt a multi-faceted approach that deal in an integrated way with reducing drug supply, providing attractive livelihood alternatives, reducing drug use and demand, reducing the harms caused by drug use and the provision of treatment and support for existing drug users.

Drug use, the sex trade and HIV

Workshop discussion highlighted the intersection between poverty, vulnerability, migration, people trafficking, drug use and the sex trade and the impact on the spread of HIV/AIDS.

The sex trade is intimately linked to drug trafficking, people trafficking and drug use. There is a strong linkage between the three in China and Vietnam. A lot of poor segments of the population, especially young women, particularly in highland areas become susceptible to drug use. They become part of the sex trade for one reason or the other, either voluntarily or involuntarily, and as result are vulnerable to drug use and this leads to HIV/AIDS (JE).

In Chang Mai, lots of casual sex workers are Burmese. The war on opium fields has left very little economic alternative for many in the region but to enter the sex trade. The sex trade leads to drugs or work in the sex trade results from a drug habit. Many sex workers have HIV (IL).

In Thailand studies are showing increased rates of sex work and drug use. In Laos, to interact in the workplace, ATS gives energy and inspiration and helps to maintain body shape and figure. Where women and boys end up in the sex trade, there is an increased incidence of drug use. What is less clear are the linkages between these and drug production (CL).

Research in Cambodia shows increased drug use among sex workers. Street children, usually girls, are particularly vulnerable to this dangerous pattern. In brothels and clubs, pimps and clients put drugs into the girls' drinks to control them — mostly ATS and heroin. Sex workers from Vietnam working in Cambodia are injecting heroin and take this habit back to their colleagues. We find that urban-rural inequalities further exacerbate the problem. Young children bought in rural areas are sold to brothel bosses. Rural Cambodia has national rehabilitation centres. Law enforcement deals with the issue

by putting them in prison-like facilities where risk and vulnerability increases (MP, MS).

On West Java, they're trafficking women to China because of the one child policy. The industry of trafficking — humans and drugs — they are all linked and sometimes trafficked by the same group (FM).

We have talked of drugs and sex and human trafficking as though they're different, but to the trafficker, they're all commodities. It might be constructive to consider it all as trafficking and study the origins of these networks (RP).

In the Pacific the drug mostly used is pot, the injected drugs are less visible. They seem to be there, but are hidden. They are not accepted in society. Most of the HIV/AIDS incidence is through sexual interaction. Some hotspots of human trafficking and prostitution do exist — most of the women are of Asian origin, migrants to the region. But people working under the poverty line also supplement income through the sex trade. No recent regulated study has been done on this in Fiji (LK).

Studies undertaken in Fiji ten years ago by the University of the South Pacific showed that young girls working as prostitutes on Asian fishing boats at the wharves were frequently paid in drugs and once addicted had to service more clients or engage in more dangerous sexual practices to maintain their habit (PT).

The situation in China is similar to Thailand, in the youth and sex workers (though you can't use that term in China). There are connections between sex and drugs as well as terrorist links in Yunnan Province (YY).

In so far as transport networks increase mobility, roads lead to bars, bars lead to casual sex workers — vectors of movements of HIV/AIDS and drugs and sex trade. There is an increase in all three along transport routes, a geographic overlap between roads, drugs and sex (CL).

Future approaches

The question raised was what can be done to reduce drug use and the harms it causes bearing in mind that development cannot be halted and change is going to occur regardless of policies. Discussion focused on the need for more widespread knowledge of the impacts of development and of drug reduction and drug eradication policies and an awareness of the need for policies to reduce their negative impacts, most particularly the spread of HIV/AIDS. The discussion called for better informed media coverage, the decriminalisation of drug users and greater national and international integration of law enforcement, prevention, harm reduction and effective treatment.

It was agreed that the economic rationale dictates policy and that this was true of governments, international development organisations and international crime syndicates.

It is not viable to consider stopping economic development, but to push for socio-political development and improvements in education, health care and more equitable livelihoods at the same times as economic development (FM).

But we certainly should try and ensure there are social and economic impact studies which include the impact of illicit drugs, for all large economic projects (GV).

We need to understand drug use — it's an important element to successful reduction programmes. Currently, there is very limited understanding of why people use drugs, the difficulties they have in giving up, and why drug use needs to be decriminalised. Advocacy is needed within governments, police forces and communities to change perceptions of drug users and to provide better understanding of drug treatment and harm minimisation (AW).

Research is needed to understand the effect of drug policies with indicators that describe the effect of the policy on people not just the number of hectares of poppies destroyed and the number of arrests. Greater focus needs to be given to understanding and implementing evidence based policies. Much greater understanding is needed of why people take drugs if prevention is to be successful and greater focus given to social indicators. And drug policies need indicators that describe effect of drug

policy, don't monitor only amount of poppy fields destroyed, number of arrests. Need impact of drug supply and demand on people. That requires basic research and strong thinking about what key indicators need to be developed (DB).

There is limited understanding that harm reduction is about protecting human life and ensuring basic human rights. The focus of drug reduction programmes must be on reducing and repairing damage to individuals and communities not punishing drug users. Harm reduction must also focus strongly on incorporating drugs users back into the community. This needs to begin when the person is still using drugs and advocacy used to encourage community understanding and support (JE).

One point Sandro made, look around the world at drug prevention or treatment programmes and we can see only a few that are good and the multilaterals don't put money into these. Yet that is one of the key aspects of what we are talking about, the issue has been sidelined. Drug demand reduction is a key part of development, and must be key part of this, and maybe AusAID needs to push the multilaterals in this direction (DB).

Road travel behaviour of the poor compared with the well-off: An example from Indonesia

Philip Hughes, Resource Management in Asia-Pacific Programme, Australian National University

Introduction

It is almost axiomatic that in rural areas in the tropics and sub-tropics the poor travel very much less than the well-off and, when they do so, they always use public transport because they are too poor to own even motorbikes, let alone cars or trucks. These poorest people make most trips on foot and, as a consequence, suffer from inadequate access to markets and to basic social services. A fundamental reason for this, suggested by the Asian Development Bank (ADB) (2002:20), is that the poor and very poor lack capital; they have little to sell and little money to buy anything but essential items. They also lack time as their days are taken up with subsistence activities and labouring, and they have little time or other resources to try to diversify their livelihoods.

In contrast, the well-off travel much more frequently by motorised transport, both public and privately owned. As a consequence they are much better placed to take advantage of local and regional road networks to access a wide range of business, employment and service opportunities which are simply not available to the poor (ADB 2002).

According to van de Walle (1998:1) there is a general consensus on the importance of roads in alleviating rural poverty, but surprisingly little hard evidence on the size and nature of such benefits. Gannon and Liu (1997:32) noted that specific data on the transport behaviour of the poor were very limited because of a lack of detailed household travel surveys. Gathering data on the travel patterns of villagers (both poor and well-off) is an essential step in assessing the poverty alleviation benefits which might arise from investments in road infrastructure, including road rehabilitation.

