Drugs and HIV/AIDS in South East Asia

A Review of Critical Geographic Areas of HIV/AIDS Infection among Injecting Drug Users and of National Programme Responses in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam
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FOREWORD

South East Asia is a major source of illicit drug manufacture and trafficking such as heroin and Amphetamine-Type Stimulants (ATS). The consequences of those trends are felt in many forms, but perhaps none as devastating to individuals, families and communities as the problems of substance misuse and dependence, such as heroin abuse. The need to face and tackle the problem of heroin abuse has increased since HIV/AIDS was first discovered in the middle of 1980s and linked to injecting drug practices. The synergies of drug injection, HIV/AIDS infection and transmission of other diseases such as Hepatitis C have swept the region. These trends have provided the impetus for a call to action by governments, international agencies, and civil society. The trends also serve as a reminder about the need to secure an effective response that prevents disastrous consequences for millions of people.

As one of many programme contributions needed in South East Asia, a regional project for Reducing HIV Vulnerability from Drug Abuse was initiated in 2003 through UNODC Regional Centre for East Asia and the Pacific, with financial support from the Governments of the United Kingdom and Luxembourg, as well as technical and financial partnerships with UNAIDS. The project is implemented by an international regional team in conjunction with national counterparts linked to national drug control agencies in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam.

Within the broad purpose to improve public security agency capacities to collaborate and contribute to an improved response to drug abuse and HIV vulnerability, the project has focused upon the development of informed partnerships, at national and regional levels, for more integrated programme development in a range of settings where drug abusers are evident, including custodial drug abuse treatment, public security and community settings.

Part of the information requirements on drug abuse and HIV trends and responses is addressed by the following review that examines the current regional and national situations in relation to ‘who is doing what and where’. The review additionally suggests measures to more regularly monitor and systematize data collection so that all interested parties in South East Asia may be informed about the evolution and changes to both trends and responses, and thereby contribute to effective, relevant programme planning and delivery for the prevention and alleviation of vulnerabilities among drug abusers.

It is hoped that the present work will provide further grounds to support our regional and national partners in their consideration of programme priorities, and the pursuit of greater understanding about this complex issue that spans public health and public security.

Akira Fujino
Representative
UNODC Regional Centre
for East Asia and the Pacific
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### ABBREVIATIONS

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<th>Abbreviation</th>
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<tr>
<td>NNCC</td>
<td>National Narcotics Control Commission (China)</td>
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<td>SODC</td>
<td>Standing Office on Drugs Control (Viet Nam)</td>
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<td>CCDAC</td>
<td>Office of the Central Committee for Drug Abuse Control (Myanmar)</td>
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<td>ONCB</td>
<td>Office of the Narcotics Control Board (Thailand)</td>
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<td>NACD</td>
<td>National Authority for Combating Drugs (Cambodia)</td>
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<tr>
<td>LCDC</td>
<td>Lao National Commission for Drug Control and Supervision (Lao PDR)</td>
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<tr>
<td>MoPH/MOH</td>
<td>Ministry of (Public) Health</td>
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<td>NFDA</td>
<td>National Food and Drug Administration (China)</td>
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<td>NCAPC</td>
<td>National Centre for AIDS/STD Prevention and Control (China)</td>
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<td>NAC</td>
<td>National AIDS Committee (Viet Nam)</td>
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<tr>
<td>MOLISA</td>
<td>Ministry of Labour, Invalids and Social Affairs (Viet Nam)</td>
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<tr>
<td>NAA</td>
<td>National AIDS Authority (Cambodia)</td>
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<tr>
<td>NCCA/B</td>
<td>National Committee for the Control of AIDS/Bureau (Lao PDR)</td>
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<td>DAF</td>
<td>Drug Abuse Forum (Cambodia)</td>
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<td>ATS</td>
<td>Amphetamine-Type Stimulants</td>
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<td>IDU</td>
<td>Injecting Drug Use</td>
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<td>IDUs</td>
<td>Injecting/Intravenous Drug Users</td>
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<tr>
<td>STI/D</td>
<td>Sexually Transmitted Infection/Disease</td>
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<td>IEC</td>
<td>Information, Education, Communication</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>NSEPs</td>
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<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<tr>
<td>UNODC-RC</td>
<td>United Nations Office on Drugs and Crime Regional Centre for East Asia and the Pacific (Bangkok)</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>NGO</td>
<td>Non Governmental Organizations</td>
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<td>INGO</td>
<td>International Non Governmental Organizations</td>
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<tr>
<td>PAF</td>
<td>Programme Acceleration Fund</td>
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<td>FHI</td>
<td>Family Health International (USA)</td>
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<td>CHR</td>
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<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
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<td>AHRN</td>
<td>Asia Harm Reduction Network (Chiang Mai, Thailand)</td>
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<tr>
<td>UNDESA</td>
<td>United Nations Department of Economic and Social Affairs</td>
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<tr>
<td>MdM</td>
<td>Medecins du Monde (France)</td>
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<tr>
<td>GFATM</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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EXECUTIVE SUMMARY

The United Nations Office of Drugs and Crime (UNODC) is fully aligned with the World Health Organization in recognition of the need to adopt a “harm reduction” approach to the problem of HIV infection among Injecting Drug Users (IDUs). Injecting Drug Use (IDU) has been the vector associated with the most rapid spread of HIV infection among most South East Asian countries, and yet the response to this problem in the region has been “too little” and “too late.” Many governments still take a heavy-handed, criminal justice approach toward illicit drug use, which has merely driven the problem underground to where it is even more difficult to treat and to prevent practices that spread HIV infection among drug users and their sexual partners.

In response to this need, UNODC Project ‘Reduction of HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22) came into being in the beginning of 2003. As part of the activities of this project, a review documenting the regional situation and service response provision in the participatory countries was required. The result of such inquiry is the present paper, which aims to briefly review: 1) the most critical geographic areas of HIV infection among IDUs; and 2) what range of international or national programmes/projects response provisions and services are already, or will be shortly, in place.

This review is limited to the six Memorandum of Understanding (MOU) signatories on Drug Control: Cambodia, China, Lao PDR, Myanmar, Thailand, and Viet Nam, and focuses on the period between 2002 and 2004. The research is organized by country, for each of which a brief review of the HIV/AIDS and IDU situation is provided, followed by a focus on critical geographical areas and an overview of projects, programmes and services that reduce harm from drug use [e.g. Needle and Syringe Programmes (NSPs); Methadone treatment and maintenance; Information, Education, Communication (IEC); Outreach; HIV/AIDS treatment and testing for drug users; Enabling environment; Policy and involvement of IDUs].

Several interesting findings have emerged from this review:

- The prevalence of HIV infection among IDUs is very alarming in China, Myanmar, Thailand and Viet Nam; with the highest-reported HIV infection rates in these countries ranging from a low of national figure of 54% in Thailand to as high as 96% in some sites in Myanmar.

- Lao PDR and Cambodia still lack sufficient research studies to establish accurate prevalence estimates, but the consensus among experts is that rates of HIV among IDUs and the practice of injecting among drug users in general are still comparatively low in these two countries. However, many risk factors were identified that could lead to an HIV epidemic among IDUs in the near future, such as: geographic proximity and cross-border traffic with China, Viet Nam, Myanmar and Thailand; ongoing development of a well-integrated transportation infrastructure within the region; and, the declining availability of opium (due to eradication programmes), which has been shown in surrounding countries to lead directly to increases in heroin use and injection practices. History has shown that given the necessary conditions, epidemics of IDU can spread very quickly.

- Harm reduction approaches have not yet been adopted to any significant degree in the region. However, those few cases in which they have been tried, such as in small-scale pilot projects, have found them to be effective in slowing, stabilizing and reversing the spread of HIV among IDUs and their sexual partners, e.g. Hong Kong, Kolkata (India), and Australia.1

The primary reason for the slow uptake of well integrated harm reduction policies and programmes is the persistence of zero-tolerance criminal justice attitudes and responses to “the drug problem”, such as that embodied in Thailand’s recent “War on Drugs,” or continued social evil approach in Viet Nam.

On a more encouraging note, most countries in the region have begun to realise that harm reduction approaches may be the only realistic way to stem the epidemic of HIV among IDUs. However, these realizations and changes in policies are limited by lack of integration with other policies and programmes. For example, whereas all of the National HIV/AIDS plans address the issue of IDU, only half of the countries mention HIV/AIDS in their drug plans. This has led to a lopsided and incoherent approach to the problem. Furthermore, in some cases harm reduction policies co-exist with zero-tolerance criminal justice policies.

Funding of harm reduction initiatives remains another formidable obstacle to putting effective programmes into action. However, donors will be more willing to fund initiatives when an enabling environment is established, consisting of coherent policies within the legislative, judicial and public health ministries, public acceptance of drug users as persons having human rights and the recognition that the harm reduction approach is the only way to realistically address the IDU/HIV interface, as scientific evidence has profusely and repeatedly shown across the world. Hopefully, this will not have to wait until HIV infection becomes a full-scale epidemic throughout the entire region, such as has happened in Sub-Saharan Africa.

Lack of human capacity to design, develop, monitor and evaluate harm reduction activities; in particular, limitations of outreach programmes remain a major barrier to scale up responses.

The recommendations herein addressed include the development of an enabling environment in the region that would allow an increase in harm reduction policies and programmes. This would help to achieve a scaling up of efforts to reach IDUs, from the current level of less than 5% to at least 60%, which represents the necessary percentage that needs to change drug related behaviour in order to reverse the HIV epidemic in this population. In reality, in order to modify the behaviours of 60% of drug users, even a greater percentage of them need to be reached. In this connection, the importance of a locally enabling environment, with or without policy endorsement, cannot be overemphasised. Most programmes or current donor funding do not address the issue of local advocacy to opinion leaders and other officials. Lack of empowering or enabling activities directed towards the IDU communities and their partners continue to represent gaps in the current discourse on HIV/AIDS vulnerability of this group.

Other recommendations include the development of cooperative efforts among international and national stakeholders in the region through a regional “mechanism” to monitor the progress, coverage, effectiveness, as well as accessibility and quality of services that reduce the harm associated with drug use in various settings.
INTRODUCTION

"The fight against AIDS will indeed require another social revolution." Nelson Mandela

The Interface between HIV/AIDS and Drug Use

Drugs, such as heroin, opium and amphetamine-type substances, have been illegal for decades, and one consequence of this has been that drug users have been, and still are to a large extent, treated within the criminal justice system for using drugs. They have been stigmatised, discriminated against and punished for their behaviour. However, when HIV/AIDS first appeared in the middle of 1980s, it modified the conceptual and physical dynamics of ‘high risk behaviour’ so that drug users have become significant vectors of the spread of a global, incurable and fatal epidemic – HIV/AIDS – by the hand of which 20 million people worldwide have already died, and another 40 million are currently infected. In 2003 alone there were 5 million new HIV infections and 3 million AIDS-related deaths.

AIDS destroys the immune system and exposes the body to all kinds of ‘opportunistic’ infections that will ultimately weaken the human organism and lead to death. Antiretroviral drugs have been found to stabilize conditions and prolong life; however, due to excessive costs only a tiny percentage of those infected in developing countries have access to them; those who are excluded and ignored face inevitable death from AIDS. Therefore, until such time that a low-cost vaccine or “cure” becomes available, prevention of HIV infection through behavioural change remains the only viable strategy for dealing with this disease.

Through risky behaviours associated with IDU, such as sharing infected syringes and injection equipment, IDUs have rapidly spread the epidemic among themselves, and further to their sexual partners and into the general population at large. This has been very well demonstrated in South East Asia, where IDU populations were the first to spread the HIV/AIDS epidemic – mainly through sharing of injecting equipment, – in China, Indonesia, Myanmar, Thailand, and Viet Nam. Furthermore, they continue to represent the largest group of new infections in China, Indonesia, Malaysia, and Viet Nam. In 2001, 50% of IDUs in Thailand were infected with HIV, 70% in China, 76% in Malaysia, and 65% in Viet Nam in 2000. Rates of sharing injecting equipment remain as high as 50% in the South East Asia region.

Need for Adoption of Harm Reduction Policies and Programmes

The fact that IDUs now threaten to spread HIV infection into the general population of countries, such as those of South East Asia (and elsewhere), has brought about the realization that it may no longer be prudent to stigmatise drug users and treat them as criminals. A more enlightened approach might be...

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to extend a helping hand to this group in order to engage them in effective drug treatment programmes and to teach them safer drug use practices that will reduce the risk of HIV infection. However, before such approaches can be adopted there should be changes in policies toward drug use and drug users who are not traffickers or peddlers.

Many of these changes are embodied in the relatively new approach referred to as “harm reduction.” Successful harm reduction is based on a policy, legislative and social environment that minimizes the vulnerability of IDUs. Harm reduction for IDUs primarily aims to help them avoid the negative health consequences of drug injecting, improve their health and social status, and often reduce social crime and cost of imprisonments. This calls for a meaningful interface between the ministry of public health and that of public security in every country in order to shift pre-established paradigms toward more up to date, pragmatic and utilitarian policies.

Harm reduction approaches recognize that for many drug users total abstinence from psychoactive substances is not a feasible option in the short term, and aim to help drug users reduce their injection frequency and increase injection safety. UNODC and WHO are fully aligned in advocating for the following components that have scientifically proven to reduce individual risk behaviours associated with drug injection and thus diminish the rate of HIV/AIDS as well as other blood born viruses, such as Hepatitis C:

1. **Needle-Syringe Programming**\(^8\) (NSP) aims to ensure that those drug users who continue injecting have access to clean injection paraphernalia, including needles and syringes, filters, cookers, drug containers and mixing water. Specific interventions that equip drug users with sterile injection equipment usually also collect used needles and syringes, and are commonly known as ‘needle exchange programmes’ (NEPs). Such programmes can also serve as information points and may engage drug users with drug treatment services. Their ability to break the chain of transmission of HIV and other blood borne viruses is well established. Disinfection programmes have been used in settings where needle exchange is not feasible.

2. **Drug substitution treatment maintenance** involves the medically supervised treatment of individuals with opioid dependency based on the prescription of opioid agonists such as methadone. Whilst the primary goal of drug substitution treatment is abstinence from illicit drug use, many patients are unable to achieve complete abstinence, despite improvements in their health and well being. However, there is clear evidence that methadone maintenance significantly reduces unsafe injection practices of those who are in treatment, and hence the risk of HIV infection.

3. **HIV/AIDS related treatment and care** primarily aims to help drug users living with HIV/AIDS cope with the infection. Involving HIV positive drug users in primary health care and/or anti-retroviral treatment programmes provides an opportunity for them to adopt and consolidate safe behaviours and may yield significant HIV preventive effects. This applies in particular to HIV/AIDS treatment and care that is provided in the context of specific information and counselling services.

4. **Information, Education and Communication (IEC)** on HIV transmission through IDU provides information which will assist drug users avoid or modify drug injecting behaviours. Involving IDUs in the development and design of information material is critical to increase its appropriateness. The content of IEC materials should cover both the risks of injection and sharing practices as well as advice on how to reduce these risks and avoid sharing of injection equipment. IEC can be delivered through a variety of channels, ranging from general awareness campaigns, the provision of targeted information through health and social services frequented by IDUs to delivery of information through peer and drug user

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\(^8\) The discussion on the harm reduction components herein addressed is from [http://www.who.int/hiv/topics/harm/reduction/en](http://www.who.int/hiv/topics/harm/reduction/en); for reference please visit the WHO website. For the complete text please see the Appendix in this paper.
networks and outreach workers. ‘Risk Reduction Counselling’ represents a particular method that is based on face-to-face communication and provides an opportunity for drug users to turn information into actual behaviour change through a process of clarification and re-enforcement. Often, risk reduction counselling is offered in the context of HIV testing and counselling.

Two important principles to ensure the appropriate delivery of the above components are: a) Outreach programmes should be available at places and timings convenient for drug users; b) Creation of an enabling policy and social environment which are conducive to drug users as well as service providers, particularly at project or service sites.

Embedding harm reduction activities into comprehensive prevention packages for IDUs is indispensable for their success. This applies in particular to complementing safer injection messages by safer sex messages and condom promotion. Comprehensive HIV/AIDS programming should aim to provide opportunities for all IDUs to access the whole range of services. Recognising the hidden and often rapidly changing nature of drug injecting, reaching as many individuals as possible who inject on a regular or occasional basis represents a particular challenge to harm reduction services and necessitates an in-depth understanding of local drug use patterns and contexts. For this reason, harm reduction programming is often informed by appropriate situation assessments. Situation assessments can also act as a catalyst for communities to learn about the necessity of evidence-based approaches to HIV prevention among IDUs and to reduce controversy about their introduction.

Studies have shown that HIV infections among IDU populations can be prevented through harm reduction programmes for a reasonable cost. The economic evaluation of the cost per person of a behavioural change intervention with IDUs in South East Asia, including STI treatment, was estimated by UNAIDS (2003) to be somewhere between 60-150 US$ per year. This is considerably less than the costs associated with HIV/AIDS treatment, which entails – if available – considerable medical costs burdened by loss of manpower and loss of parents and spouses, many of whom are wage earners.

One of the greatest challenges across all countries is to advocate for an intersectoral approach to the epidemic because HIV/AIDS does not respect political or legal boundaries set up by governments to address public policy. Governments now face the question of how to address the epidemic in a concerted manner across their respective ministries: drug addiction has not been considered a disease in most countries until the middle of 1980s when the HIV virus first appeared. Now drug addiction must be viewed and treated as a primary health issue of foremost importance if the HIV epidemic is to be controlled across Asia and indeed all over the world. Existing political and legal paradigms have to be rethought, reviewed and adapted to contemporary social challenges. Bringing policy up to date is a must and this requires a social revolution.

Governments everywhere should look at Africa and tremble. In some countries, more than half the population will still die of AIDS. All of Africa’s famines are now AIDS-related: hungry people lack the strength to fight off sickness, sick people lack the strength to grow food, and dead parents cannot teach their children how to farm. Other regions can avoid this, but they must act now.9

AIMS OF THIS REVIEW

In response to the above regional situation, UNODC Project ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22) has been advocating for intersectoral collaboration and integrated work plans by the respective ministries of public health and security to jointly address the HIV/AIDS – IDU interface. As part of the activities of this project, a review documenting the regional situation and service response provision and capacity in the participatory countries was required. The result of such inquiry is

the present review. In particular, this paper aims to: 1) briefly review the most critical geographic areas of HIV infection among IDUs in each of the signatory countries; and 2) what range of international or national programmes/projects response provisions are in place and what specific services they provide.

The rationale behind this exercise is to provide an initial overview of ‘who is doing what and where’ to strengthen the coordination between national needs and international programmes and projects as well as foster integration and information exchange among multiple level activities and actors. This review is only a first step of such an exercise; it is the intention of this paper to recommend the establishment of a specific regional ‘mechanism’ that will monitor the progress and quality of and gather information on harm reduction services in the region on a regular basis and in a comprehensive manner. The ultimate objective of such mechanism, apart from advocating for exemplary practices that reduce harm from drug abuse in the region, will include an increased collaboration among international projects to encourage synergies while avoiding useless replication in the hope that resources can be maximized in a concerted and educated effort to thoroughly answer national needs in the best possible way to curb the impact of the HIV/AIDS epidemic among drug users in South East Asia.
METHODOLOGY

This document is based on a review of literature and project documents retrieved from UN agencies; UNODC commissioned ‘Organizational Capacity Assessments of Drug Agencies’ (2003) for every country herein addressed; UNODC Reports from the subregional project to develop institutional capacity for Demand Reduction among high risk groups (2001); current surveys by universities; consultations with government officials, UNODC’s, UNAIDS’ and WHO’s country and regional field offices; as well as NGOs and INGOs’ experts in the region.

The review covers the six Memorandum of Understanding (MOU) signatories on Drug Control: Cambodia, China, Lao PDR, Myanmar, Thailand, and Viet Nam, from 2002 to 2004, approximately.

Most of the sources used for the present review are unedited and were forwarded to UNODC directly by those working in the field. Consultations with experts and researchers provided further insight behind the facts. Thus, most of this information should be treated as provisional. However, given the gravity of the issue at hand and the need for a timely response it was considered better to present the data in its present form rather than to wait for more carefully prepared data and reports. It should be noted that except for the present document, no such database on harm reduction projects in the region yet exists. It is hoped that this paper will provide the ground work for the establishment of a sound database in the future.

The research is organized by country, and for each country, a brief review of the situation regarding the interface between HIV/AIDS and IDU is provided, followed by a section focusing on the most critical geographic areas within the country. Next, an overview is given of all projects and programmes related to HIV and drug use; this section aims to also provide an overview of services [e.g. NSP, drug substitution treatment, Information, Education, Communication (IEC), Outreach, etc.] that reduce harm associated with drug use. A table summarizing all programmes and projects as well as services is provided for quick reference on a national basis. Finally, a section commenting on ‘national specifics’ in regard to the implementation of harm reduction measures in the country is provided.
REGIONAL ANALYSIS

As Table 1 below illustrates, the six countries examined find themselves in different positions regarding harm reduction policies and services. A major difference exists between those countries that need interventions given the high prevalence of HIV/AIDS cases among IDUs, e.g. China, Myanmar, Viet Nam and Thailand; and those countries where such prevalence is still low, namely Cambodia and Lao PDR, which may need to focus more on a prevention approach of HIV/AIDS vulnerability from drug use.

A review of the six country chapters revealed that in general there were major obstacles to adoption of harm reduction policies and services, such as: lack of political will and direct responsibility and leadership in addressing HIV/AIDS – IDU interface; lack of clear policies; lack of national priority with regard to the urgency of harm reduction approaches; scepticism and prejudices against harm reduction and a preference for the zero-tolerance criminal justice approach; lack of adequate financial, human resources and civil society organizations; and problems of scaling up pilot projects. This state of affairs has slowed delivery of interventions and prevented appropriate coverage of target populations, which is still largely inadequate to curb the HIV/AIDS epidemic throughout the region.

In particular, it was observed that a very low level of dialogue and cooperation exists between drug control agencies and their health counterparts. Although UN agencies and other stakeholders in the region are investing heavily to foster intersectoral cooperation and integrated work plans, much more effort is still needed. Overall, it was observed that although drug use is often included in national HIV/AIDS prevention strategic plans, HIV/AIDS prevention is rarely addressed in national drug control plans. It appears that drug control agencies are reluctant to incorporate the HIV/AIDS component into their drug control plans because they have traditionally operated exclusively within the law enforcement paradigm, which does not include health components.

Policies regarding drug abuse continue to be dominated by historical precedents and beliefs rather than scientific evidence. The resulting limitations of this approach are evident in a ‘coercive, punitive and education’ approach, which continues to dominate the drug policy paradigm. Criminalization of drug users, which was evident in all countries reviewed, has some very harmful consequences. For example, where drug users are perceived to be more like criminals than patients, they are generally locked up in prisons or compulsory treatment centres where HIV/AIDS spreads very quickly. Many start injecting while in prisons, where drugs are available but sterile paraphernalia are not; hence, this results in high rates of sharing of needles and other contaminated equipment. Increased concerns of the danger of HIV transmission among IDUs in confined settings are reflected in new initiatives by UNODC, UNAIDS and WHO, as well as other stakeholders in South East Asia and other regions, such as Russia, Europe, Australia and Iran. While research from these areas clearly testify to the danger of HIV transmission among IDUs in confined settings, more indigenous research clearly is needed to assess the magnitude of the problem in South East Asia.

Although the discourse of harm reduction policies is generally accepted in principle – as it is heavily advocated by UN agencies – there is still an overall lack of understanding of drug use and addiction, which translates into increased prevalence of HIV infection and recidivism rates as high as 90% or greater for most of the countries in the study. Relapse is inevitable for the treatment of any compulsive disorder including drug dependence, but relapse rates may also be warning signs about the accessible range of treatment options and quality of treatment services that are available.

International evidence also shows that breakthroughs can occur with heavy investment in the harm reduction approach. These steps are exemplified in Cambodia’s recent workshop on harm reduction related to UNODC Project AD/CMB/01/F14 ‘Strengthening the National Control Programme of Cambodia and the Secretariat of the National Authority for Combating Drugs’. During the workshop
(5-6 May 2003), Cambodia’s Prime Minister, Hun Sen, was very supportive of harm reduction policies and he openly encouraged the view of drug users, not as criminals, but as patients that need help. Twenty six actions were produced to actively pursue these efforts at the government level; further developments will testify to these commitments.

China’s opening toward methadone maintenance availability and needle and syringe social marketing and exchange also show promise. Certainly, much more is expected given the sheer size of the IDU problem in China, but all stakeholders are increasingly seeking channels for cooperation and further collaboration at different levels.

At the international level, increased interest of donors in the harm reduction approach is very encouraging; this is mirrored by the plethora of international initiatives in the region especially in priority countries such as China, Myanmar, Thailand and Viet Nam. In these circumstances, an increase in coordination among all stakeholders will be a necessary condition for success.

UN agencies are actively advocating their common stand as reflected by the Position Paper of the UN System on Preventing the Transmission of HIV among Drug Users (available in Annex I of this paper). Furthermore, the 2001 Declaration of Commitment on HIV/AIDS makes clear that preventing HIV from drug use should be a foremost priority of any national HIV/AIDS strategic plan. However, political will and determination at the national level are now much needed.
TABLE 1. REGIONAL ANALYSIS

<table>
<thead>
<tr>
<th>Country</th>
<th>Cambodia</th>
<th>China</th>
<th>Lao PDR</th>
<th>Myanmar</th>
<th>Thailand</th>
<th>Viet Nam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence HIV/IDU (highest rates reported)</strong></td>
<td>No data</td>
<td>85%</td>
<td>No data</td>
<td>96%</td>
<td>54%</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Estimated number of IDUs</strong></td>
<td>No data</td>
<td>3-3.5 mill.</td>
<td>No data</td>
<td>150,000-250,000 (likely to be conservative)</td>
<td>100,000-250,000</td>
<td>70,000 (likely to be conservative)</td>
</tr>
</tbody>
</table>


1. **Legal Aspects**
   1.a Drug Control policy lead agency
      NACD NNCC LCDC CCDAC ONCB SODC
   1.b Specific legal constraints to reduce harm from IDU practices
      None None None None None None
   1.c Use of drugs an offence in itself
      No Yes Yes No No Yes
   1.d Possession of needle and syringes unlawful
      Unclear Yes Unclear No Yes Unclear
   1.e Police often arrest people for possession of needles and syringes
      Unclear Yes Unclear No Yes Yes

2. **Drug Treatment**
   2.a Voluntary (self referral)
      Yes Unclear Yes Yes Yes Yes
   2.b Compulsory
      Yes Yes Yes Yes Yes Yes
   2.c Both
      Yes Yes Yes Yes Yes Yes
   2.d Drug free only (abstinence approach)
      Yes No Yes No No Yes
   2.e Methadone for Detoxification
      No Yes Yes No Yes No
   2.f Lead agency
      NAA MoPH/NFDA MoH, NCCA MoPH MoPH MOLISA

3. **Prevention of HIV among IDUs**
   3.a Substitution Therapy
      No Yes No No Yes No
   3.b NSEP's
      No Yes No No Yes Yes
   3.c IDU Peer led approaches
      No Yes No No Yes Yes
   3.d Opposed to substitution therapy
      No No No No No No
   3.e Willing to consider
      Yes Yes No Yes Yes Yes
   3.f Opposed to NSEP
      No No Unclear No No No
   3.g Willing to consider
      Unclear Yes No Yes Yes Undecided
   3.h Opposed to peer education
      No No No No No No
   3.i Willing to consider
      Yes Yes Yes Yes Yes Yes

4. **Overall coverage of IDUs by the above services**
   N/A No data N/A No data 1% < 1%

5. **Policy and Programme Issues**
   5.a Drug use addressed in last HIV/AIDS national plan
      Yes Yes Yes Yes No Yes
   5.b HIV/AIDS addressed in last national drug plan
      Yes No Yes No No Yes

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10 Paulina G. Padmhoedodo who prepared UNODC commissioned Organizational Assessments of the Drug Agencies of the countries herein examined originally created this table. Prevalence of HIV/AIDS – IDU interface, number of IDUs, and percentage of coverage of IDUs by the services come from Reid G. and Costigan G., *Revisiting the Hidden Epidemic*. 2002; and UNAIDS 2003 publications.
RECOMMENDATIONS

Overall, the region is in strong need of a massive scaling up of efforts to change the behaviour of at least 60% of IDUs, which is the target that experts have determined, must modify drug using practices in order to reverse the epidemic; to achieve this objective, around 80% of IDUs should be reached. At present, current harm reduction activities cover at best 5% of drug users in South East Asia, whose numbers were estimated to be 6.4 million in 2002, and with HIV prevalence in some pockets of IDU populations as high as 80-90%.11

In order to achieve such a target at this critical moment the establishment of an “enabling environment” for clear and assertive harm reduction policies and legal frameworks, under which such activities can be maximally supported, are urgently needed everywhere.

Furthermore a holistic approach and a comprehensive package of interventions – rather than bits and pieces of programmes – are also crucial for success; effective regional practices should in fact be exchanged and applied in their entirety and through full technical knowledge transfer. In this context, note the regional response to SARS: a total, regional, collaborative and concerted response that produced sound and effective results.

In this regard, a massive effort is needed in both advocacy and the building up of human resource capacity to adequately address the HIV/AIDS – IDU interface.

Augmented knowledge about the current environment of harm reduction services in the region should be addressed through the development of a regional monitoring mechanism. This could be achieved by partnerships of major international stakeholders in the region, namely UNODC; UNAIDS; WHO; CHR; AHRN, FHI, etc., together with national stakeholders.

This “mechanism” would monitor the progress, coverage, effectiveness, accessibility, as well as quality of measures and services that reduce the harm associated with drug use, particularly IDU, in all settings, including confined ones, such as prisons and compulsory drug treatment centres; and, it would further serve as an advocacy tool in the region to fuel consensus for science-based and effective practices on the matter. Such a regional mechanism could also identify and advocate best practices to foster a unified approach and understanding.

It is further recommended that this regional monitoring mechanism be embedded in the activities of the integrated national work plans supported within the UNODC Regional Project ‘Reducing HIV Vulnerability from Drug Abuse’ framework.

In this regard, the present review is but an initial step towards learning ‘who is doing what and where’ in the region in terms of harm reduction projects, programmes and services. The above mechanism will further serve as a periodic update of the information herein contained, while also providing a more comprehensive picture encompassing all programmes/projects, and thus will offer an opportunity to unite forces and exploit ‘know how’ synergies as well as maximize financial and human resources.

Eventually, it would be ideal if the regional monitoring mechanism could serve as an on-line map of harm reduction services and be updated on a regular basis to help enhance the network and thus encourage collaboration efforts.

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11 Centre for Harm Reduction (http://www.chr.asn.au) and UNAIDS 2003 publications.
COUNTRY PROFILES
CAMBODIA

1. OVERVIEW

Since 1997 Cambodia became an important drug trafficking country. Although more drugs are being used, drug use is not considered an issue of great concern due to poverty, isolation and historical political instability. The Government’s financial commitment to public health was only 3% of GDP – one of the lowest in the world.

Contrary to other countries in the region, the driving force behind HIV infection is not IDU but rather heterosexual sex through commercial sex workers – where HIV prevalence reaches 31%. In response to this situation, the government launched the national 100% Condom Use campaign in all sex establishments. As a result, by 2001 the government had already announced a decline in the rate of people infected with HIV from 3.9% in 1997, to 2.8% in 2001.12

2. OVERVIEW OF CRITICAL GEOGRAPHIC AREAS

Critical areas for HIV and drug use tend to be urban centres in general; particularly, Phnom Penh and its neighbourhoods. However, given the still low prevalence of drug users in the country, and the consequent lower priority that this issue represents for the government, no drug related HIV estimates are available.