This case study presents data from one broad ranging, in-depth study which can be used to test the specific hypothesis that the well-off travel more than the poor, and that in doing so they use both public and private modes of transport whereas the poor use only public transport.

Indonesian case study

In the course of the baseline phase of a programme which monitored the socio-economic benefits of the ongoing Road Rehabilitation (Sector) Project in Indonesia¹ detailed household travel surveys were carried out in 300 households in ten provinces.² The roads are all national and provincial highways and roads, rather than local rural roads. It is planned that surveys will be repeated after road construction works have been completed in 2006, and the results of the two surveys will be compared to answer the following broad question: *Will the road rehabilitation works improve the socio-economic conditions of people living along it, and if so can we measure that improvement quantitatively as well as qualitatively?*

The household travel survey questionnaire had three components:

- household details and house construction and services, which could be used to produce a household profile;
- travel patterns and transportation, which included questions about how often people travel, where to, why, by what means, how long it takes and what it costs; and
- roadside economic activity.

The standard of living of each household was semi-quantitatively assessed on a scale of 1 (very poor) to 5 (very well-off) using the criteria set out in Figure 1. This was done to assist in characterising the sample of households in each village, and specifically to allow comparisons to be made between standard of living and a range of travel data derived from the survey data, especially total number of trips to all destinations. Information on individual household travel patterns therefore was not included as a criterion in assessing household standard of living.

Findings

The frequencies of travel compared with standard of living for all 300 households interviewed are shown in Figure 2.¹ In total, these 300 households make on average 4,565 trips per month, almost all by motorised vehicles, with a small number by bicycle. This graph shows the frequency of travel by households in the samples is very strongly influenced by standard of living, there being a more than 80-fold difference between the very poor (one trip per household per month) and the very well-off (86 trips per household per month). These results provide strong support for Gannon and Liu's (1997:32) observation that typically the poorest people use almost no motorised transport.

There was also a very clear correlation between the standard of living of households and the extent to which they use public versus private transport (Figure 3). As standard of living increases there is a progressive decline in the proportion of travel by public modes of transport and a corresponding rise in private modes of travel. At one extreme the very poor households (who cannot afford to own private vehicles) use only public transport and, at

Figure 1: Rating household 'standard of living'

Context

This standard of living rating takes into account both 'wealth' (that is, income, expenditure and material assets), and 'quality of life' indicators such as education level attained by members of household, or the standard of education being afforded to children in the household. Each household was placed into one of five categories as follows:

- 1 = very low standard of living (or very poor)
- 2 = low standard of living (or poor)
- 3 = intermediate standard of living
- 4 = good standard of living (or well off)
- 5 = very good standard of living (or very well off)

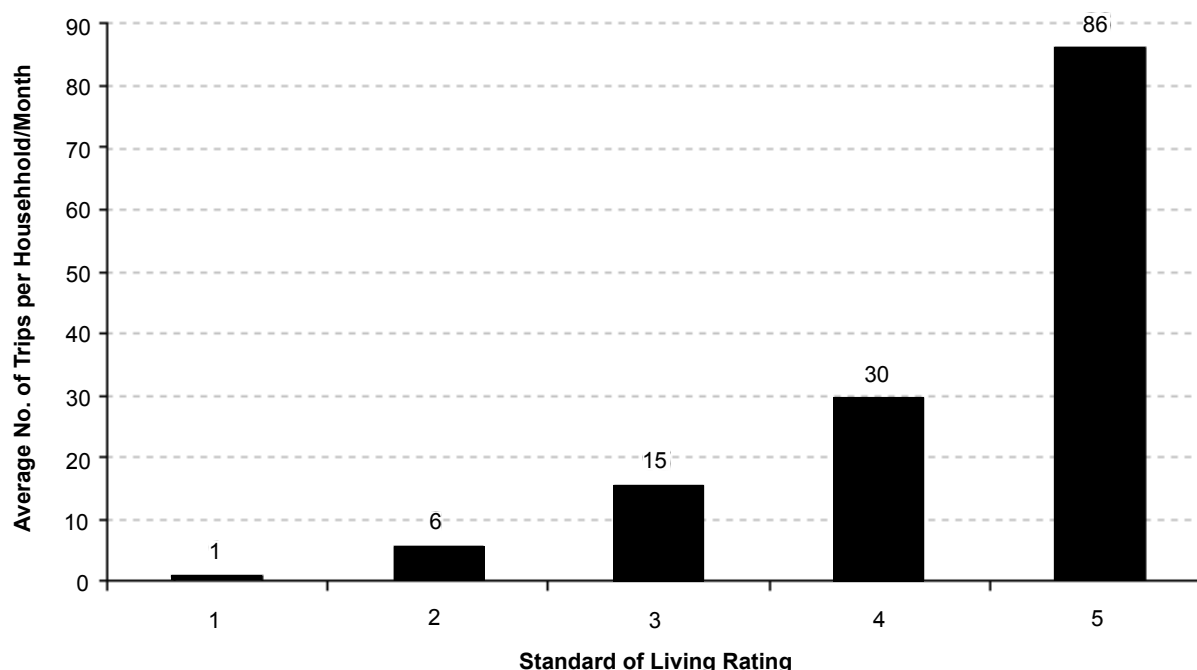
Income and expenditure surveys would theoretically provide the most direct data for determining the status of households, but these were not measured during the survey. However, the following range of 'standard of living' indicators were used to assess each household.

'Standard of living' indicators

1. Standard of housing and furnishings (Range 1-5);
2. Whether or not the household has electricity (1 if none, 5 if connected);
3. Profession, employment status/business activities (Range 1-5);
4. Level of education attained by head of household and spouse (Range 1-5);
5. Education being afforded to their children, eg. senior high school or tertiary;
6. Education, daily travel to another centre for schooling, or boarding school (Range 1-5);
7. Private vehicle ownership (if yes, normally indicates overall rating of at least 3 for motorbike, and 4-5 for car, truck and bus, especially if more than one vehicle per household); and
8. Ownership of satellite TV dish and/or of hand phone (where reception for hand phones occurs) (if yes, normally indicates overall rating of at least 3-4)

The assessment was undertaken by team members who took part in the particular survey, with input from one or more other team members who did not participate. Other information such as photographs of the household/house and comments in the notes section of the survey database were also used in assigning the 'standard of living' ratings.

Figure 2: Frequency of travel compared with standard of living for all 300 households interviewed



the other, the very well-off households use almost entirely private transport (92 per cent).

The main purposes people gave for travelling were as follows:

- travel for paid work, mainly as public servants, but also in the agricultural and plantation sectors, 27.2 per cent;
- access to services (mainly education, but also health and occasionally banking), 24.8 per cent;
- to buy goods for re-sale in household businesses, 12.5 per cent;
- visiting relatives and friends, 10.4 per cent;
- to sell agricultural and other primary produce (and occasionally manufactured food products), 9.4 per cent;
- household shopping, 8.5 per cent; and
- other reasons, 7.7 per cent.