3. PROGRAMME RESPONSE CAPACITY

The National AIDS Authority (NAA) was established in 1999 in order to respond to the AIDS epidemic; the NAA, comprising representatives from 15 ministries and all provincial governments developed the 2001-2005 strategic plan that is both comprehensive and multisectoral. In 2001 the chair of the NAA suggested including NACD in to the Policy Board of the NAA13, and while there is no evidence to date that this has happened, a formal agreement has recently been established between NAA and NACD to collaborate in the reduction of illicit drug use and HIV/AIDS transmission.14

Harm reduction services do not yet exist in Cambodia except for some small scale initiatives for street children in selected urban areas such as Phnom Penh and Poipet. Methadone is not available because of costs and a very early Needle and Syringe Programmes (NSPs) has just started.

As a consequence, international cooperation on preventing HIV vulnerability among drug users remains rather limited:

1. The UNODC Regional Project ‘Reducing HIV Vulnerability from Drug Abuse’15 aims, as in the rest of the signatory countries of this project, to foster intersectoral links between the Ministry of Public Health and that of Public Security, in particular the establishment of a National Task Force formed by the National AIDS Authority (NAA) and the National Authority for Combating Drugs (NACD). Given the relatively low prevalence of HIV among drug users in both Cambodia and Lao PDR, the project aims at supporting an integrated action plan that focuses on prevention rather than intervention in these countries. The UN Theme Group on HIV/AIDS is also envisioned to play a central role to encourage programme development of an integrated agenda.

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13 Ibid.
14 A Memorandum of Understanding between the NAA and NACD was signed in January 2004 in Phnom Penh.
15 Please refer to Annex III in this paper for a description of the UNODC Regional Project “Reducing HIV Vulnerability from Drug Abuse” (AD/RAS/02/G22) and the Asia Regional HIV/AIDS Project (ARHP).
2. UNODC Human Security Fund Project, ‘Community-Based Drug Abuse Counselling, Treatment and Rehabilitation Services in Cambodia’ (US$ 1.186 mill. over 3.5 years), will foster community-based treatment and rehabilitation services for drug users including methadone substitution treatment. Depending on the availability of funding, the project should start in January 2004. Implementing partners in collaboration with UNODC Phnom Penh include: members of the Non-Governmental Drug Abuse Forum (DAF) in association with the Ministry of Health. The project is to select 4 geographic areas for intervention including the capital. HIV prevention is anticipated on the programme development.

3. In August 2003, the NGO Friends/Mith Samlanh, set up a NSEP as well as outreach related HIV/drug use information, education and communication (IEC) strategies for street children in Phnom Penh. The funds to support these small scale services come from different sources on an ongoing basis. It is worth mentioning here that ‘Our Home’, another NGO involved in drug-related social issues, has also set up methamphetamine addiction treatment for youth. These are very small scale projects.

4. The Programme Acceleration Fund (PAF) supports two projects executed by UNAIDS and WHO, respectively. For both there is a budget of 65,000 US$ focusing on a ‘nationwide assessment of high risk behaviour and institutional opportunities for intervention and intervention design among selected sub-population’ (UNAIDS) and a ‘qualitative assessment of drug use and HIV infection’ (WHO).

### Summary of Cambodia’s concurrent programmes/projects:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donors</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reducing HIV from drug abuse (AD/ RAS/02/G22)</td>
<td>UNAIDS/UK Luxembourg</td>
<td>UNODC-RC</td>
<td>2 years</td>
<td>3/03-3/05</td>
<td>1.3 mill.</td>
<td>Yes</td>
<td>Intersectoral collaboration/training/support for selected activities (TBD)</td>
<td></td>
</tr>
<tr>
<td>2 Community-Based Drug Abuse Counselling, Treatment and Rehabilitation Services</td>
<td>Trust Fund for Human Security/Japan</td>
<td>UNODC- Cambodia and MOH/DAF</td>
<td>3½ years</td>
<td>1/04-6/07</td>
<td>1.2 mill.</td>
<td>Probably same as UNODC G22</td>
<td>Drug treatment and Rehabilitation (Including Methadone Maintenance)</td>
<td>4 selected locations including Phnom Penh where 4 service centres will be established and staff trained</td>
</tr>
<tr>
<td>3 Harm Reduction Project (very small scale)</td>
<td>Information not available</td>
<td>NGO: Friends/Mith Samlanh</td>
<td>Information not available</td>
<td>Information not available</td>
<td>Information not available</td>
<td>No</td>
<td>NSEP, Outreach, Information, Education, Communication (IEC)</td>
<td>Phnom Penh</td>
</tr>
<tr>
<td>4 PAF (Programme Acceleration Fund)</td>
<td>CDC and UNAIDS</td>
<td>Two UN agencies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. UNAIDS</td>
<td></td>
<td>1. Information not available</td>
<td>1. Information not available</td>
<td>1. 65,000</td>
<td>1. Assessment of high risk behaviours and intervention institutional opportunities</td>
<td>1. Information not available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. WHO</td>
<td></td>
<td>2. 1 year</td>
<td>2. 10/03-10/04</td>
<td>2. 65,000</td>
<td>2. Qualitative assessment of HIV/drug use interface</td>
<td>2. Phnom Penh and Poipet</td>
<td></td>
</tr>
</tbody>
</table>
4. COUNTRY SPECIFICS

Identified highlights in recent Cambodian politics: a progressive move!

A workshop was recently held (5-6 May 2003) in relation to UNODC Project AD/CMB/01/F14 ‘Strengthening the National Control Programme of Cambodia and the Secretariat of the National Authority of Combating Drugs’, which focuses on increasing capacity building for these bodies. The meeting was the first of its kind to have been held in Cambodia, and was organized by the National Authority for Combating Drugs (NACD), with technical guidance from UNODC AD/CMB/01/F14 Project, Phnom Penh office, together with financial support of $20,000 from the US Centre for Disease Control and Prevention (CDC) in Phnom Penh. Group discussions led by UNODC staff focused on HIV vulnerability from drug use, mobilization of civil society to foster an enabling environment for effective policies and drug use treatment and rehabilitation services.

The outcome of the workshop was very progressive; 26 actions/recommendations were adopted to form the basis of a national drug control master plan to be developed by NACD in consultations with all interested agencies and groups, and with technical support provided by UNODC national drug control capacity building Project AD/CMB/01/F14.

The workshop was closed by Cambodia Prime Minister, Hun Sen, who affirmed the Government’s intention to ratify all three international drug control conventions by the end of 2003. Regarding reducing HIV vulnerability from drug use, the Prime Minister stated the following encouraging words: ‘...Drug addicted people badly need health support and support from society rather than leaving them as outlawed people of society...’ and he emphasized the interface between HIV/AIDS and drug use, and continued ‘...we have to educate this issue comprehensively among our youth with the objective to help them to protect themselves from drugs and to know how to use condoms... The real barrier to allowing drugs to condemn our social and economic future is the people of Cambodia.’

In an additional positive note, again within the framework of UNODC project AD/CMB/01/F14 and as part of the project’s plan to assist the government in drafting a national drug control master plan on November 19, 2003, the NACD agreed to accept harm reduction as an appropriate approach for drug users in Cambodia and to amend the 1997 drug control law in order to legalize harm reduction (provided authorization is given by the NACD prior to such activities commencing).16

This is a definitive start in favour of a contemporary approach to HIV/AIDS and drug use; condemning stigma, discrimination and adoption of a ‘health promotion approach’ rather than criminalization of drug use represents a progressive political determination and a pledge toward pragmatism. A follow up of policies will testify to the sincerity of these commitments which, if implemented as stated in the 26 actions extracted from the aforementioned Workshop, will not only allow Cambodia to prevent an HIV/AIDS epidemic among IDUs, but it will also set an important example in the region.

Finally, as of 6 January 2004, a Memorandum of Understanding between the NAA and NACD was signed to coordinate a joint plan of action to reduce and prevent HIV/AIDS transmission from drug use. The commitment of these two bodies to work together in an effort to improve intersectoral collaboration – with the assistance of the UN Theme Group on HIV/AIDS, UNAIDS, WHO, UNODC and Non-Governmental Organizations (NGOs), – and to meet monthly to review progress, will provide a crucial forum to combat HIV transmission from drug use in Cambodia.

16 These comments were provided by UNODC Phnom Penh, Cambodia. December 2003.
CHINA

1. OVERVIEW

Since the opening of the border in 1980, China has become a prominent trafficking route – especially from Myanmar – and a hub for the HIV epidemic in Asia. It is estimated that China has 7 million drug users, half of whom are IDUs. In 2001, 27 out of 31 provinces identified cases of HIV infection, and 7 have a particularly serious situation among IDUs. Overall, 70% of all reported HIV infection cases are found among IDUs, but rates exceeded 80% in Yunnan and Xinjiang provinces (see table below).

In 2002, the total number of counties (cities and districts) affected by drugs amounted to 2,148, an increase of 97 over the previous year; 214 of them contained more than 1,000 drug users. Heroin remains China’s drug of choice. Almost 90% of registered drug users are heroin users. Thus, IDU is the pivotal vector for HIV spread in this country; in fact, in 2002 all 31 provinces (municipalities and autonomous regions) reported HIV infection among IDUs.

The reason why IDU represents such an optimal HIV transmission route is because of the high rates of injection and needle sharing among heroin users. Sharing of injecting equipment has increased, because injecting is a much more economic and effective practice than smoking; in fact, about 20% of the drug is wasted when smoked versus nearly 0% when it is directly injected. It is estimated that more than 50% of IDUs share paraphernalia. Given this familiarity with injecting, concerns arise regarding the Amphetamine-Type Stimulant (ATS) epidemic in the region and the possibility of injecting forms of crystal methamphetamine already available in China, Lao PDR and the Philippines.

2. OVERVIEW OF CRITICAL GEOGRAPHIC AREAS

The following table gives the areas where the highest HIV prevalence among IDUs has been found. Xinjiang and Yunnan have substantially higher rates than other provinces due to the presence of drug trafficking routes and porous border sharing and proximity to India, Myanmar, Lao PDR and Viet Nam. Mobility associated with migrant labour across these areas, drug production, trafficking, using and re-using of injection equipment, unsafe blood collection and sale, sex work, and low condom use create a substantial vulnerability for this area to become a geographical hub of HIV infection.

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Sites and Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xinjiang</td>
<td>Yining 84%, Urumqi 39%</td>
</tr>
<tr>
<td>Yunnan</td>
<td>Ruili &gt;80%, Wenshan 75%, Kaiyuan 58%, Yingjiang 70%</td>
</tr>
<tr>
<td>Guandong</td>
<td>Sentinel Site: 21%</td>
</tr>
<tr>
<td>Guangxi</td>
<td>Baise 30-40%, Pingxiang 12%, Liuzhou 12%</td>
</tr>
<tr>
<td>Jiangxi</td>
<td>Sentinel Site: 17%</td>
</tr>
</tbody>
</table>


3. PROGRAMME RESPONSE CAPACITY


Although the National Narcotics Control Commission (NNCC), which is comprised of 25 ministries, has shown enthusiasm to liaise with other ministries to jointly tackle HIV vulnerability among IDUs, collaboration and execution of activities remain limited, particularly at the provincial level; the mandate far exceeds their resources at present. UNODC commissioned a capacity assessment of NNCC and found it to be very limited. There are only 46 people working in the entire department and the Demand Reduction Section is rather small.18

National and international responses to China’s national commitments are demonstrated in several national and international projects and programmes. The following paragraphs contain a current listing of projects by multiple stakeholders working to reduce HIV vulnerability from drug abuse in China. The purpose of this list is to provide an overview of available or proposed services. The table following these descriptions gives details about the start/end dates and duration of each project.

1. UNODC Regional Project ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22) – often referred to as ‘UNODC G22’ – aims at creating interdepartmental links between the Department of Public Health and that of Public Security – especially the NNCC and the AIDS cluster for China – in order to foster a holistic and balanced strategy and an integrated work plan that will address HIV prevention from drug abuse. The project aims at achieving these objectives through the establishments of national work forces or working groups in each of the signatory countries: China, Viet Nam, Myanmar, Lao PDR, Cambodia and Thailand. For China, a multisectoral task force has been established and it periodically meets to provide strategic advice. UNODC has also access to a portion of the Programme Acceleration Fund (PAF) 2002, to address specific issues of stigma and discrimination through a cooperative arrangement with NNCC and UN Theme Group on HIV/AIDS.

2. The Asia Regional HIV/AIDS Project (ARHP), financed by AusAID and implemented by the Centre for Harm Reduction (CHR), is a parallel project to the regional UNODC Project ‘Reducing HIV Vulnerability from Drug Abuse’ (G22), with very similar objectives. However, the ARHP extends to only three countries, namely China, Myanmar and Viet Nam. To fulfil the ARHP’s objective of establishing a supportive policy environment for effective approaches to prevent HIV/AIDS among IDUs, comprehensive curricula to train law enforcement officers on the issues of harm reduction are being developed as part of the projects activities. (See Annex III for further information on regional projects.)

Apart from the Asia Regional HIV/AIDS Project, the Centre for Harm Reduction has also conducted bilateral training activities in China, including Xinjiang, Yunnan, Guangxi and Beijing. Family Health International (FHI), Department for International Development (DFID-UK), Johns Hopkins University and Abt Associates are partners to the above training activities.

3. With the support of the UNAIDS Programme Acceleration Fund (PAF), the National Centre for AIDS/STD Prevention and Control is carrying out the needles social marketing pilot programme in four counties in the province of Guandong and Guangxi Autonomous Region.

4. The China UK HIV/AIDS Prevention and Care Project, sponsored by the British government, is carried out in the Sichuan and Yunnan Provinces. Peer education and needle exchange programmes are among its activities. A task force is also in place for this project.

5. The Ministry of Public Health, the Ministry of Public Security and the National Food and Drug Administration are jointly carrying out the National Pilot Project on Community-based Methadone Maintenance. Three to five provinces are to be selected as pilot sites, and selection will be based on the economic situation, location and prevalence of HIV infection among IDUs. A national task force addressing the matter is also to be established for this national initiative.

### Summary of China’s concurrent IDU/HIV programmes/projects:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donor/s</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reducing HIV from drug abuse (AD/RAS/02/G22)</td>
<td>UNAIDS/UK/Luxembourg</td>
<td>UNODC-RC</td>
<td>2 years</td>
<td>3/03-3/05</td>
<td>1.3 mill.</td>
<td>Yes</td>
<td>Intersectoral collaboration/training/support for selected activities</td>
<td>Sichuan; Yunnan</td>
</tr>
<tr>
<td>2 Asia Regional HIV/AIDS Project</td>
<td>AUSAID</td>
<td>CHR/ACIL Australia Ltd.</td>
<td>4 years</td>
<td>7/02-7/06</td>
<td>8 mill.</td>
<td>No</td>
<td>Training to law enforcement on harm reduction</td>
<td>Guangxi; Yunnan</td>
</tr>
<tr>
<td>3 HIV/AIDS from IDU (PILOT)</td>
<td>PAF</td>
<td>NCAPC</td>
<td>2002</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Needle/syringes social marketing pilot projects</td>
<td>Guangxi; Yunnan</td>
</tr>
<tr>
<td>4 China-UK HIV/AIDS Prevention and Care</td>
<td>UK</td>
<td>FHI</td>
<td>5 years</td>
<td>6/00-6/05</td>
<td>24 mill.</td>
<td>Yes</td>
<td>Peer Education/ AIDS patients’ care/NSEP</td>
<td>Sichuan; Yunnan</td>
</tr>
<tr>
<td>5 National Pilot</td>
<td>Government/DFID/AusAID</td>
<td>MPH/MPS/NFDA</td>
<td>5 years</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Methadone Maintenance</td>
<td>Sichuan; Yunnan; Guangxi; (one more province to be chosen)</td>
</tr>
</tbody>
</table>

### 4. COUNTRY SPECIFICS

An analysis of the response to IDU/HIV within the treatment system in China indicated the following gaps in service responses:

- Many drug treatment programmes, especially standard drug detoxification ‘re-education’ camps, do not provide HIV information/prevention services;
- Migrants, estimated at 100 million, are not specifically targeted;
- There is a need to enhance skills to improve human resource capacity. From the UNODC commissioned assessment report on NNCC, out of 78 universities that offered social work careers, none offered any training on drugs and HIV²¹.

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¹⁹ National Centre for AIDS/STD Prevention and Control (China).
²⁰ Ministry of Public Health; Ministry of Public Security; National Food & Drugs Administration (China).
**Gender issues:**

16 to 25% of IDUs in treatment in Yunnan and Guangxi are females and 80% are involved in commercial sex work to support their drug dependence. The All-China Women's Federation represents a major partner to the NNCC in the fight against drugs. Their major concerns are migrants and families as a whole. By 2002, they had provided awareness-raising activities for migrant women in 7 provinces. Gender needs special consideration in these settings.

**Penal system and treatment:**

China has a total of 746 compulsory rehabilitation centres and 168 treatment and re-education programmes through labour centres. Once a drug user has relapsed after a rehabilitation period, he/she is sent to ‘re-education through labour’ camp for 2-3 years. Coercive treatment approaches are not effective; the average rate of recidivism is 90%, and rates of HIV transmission in these settings are believed to be high, although no data is yet available specifically for China.

**In conclusion:**

China has recently shown interest in harm reduction policies as IDUs, through the sharing of injecting equipment, primarily drive the HIV/AIDS epidemic in this country. Although national initiatives such as community-based approaches and drug substitution programmes are emerging, China has still to adopt a standardized method of data collection and epidemic surveillance that would allow the full utilization of data sources and provide services on a mass scale.

Although concerted advocacy efforts have been carried out politically, much needs to be accomplished in scaling up responses, which at present, remain at pilot levels with the subsequent incapacity for proper coverage and inherent deficiencies to progress beyond initial stages. Condom use, needle exchange, outreach and methadone maintenance still all require a supportive environment and relevant policies. For example, arguments still exist on whether condoms and syringes should be admissible as evidence of prostitution and drug taking, which of course is not conducive to effective HIV/AIDS effective prevention.

Adding to China’s challenges, there is also the issue of migrant populations now totalling about 100 million people. Stripped of their resident status due to restrictions of China’s Household Registration System and subsequently excluded from security and medical care, Chinese (mainly internal) migrants are particularly vulnerable to the HIV/AIDS epidemic and drug use. This population needs a great deal of attention in terms of education, care, awareness and prevention as their status prevents them from conducting a normal ‘family life’ or enjoying the rights of urban residency as such.

As the world’s most populous country, China has the responsibility to acknowledge its weight and respond to it. As the UNAIDS Executive Director mentioned at the last World AIDS Conference, ‘if the HIV epidemic has to be controlled worldwide, it will have to be controlled in China first’. Not only does the limited awareness of the population of China on HIV/AIDS represent a concern for the region but also throughout the world, as China becomes more internally, regionally and globally mobile.

In addition, China’s actions exercise tremendous political influence in South East Asia and the Pacific’s geopolitical arena, thus placing this country in a singular and powerful position of leadership. China’s fast economic growth, now sustained at 9% a year, speaks loudly about its economic and political leadership potential.

Regarding harm reduction policies, if China decides to expand its pilot projects to a larger scale, it will set a very powerful example in the region, an example that other countries may wish to emulate.

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LAO PDR

“Lao PDR has been the quiet achiever at keeping the spread of HIV at bay, but this could all change... The country is facing the same issues that its neighbours have faced in the past, and the threat of HIV/AIDS is as big as ever. As the pace of development increases, so does the AIDS risk” Tony Lisle, UNAIDS

1. OVERVIEW

Lao PDR’s traditional illicit drug of choice is black opium; opium consumers are estimated to exceed 2% of the population making it the world’s second largest consumer of opiates per capita next to Iran. Injection is not widely spread but National Surveillance has disclosed that 2% of the estimated 1,400 HIV infected persons in Lao PDR acquired the infection through IDU. According to the opium survey conducted by the Lao National Commission for Drug Control and Supervision (LCDC) in 1999, in the Northern provinces, opium addiction is affecting as much as 5% of the population and up to 10% among ethnic minorities.

Lao PDR is also an important trafficking route country as reflected by drug seizures data; in 2000, seizures of heroin increased 39% and seizures of methamphetamine tablets increased 86% from 1999. And, over 1.5 million methamphetamine (or ‘yaba’) tablets were reportedly seized in 2001.

Yaba is now the most widely used drug in Vientiane. And although usually ingested or smoked, a UNODC school survey found that 12% of yaba users inject. This raises concerns for HIV/AIDS transmission through injection as well as other general risk behaviours associated with the use of yaba.

2. OVERVIEW OF CRITICAL GEOGRAPHIC AREAS

The most critical geographic areas of HIV among IDUs can be found at border points with Yunnan, China, where licit and illicit trade and a whole range of activities associated with casinos, migration, mining, drug trafficking and sex work are rampant. A similar worrying situation can be found at the border crossing to the Kachin and Northern Shan States of Myanmar.

In addition, areas all along the construction of the Asian Highway System, present points of concerns for the reasons mentioned above. Major urban centres are also indicated as being particularly at risk.

3. PROGRAMME RESPONSE CAPACITY

Harm reduction activities are not a priority for the government and none exist at present.

In the National HIV/AIDS/STD Plan for 1997-2001, the National Committee for the Control of AIDS’ (NCCA) indicated its intention to work closely with the Lao National Commission for Drug Control and Supervision (LCDC) to find ways to reduce the transmission of HIV among drug users through harm reduction activities; however, close cooperation with LCDC has only started recently and there has yet been no mention of needle and syringe programmes (NSPs). The national response partners such as the NCCA Bureau (NCCAB) and the HIV/AIDS trust, are challenged to build both the political commitment

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and the capacity of a multi-sectoral partnership at both the national and provincial levels and to work closely together on this subject.

Recently the NCCAB and LCDC have commenced cooperation as reflected in the National Drug Demand Reduction Strategy 2003-2005, in which data collection, prevention, treatment and rehabilitation of drug users as well as drug use related health consequences such as HIV/AIDS, have been addressed. This demand reduction strategy will be part of the National Master Plan on Drug Control. Cooperation is also apparent from the recent National Strategic Plan on HIV/AIDS/STD 2002-2005; however within this plan drug use applications remain minimal.

The following are UN initiatives that envision a preventive/preparedness approach, given the very real possibility that an increase in HIV prevalence might occur among drug users.

1. The UNODC Regional Project ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22) aims, as in the rest of the signatory countries, to foster intersectoral links between the Ministry of Public Health and that of Public Security, in particular LCDC and NCCAB. In Cambodia and Lao PDR, the project aims at supporting an integrated action plan that focuses on prevention rather than intervention, given the relatively lower prevalence of HIV among drug users in these countries. Activities of the integrated plan are not yet established.

2. Within the UN Joint Programme on HIV/AIDS, UNODC implementation responsibilities comprise: prevention of HIV among female commercial sex workers and other out-of-school (i.e., non-captive) risk groups, and prevention of HIV/AIDS among youth, including mass media mobilization and drug counselling for both youth and health workers at Vientiane youth centres. Planned activities for 2003 include: 1) capacity development: capacity building of local health personnel on treatment and rehabilitation approaches for Amphetamine Type Stimulants (ATS); 2) prevention of HIV among female commercial sex workers: assessment of drug abuse and HIV/AIDS among non-captive groups in Vientiane province, Luang Prabang and Savannakhet; 3) prevention of HIV/AIDS, drug use among youth (both in and out of school): promotion of awareness campaigns on drug use and HIV/AIDS; strengthening of drug counselling; promotion of community outreach/drug education/life skills; training courses on peer education in schools and out of schools; collaboration with Ministry of National Security (MONS) and the Ministry of Public Health (MOH) to improve medical and social services for drug users in the Criminal Justice System; and 4) prevention among the general population: information campaigns on ATS and risk of HIV/AIDS at the work place.
Summary of Lao PDR’ concurrent programmes/projects:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donors</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reducing HIV from drug abuse (AD/ RAS02/G22)</td>
<td>UNAIDS, UK, Luxembourg</td>
<td>UNODC-RC</td>
<td>2 years</td>
<td>3/03-3/05</td>
<td>1.3 mill.</td>
<td>To be established</td>
<td>Intersectoral collaboration/training/ support for selected activities (TBD)</td>
<td></td>
</tr>
<tr>
<td>2 UN Joint Plan of Action on HIV/AIDS</td>
<td>UNAIDS/ UNODC etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1) Capacity building of local health personnel on treatment and rehabilitation approaches for ATS;</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2) Prevention of HIV among female commercial sex workers;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3) Prevention of HIV/AIDS and drug use among youth; promotion of awareness campaigns; drug counselling; community outreach/drug education/life skills; training courses on peer education in schools and out of schools;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4) Prevention among general population; information campaigns on ATS and risk of HIV/AIDS at the work place.</td>
<td></td>
</tr>
</tbody>
</table>

4. COUNTRY SPECIFICS

Identified current risk factors:

The prevalence of IDU in Lao PDR remains negligible; however, the country faces certain identified risk factors which need to promptly be better understood in order for a preventive strategy to be in place and address the coming challenges in a holistic and effective manner. Some of the more salient risks that Lao PDR faces are:

1. Geographic position:

Among this precarious calmness of low prevalence of IDU and HIV, Lao PDR finds itself in a key geographic position to become a major hub for the rapidly increasing double epidemic of IDU and HIV/AIDS. Located in the midst of the Golden Triangle, bordering Yunnan (China), Myanmar, Thailand and Viet Nam, Lao PDR is exposed to the most worrying drug injecting and HIV trends in South East Asia. Trafficking of injectable heroin at these increasingly porous border points may soon influence drug use practices in the country.
2. The Mekong Highway System:

The building of the East-West Corridor and the Northern Economic Corridor projects, funded by the Asian Development Bank and in collaboration with the Greater Mekong Subregion Governments (China, Thailand and Viet Nam), form part of what is known as the Mekong Highway System, which will increase road access throughout the region and provide a major boost to the development of Lao PDR in particular and to the whole region in general. However, increased access for licit goods also means the possibility of greater illicit drug trafficking and increases in numbers of migration workers and sex workers. Lao, Vietnamese, Chinese and Thai workers will join together to provide labour and equipment for the highway system. These developments, together with increased drug trafficking and exposure to injecting practices along the borders, will result in social demographic changes that will need to be closely monitored.

For example, following the construction of the highway from Mandalay and Lashio in Myanmar to the most important Myanmar/China border crossing, Muse, in 1997, rates of HIV prevalence amongst IDUs were monitored and compared to the rates taken just before construction began. The following increases were recorded in the 2-year period from 1996 to 1998: Mandalay 51-88%, Lashio 34-74%, Muse 86-92%. This scenario could happen in Lao PDR when the Mekong Highway System is completed.

3. Opium eradication and new drug trends:

Opium eradication constitutes an additional risk factor because it has been shown to lead to subsequent increases in heroin, use as a replacement for opium, and with the practice of injection. With the recent increases in heroin trafficking, primarily from Myanmar and Thailand, it is generally understood that a transition from smoking black opium to injecting heroin (as well as other drugs, such as amphetamines) is taking place. Like Cambodians, Laotians are also very familiar with use of needles and syringes and with injecting a wide range of drugs.

4. HIV/IDU interface as low priority on the government agenda:

The government recognizes the presence of HIV among drug users as the fifth priority in its National Strategic Plan, 2002, which was developed by the National Committee for the Control of AIDS (NCCA) and based on a multi-sectoral approach. However, the low prevalence of IDU and HIV has reduced the priority of prevention activities. Furthermore, there are substantial needs to strengthen the plan and to provide training of its implementing partners. Although the plan testifies to the government’s commitment and recognition of this potential plight, political priority of this issue remains negligible.

Other risk factors include a very high incidence of poverty, high external and internal migration, very low awareness about HIV prevention at all level of the Laotian society and very poor access to STD treatment and/or medical referrals. Furthermore, the interactions at the Lao PDR/Viet Nam and the Lao PDR/Thailand borders amongst drug users, sex workers, migrants and all persons involved in trade signal warning signs of the possibility of mutual detrimental influences.

No data exists regarding HIV prevalence among drug users in prison settings and work camps; hence no estimates are available to assess such a situation, which have yielded worrying statistics in other similar situations where statistics are available: for example, Viet Nam, Thailand, Malaysia, Myanmar to mention but a few in South East Asia only.

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25 See Reid G. and Costigan G. Revisiting the Hidden Epidemic. 2002. As indicated in the Thailand section, opium eradication can lead to the emergence of new drugs especially injectable heroin.


27 Ibid.
In conclusion, given all of the above risks faced by Lao PDR, it is difficult not to predict an imminent change in the situation of HIV and IDU; furthermore, it is also not sufficiently proven that IDU is as low as commonly believed at present.\textsuperscript{28} Thus, the government should endorse the scaling up of a preventive approach before it becomes too late to avoid the catastrophe suffered by its neighbours.

More research is needed to assess the actual drug use situation in Lao PDR; indeed, while prevalence of IDU is considered small, studies have not proven this fact. While more research is needed in this area, close monitoring and preventive responses of the present challenging developments is of foremost importance. Lao PDR finds itself at a crossroad: full-scaled prevention or another potential catastrophe – as its close neighbouring countries have already experienced with IDU.

\textsuperscript{28} Ibid.
MYANMAR

1. OVERVIEW

Myanmar has one of the highest HIV infection rates among IDUs in Asia. HIV prevalence among IDUs in 2000 reached as high as 96% in selected areas, and it is estimated that between 150,000 to 250,000 IDUs are living in the country.\(^{29}\) National surveillance data shows that IDUs in Myanmar often become infected with HIV early in their injecting career, which is rare in other parts of the region.\(^{30}\)

It is important to note that sentinel surveillance is poor across the entire country, and figures quoted are likely to be considerably understated. Many populations of IDUs live in marginalized settings where unsafe injecting is the norm rather than the exception.

Myanmar has been exposed to harm reduction initiatives since 1995 through the United Nations Drug Control Programme (UNDCP); in 2001 officials from the Ministry of Public Health were first sponsored to participate at the International Conference on the Reduction of Drug Related Harm held in New Delhi. Since then they have continued to participate actively in such meetings and to embrace the harm reduction approach in various ways. Despite representing an example of collaboration and openness in the understanding of the seriousness of the HIV epidemic among IDUs in the region, Myanmar’s rate of HIV infected drug users remains the highest in the world. Perhaps this underscores the importance of acting quickly during the early stages of an epidemic.\(^{31}\)

2. OVERVIEW OF MOST CRITICAL GEOGRAPHIC AREAS

The areas most affected by HIV infection among drug users were first revealed through a study in 1990s, which showed that Yangon, Mandalay, the Sagaing Divisions, the Shan and Kachin States and the mining areas in the Northeast were the most affected. Generally, urban centres are most at risk; also particularly important are the seasonal internal immigrants that crowd the jade and ruby mines of Lashio in the Northern Shan State. ‘Shooting galleries’ and sex work are widespread in these areas and rates of sharing injecting equipment exceed 60% among heroin users. HIV prevalence among IDUs in 2000 can be seen in the following table.

**Myanmar’s most critical geographic areas of HIV prevalence among IDUs, 2000:**

<table>
<thead>
<tr>
<th>Sites</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yangon</td>
<td>37%</td>
</tr>
<tr>
<td>Mandalay</td>
<td>58%</td>
</tr>
<tr>
<td>Lashio</td>
<td>76%</td>
</tr>
<tr>
<td>Myitkyeena</td>
<td>90%</td>
</tr>
</tbody>
</table>


\(^{30}\) Ibid.

3. PROGRAMME RESPONSE CAPACITY

The following is a descriptive list of programmes and projects operating in Myanmar to reduce HIV transmission among IDUs. Major international stakeholders have a crucial role to play.