Most of the travel, regardless of standard of living, was to nearby villages and towns, including local sub-district centres, where government offices were based, where goods could be bought and sold and where educational and other services were concentrated. Trips to these nearby destinations (generally not more than 20 kilometres away) accounted for about three-quarters of all trips. About 22 per cent of the trips were to the nearest regency or provincial capital cities, on average 45 kilometres away. For seven out of the ten provinces this was the modal destination. Overwhelmingly these trips were made by the better-off households, mainly for work, educational

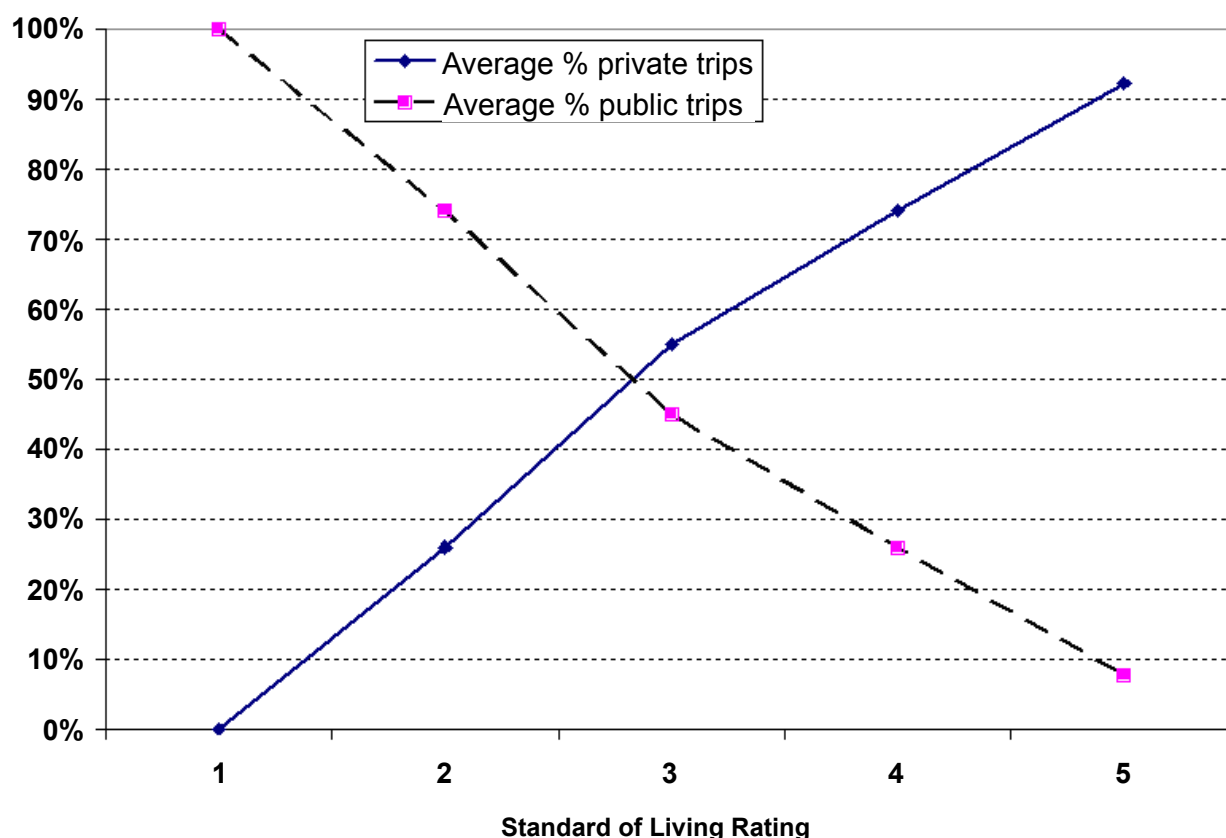
and business purposes. Hence the better-off not only travel more frequently than those in the poorer households, they also make proportionally more long-distance trips, especially to larger cities.

Conclusions

These examples illustrate the value in using detailed household travel surveys to provide specific data on the transport behaviour of rural villagers, both poor and well-off. These kinds of data can be extremely useful in predicting and measuring the socio-economic benefits arising from road improvement works.

In the villages in this Indonesian case study the amount of road travel undertaken by the poor and very poor is low to extremely low. Although road travel and transportation should improve markedly as a result of this road rehabilitation project, all of the villages are currently served by roads which, although in poor condition, are with few exceptions passable in all but extreme weather conditions. The relatively high frequencies of travel of the well-off (30 trips per month) and very well-off households (86 trips per month) indicate that the generally poor road conditions are not in fact a severe impediment to travel. If so, the low to extremely low amounts of road travel by the poor and very poor are not primarily a function of the poor road conditions (a conclusion supported by other aspects of the socio-economic study), but rather reflect the constrained circumstances in which these households find themselves, as outlined in the introduction.

Figure 3: Proportions of use of public and private modes of transport compared with standard of living



Given this, it is expected that after the roads have been improved the frequency of travel of this sample of 300 households as a whole will increase, but that most of this increase will be by the better-off households. The household travel survey methodology used in this Indonesian case study will allow this and other before and after rehabilitation expectations to be assessed and measured quantitatively.

Note

- 1 The author is the Senior Poverty/Environment Specialist, Core team Consultants, Road Rehabilitation (Sector) Project which is funded by ADB Loan No.1798-INO and is being undertaken by the Ministry of Public Works. He is responsible for the project's on-going Socio-Economic Monitoring and Evaluation Programme (SEMEP).

- 2 The data are from 30 households in an individual village (or in one case two neighbouring villages) along a single sub-project road in each of the following provinces: North Sulawesi, East Kalimantan, South Kalimantan, West Kalimantan, South Sumatra, Bengkulu, Lampung, Banten, D.I. Yogyakarta and East Java.
- 3 The numbers of households in each category were: very poor (n=5), poor (n=104), average (n=132), well-off (n=56) and very well-off (n=3).

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Building peace through creating and strengthening friendships between Australia and East Timor

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(P)acebuilding understands that relationships create and emanate social energy and are places to which energy returns for a sense of purpose and direction (Lederach 2005:75).

Introduction

This paper explores and evaluates the principles, dynamics, and activities of the friendship agreements. Friendship agreements represent a new phase in Australian-East Timorese relationships and offer new possibilities in the way we interact with neighbours. This paper forms part of a larger project, funded by the Australian Research Council, exploring processes of peacebuilding and reconstruction in Timor-Leste. It is divided into four sections: in the first the beginnings of and the meaning attached to the friendship agreements are explored. Then the successes and challenges faced by current friendship groups are evaluated from a peacebuilding perspective. Finally, there is a list of recommendations, some of which are from seasoned groups wanting to pass on lessons learned to new groups, and some of which represent key findings from this research.