1. The Joint Programme for HIV/AIDS for Myanmar is coordinated by the United Nations Expanded Theme Group for Myanmar; ‘Expanded’ because the group now includes strategic actors such as donors and NGOs as well as government agencies including the Office of the Central Committee for Drug Abuse Control (CCDAC). The Programme aims at supporting the National Strategic Plan for expansion and upgrading of HIV/AIDS activities, the National Health Plan and the Operational Plans of Implementing Partners for 2003-05. It also aims at providing a commonly agreed-upon framework for international support and a point of reference to the national responses to HIV/AIDS. The Joint Programme comprises five components based on priorities identified by the Implementing Partners; the second of such components, namely ‘Individual risk of HIV transmission among IDUs and their partners reduced’ aims at strengthening existing harm reduction initiatives and improving access to quality drug treatment services. This component is implemented by UNODC with funding from the Fund for HIV/AIDS in Myanmar (FHAM) and through the establishment of a Technical Coordination Unit (TCU).

Within this framework, the Asia Harm Reduction Network (AHRN) is also operational. AHRN is involved in two of the five components: component 2, ‘Injecting Drug Use’, and component 5, ‘Enabling Environment’.

The main purpose of the project is to reduce HIV transmission among IDUs and their sexual partners by providing support to implement harm reduction interventions and to create an enabling environment, as well as to build capacity through advocacy, training and service provision. The field sites are mainly located in the Shan and Kachin states.

The Joint Programme has a potential ‘super goal’ for scaling up activities of 15 to 20 activities per year (and a ‘sub goal’ for 10); the requested funds amount to US$ 51 million, and as of December 2002 a total of US$ 21 million had been pledged for the FHAM.\(^\text{32}\)

UNODC Project ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22), which aims at creating interdepartmental links between the Department of Public Health and that of Public Security to foster a balanced strategy to prevent HIV transmission among IDUs, is integrated into the Joint Programme. It also provides specific support to CCDAC in building capacity to advocate and guide responses to drug related HIV/AIDS issues.

A working group comprised of CCDAC, the Ministry of Public Health and local NGOs has been established, under the joint programme, to advocate the incorporation of HIV prevention, care and intervention activities within drug abuse treatment and rehabilitation strategies in Myanmar.

2. The Asia Regional HIV/AIDS Project (ARHP), an AusAID funded Project, technically supported by the Centre for Harm Reduction (CHR), is a parallel project to the UNODC regional UNODC ‘Reducing HIV Vulnerability from Drug Abuse’ one, and the objectives are very similar. The Asia Regional HIV/AIDS Project only extends to three countries, namely China, Myanmar and Viet Nam. Among other activities, the Project aims at developing training curricula for both law enforcement officials and health professionals on reducing HIV transmission among IDUs. From early consultations and onwards, the government of Myanmar has been very accepting of such approaches and eager to collaborate with the international community on harm reduction measures.

3. Task Forces or working groups, – advisory bodies comprised of different government sectors as well as NGO and INGOs – addressing HIV infected drug users were set up under different projects. For example, in 2002 a workshop conducted by CARE/CCDAC with funding assistance from the United Nations Department of Economic and Social Affairs (UNDESA), established task forces at national, state/division, and township levels. UNODC ‘Reducing Injecting Drug Use and Harmful Consequences in the Union of Myanmar’ (AD/MYA/03/G54) intends to work through the above-mentioned Task Forces to implement project activities. UNODC Project G54 aims at reducing IDU and its harmful consequences for both drug users and their partners, especially through increased access to information and services. Community-based activities will be conducted in townships of the Kachin and Northern Shan States. Also, institutional based activities will be conducted in 45 sites of 30 townships. A 4-month base line assessment task was included in the initial plan. The aim of this task was to make a database available for use as a reference point for monitoring the changing patterns of HIV risk behaviour of IDUs in project townships. A comprehensive questionnaire for IDUs was drafted and translated in Burmese.

### Summary of Myanmar’s concurrent IDU/HIV programmes/projects:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donor/s</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Asia Regional HIV/AIDS Project</td>
<td>AUSAID</td>
<td>CHR/ACIL Australia Ltd.</td>
<td>4 years 7/02-6/06</td>
<td>8 mill.</td>
<td>No</td>
<td>RAR stage</td>
<td>Conducting RAR in Yangon, Mandalay, Lashio, Muse, Myitkyina and Tarchilek</td>
<td></td>
</tr>
<tr>
<td>3 AD/MYA/03/G5424</td>
<td>European Union (EU)</td>
<td>UNODC-Myanmar/ 3. AHRN 4. CCDAC</td>
<td>3 years Not started yet</td>
<td>1.1 mill.</td>
<td>Yes</td>
<td>Pre-implementation stage</td>
<td>Aim of 45 sites of 30 townships (Kachin and Northern Shan State)</td>
<td></td>
</tr>
</tbody>
</table>

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23 The Joint Programme for HIV/AIDS, Myanmar 2003-2005 has two modalities for funding: 1) through the Fund for HIV/AIDS in Myanmar (FHAM) where 21.3 million US$ of commitments was made by donors including Britain’s Department for International Development (15.7 million US$), Norway (823,000 US$) and Sweden (4.7 million US$). Of the commitments, 7.5 million US$ has already been made available in contracts for the first year. The other modality refers to the Global Fund (GF), and it is worth noticing that under the GF, the Central Committee for Drug Abuse Control (CCDAC) with implementing partners have submitted proposals which includes NSEP and substitution programmes such as methadone.

24 The AD/MYA/03/G54 is the ‘Reducing Injecting Drug Use and its Harmful Consequences in Union of Myanmar’. The project is in its pre-implementation stage in partnership with UNODC, MdM and CARE International.
4. COUNTRY SPECIFICS

**Identified preliminary gaps in service provision:**

Overall, there exist large gaps in harm reduction service provision. In fact, there are only limited government operated drug treatment and related centres; no methadone provision; no out-patient drug treatment services; no outreach activities, and no peer support or NSEPs.

Although the government might be supportive of harm reduction activities, certain legal provisions are still in place that hamper implementation. This has been made worse by a lack of funding possibilities, which is often linked to international political sanctions against Myanmar. Furthermore, technical capacities concerning harm reduction strategies are very limited or non existent. The same applies for the availability of information, education, and communication (IEC) materials to reduce the harm associated with drug use in Burmese and other local languages.

To address such constraints, further ‘moral’ and financial support of already existing players will be required to facilitate the process of scaling up projects and to create opportunities for training in order to develop local human resources and advocacy materials at local levels.\(^3\)

To balance the above national needs and favour harm reduction activities, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) resources have been allocated to Myanmar in 2003; out of a 54 million US$ plan, the IDU component aims at covering 16,000 IDUs. Such activities are planned for implementation in 2004.

\(^3\) These comments were provided by courtesy of interview with Willy De Maere, AHRN-FHAM, Yangon.
THAILAND

1. OVERVIEW

Since 1997 the prevalence of illicit drug use drugs in Thailand has widened from heroin, cannabis, and other substances to also include the use of amphetamines or ‘yaba.’ Between 1993 and 2001, there was a 1,000% increase in the use of this new drug. In Thailand the most common manner of administering yaba is not injecting but inhaling the fumes, a practice known as ‘chasing the dragon.’ Although this would seem to balance the spread of HIV among IDUs, HIV among such a group has increased nevertheless. The yaba epidemic also has a direct influence on the spread of HIV to the general population due to the increased prevalence of high-risk behaviours (such as sexual contact) under the effects of the drug. Furthermore, yaba users are not a marginalized population, which increases the likelihood of spread among the general population.  

The increasing rate of HIV among IDUs is due to frequency of injecting, high rates of sharing paraphernalia, and of imprisonment of drug users. Drug users in Thailand number about 2 to 3 million nationwide, which is approximately 5% of the population. According to estimates calculated in 2001, 274,200 of these are heroin users; the preferred method of administering heroin with regard to treatment data is still by injecting: 70% to 80% of heroin users inject. Prevalence of injecting heroin has increased from 52% of all heroin users in 1993, to about 70% in 1998. The Office of Narcotics Control Board (ONCB) estimates that there is an increase of about 25,000 new drug users every year; furthermore, it is estimated that the HIV seroconversion rate is between 5-10% of IDUs who become newly infected each year.

In Thailand, the epidemic among IDUs exploded in the late 1980s despite the first case being found in 1984. In one year (1987-88), HIV prevalence among IDUs rose from 2 to 43%. In Chiang Mai, in Northern Thailand, the increase in infection rates went from 1% in 1988 to 61% a year later. Although in 1999 there was a general and sharp decrease of HIV cases among sex workers, pregnant women and army conscripts, HIV prevalence among IDUs remained high, and with bleak prospects for the future, under the current policy and programme environment.

2. OVERVIEW OF CRITICAL GEOGRAPHIC AREAS

In some parts of the Northern provinces, especially Chiang Rai and Chiang Mai, HIV prevalence among IDUs is 90%.

In 1993-95 in the Northern provinces, HIV prevalence among IDUs was 18%, and risk factors included being Thai as opposed to ethnic minority, older, single, low levels of education and being employed in agriculture or in the trading sector. Remarkably, a study in 1994 showed that the IDU/HIV interface was not a risk factor in 28 ethnic hill tribe villages (0% in Karen, 0.6% Hmong, 5% among Yao/Akha, 8.8% in Shan people). The reason why HIV prevalence remains relatively low among hill

36 Yaba use is socially acceptable as it is generally associated with ‘better performance’ especially for workers to work longer hours. For this reason there is not either social pressure to stop using or discrimination and stigma attached to its use. It is assumed that this situation has also contributed to its wide use, among other factors, such as relatively low price and availability.
37 UNDCP 2000.
39 Ibid.
tribes is because these populations customarily smoke opium or heroin and do not inject the drug. However, this has been slowly changing over the years.

Further confirmation for these findings comes from data collected under the Johns Hopkins University and Chiang Mai University’s ‘OUR’ study conducted in Chiang Mai, which tested 1665 male IDUs and 200 female IDUs and showed that prevalence of HIV positive status among males were: 12% for Thai men, 6% for Hill Tribe men, and 10% of total males tested in the sample. For female IDUs, data was as follows: 7% positive among the overall sample, 6% for Hill Tribe women, and 9.5% for Thai women.

3. PROGRAMME RESPONSE CAPACITY

The government acknowledged the high prevalence of HIV among IDUs in 1997, but did not support harm reduction approaches that targeted injecting behaviour; indeed, such services remain very limited to the time of this writing. Only in 2001 did the Ministry of Public Health advocate the reform of narcotic regulations to extend the methadone treatment period from 45 days to 1-2 years. Furthermore, there appears to be only one NSEP at a relatively early stage operating in the North for the Akha tribal people.

In terms of infrastructure, Thailand’s 2100 district community health services are given the responsibility of providing drug treatment, including methadone for detoxification; however, high threshold guidelines to enter the methadone programme, and inadequate numbers of overworked health professional staff undermine the capacity of these centres to deliver the desired services.

The following international intervention projects provide an overview of harm reduction activities in the country:

1. The UNODC Regional Project ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22) aims to foster intersectoral links between the Ministry of Public Health and that of Public Security, in particular ONCB. A task force in this regard has already been initiated and a work plan is expected to be organized in 2003 or early 2004 with guidance and support from UNODC, UNAIDS and WHO.

2. Methadone Treatment as administered by the Ministry of Public Health has been rather limited in duration and location. However, long-term methadone treatment has recently been approved and it is supported by the amendment of Narcotic Act B.E. 2522 (i.e., 1979). The Ministry of Health is in the process of reviewing entry guidelines for long term Methadone Maintenance Programmes; a revival of Methadone initiatives is thus expected given the recent enthusiasm of Thai health authorities in comprehensively addressing these issues.

3. The HIV/AIDS Prevention and Care for Hill Tribes of Northern Thailand (HAHP) has been working with the Akha people in Chiang Rai since the middle of 1990s. In order to reach drug users, the project has targeted about 9 villages and their surroundings. Their main activities are Needle and Syringes Exchange Programmes (NSEPs) and long-term methadone maintenance treatment; one of these is the Mae Chan Methadone Project, which is considered a progressive Methadone maintenance service in Thailand. In Saen Suk village, the project covers about 104 households and aims at providing drug dependence treatment, reducing illicit drug use, injection, risk behaviours and providing HIV/AIDS prevention and care for HIV positive drug users through community services. The project has already yielded encouraging results, such as decreased drug abuse, elimination of IDU, prevention of deaths from overdose, improved health and job opportunities, decreased family problems and reduced property crime.

4. Johns Hopkins University and Chiang Mai University’s project ‘Peer intervention trial amongst heroin injectors in Northern Thailand’ is a study designed to test the effectiveness
of peer-based harm reduction mentoring among injectors and their social networks. The study is part of a global trial under the banner of HIV Prevention Trial Networks, with sister sites in India and Seattle (USA). The project had almost reached the 440 injector-workers needed to conduct the study, but recent government policy related to Thailand’s “War on Drugs” has complicated the work and has led to most of the recruited drug users going into hiding in order to avoid punishment.

Also under the same banner is the ‘Reducing drug related harm and STD risk among young amphetamine (yaba) users in Northern Thailand’. This is a four year study divided into two phases: the first comprised an ethnographic phase to explore the use of yaba and associated risky behaviours. The second phase is to pilot social interventions based on the findings from the first phase.42

The third Johns Hopkins sponsored project is called ‘OUR’, a prospective epidemiological study of HIV infection among opiate users. This study is based on providing harm reduction awareness to residents of the Northern drug treatment centre while periodically monitoring their HIV status.

5. The International HIV/AIDS Alliance, UK, is funding six NGOs in Thailand through AIDSNET, Chiang Mai. The main focus of this pilot project is harm reduction for yaba users in Chiang Mai and Chiang Rai. The project started in 2001 with participatory assessment and is now in its 2nd year of implementation. Funding is confirmed until 2004.

Summary of Thailand’s concurrent projects/programmes:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donor/s</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reducing HIV from drug abuse (AD/ RAS/02/G22)</td>
<td>UNAIDS/UK/ Luxembourg</td>
<td>UNODC-RC</td>
<td>2 years</td>
<td>3/03-3/05</td>
<td>1.3 mill.</td>
<td>Yes</td>
<td>Intersectoral collaboration/ training/support for selected activities (TBD)</td>
<td></td>
</tr>
<tr>
<td>2 Methadone Treatment</td>
<td>Ministry of Public Health</td>
<td>Ongoing</td>
<td>No</td>
<td>Methadone Treatment</td>
<td>Bangkok, Chiang Rai and Chiang Mai</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Pilot Project Akha Hill Tribe</td>
<td>USAID</td>
<td>FHI</td>
<td>1990</td>
<td>Ongoing</td>
<td>Community services; Long Term Methadone Maintenance treatment Programme; Counselling; NSEP</td>
<td>Chiang Rai (Akha Tribal people in 9 villages including Mae Chan and Saen Suk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Peer Intervention Trial amongst injectors in Northern Thailand</td>
<td>Johns Hopkins School of Public Health</td>
<td>Chiang Mai University Research Institute for Health Science</td>
<td>3 years</td>
<td>2002-2005</td>
<td>No</td>
<td>Peer based harm reduction mentoring among injectors and their social networks</td>
<td>Chiang Mai</td>
<td></td>
</tr>
</tbody>
</table>

4. COUNTRY SPECIFICS

Identified preliminary gaps in service provision

Thailand has been comprehensively lobbied by INGOs and NGOs for the past five years to respond to the HIV/IDU interface; however, only limited harm reduction programmes are in place – only one NSPE for the Northern Hill Tribe and the current Methadone Treatment programmes, most of which predated the onset of HIV in Thailand. Nation-wide measures to reduce HIV among IDUs are severely lacking.

One reason for this situation seems to stem from a lack of coordination between the National AIDS Prevention and Control Committee (NAPCC), ONCB and the Ministry of Justice; however, while the Ministry of Public Health acknowledges the seriousness of the HIV epidemic among IDUs and reflects this
concern in the priorities of the public health national work plan, ONCB does not include an HIV prevention component in the National Drug Control Action Plan 2001-2005. Lack of communication, information sharing and separate mandates contribute to the absence of an integrated action plan that accounts for HIV and drug use in Thailand.