How is friendship interpreted?

Friendship agreements are a product of the troubled history shared by Timor-Leste and Australia. They have their roots in World War II when Timorese villagers assisted Australian soldiers as they battled the Japanese army. More than 40,000 Timorese were killed by the Japanese in reprisal for their spontaneous support for the Australians. After the withdrawal of Australian troops, the then Australian Government dropped hundreds of leaflets by air over the villages in Timor-Leste that read: 'Your friends will never forget you.'

Some 55 years later, when the people of Timor-Leste were voting in the national popular consultation, the Victorian Local Government Association in partnership with the Australian Council for Overseas Aid facilitated the attendance of 40 Australians as international observers to the ballot. In the horrific aftermath, many Australians including a variety of community groups and local government associations offered practical humanitarian and material support to Timor-Leste.

In late 1999, the Timorese CNRT representative to Southern Australia, Abel Guterres, was approached by Darebin, Moreland and Port Phillip City Councils to establish friendship agreements with towns in Timor-Leste. Members of these councils had

witnessed the ballot and the aftermath and wanted to formalise their support for the new nation. These relationships were viewed by those initially involved as different to the sister city relationships that many local governments are involved with, in that their guiding principles were to be the promotion of peaceful coexistence and giving support. These friendship agreements sparked enthusiasm among other local government associations, community groups and faith based organisations and today there are 37 in existence.

Friendship agreements are striking in their lack of homogeneity. Although a statement of principles and set of guidelines exist, the communities involved in promoting the agreements have adapted the concept of friendship to equate with their requisite set of skills and available resource base. For example, those groups with volunteers that have skills in development work take a community development oriented approach; those with volunteers with experience in local government issues are developing agreements based around transferring local governance skills; and those groups with volunteers whose perspective is charity or faith based have concentrated on providing material goods and assistance.

The meaning the groups place on the term friendship differs from group to group and is informed by their perspective on what it is they are trying to achieve. Although all recognise that friendship is necessarily a two-way process, those groups that concentrated on material assistance are extremely unclear about what they as Australians could learn from the East Timorese. They viewed their friendship as an act of giving material assistance to people who had less access to resources or skills. The act of giving constituted friendship. They expected little back as they measured the relationship in terms of what they could give. They placed emphasis on the logistics of getting material assistance to Timor-Leste, concentrated less on the more intangible relationship building side and were often frustrated by the lack of progress in the development of their agreement.

Those groups that had firmly established relationships were quite clear about what friendship meant. Being friends meant building a relationship based on respect, mutuality, exchange and compassion. The relationship was seen as very complex with no set rules and groups recognised that their particular

friendship would be influenced by the activities that were pursued. Friendship was interpreted as a network of links between Australian individuals and their community, and the East Timorese individuals and their community. The aim of the agreement was to widen and deepen those networks. Several groups emphasised that these agreements fundamentally differed from sister city agreements in that there was no obligation of mutuality. They were also very definite about what Australian participants were receiving in return: lessons on humility, forgiveness and sacrifice. Many spoke of witnessing the benefits of collectivism over individualism, something Australia had lost. All recognised the difficulties of building cross-cultural relationships within a context where access to reliable means of communication is limited, and saw it as a slow process of building trust and confidence.

What constitutes success?

Successful agreements were characterised by the number and scope of activities achieved or the strength of the relationships built within Australia as well as between Australians and East Timorese. Agreements were seen as means of community building in Australia — getting people who would not normally mix working towards a common goal. It also brought people into closer contact with their local government association and made them aware of what their local council could offer in terms of resources, skills and networking capacity.

Those groups with the financial resources to employ an Australian based project officer and/or a Timor-Leste based Australian volunteer were much further developed in terms of activities, relationships and strategic vision. Having a paid employee to devise, manage and progress the agreement resulted in more concrete results as well as more solid connections. Those agreements with project officers had committees set up in both Australia and Timor-Leste and were actively working on their chosen activities and developing plans for continuing activities. Groups that relied solely on the goodwill of volunteers were limited in how much they could achieve. They depended on the volunteers having the time and energy to plan and promote activities and grow the friendship. Groups that had the funds to place an Australian volunteer in Timor-Leste had a solidity and continuity of connection that allowed meaningful and sustainable relationship building to occur. They worked and lived in the community, were present at meetings of the East Timorese committee and were able to oversee and encourage the development of activities.

The *Baucau Buka Hatene* Centre is a clear example of what can be achieved with the assistance and encouragement of a Timor-Leste placed volunteer (see French paper, this issue). Similarly, the Youth Centre in Suai represents a vibrant resource tailored directly to community needs and community capacity to provide those needs. The centre provides Suai youth with

leadership training, English and Portuguese language classes, computer software and hardware, and HIV/AIDS prevention awareness. Furthermore, under the auspices of the centre a district youth council was established which has become the umbrella for all the district's youth organisations.

Other key successes relate to the provision of essential infrastructure and services such as the:

- provision of water reticulation in Manatuto;
- medical equipment in Aileu;
- electric generators for the hospital in Liquiça; and
- playground and kindergarten equipment in Same and Los Palos.

Challenges

The main challenges identified by the groups are listed below with some reference to similar findings in the international literature pertaining to municipal linking across cultures.

1. Reliable and consistent access to means of communication.
2. Unequal partnerships where the East Timorese are viewed as passive recipients of Australian largesse.
3. Essential nature of bipartisan political support. International literature confirms that bipartisan support and formalising links are essential if municipal links are to succeed (see, for example, Cremer et al. 2001; Hewitt 1999a, 1999b, 2000).
4. Lack of finances from either partner. Groups not financially supported by their local government authorities depend on fundraising activities, therefore volunteer time and energy is spent raising the resources to be able to function rather than actually planning and implementing programmes and activities.
5. Meaningful evaluation procedures to ensure the activities and principles of the agreements continue to remain relevant. Evaluation needs to be based on questions such as: What were the short- and long-term impacts of a link? Who benefited? Who lost? Was there genuine joint planning and consultation? Was there genuine human growth on both sides? Does the link equip both communities to be more responsible participants in world affairs?
6. Ensuring sustainability, in terms of both project and personnel. Changes to key personnel in the district administration or local government can lead to a hiatus in the relationship. Of equal importance is ensuring the sustainability of the volunteers of friendship committees and groups. Groups may have to spend time devising strategies

to ensure that there is a continuation of volunteers; they may also consider giving long-term volunteers breathing space while encouraging them not to give up the group completely. Deepening the networks between the various groups is one definite way in which groups can enhance their prospects for sustainability.

Key recommendations

Those interviewed for this study were very aware of the lessons they had learned. Of primary importance to all groups with local government connections was the necessity of devising and implementing activities and plans in partnership with the district or sub-district administration to ensure that friendship efforts do not block, interfere with or duplicate Timor-Leste's National Development Plan. A visit to the linked area and community soon after the agreement is first formed was also deemed essential.

It was also suggested that agreements would be more successful if the groups form durable partnerships with others working in the same district or elsewhere in Timor-Leste. Some groups gave examples of how they had networked with Australian Volunteers International, members of the Catholic Church, Rotary, linked school programmes and other friendship groups.

All emphasised the necessity of starting small by focusing on something achievable. This would involve not only assessing and prioritising the needs of the East Timorese counterparts, but more importantly, recognising the limits of a group's capacity in terms of skills base, energy levels and practical support potential. It is vital to be able to deliver on what you promise.

The goals and objectives of the agreement need to be clearly articulated. This will involve being clear on what is meant by friendship and working towards strengthening the relationship side of the agreement as well as providing skills transfer and services. One key informant emphasised the importance of recognising the skills and capacity that had allowed the East Timorese to endure years of oppression and build a strong resistance movement that directed the transition to independence. Agreements that situate their efforts at strengthening that capacity, working with what already exists rather than assuming that the East Timorese have little and need training and their skills base improved, will have a greater chance of success.

Having a strategic plan with clear goals and objectives and the personnel and resources allocated to meet these will ensure that both parties to the agreement know what is expected. This will involve being aware of a group's volunteer skills base and recognising that people may be brimful of enthusiasm yet not have the capacities to deliver on projected plans and outcomes.

Ensuring regular and open channels of communication will allow for more open consultation around needs and priorities. Given the current difficulties with communication in Timor-

Leste, it is hoped that the new friendship liaison officer can act as a conduit for the groups.

Groups also learned the necessity of being sensitive to the environment in which the agreement is operating. This involved respecting East Timorese needs while being aware of the implications of material aid. To what extent are the goods being sent dependent upon continuous supplies of electricity and regular maintenance? It is vital that the assistance given is both useful and able to be utilised by the recipient community. Perhaps the most appropriate question to ask is what is the most appropriate and practical assistance a group can deliver that will produce tangible outcomes?

Finally, many emphasised the primary importance of investing time and energy in building durable relationships, recognising that these relationships may become fractured due to changes in personnel and thus will need constant nurturing if agreements are going to succeed. Building a strong and durable friendship will require a long-term commitment from both parties. Relationships such as these are about building trust and confidence and this is necessarily a slow process.

Conclusion

Friendship agreements can and do contribute significantly to building and strengthening Australian-Timorese relationships. They represent a new dynamism in community-to-community linking, one that is focused on building relationships, and in doing so, go some way to meeting the needs of conflict-affected communities. If these relationships are durable and continue to grow, then it is possible that we will witness real community commitment to fostering healthy international relations built on notions of mutuality and respect rather than fear and deterrence.

In order to achieve this end it will be necessary to guard against the paternalism and lack of coherence that has typified many attempts to interact across cultures. Prioritising needs, clearly articulating intentions and capacity and the limits thereof, and recognising that relationship building is a complex long-term process are key factors to achieving durable vibrant friendships.

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Organisations and web resources

Asian Harm Reduction Network (AHRN)

<http://www.ahrn.net/>

A global information and support network created to link and support people and programmes working throughout Asia to stop HIV among injecting drug users. AHRN is involved in five key areas: networking; information sharing; advocacy and support for harm reduction enabling policies; programme and policy development; and training, including strategic partnerships with international organisations and representation at key events, a resource centre, a newsletter and special reports. In support of these five key areas, AHRN also conducts research, including mapping of programmes and policies and a multi-site research on the environmental factors that shape the drug careers of young people as well as access to treatment among HIV positive injecting drug users.

Asia and Pacific Amphetamine-Type Stimulants Information Centre (APAIC)

<http://www.apaic.org/>

An off-shoot of the United Nations Office on Drugs and Crime (UNODC) Regional Centre for East Asia and the Pacific, this site focuses on disseminating information on Amphetamine-Type Stimulants (ATS). Results of a 2004 UNODC survey on regional ATS patterns and trends is one of the reports available for download. Also found here are maps on regional and national ATS trends, as well as details of related UNODC projects, ATS information, a searchable electronic library of related UN and WHO documents and an international links page.

Asia Regional HIV/AIDS Project (ARHP)

<http://www.arhp.org.vn/>

The AusAID-funded ARHP aims to progress the adoption of harm reduction approaches to HIV transmission in the Asia Region and to strengthen the capacity of governments and communities to address HIV-related harm associated with injecting drug use. To support this effort, the Project, working with partner governments in China, Myanmar and Viet Nam, has developed a range of harm reduction training materials for police, health workers and local communities.

These materials include five harm reduction training videos for local communities, police, drug users, health and outreach workers; a booklet explaining the principles of harm reduction for government officials; and a training manual for implementing Rapid Assessment and Response (RAR) programs. These materials are all available in Chinese, Myanmar and Vietnamese. Projects and regional organisations interested in using these materials can download them from the Project website, given above, or request hard copies by email: arhp@fpt.vn.

Australian National Council on Drugs (ANCD)

<http://www.ancd.org.au/index.htm>

The ANCD was established as part of the Federal government's response to reduce the harm caused by drugs in the Australian community. An important component of the ANCD's work is to ensure that policies, strategies and directions in the drug and alcohol field are consistent with the National Drug Strategic Framework.

The site carries downloads of a range of ANCD publications, including research papers and position papers. It has a dedicated page to the Asia-Pacific region, with some information on its regional drugs issues committee. An extensive page of links to agencies in Australia and the region.

The Burnet Institute

<http://www.burnet.edu.au/home>

The Burnet Institute is Australia's largest communicable diseases research institute, investigating viral infections including HIV/AIDS and hepatitis. The Institute integrates basic and applied laboratory research in virology and other communicable diseases with field research and the design, implementation and evaluation of public health programs.

It also assists socially marginalised groups by tackling tough problems: HIV/AIDS, sexually transmitted infections, hepatitis, and illicit drug use. The Burnet Institute is the only medical research institute to be accredited for funding by AusAID, and in 1998, was accorded Collaborating Centre status by the United Nations Program on AIDS (UNAIDS), one of 12 such centres in the world.

The Burnet Institute also provides training in research and in public health at the undergraduate and postgraduate level through its associations with the University of Melbourne, Monash University, RMIT University, LaTrobe University and University Udayana in Indonesia.

The Centre for Drug Research (CEDRO)

<http://www.cedro-uva.org/>

The Centre for Drug Research, based in the Netherlands, ceased to exist as an independent drug research institution in January 2004, however most of the CEDRO research work is published on the Centre's website. The CEDRO website also has many publications on social issues connected to drug use, on drug policy, and on the politics of knowledge construction about drugs and its history. These articles are authored by former CEDRO staff and guest researchers.