**Treatment for drug users:**

In general a wide range of drug prevention and treatment approaches for drug users in Thailand are well administered, especially if compared to the rest of the region (with the exception of Hong Kong). Pharmacotherapy, therapeutic and motivational skills such as peer approaches, outreach programmes, and community-based approaches are conducive factors to enabling HIV prevention among drug users.

Methadone was introduced in Thailand in 1976, and it is now provided throughout the capital and beyond. However, it appears that guidelines to register a drug user into a Methadone programme are inadequate.43

Generally, reports indicate that needle syringe programmes are too few to have any impact and methadone therapy, while available, is so constrained as to be ineffective in countering HIV/AIDS transmission.44

**Thai youth at great risk:**

UNAIDS reports testify that Thai youth are at a major risk of contracting the HIV virus because their sexual judgment is impaired when using drugs, such as yaba. Prevention in this direction is urgently needed in addition to the issue of IDU; indeed, major behavioural change work is required.

**The War on Drugs and the Thai Drug Users’ Network (TDN):**

It is important to reflect on the immediate effects of policy; usually this can only be achieved after many years and trial and error or distinguishable results. The effect of the government’s ‘war on drugs’ could already be seen after only a few months; if the war started on January 2003, the effects showed by the summer of that same year. A study conducted by Chiang Mai University’s Research Institute for Health Science, the Public Health Ministry and Johns Hopkins University, showed that 37% of drug users who used to visit rehabilitation clinics in Chiang Mai before the ‘war’ had moved out from their houses due to government suppression and thus were not found anymore. Many drug users under pressure from the government’s anti drug campaign went into hiding, thus becoming likely to share needles as they became less available, which then exposed them to greater HIV risk of infection45. Furthermore, although some researchers worried that the sudden fall in the supply of methamphetamine pills, the main drug of choice in Thailand, could have potentially led to a shift to heroin use, no such trend was reported.46

In addition, large numbers of IDUs sought methadone treatment in the initial phases of the drug war as this option was preferable to arrest. Unfortunately the public hospitals charged with dispensing methadone subsequently ran out of supplies very early in the ‘war’, thus forcing those who willingly sought treatment back underground in search of heroin.47

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46 Researchers say that the reduction in the consumption of yaba was due to higher costs and fear of persecution rather than any supposed drop in supply.

When Hina Jilani, the Special Rapporteur on Human Rights Defenders, visited Thailand in May 2003, a ‘climate of fear’ was observed in civil society referencing extra judicial killings associated with the anti-narcotics campaign.

Although this kind of ‘war’ has been ongoing on a larger scale in South East Asia; in Thailand, the immediate results of the ‘war on drugs’ have demonstrated how extreme punitive actions towards illicit drug use actually increase HIV risk behaviour amongst drug users and their social networks.

As a result of this campaign, whereby approximately 2,500 people lost their lives within just a few months (the number changes greatly depending on the source), the Thai Drug Users’ Network (TDN) was born. Although initially organized to advocate for human rights for drug users in response to the government’s anti-drug campaign, the TDN has also embraced the crusade to advocate drug users’ right to meaningful drug treatment, such as Methadone Maintenance, Needle and Syringes Exchange Programmes (NSEPs), Voluntary Counselling and Testing (VCT) and Outreach, and to generally push the harm reduction agenda in collaboration with both the Ministry of Justice and that of Public Health.

Certainly, TDN’s inclusion in the decision-making process sets a powerful precedent; TDN’s meeting with the Deputy Prime Minister led to the assurance that distinctions would be drawn between drug users and drug dealers and the lifting of the restrictions that made drug users ineligible under the antiretroviral (ARV) treatment protocol.

The TDN has conducted a very worthy and brave work and is being supported by UNAIDS, UNODC and WHO. TDN is also closely working and contributing to the advancement of these organizations’ own agendas in Thailand.

On 15 October, 2003 the TDN was awarded the grant from the GFATM to start harm reduction activities in Thailand. 1.3 million US$ are expected to be used to implement Outreach, Education, Information and Communication (EIC), as well as referral services for IDUs in 2004. This is a very significant achievement for Thai drug users and civil society’s empowerment at a crucial time for Thailand.

In sum, Thailand’s present government drug policy appears to be the reason behind negligible harm reduction actions. Experts think that once such policy is amended and its objectives become more health focused, thus provide an ‘enabling environment’, a plethora of NGOs will not hesitate to provide more services to reduce the HIV transmission among drug users. The prospects of such a process are to be encouraged.
VIET NAM

1. OVERVIEW

The overall prevalence of HIV infection among Vietnamese IDUs was estimated to be around 65% in 2000. Rates as high as 84% have been reported in North Viet Nam. Reasons for such high prevalence of HIV infection among IDUs include a scarcity of injecting equipment and also the common use of professional injectors and shooting galleries. Sharing of needles and syringes occurs in more than 40% of injection cases in Ho Chi Minh City (HCMC), and more than 50% of HIV positive people continue to use drug injection and share needles with their friends. Furthermore, the rate of female sex workers (FSWs) that inject drugs is more than 40% in Hanoi. As a consequence of these interfaces, the prevention of HIV transmission among IDUs in Viet Nam is crucial in controlling the epidemic.48

2. OVERVIEW OF CRITICAL GEOGRAPHIC AREAS

HIV is transmitted through drug injection more in Northern and Central provinces than in the Southern provinces of Viet Nam, most notably Hai Phong, Lang Son and Quang Ninh provinces. However, it appears that HCMC, which attracts migrants from Hanoi and Cambodia, is another focal point of the HIV epidemic in Viet Nam – HIV prevalence among IDUs was estimated to be as high as 75% in 2002. Adding to these already worrying statistics, it was found that 25% of sex workers in Hanoi and HCMC are injecting drugs.

Viet Nam’s most critical geographic areas of HIV prevalence among IDUs, 2001:

<table>
<thead>
<tr>
<th>Sites</th>
<th>HIV Infection Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binh dinh</td>
<td>&gt; 80%</td>
</tr>
<tr>
<td>HCMC</td>
<td>&gt; 80%</td>
</tr>
<tr>
<td>Hai phong</td>
<td>&gt; 70%</td>
</tr>
<tr>
<td>Cantho</td>
<td>&gt; 40%</td>
</tr>
<tr>
<td>An Giang</td>
<td>&gt; 30%</td>
</tr>
<tr>
<td>Hanoi</td>
<td>&gt; 20%</td>
</tr>
</tbody>
</table>


3. PROGRAMME RESPONSE CAPACITY

The Vietnamese authorities have fully recognized that the spread of HIV infection among IDUs is alarming and have thus made this issue a priority in Viet Nam’s Drug Control Master Plan, which makes reference to HIV prevention. HIV infection among IDUs is also mentioned in the National HIV/AIDS Prevention Plan. However, despite such commitments in intention and practices (e.g., many harm reduction pilots have been implemented in the country), the actual legislation behind such approaches remains confused and incoherent. This confusion is evidenced by the persistence of ‘social evils’ campaigns that strive to eradicate all drug use, without recognizing shorter term health objectives that are

compatible with the ‘harm reduction’ approach. Indeed, the government of Viet Nam has implemented pilots of Needle and Syringe Exchange Programmes (NSEP) and Methadone maintenance and treatment in several provinces while continuing to mount ‘social evils’ campaigns.

The government has allocated the highest level of funding in comparison to all other health priorities to HIV/AIDS prevention; however the total financial support from the government is limited to only US$ 48 million, which is insufficient to support the magnitude of needed interventions.

The government established the National AIDS Committee (NAC) in 1990 with multisectoral representation from 11 ministries and 5 mass organizations. The NAC developed and implemented the first Medium-Term Plan for HIV/AIDS control 1991-1993 and developed a second plan for 1994-2000 where priorities focus on reducing HIV from IDUs. Prior to initiation of the second plan, a target to reduce harm and prevent drug abuse was set in the Drug Control Master Plan. The Plan states:

“To measurably reduce drug abuse and to promote harm-reducing and preventive drug abuse/HIV programmes, to develop a national plan for prevention of drug abuse and related harm, and for the plan to be closely correlated and where appropriate integrated with the National Plan for HIV/AIDS prevention.”

The following list of intervention projects provides an overview of harm reduction activities within the country. Although many international and national initiatives have been implemented more sound and clear policies placed within a well defined legal framework are still needed to effectively reduce the trend toward drug related HIV transmission.

1. The UNODC Regional Project ‘Reducing HIV Vulnerability from Drug Abuse’ aims to foster intersectoral links between the Ministry of Public Health and that of Public Security, in particular the Standing Office on Drug Control (SODC). In particular UNODC will support an assessment of the 05-06 Treatment Centres, which are compulsory detoxification centres (known as 05 for sex workers and 06 for drug users). It is estimated that about 30,000 drug users are treated in the 06 centres (10,000 in Hanoi and 20,000 in HCMC) where they are kept between 2 to 5 years; of these inpatients 25% are HIV-infected. Furthermore, 05-06 Centres’ modalities tend to focus only on detoxification, which is insufficient to enable recovery among IDUs; a 99% rate of recidivism within these drug treatment centres testifies to this assertion.

UNODC Regional Centre (Bangkok) will also support training for SODC in project management and demand/harm reduction in partnership with WHO (using WHO toolkits). With a glance into the future, the 05-06 Treatment Centres’ assessment will eventually contribute to the UNODC-Viet Nam Project ‘Capacity Building in Treatment and Rehabilitation Services’ (2004-2007) whose objective focus is in reducing recidivism, enhancing the variety of treatment services, and building on best practices in treatment and rehabilitation.

2. The UNODC-Viet Nam Project ‘HIV/AIDS Prevention among Injecting Drug Users’ will address HIV-IDU link at the provincial level and will address capacity building for the much needed scaling up of activities regarding IDU. This project is based on lessons learned and best practices as derived from the previous UNODC project (AD/VIE/B07) in an attempt to sustain the existing HIV prevention programme. The project is divided into 3 tracks: Track 1 will identify 5 provinces for intervention; Track 2 will expand these interventions in 5 other provinces; while Track 3 will attempt to reduce the need for international assistance by transferring the ‘know how’ to national capacity. The project will be executed by UNODC

with coordination support from UNAIDS; the government counterpart will be the National Committee on AIDS, Drugs and Prostitution Control (NCADP).

3. UNODC-Viet Nam Project ‘Drug Abuse Prevention among Ethnic Minorities in Viet Nam’ (AD/VIE/01/B85) aims at addressing, in a unique design, drug-related harm problems among six remote ethnic communities in three highland border provinces. Coordination and cooperation agreements surrounding the adoption and implementation of ‘best practices’ drug demand and harm reduction activities have been arranged with INGOs, NGOs, UN and government agencies and organizations. Additional support to scaling up the project model will eventually be required. This project is the first and only one of its kind addressing these concerns in marginalized, poor and remote border populations. It will be executed by UNODC Viet Nam in collaboration with the Committee for Ethnic Minorities.

4. The Asia Regional HIV/AIDS Project, an AusAID-funded project and technically supported by the Centre for Harm Reduction (CHR), is a parallel project to the UNODC regional UNODC ‘Reducing HIV Vulnerability from Drug Abuse’ project, and the objectives are very similar. The Asia Regional HIV/AIDS Project only extends to three countries, namely China, Myanmar and Viet Nam. Training curricula for both law enforcement officials and health professionals are being developed.

5. AusAID is financing the Centre for Harm Reduction’s project, ‘Implementing Harm Reduction in Two Provinces of Viet Nam’, which is being done in collaboration with the Provincial AIDS and Standing Bureau (PASB). The two provinces that were selected are Bac Giang and Thanh Hoa. The project aims at providing harm reduction training to local police, in collaboration with public organizations (e.g., Farmers’ Union, Women Union, National Frontiers Union, etc.). The project focuses on local law enforcement training because police play a crucial role in reducing harm from IDU in Viet Nam where 60-80% of IDUs interface with criminal acts. A key activity, however, focuses on developing sustainability for drop-in centres through which 35,000 syringes were distributed by peer educators in the first 8 months (Jan-Aug 2003) in Bac Giang; another 32,000 were distributed in the same period in Thanh Hoa. The project also addresses: Information, Education and Communication (IEC) on HIV/AIDS, opiate dependency and harm reduction and building counselling capacity for health staff on HIV and sexually transmitted infections (STIs). The project is now looking for additional funding as its term is ending. From the evaluation of this project, it has been learned that communities become enthusiastic and supportive of harm reduction activities as their understanding of the issue and of the importance of their role increases. Indeed, more and more communities are beginning to realize, given the high rates of recidivism in treatment centres that harm reduction approaches are much more effective to prevent and control HIV spread among drug users than standard detoxification drug treatment centres.

6. The ECHO Seagull project ‘Injecting Drug Use Intervention’, executed by Family Health International (FHI), is based on and tries to replicate the Eastern Connecticut Health Outreach Project that directly involved IDUs as peer educators; this approach is referred to as Peer Driven Intervention (PDI). Researchers have found that this is a much more effective way to mobilize and reach target populations. The project, implemented in Haiphong and Campha, has just entered its second phase – the first phase being from May 2000 to December 2002. The project established ‘drop in centres’ for IDUs in both locations; needles and syringes are provided by the provincial health service. The funding for the project amounts to 220,000 US$ for the next two years.

7. Johns Hopkins University is conducting a research intervention study in collaboration with the department of Health, in the Bac Ninh Province, Northern Viet Nam. The focus of this research is on the use of social network-oriented peer educators on HIV/STI interventions.

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for IDUs and their sexual partners. A cross-sectional survey of 309 IDUs, recruited through outreach workers, was conducted as part of the first year (2003). This survey consisted of a standardized questionnaire, voluntary counselling and testing (VCT) for HIV/STIs, laboratory testing, diagnosis and treatment of selected bacterial STIs. In 2004, an experimental study will be conducted in which IDUs, their regular sex partners and injecting partners will be randomly assigned to network-oriented, peer-led interventions or, alternatively, to control conditions. The participants will be followed-up at 3-6 months intervals for a maximum of 24 months. Subsequent evaluations will compare sexual and drug behavioural risks, HIV and STD incidence among IDUs and their network members who receive intervention, with IDUs who receive the control sessions. The intervention phase will likely be conducted in two Northern provinces in Viet Nam.

8. The Life/GAP Project, funded by the Centre for Disease Control (CDC) Atlanta, and implemented by the Provincial AIDS and Standing Bureau (PASB) is to set up voluntary counselling and testing (VCT) in 16 provinces, one VCT service per province. The Ministry of Public Health will collect data and act as coordinator of the project. A pilot programme has already been conducted in Quang Ninh province in October, 2002. CDC will further support the building of outreach model-based treatment services for opportunistic infections associated with HIV.

9. The Department for International Development (DFID-UK) has given 25 million US$ in support of the Project to reduce HIV transmission in Viet Nam, which is being implemented by WHO. The project will cover 21 provinces and it will devote approximately 15 million US$ alone for condoms and US$ 1 million for HIV prevention among IDUs. The project will make a special attempt to identify sex workers that are also IDUs and provide them with condoms, NSEP, peer education and community-based intervention services to promote a positive change in behaviour, especially reduction in sharing of injecting equipment.

10. HIV infection passes between the border of Viet Nam into China, thus fuelling the epidemic on both sides. Epidemiologists who study molecular changes in the virus have found evidence that those strains of HIV infecting IDUs in Southern China come from Northern Viet Nam, where heroin is purer and cheaper. To address this problem, Abt Associates, a consulting firm of Boston, Massachusetts, organized a meeting in Kunming, China, sponsored by the Ford Foundation. One outcome from this meeting was the idea of establishing a Cross-Border HIV Prevention Intervention Project. NSEP were planned in both countries, but China alternatively opted for a syringe ‘social marketing’ approach. The project received US$ 2 million from the US National Institutes of Health (NIH) over 4 years. Researchers found a prevalence of 47% HIV infection among IDUs in Lang Son Province and 18% in Guangxi Province. The programme in Lang Son has stabilized incidence of HIV infection, which has not grown for more than a year.51

11. The Ford Foundation also funds a peer-driven intervention (PDI) for HIV prevention among drug users in Ha Giang, Lang Son, and Khanh Hao Provinces and HCMC – this is part of the overall Cross-Border Project mentioned above. All of these interventions have needle and syringe components. Others that incorporate harm reduction education through peer education and support include projects in six 05-06 Treatment Centres in Hanoi, Thai Nguyen and Khanh Hao provinces.