The Centre for Harm Reduction

<http://www.chr.asn.au/home>

The Centre for Harm Reduction at the Burnet Institute brings together people

working throughout Asia, and globally, with expertise in the prevention of drug related harm: in particular the prevention of transmission of HIV/AIDS and Hepatitis C among and from injecting drug users. The Centre's aims and objectives are:

- To implement harm reduction and related programs;
- To build capacity and deliver training in harm reduction practice for a variety of audiences;
- To develop strategic alliances and partnerships for the promotion and implementation of harm reduction activities;
- To promote and support advocacy for harm reduction; and
- To conduct comprehensive research into harm reduction issues and to widely disseminate findings.

The Centre's easy-to-read website includes overviews of projects and resources including fact sheets, an electronic library and a links page.

DRCNet Online Library of Drug Policy

<http://www.druglibrary.org/>

The information arm of the US-based Drug Reform Coordination Network, a network of parents, educators, students, lawyers, health care professionals, academics, and others working for drug policy reform from a variety of perspectives, including harm reduction, reform of sentencing and forfeiture laws, medicalisation of currently schedule I drugs, and promotion of an open debate on drug prohibition. The Drug Reform Coordination Network's founding purpose is to stop the violence surrounding the illegal drug trade, end the bondage of mass incarceration suffered by non-violent offenders, stem the spread of deadly epidemic disease, secure the right of patients to appropriate medical treatment, restore US Constitutional protections and ensure just treatment under the law for

all. Network founders believe current policies of punitive prohibition place illegal drugs and drug markets outside of the law, therefore beyond society's control and ability to mitigate harm.

The electronic library contains searchable archives on drug policy reform issues, links to global drug policy sites, as well as weekly online reports on reform efforts.

International Harm Reduction Association (IHRA)

<http://www.ihra.net/>

This is the leading global organisation promoting the reduction of drug and alcohol-related harm on a global basis. From its foundation in the mid-1990s the Association has focused on supporting the development of harm reduction, exchanging knowledge about harm reduction, and providing a supportive environment for harm reduction workers. IHRA has in more recent times increasingly focused on getting harm reduction on the international agenda. The web site hosts a broad range of discussion papers, conference details, awards and research, e-newsletters, news and documents as well as an extensive links page. Some publications have also been translated into Portuguese and Spanish.

Turning Point Alcohol and Drug Centre

<http://www.turningpoint.org.au/>

Turning Point is a multidisciplinary alcohol and drug research and treatment institute that strives to promote and maximise the health and wellbeing of individuals and communities living with and affected by alcohol and other drug-related harms. Its aim is to ensure the safest possible environment in relation to alcohol and other drugs today and into the future, for local, regional and global communities. Turning Point's web site publishes the results of the Centre's research for a wide range of purposes including guidelines for professional practice, education and training, and the development of client resources.

United Nations Office on Drugs and Crime (UNODC)

<http://www.unodc.org/unodc/index.html>

UNODC was established in 1997 as the UN's central pillar in the fight against illicit drugs and international crime. Its headquarters are in Vienna and it has 21 field offices as well as a liaison office in New York. UNODC is mandated to assist Member States in their struggle against illicit drugs, crime and terrorism.

The three pillars of the UNODC work program are:

- Research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence base for policy and operational decisions;

- Normative work to assist States in the ratification and implementation of the international treaties, the development of domestic legislation on drugs, crime and terrorism, and the provision of secretariat and substantive services to the treaty-based and governing bodies; and
- Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism.

UNODC's main web site includes links to its field offices, as well as a wealth of reference material on anti-illicit drug initiatives.

UNODC Regional Centre for East Asia and the Pacific Drugs and HIV/AIDS in South East Asia

<http://www.unodc.un.or.th/drugsandhiv/default.htm>

This is the UNODC South East Asia regional centre's dedicated HIV/AIDS page, and contains a wealth of key reference information. In the publications section, for instance, are key UN papers mapping the HIV/AIDS and illicit drug taking epidemics in Southeast Asia, as well as outlines of UN responses to these issues. There are also links here to the English language sites of partner national drugs control bodies in Myanmar and Thailand.

Breaking the link between injecting drug use and HIV vulnerability in Asia and the Pacific

UNODC, UNESCAP, UNAIDS SEAPICT, WHO SEARO, 2004. Available from <<http://www.unodc.un.or.th/publications/BreakLink.pdf>>.

This brochure delivers a snap shot of the key role injecting drug users have played in the transmission of HIV/AIDS to low risk populations in China, Indonesia, Malaysia and Viet Nam. It also outlines UN systems principles and strategic approaches to preventing the transmission of HIV among drug users.

Drugs and HIV/AIDS in South East Asia

Sonia Bezziccheri and Wayne Bazant for the UNODC, February 2004. Available from <http://www.unodc.un.or.th/drugsandhiv/publications/HIV_AIDS.PDF>

This report documents the regional situation in regards to drugs and HIV/AIDS as well as service response provision in Cambodia, China, Laos, Myanmar, Thailand and Viet Nam, focusing on the period between 2002 and 2004. It also provides a compilation of project/programmes on harm reduction in these countries. The research is organised by country, comprising an overview of the HIV/AIDS and injecting drug user situation, followed by a focus on critical geographical areas and international/national programmes and services that reduce harm from drug use.

Drug Injection and HIV/AIDS in Asia

Monitoring the AIDS Pandemic 2005, <http://www.mapnetwork.org/docs/MAP_IDU%20Book%2024Jun05_en.pdf>.

One of a series of three programming-themed booklets based on AIDS in Asia: Face the Facts, aimed at providing insight into how to respond to the behaviours driving the spread of HIV in Asia's most at-risk populations. (The other two are MAP Report 2005: Male-Male Sex and HIV/AIDS in Asia). This booklet summarises what researchers have learned about the epidemiology of HIV/AIDS within Asian Injecting Drug User networks and discusses the programmatic implications of those findings.

Global overview of injecting drug use and HIV infection among injecting drug users

Aceijas, C, GV Stimson, M Hickman and T Rhodes, 2004, Centre for Research on Drugs and Health Behaviour on behalf of the United Nations Reference Group on HIV/AIDS Prevention and Care among IDUs in Developing and Transitional Countries, London.

This paper provides global estimates of the prevalence of injecting drug use (IDU) and HIV prevalence among IDU with a special focus on developing and transitional countries. It concentrates on the period between 1998-2003, using existing estimates of IDU and HIV prevalence from published and unpublished documents.

Mitigating the effects of illicit drugs on development: Potential roles for the World Bank

Peter Reuter, Justin L. Adams, Susan S. Everingham, Robert Klitgaard, J.T. Quinlivan, K. Jack Riley with Kamil Akramov, Scott Hiromoto and Sergej Mahnovski, February 2004. RAND Corporation. Available from <<http://www.gtz.de/de/dokument/en-wb-effects-drug-dev-afg.pdf>>

This report provides descriptions of the ways in which illicit drug industries impact development, and aims to inform World Bank approaches to the issue. It provides a general overview of the trade in heroin and cocaine in particular, and the socio-economic impacts of illicit drug use and its industry on developing countries. It examines a variety of drug control approaches, and evaluates their effectiveness, as well as implementation issues. In doing so it sets out to provide a framework for the Bank to determine how it might engage in this development arena.

The pro-heroin effects of anti-opium laws in Asia

Westermeyer, J 1976, Archives of General Psychiatry, 33(9), 1135-1139

Over 25 years anti-opium laws were enacted by three Asian governments in countries where opium use was traditional. Within months, heroin use suddenly appeared; and within a decade, heroin addiction surpassed opium addiction. The laws led to: increased price of narcotic drugs; a heroin 'industry'; corruption of the law enforcement system; and major

health problems. The Asian experience indicates that anti-narcotic laws can be effective only with careful preparations: changing society's attitude toward the traditional drug from ambivalence to opposition; mobilising resources to treat and rehabilitate all addicts within a short period of time; developing the social will to incarcerate all 'recidivist' addicts for a prolonged period; and preventing narcotic production or importation.

Situational analysis of drug issues and responses in the Asia-Pacific Region

Centre for Harm Reduction, Burnet Institute, and Turning Point Alcohol and Drug Centre, February 2006. Available from <<http://www.ancd.org.au/publications/index.htm#>>.

Drug issues and responses in seventeen countries in the region are under the spotlight in this report commissioned by the Australian National Council on Drugs Asia Pacific Drugs Issues Committee. Six core areas of investigation in the research countries are: government responses to drug issues; non government responses to

drug issues; policy process to drug issues; international involvement in drug issues in the Asia Pacific region; Australia's involvement in drug issues in the region; and contextual information including social and cultural factors influencing drug use.

World Drug Report 2005

United Nations Office on Drugs and Crime (UNODC), Vienna, www.unodc.org/unodc/world_drug_report.html

The World Drug Report 2005 provides a comprehensive overview of illicit drug trends at the international level. In addition, it presents the work of UNODC in two areas of research: an estimate of the financial value of the world drug market, and the preliminary steps towards the creation of an illicit drug index. The analysis of trends, some going back ten years or more, is presented in Volume 1. Detailed statistics are presented in Volume 2. Taken together these volumes provide the most up to date view of today's illicit drug situation.

Journals

Behaviour: An Interdisciplinary Journal

Editor-in-chief: Craig J. Forsyth, Department of Sociology and Anthropology, University of Louisiana, US. Print ISSN: 0163-9625, Online ISSN: 1521-0456; 6 issues a year; Institutional rate US\$521, Individual rate US\$203; Published by Routledge, part of the Taylor & Francis Group, Level 2, 11 Queens Rd, Melbourne, Victoria 3004, Australia Tel: +61 (0)3 9866 2811, Fax: +61 (0)3 9866 8822; E: enquiries@tandf.com.au, Web: www.tandf.co.uk.

Deviant Behavior specifically addresses social deviance. International and interdisciplinary in scope, it publishes refereed theoretical, descriptive, methodological, and applied papers. Aspects of deviant behaviour discussed include crime, juvenile delinquency, alcohol abuse and narcotic addiction, sexual deviance, societal reaction to handicap and disfigurement, mental illness, and socially inappropriate behaviour.

Drug and Alcohol Dependence

Editors include: Robert L. Balster, James C. Anthony, Michigan State University, Steffanie A. Strathdee, University of California School of Medicine, Kathryn A. Cunningham, University of Texas Medical Branch, Chris-Ellyn Johanson, Wayne State University School of Medicine, Eric C. Strain, Johns Hopkins University School of Medicine. Print ISSN: 0376-8716; Institutional rate US\$1,972, Individual rate US\$239; Published by Elsevier; subscription enquires in Australia Pacific region to: customer service department, 30-52 Smidmore St, Marrickville NSW 2204, Australia, Tel: +61 2 95178999; Fax: +61 2 95172249; E: service@elsevier.com.au; Web: www.elsevier.com.au

Drug and Alcohol Dependence is an international journal devoted to publishing original research, scholarly reviews,

commentaries, and policy analyses in the area of drug, alcohol and tobacco use and dependence. Articles range from studies of the chemistry of substances of abuse, their actions at molecular and cellular sites, *in vitro* and *in vivo* investigations of their biochemical, pharmacological and behavioural actions, laboratory-based and clinical research in humans, substance abuse treatment and prevention research, and studies employing methods from epidemiology, sociology, and economics. The rationale for this coverage is the belief that drug, alcohol and tobacco use/dependence cannot be understood from a single perspective and that without an understanding of other areas of research, studies by individual investigators may be limited.

Drugs and Alcohol Review

Editors: John B. Saunders, Centre for Drug and Alcohol Studies, School of Medicine, University of Queensland, Australia; Simon Lenton, National Drug Research Institute, Curtin University of Technology, Perth, Australia; Robert Ali, Drug and Alcohol Services Council of South Australia, Parkside, Australia. Print ISSN: 0959-5236, Online ISSN: 1465-3362; 6 issues a year; Institutional rate AUD1800, Institutional online AUD1710, Personal AUD547. Published by Taylor & Francis, Level 2, 11 Queens Rd, Melbourne, Victoria 3004, Australia Tel: +61 (0)3 9866 2811, Fax: +61 (0)3 9866 8822; E: enquiries@tandf.com.au, Web: www.tandf.co.uk

The Drug and Alcohol Review is the journal of The Australian Professional Society on Alcohol and Drugs. The journal is an international forum for the views, expertise and experience of those involved in the study of treatment of alcohol, tobacco and drug problems. The journal targets an audience comprised of clinicians, drug and alcohol agency staff, researchers, policy makers, and alcohol service administrators.

Harm Reduction Journal

Editors: Ernest Drucker, Montefiore Medical Center/Albert Einstein College of Medicine; Nick Crofts, Centre for Harm Reduction, Melbourne; Fabio Mesquita, Indonesia HIV/AIDS Prevention and Care Project. For subscription details contact the publisher BioMed Central Ltd, Middlesex House, 34-42 Cleveland Street, London W1T 4LB, UK, Tel: +44 (0)20 7323 0323, Fax: +44 (0)20 7631 9923; Web: www.biomedcentral.com

A peer-reviewed, online journal focused on patterns of psychoactive drug use, the public policies meant to control them, and the search for effective methods of reducing the adverse medical, public health, and social consequences associated with both drugs and drugs policies. A special interest in studies of the evolving patterns of drug use around the world, their implications for the spread of HIV/AIDS and other blood-borne pathogens, and in accurate descriptions and rigorous evaluations of innovative policies and practices for harm reduction in diverse societies.