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## Summary of Viet Nam’s concurrent programmes/projects:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donor/s</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reducing HIV from drug abuse (AD/RAS/02/G22)</td>
<td>UNAIDS/UK Luxembourg</td>
<td>UNODC-RC</td>
<td>2 years</td>
<td>3/03-3/05</td>
<td>1.3 mill.</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 HIV Prevention among IDUs (AD/VIE/DR14)</td>
<td>UNODC-Viet Nam</td>
<td></td>
<td>3 years</td>
<td>2004-2007</td>
<td>No</td>
<td></td>
<td></td>
<td>Track 1: 5 provinces; Track 2: additional 5 provinces Track 3: Reduce Intl’ assistance to increase national capacity</td>
</tr>
<tr>
<td>3 Drug Abuse Prevention/ Ethnic Minorities (AD/VIE/B85)</td>
<td>UNODC-Viet Nam</td>
<td></td>
<td>3 years</td>
<td>2004-2007</td>
<td>No</td>
<td></td>
<td></td>
<td>Highland Ethnic Minorities</td>
</tr>
<tr>
<td>4 Asia Regional HIV/AIDS Project</td>
<td>AUSAID</td>
<td>CHR/ACIL Australia Ltd.</td>
<td>4 years</td>
<td>7/02-6/06</td>
<td>8 mill.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Pilot HR Project in 2 Provinces</td>
<td>AUSAID</td>
<td>CHR and PASB</td>
<td>1 year</td>
<td>2002-2003</td>
<td>16,000</td>
<td>No</td>
<td></td>
<td>Provincial Police Training Workshop on NSEP; Drop-in centres; Peer Outreach; Building Counselling and Testing capacity</td>
</tr>
<tr>
<td>6 ECHO &amp; Seagull Model/IDU intervention Project</td>
<td>Joint funding</td>
<td>FHI</td>
<td>2 years</td>
<td>5/03-4/05</td>
<td>230,000</td>
<td>No</td>
<td>Drop in centre for drug users/ Peer Driven Intervention (PDI)</td>
<td>Haiphong and Campha (Quang Ninh)</td>
</tr>
<tr>
<td>7 Outreach Intervention Research Study</td>
<td>Johns Hopkins Bloom/ School of Public Health</td>
<td>Johns Hopkins</td>
<td>5 years</td>
<td>10/02-10/07</td>
<td>No</td>
<td>Peer education, VCT</td>
<td>Bac Ninh Province and Thai Ngueyn Province</td>
<td></td>
</tr>
<tr>
<td>8 Life-GAP Programme</td>
<td>CDC-Atlanta</td>
<td>PASB</td>
<td>5 years</td>
<td>2001/2006</td>
<td>2 mill./year</td>
<td>n/a</td>
<td>Community Outreach; VCT and care and treatment for PLHWA</td>
<td>18 provinces including Lang Son; Quang Ninh and Hai Phong</td>
</tr>
<tr>
<td>9 DFID Project – Harm Reduction Component</td>
<td>DFID</td>
<td>WHO</td>
<td>5 years</td>
<td>5/03-5/08</td>
<td>25 mill.</td>
<td>Yes</td>
<td></td>
<td>21 Provinces – based on HIV vulnerability to yet be selected</td>
</tr>
</tbody>
</table>


### Summary of Viet Nam's concurrent programmes/projects: (continued)

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Donor/s</th>
<th>Executing Agency</th>
<th>Duration</th>
<th>Start/End Date</th>
<th>Budget US$</th>
<th>Task Force</th>
<th>Service Provision</th>
<th>Geographic areas of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project on Harm Reduction</td>
<td>Ford Foundation</td>
<td>Local health authorities</td>
<td>n/a</td>
<td>n/a</td>
<td>1.2 mill.</td>
<td>NSEP, PDI – at risk group (e.g. construction workers) Peer education and support in 05-06 Drug Treatment Centres</td>
<td>Ha Giang, Lang Son, Khanh Hoa Provinces and HCMC (05-06) Hanoi, Thai Nguyen and Khanh Hoa Provinces</td>
<td></td>
</tr>
</tbody>
</table>

### 4. COUNTRY SPECIFICS

**Identified preliminary constraints in response provision:**

**Lack of legal and policy framework:**

Harm reduction programmes have been piloted and expanded in Viet Nam since 1993 and have yielded positive outcomes. However, because of political and legal constraints as well as lack of a uniform consensus behind this approach, harm reduction programmes have not yet curbed national HIV infection rates among IDUs.

Chief among the constraints for implementing harm reduction activities in Viet Nam lies the lack of a coherent legal framework. Indeed the distribution of needles and syringes is illegal, and so peer educators can carry out their work only through verbal agreements between NGOs/INGOs and local authorities. However, the lack of a coherent national policy infringes upon the overall scheme of harm reduction objectives by acting as a permanent deterrent to general participation at outreach programmes.

**The ‘social evil’ campaigns:**

Related to the lack of national policy on harm reduction – and current counter national policies in this regard such as ‘social evil’ campaigns – stigma and discrimination inevitably push IDUs in perpetual hiding, thus representing a major roadblock in addressing the epidemic among this group. For example, although syringes are available and can be bought at retail pharmacies, IDUs are reluctant to go there for fear of being caught by the police, and pharmacy personnel are reluctant to sell needles and syringes to IDUs citing questionable ‘moral reasons’ for their use.52

**‘Boutiques’ or large scale?**

“*The challenge in next two years will be to put large-scale international programmes in place.*” Mr Richard Feachem,
Further related to the inadequacy of a coherent legal/political framework for harm reduction strategies, most programmes are operating at the ‘pilot’ level. As in other countries, the so-called ‘boutique’ approach is inherently inadequate to address the magnitude of the epidemic among IDUs for various reasons:

- Pilot projects take time to prove their effectiveness (at least 1-2 years);
- Pilot projects are designed on a small scale but when/if scaled up they expose inherent technical problems;
- Pilots are usually the product of international funding; however, once funding is withdrawn local resources are unlikely to sustain the programmes, especially if they hope to scale up coverage;
- Pilots are unlikely to be scaled up in the absence of a legal sound framework, which is absent in Viet Nam and most of the other countries.

Considering that there are 10 ministries and 5 mass public organizations involved in the fight against HIV/IDS another formidable constraint derives from the lack of coordination among various harm reduction activities. In fact, no ministry seems to be willing to take direct responsibility in leading interventions that address the HIV/IDU interface. Indeed, although an agreement has been reached at the highest political level, an inherent lack of coordination, communication and collaboration prevail at the operational level. Understandably, the lack of a legal framework contributes to this dilemma.

Finally, the government budget for harm reduction activities is still extremely limited.

**Methadone Maintenance Treatment Programme:**

Methadone maintenance treatment is not offered in Viet Nam. However, the National Institute for Mental Health had set up pilot phases of methadone treatment in Hanoi, Hai Phang and Quang Ninh provinces between 1996-97. Encouraging findings indicated a decrease in ‘offensive/criminal’ behaviours of IDUs, and to a general increase in their health status; these positive results seem to have led to a consensus within the Ministry of Public Health and they now appear to finally be willing to scale up methadone programmes by 200453. Within this context, it is interesting to note that Viet Nam produces methadone very cheaply.

**In conclusion:**

Although much is being achieved in Viet Nam in terms of international and national attention to reducing HIV vulnerability from drug abuse, commitment at the highest political level toward a harm reduction approach is needed to scale up interventions and maximize efficiency of existing and future activities. In fact, even if the epidemic has stabilized among IDUs in certain parts of the country due to effective interventions, the overall trend of increasing HIV prevalence among IDU remains strong nationally.

particularly for Viet Nam, coordination among the many international and national initiatives that address the HIV/IDU interface is needed, especially when facing future challenges of scaling up pilots and when international funding comes to an end. Sources of funding for projects will also be a salient concern.

53 Courtesy of direct consultations with the Ministry of Public Health Staff. October 2003. Hanoi, Viet Nam.
Annex I

A position paper of the United Nations System on Preventing the Transmission of HIV among Drug Abusers

Annex to the Report of the 8th Session of ACC Subcommittee on Drug Control,
28-29 September 2000

Background

1. The aim of this paper is to present a United Nations (UN) system wide position on policy and strategies to prevent the transmission of HIV among drug abusers. Drug abuse and HIV/AIDS issues cut across much of the work of the United Nations family. Both are directly and indirectly associated with many complex public health and social problems. They affect the workplace, undermine social and economic development, and affect the lives and well being of children.

2. This paper is based on the experiences of various UN agencies and programmes in their work to prevent and treat drug abuse and HIV infection as well as on relevant policy principles guiding the work of the United Nations. It draws on research findings to recommend evidence-based practice, to provide general guidance, and to indicate some programming principles for the prevention of drug abuse and HIV/AIDS.

3. Sharing or use of contaminated needles is a very efficient way of spreading HIV. Since injecting drug abusers are often linked in tight networks and commonly share injecting equipment, HIV can spread very rapidly in these populations. Currently, 114 countries have reported HIV infection among drug injectors. Injecting drug abuse is the main or a major mode for transmission of HIV infection in many countries of Asia, Latin America, Europe, and North America.

4. In 1998, 136 countries reported the existence of injecting drug abuse. This is a significant increase as compared to 1992, when 80 countries reported injecting. This illustrates a worrying trend for diffusion of injecting into an increasing number of developing countries and countries in economic transition, where previously the behaviour was often virtually unknown.

5. Numerous studies have also found drug injectors to be disproportionately likely to be involved in the sex industry or to engage in high-risk sexual activities. Drug injecting may also contribute to an increased incidence of HIV infection through HIV transmission to the children of drug injecting mothers, and through sexual contacts between drug injectors and non-injectors.

6. HIV risk among drug abusers does not arise only from injecting. Many types of psychoactive substances, whether injected or not, including alcohol, are risky to the extent that they affect the individual’s ability to make decisions about safe sexual behaviour. Studies have associated crack-cocaine use with elevated levels of high-risk sexual behaviours, for example in the United States, where crack-cocaine abusers account for an increasing proportion of AIDS cases.

7. Deciding on the implementation of the intervention strategies to prevent HIV in injecting drug abusers is one of the most urgent questions facing policy makers. Studies have demonstrated that HIV transmission among injecting drug abusers can be prevented and that the epidemic already has been slowed and even reversed in some cases. HIV prevention activities, which have shown impact on HIV prevalence and risk behaviour, include AIDS education, access to condoms and clean injecting equipment, counselling and drug abuse treatment.

8. Drug abuse treatment is one approach that may have an impact on preventing HIV infection. Many large-magnitude studies have shown that patients participating in drug substitution treatment such as methadone maintenance, therapeutic communities, and outpatient drug-free programmes decrease...
their drug consumption significantly. Several longitudinal studies examining changes in HIV risk behaviours for patients currently in treatment have found that longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours or an increase in protective behaviours. However, studies have found more effectiveness for changing illicit drug use than changing sexual risk behaviour.

9. Drug abuse treatment is not chosen by all drug abusers at risk from HIV infection, or may not be attractive to drug abusers early in their injecting habits. In addition, recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Relapses to drug abuse and risk behaviour can occur during or after successful treatment episodes. Various outreach activities have been designed to access, motivate and support drug abusers who are not in treatment to change their behaviour. Findings from research indicate that outreach activities that take place outside the conventional health and social care environments reach out-of-treatment drug injectors, increase drug treatment referrals, and may reduce illicit drug use risk behaviours and sexual risk behaviours as well as HIV incidence.

10. Several reviews of the effectiveness of syringe and needle exchange programmes have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase into IDU or other public health dangers in the communities served. Furthermore, such programmes have shown to serve as points of contact between drug abusers and service providers, including drug abuse treatment programmes. The benefits of such programmes increase considerably, if they go beyond syringe exchange alone to include AIDS education, counselling and referral to a variety of treatment options.

**United Nations System Policy**

11. Several UN documents provide the framework/foundation for the formulation of strategic approaches to preventing the transmission of HIV among injecting drug abusers.

**UN Drug Control Conventions and the Declaration on the Guiding Principles of Drug Demand Reduction**

12. The policy of permitting the use of narcotic drugs for medical and scientific needs, while preventing their use for non-medical purposes, goes back to the late nineteenth and early twentieth centuries. At that time there was an increasing awareness of the dangers associated with the narcotic drugs that had previously been widely used for pain relief, especially opium-based preparations. Hence, many countries began to restrict the distribution of such drugs, while permitting their use for medical and scientific purposes.

13. This policy is articulated in the preamble to the 1961 Single Convention on Narcotic Drugs, which reads as follows:

“Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes, Recognizing that addiction to narcotic drugs... is fraught with social and economic danger to mankind..., Desiring to conclude a generally acceptable international convention replacing existing treaties on narcotic drugs, limiting such drugs to medical and scientific purposes...”.

The Convention further specifies that the ‘parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts’ (Article 38).

14. Also the 1971 Convention on Psychotropic Substances in its Article 20, paragraph 1 states that parties to the convention shall take all appropriate measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, and rehabilitation and social reintegration of the persons involved.
15. The 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in its Article 14, paragraph 4 indicates that parties to the convention shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and narcotic substances, with a view to reducing human suffering.

16. In 1998, the UN General Assembly adopted the Declaration on the Guiding Principles of Drug Demand Reduction, the first international instrument to deal exclusively with the problem of drug abuse. The Declaration emphasises that demand reduction programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and society as a whole.

**UN Human Rights Documents**

17. The Universal Declaration of Human Rights, which was adopted fifty years ago as a common standard of achievement for all peoples and all nations, states:

   “Everyone, as a member of society, has the right to social security and is entitled to realization ... of the economic, social and cultural rights indispensable for his dignity and the free development of his personality” (Article 22).

   “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...” (Article 25).

18. In 1999, the Commission on Human Rights passed a resolution (1999/49) which invited States, United Nations bodies as well as international and non-governmental organizations “to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related rights...”

19. In May 2000, the Committee on Economic, Social and Cultural Rights, which is the United Nations human rights monitoring body, adopted a General Comment on the right to health. The Comment proscribes “any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health” (paragraph 18).

**UN Health Promotion Policy Documents**

20. Respect for human rights and the achievement of public health goals are complementary. Health, as defined in the Constitution of WHO (1946), is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The Constitution proclaims that “the enjoyment of the highest attainable standard of health” is one of the fundamental human rights of every human being without distinction for race, religion, political belief, economic or social condition.

21. The concept and vision of Health for All, which was adopted in 1977 by the Thirtieth World Health Assembly, sets the main social target of governments and WHO as ‘the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life’.

22. The Ottawa Charter on Health Promotion (1986) outlines five areas for action: building public health policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. These areas are all relevant to drug abuse issues and HIV/AIDS.
23. During its session in May 1998, the World Health Assembly endorsed the new World Health Declaration and the new global health policy Health for All in the 21st Century. Health for All in the 21st Century guides action and policy for health at all levels and identifies global priorities and targets for the first two decades of the 21st century. Key values such as human rights, equity, ethics and gender sensitivity should underpin and be incorporated in all aspects of health policy. A key feature is the strengthening of the participation of people and communities in decision-making and actions for health.

24. Important global “health for all” targets by 2020 include:

“... the worldwide burden of disease will be substantially decreased. This will be achieved by implementation of sound disease-control programmes aimed at reversing the current trend of increased incidence and disability caused by tuberculosis, HIV/AIDS, ...all countries will have introduced, and be actively managing and monitoring, strategies that strengthen health-enhancing lifestyles and weaken health-damaging ones, through a combination of regulatory, economic, educational, organizational and community-based programmes”.

Principles and Strategic Approach

25. Protection of human rights is critical for the success of prevention of HIV/AIDS. People are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Where civil rights are not respected, it is difficult to respond effectively to the epidemic.

26. HIV prevention should start as early as possible. Once HIV has been introduced into a local community of injecting drug abusers, there is the possibility of extremely rapid spread. On the other hand, experience has shown that injecting drug abusers can change their behaviour if they are appropriately supported.

27. Interventions should be based on a regular assessment of the nature and magnitude of drug abuse as well as trends and patterns of HIV infection. Interventions need to build on knowledge and expertise acquired from research, including empirical knowledge about the social milieu around which drug taking revolves as well as lessons learned from the implementation of previous projects and interventions.

28. Comprehensive coverage of the entire targeted populations is essential. For prevention measures to be effective in changing the course of the epidemic in a country, it is essential that as many individuals in the at-risk populations as possible are reached.

29. Drug demand reduction and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes. Specific interventions for reducing the demand for drugs and preventing HIV should be sustained by a supportive environment in which healthy lifestyles are attractive and accessible, including poverty reduction and opportunities for education and employment. It is desirable to include multi disciplinary activities and provide appropriate training and support to facilitate joint working.

30. Drug abuse problems cannot be solved simply by criminal justice initiatives. A punitive approach may drive people most in need of prevention and care services underground. Where appropriate, drug abuse treatment should be offered, either as an alternative or in addition to punishment. HIV prevention and drug abuse treatment programmes within criminal justice institutions are also important components in preventing the transmission of HIV.

31. The ability to halt the epidemic requires a three part strategy: (i) preventing drug abuse, especially among young people; (ii) facilitating entry into drug abuse treatment; and (iii) establishing effective outreach to engage drug abusers in HIV prevention strategies that protect them and their partners and families from exposure to HIV, and encourage the uptake of substance abuse treatment and medical care.
32. Treatment services need to be readily available and flexible. Treatment applicants can be lost if treatment is not immediately available or readily accessible. Treatment systems need to offer a range of treatment alternatives, including substitution treatment, to respond to the different needs of drug abusers. They also need to provide ongoing assessments of patient’s needs, which may change during the course of treatment. Longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours or an increase in protective behaviours.

33. Developing effective responses to the problem of HIV among drug abusers is likely to be facilitated by considering the views of drug abusers and the communities they live in. Programmes need to be reality based and meaningful to the people they are designed to reach. The development of such responses is likely to be facilitated by assuring the active participation of the target group in all phases of programme development and implementation.

34. Drug abuse treatment programmes should provide assessment for HIV/AIDS and other infectious diseases, and counselling to help patients change behaviours that place them or others at risk of infection. Attention should be paid to drug abusers’ medical care needs, including on-site primary medical care services and organized referrals to medical care institution.

35. HIV prevention programmes should also focus on sexual risk behaviours among people who inject drugs or use other substances. Epidemiological research findings indicate the increasing significance of sexual HIV transmission among injecting drug abusers as well as among crack cocaine abusers. Drug abusers perceive sexual risk in the context of a range of other risks and dangers, such as risks associated with overdose or needle sharing, which may be perceived to be more immediate and more important. The sexual transmission of HIV among drug abusers may often be over-looked.

36. Outreach work and peer education outside the normal service settings, working hours and other conventional work arrangements is needed to catch those groups that are not effectively contacted by existing services or by traditional health education. It is necessary to have a back up of adequate resources to respond to the increase in client and casework load that is likely to result from outreach work.

37. A comprehensive package of interventions for HIV prevention among drug abusers could include: AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, bleach materials, and referral to a variety of treatment options.

38. Care and support, involving community participation, must be provided to drug abusers living with HIV/AIDS and to their families, including access to affordable clinical and home-based care, effective HIV prevention interventions, essential legal and social services, psychosocial support and counselling services.
Annex II

Bibliography


**Relevant Websites:**

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- http://www.unaids.org
- http://www.who.int/hiv/topics/harm/reduction/en/
- http://ww1.aegis.org
- http://www.chr.asn.au/projects
- http://www.ihra.net/
- http://www.ahrn.net/
- http://www.idurefgroup.org/indicators/indicator.php
- http://www.harmreduction.org
Annex III
Regional Projects

1. UNODC Project ‘Reducing HIV Vulnerability from Drug Abuse’
   (AD/RAS/02/G22)

The Regional UNODC Project ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22) was designed to address the emergent HIV epidemic among drug users, especially injecting drug users (IDUs) in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam. The regional project’s overall objective is to address the interface of HIV/AIDS and drug use by decreasing the chances of HIV-related risk behaviours connected to the use of drugs, in particular those that are injected. In addressing the above objective, the regional project aims at establishing interdepartmental links between the ministry of public security and that of public health in each of the above-mentioned countries. In the process of establishing such intersectoral partnerships, the project engaged in organizational assessments of every drug agency; on the basis of the latter, the project will provide training to increase each respective drug agency’s organizational capacity to produce integrated national work plans to reduce HIV vulnerability from drug abuse. In the second year, the project will further support national work plans while also undertaking regional development of primary prevention through a life skills approach toward youth, and the development of a sustainable network of national and regional interests in light with best practices identified as major HIV prevention strategies among drug users.

2. Asia Regional HIV/AIDS Project (ARHP)

The Asia Regional HIV/AIDS Project (ARHP), an A$ 9.37 million AusAID-funded Project is designed to target regional action to strengthen the capacity of countries to take a more strategic and evidence-based approach to policymaking, planning and programming to reduce HIV related harm associated with injecting drug users (IDUs). The geographic areas of activities are China, Myanmar and Viet Nam. In China, Project activities take place in Guangxi Zhuang Autonomous Regions and Yunnan Province, with limited work at the national level. The Project is based on four components: 1) Institutional capacity building: To establish a supportive policy environment for effective approaches to HIV/AIDS and IDUs. This component focus on institutional capacity building in the law enforcement and health sectors to build their awareness and capacity in relation to effective strategies to prevent HIV infection among IDUs; in this regard, police curricula on harm reduction will be administered. Furthermore, this component aims at building collaborative linkages between law enforcement and health authorities in order for the two sectors to work together to develop a supportive policy environment for effective future interventions. 2) Expanding effective approaches: To facilitate implementation of an expanded range of effective interventions addressing HIV/AIDS among IDUs. Component 2 focuses on community level capacity building and support to generate and publicize evidence-based responses to HIV/AIDS and IDU problems. 3) Regional Cooperation: To strengthen regional cooperation in addressing the HIV epidemic among IDUs. This component focuses on activities to raise evidence dissemination and discussion of effective approaches to the inter-country and to the regional level; study tours and consultations will be part of this component among other activities. 4) Project Management.
Annex IV

List of Documents Previously Distributed by UNODC Regional Centre for East Asia and the Pacific (Bangkok)

1/2000 Summary of the Meeting on the Regional Centre’s Strategies for the Pacific Region
2/2000 Report of the Conference on Amphetamine-Type Stimulants in East and South East Asia, Tokyo, Japan, 24-27 January 2000
5/2000 Eastern Horizons No. 1 March 2000
7/2000 China Country Profile
9/2000 UNDCP and ASEAN Drug Demand Reduction Strategies
11/2000 Status of donor contributions to all projects as of end March 2000
12/2000 Tripartite Review Meeting (Terminal): Reducing Illicit Drug Use in the Highlands of East Asia
14/2000 Eastern Horizons No. 2 June 2000
15/2000 UNDCP Activities Report in East Asia and the Pacific: Thirty years fighting drugs through leadership and participatory cooperation
18/2000 Lights on harm of drug abuse, corruption and violence (press kit), International Day against Drug Abuse and Illicit Trafficking, 26 June 2000
19/2000 Subregional Workshop for Cross-Border Law Enforcement Cooperation in East Asia (AD/RAS/99/D91), 4-6 July 2000
20/2000 Terminal Report for Interdiction and Seizure Capacity Building in Yunnan Province, China (AD/RAS/94/714-968)
21/2000 Terminal Report for Interdiction and Seizure Capacity Building between China and Myanmar (AD/RAS/93/713-913)
22/2000 Eastern Horizons No. 3 September 2000
24/2000 Good Practices and Lessons Reducing Illicit Drug Use in the Highlands of East Asia
25/2000 A “World Class” Training Opportunity to Strengthen Drug Control Measures
12/2001 Pacific Islands Regional Profile
13/2001 IDU and HIV Vulnerability: Choices and Consequences in Asia and the Pacific
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1/2004  Project Activities Report (AD/RAS/00/F73)

2/2004  Drugs and HIV/AIDS in South East Asia: A Review of Critical Geographic Areas of HIV/AIDS Infection among Injecting Drug Users and of National Programme Responses in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam (AD/RAS/02/G22)

The above documents can be obtained through the website of UNODC Regional Centre for East Asia and the Pacific: http://www.unodc.un.or.th
APPENDIX

World Health Organization (WHO) Definition of Harm Reduction

What it is

In public health, ‘Harm Reduction’ is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, ‘harm reduction’ components of comprehensive interventions aim to prevent transmission of HIV and other infections that occurs through sharing of non-sterile injection equipment and drug preparations.

Why it is Important

- Re-using and sharing needles, syringes or other equipment for preparing and injecting drugs represents a highly efficient way of HIV transmission. Worldwide there may be as many as 2-3 million past and current IDUs living with HIV/AIDS, and more than 110 countries now report HIV epidemics that are associated with IDU.
- In the absence of harm reduction activities, HIV prevalence among IDUs can rise to levels up to 40% or more within 1 or 2 years of introduction of the virus in their communities.
- HIV transmission through sharing of non-sterile injection equipment is augmented by sexual transmission both among IDUs and between IDUs and their sex partners. Hence, harm reduction carries significant HIV preventive potential for both IDUs and the general population.
- Interventions for IDUs that reduce HIV risks also have the potential to engage drug users in drug dependence treatment services that may ultimately lead to abstinence from drug use. Finally, such programmes can help to avoid other harmful consequences of drug use, including hepatitis B/C infections and overdose deaths.

How it is Done

Successful harm reduction is based on a policy, legislative and social environment that minimizes the vulnerability of IDUs. Harm reduction for IDUs primarily aims to help them avoid the negative health consequences of drug injecting and improve their health and social status. To this end, harm reduction approaches recognize that for many drug users total abstinence from psychoactive substances is not a feasible option in the short term, and aim to help drug users reduce their injection frequency and increase injection safety. The following are typically components that have a significant potential to reduce individual risk behaviours associated with drug injection:

- Needle-Syringe Programming (NSP) aims to ensure that those drug users who continue injecting have access to clean injection paraphernalia, including needles and syringes, filters, cookers, drug containers and mixing water. Specific interventions that equip drug users with sterile injection equipment usually also collect used needles and syringes, and are commonly known as ‘needle exchange programmes’ (NEPs). Such programmes can also serve as information points and may engage drug users with drug treatment services. Their ability to break the chain of transmission of HIV and other blood borne viruses is well established. Disinfection programmes have been used in settings where needle exchange is not feasible. It is hoped that drug users who disinfect their injection paraphernalia after use with chemical substances (usually household bleach) adequately decontaminate the

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54 The section on the ‘definition of harm reduction’ is quoted from http://www.who.int/hiv/topics/harm/reduction/en; for references and more information, please see the WHO website.
equipment before reuse. The effectiveness of disinfection procedures depends to a large extent on the method used, is of varying efficiency, and is therefore only seen as a second line strategy in needle-syringe programming.

- **Drug substitution treatment** involves the medically supervised treatment of individuals with opioid dependency based on the prescription of opioid agonists such as methadone. Whilst the primary goal of drug substitution treatment is abstinence from illicit drug use, many patients are unable to achieve complete abstinence, despite improvements in their health and well being. However, there is clear evidence that methadone maintenance significantly reduces unsafe injection practices of those who are in treatment, and hence the risk of HIV infection.

- **HIV/AIDS related treatment and care** primarily aims to help drug users living with HIV/AIDS cope with the infection. Involving HIV positive drug users in primary health care and/or anti-retroviral treatment programmes provides an opportunity for them to adopt and consolidate safe behaviours and may yield significant HIV preventive effects. This applies in particular to HIV/AIDS treatment and care that is provided in the context of specific information and counselling services.

- **Information, education and communication (IEC)** on HIV transmission through IDU provides information which will assist drug users avoid or modify drug injecting behaviours. Involving IDUs in the development and design of information material is critical to increase its appropriateness. The content of IEC materials should cover both the risks of injection and sharing practices as well as advice on how to reduce these risks and avoid sharing of injection equipment. IEC can be delivered through a variety of channels, ranging from general awareness campaigns, the provision of targeted information through health and social services frequented by IDUs to delivery of information through peer and drug user networks and outreach workers. ‘Risk Reduction Counselling’ represents a particular method that is based on face-to-face communication and provides an opportunity for drug users to turn information into actual behaviour change through a process of clarification and re-enforcement. Often, risk reduction counselling is offered in the context of HIV testing and counselling.

Embedding harm reduction activities into comprehensive prevention packages for IDUs is indispensable for their success. This applies in particular to complementing safer injection messages by safer sex messages and condom promotion. Comprehensive HIV/AIDS programming should aim to provide opportunities for all IDUs to access the whole range of services described in this document. Recognising the hidden and often rapidly changing nature of drug injecting, reaching as many individuals as possible who inject on a regular or occasional basis represents a particular challenge to harm reduction services and necessitates an in-depth understanding of local drug use patterns and contexts. For this reason, harm reduction programming is often informed by situation assessments. Situation assessments can also act as a catalyst for communities to learn about the necessity of evidence-based approaches to HIV prevention among IDUs and to reduce controversy about their introduction.

**Human resources, Infrastructure and Supplies Needed**

Providing IDUs with access to information, motivational and skills training, clean injection equipment and condoms is a time intensive process and requires significant human resources. In particular, drug dependence and HIV/AIDS treatment require specific medical expertise and are usually provided by specialized clinics. However, the communication of basic harm reduction messages and skills alone does not necessitate complex education, and health personnel can be trained at low cost to deliver such prevention messages through existing health services. Likewise, community based HIV prevention services for IDUs may involve lay personnel if trained appropriately. Particularly promising are peer led approaches to outreach work that rely on the diffusion of safe injection messages into drug using networks, as are models of organizing needle syringe programming through such networks.
Harm reduction programmes aim to provide their services in close contact to IDUs. Often they operate out of community based centres, and some countries have used existing infrastructure, such as health services or pharmacies. Of particularly importance are approaches that reach out to where the drug users are, using vehicles and/or outreach workers. Key supplies needed include information material, condoms, and injection paraphernalia. Programmes that only reach a minority of IDUs may yield benefits for those participating but are unlikely to significantly influence the course of the HIV epidemic at the population level. Hence, appropriate coverage of IDUs is an important target for national HIV/AIDS programming, and should include IDUs involved in sex work, living in prisons or forming part of ethnic minorities.

Cost Information

The economic evaluation of a harm reduction programme in Belarus has shown that one HIV infection could be averted for as little as US$ 68 – a powerful example of the favourable cost effectiveness of such interventions. However, the financial costs of harm reduction services will vary widely between countries, depending both on the appropriate mix of services and associated time and material costs.  

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55 The economic evaluation of the cost per person of a behavioural change intervention with IDUs in South East Asia, including outreach and STI treatment, was estimated by UNAIDS (2003) to be somewhere between 60-150 US$.  
56 This section was downloaded from the World Health Organization’s (WHO) website (www.who.int/hiv/topics/harm/reduction/en). WHO in collaboration with AusAID is providing active support in strengthening country capacity for HIV/AIDS prevention among IDUs. Technical assistance – such as the WHO training and information toolkits – has been provided to China, Indonesia, Myanmar and Viet Nam in collaboration with regional partners to scale up HIV/AIDS prevention activities such as advocacy, assessments, surveillance, planning, programming and capacity building. WHO activities will complement the work of other UN agencies efforts in the region, namely UNAIDS and UNODC.