International Journal of Drug Policy

Honorary Editor-in-Chief: Gerry Stimson; Editor Tim Rhodes (UK); Assistant Editors Francisco Bastos (Brazil), David Moore (Australia), Matthew Hickman (UK), Steffanie Strathdee (US), Samiran Panda (India), Evan Wood (Canada). ISSN: 0955-3959. Subscription prices available upon request from the publisher, reached online at <http://www.elsevier.com/locate/drugpo>, or through the regional sales office: Elsevier, Customer Service Department, 3 Killiney Road, #08-01 Winsland House 1, Singapore 239519. Tel: (+65) 6349 02222, Fax (+65) 67331510.

This journal aims to provide a forum for the dissemination of current research, reviews, debate and critical analysis on drug use and drug policy in a global

context. It seeks to publish material on the social, political, legal and health contexts of psychoactive substance use, both licit and illicit. The journal is particularly concerned to explore the effects of drug policy and practice on drug-using behaviour and its health and social consequences.

Journal of Drug Issues

Editors include: Bruce Bullington, Florida State University; Lotte Feinberg, City University of New York. Published quarterly in the winter, spring, summer and fall; online access is available with the print subscription. Institutional rate US\$120 (US\$130 international), individuals US\$95 (US\$105 international). Published by Florida State University, School of Criminology and Criminal Justice, Journal of Drug Issues, PO Box 66696, Tallahassee, FL 32313-6696. Back issues are available for sale. Tel: +1-877-823-0015; E: jdi@garnet.fsu.edu; Web: <http://www2.criminology.fsu.edu/~jdi/default.htm>

The *Journal of Drug Issues* (JDI) was a non-profit entity within the State of Florida from 1971, and in 1996 was transferred to the Florida State University School of Criminology and Criminal Justice. Since its inception, JDI has been dedicated to providing a professional and scholarly forum centred on the national and international problems associated with drugs, especially illicit drugs. It is a refereed publication with international contributors

and subscribers. JDI is an instrument widely used by research scholars, public policy analysts, and those involved in the day-to-day struggle against the problem of drug abuse.

Substance Use & Misuse

Chief Editor: Stanley Einstein, Institute for the Study of Drug Misuse; Print ISSN: 1082-6084, Online ISSN: 1532-2491; 14 issues a year; Institutional rate US\$2866, Individual rate US\$412.00. Published by Taylor & Francis, Level 2, 11 Queens Rd, Melbourne, Victoria 3004, Australia Tel: +61 (0)3 9866 2811, Fax: +61 (0)3 9866 8822; E: enquiries@tandf.com.au, Web: www.tandf.co.uk

Formerly the *International Journal of the Addictions*, *Substance Use & Misuse* provides an international multidisciplinary platform for the exchange of facts, theories, viewpoints, and unresolved issues concerning substance use, misuse (licit and illicit drugs, alcohol, nicotine, and caffeine), 'abuse', and dependency, eating disorders, and gambling. *Substance Use & Misuse* features original, peer-reviewed articles, notes, and book reviews, as well as special issues devoted to single topics. The journal also publishes proceedings and symposia that describe and analyse research; and information on clinical prevention, training, law enforcement, and policy efforts. Topics covered include: measurements, instruments, scales, and tests; failure and drug use intervention;

student substance use; gender and substance use; issues, credos, caveats, and unresolved issues; social pharmacology; classical-historical articles, reviews, and documents; prevention programs; artificial sciences and substance use/misuse intervention; ethnicity and substance abuse; topic-focused bibliographies.

Social Science and Medicine

Editors include: E. Annandale, Department of Sociology, University of Leicester, Leicester, UK; R. Mowat, Department of Sociology, University of Leicester, Leicester, UK. Print ISSN: 02779536; Institutional rate US\$4624, Individual rate US\$363. Published by Elsevier; subscription enquires in Australia Pacific region to: customer service department, 30-52 Smidmore St, Marrickville NSW 2204, Australia, Tel: +61 2 95178999; Fax: +61 2 95172249; E: service@elsevier.com.au; Web: www.elsevier.com.au

Social Science & Medicine provides an international interdisciplinary forum for the dissemination of research findings, reviews and theory in all areas of common interest to social scientists, health practitioners and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines, and material relevant to the social sciences from any of the professions concerned with physical and mental health, and with health care practice, policy and organisation.

Books

Poppies, Pipes and People: Opium and its use in Laos

Westermeyer, J 1982, University of California Press, US.

For three years between 1965 and 1975, Joseph Westermeyer practiced medicine and studied the function of opium in Laos, and spent an additional six months studying opium addiction in other parts of Asia. His work delivers a clear picture of the very different ways opium and its uses are regarded in a developing agricultural society.

The United States and International Drug Control 1909-1997

Bewley-Taylor, David R 1999, Pinter, London, UK.

This book provides a history of the rise of worldwide drug prohibition and emphasises the central role of the US in establishing the key international drug control treaties and institutions.

The Manual for Reducing Drug-Related Harm in Asia, second edition

Costigan, G, N Crofts and G Reid 2003, Centre for Harm Reduction, Melbourne, Australia. <http://www.chr.asn.au/freestylers/gui/files/Manual.pdf>

This manual presents current understandings of the principles and practices underlying successful approaches to harm reduction in Asia. Case studies from programmes in the region illustrate how successful approaches have been achieved.

It provides the background to and rationale of drug use and its associated HIV vulnerability, as well as the links between supply, demand and harm reduction. Useful appendices related to blood-borne viruses, drugs and their actions and sexual transmitted infections, are also included. The first edition is also available for download in Thai and Bahasa Indonesian.

The Politics of Heroin: CIA Complicity in the Global Drug Trade

McCoy, AF 1991, Lawrence Hill Books, Brooklyn, NY, US.

One of the most definitive texts written on the history and organisation of the opium trade in Southeast Asia, 30 years after publication it still carries pertinent information. Its author has strong views on who benefits from the opium trade.

Dangerous Harvest: Drug Plants and the Transformation of Indigenous Landscapes

Steinberg, MK, JJ Hobbs and K Mathewson (eds), Oxford University Press, US.

This book presents a global overview of indigenous peoples' relations with drugs. It presents case studies from various cultural landscapes that are involved in drug plant production, trade, and use, and examines historical uses of illicit plant substances. It also covers eradication efforts, and the environmental impact of drug plant production. In its final chapter, it synthesises the major points made and forecasts future directions of crop substitution programmes, international eradication efforts, and changes in indigenous landscapes. The book helps unveil the farmer to show the deep historical, cultural, and economic ties between farmer and crop.

Global Habit: The drug problem in a borderless world

Stares, P 1996, Brookings Institute, Washington, DC.

In *Global Habit*, Paul B. Stares, a senior fellow at the Brookings Institute in Washington, sheds light on the complexity of issues surrounding the use and trade in illicit drugs. Sanctions against drug trafficking should be maintained, he says, but treatment and prevention must become the dominant means of reducing production and consumption. Serious worldwide cooperation, he argues, is the only way to end the epidemic.