



Rapid assessment and response: Preparation for the scale-up of comprehensive harm reduction services in Thailand



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Foreword

Harm reduction has been slow in coming to Thailand. This has no doubt been due to a repressive environment, exemplified by “suppression” campaigns, such as the well-documented “War on Drugs” conducted in 2003–2004. This has worked against harm reduction efforts by creating a climate of fear in which people who inject drugs (PWID) have been driven underground. In contrast to this, Global Fund support for the Champion IDU Programme aims to establish a government backed enabling environment for the scale-up of harm reduction services in Thailand. The enactment of a national harm reduction policy, which is currently under review, would further facilitate the provision of services to reverse the spread of human immunodeficiency virus (HIV) among PWID and their partners and families, assist in the scale-up of antiretroviral treatment and improve the delivery of opiate substitution therapies.

The rapid assessment and response (RAR) studies that are summarized in this report provide a foundation on which we can build a more accurate picture of injection drug use in Thailand. This will allow us to develop better informed harm reduction interventions. As such, this set of RARs should also be viewed as the beginning of a coordinated research programme, which will include other studies such as the Integrated Biological and Behavioral Survey, PWID population size estimation and other epidemiological research studies.

The RARs have raised many questions that were not answerable within the scope of a rapid assessment, in particular regarding methamphetamine use and the transition from smoking to injection of methamphetamine, which is particularly worrisome given the large numbers of methamphetamine users in Thailand. Another issue raised is the need for scaled-up needle and syringe programmes throughout the country; more research is needed to identify the specific locations, target groups and types of programmes required.

We hope that this report will help to stimulate coordinated momentum in research and the rapid development and implementation of well-informed harm reduction programmes, whether through the CHAMPION IDU Programme or otherwise.

Drug users and in particular PWID have waited far too long.



Ton Smits
Executive Director
Asian Harm Reduction Network
Chiang Mai, Thailand
June 2010

'Harm reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.

International Harm Reduction Association
www.ihra.net



Abbreviations

AHRN	Asian Harm Reduction Network
AIDS	acquired immunodeficiency syndrome
APMG	AIDS Projects Management Group
ART	antiretroviral therapy
ASCAN	Administrative Committee for the Substance Abuse Academic Network
DIC	drop-in centre
FHI	Family Health International
HCV	hepatitis C
HIV	human immunodeficiency virus
IBBS	Integrated Biological and Behavioral Survey
IDU	injection drug use
MARP	most-at-risk population
MOPH	Ministry of Public Health
MSM	men who have sex with men
NAMC	National AIDS Management Centre
NSAC	Northern Substance Abuse Center
NSP	needle syringe programme
ONCB	Office of Narcotic Control Board
PSI	Population Services International
PWID	people who inject drugs
RAR	rapid assessment and response
STI	sexually transmitted infection
TDN	Thai Drug Users Network
TUC	Thai US Collaboration on Disease Control
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
US	United States
WHO	World Health Organization

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I Introduction

Thailand has been rightfully held up as an international example in responding to the human immunodeficiency virus (HIV) epidemic, through its well-reported 100% Condom Programme, which significantly reduced HIV incidence and prevalence among female sex workers. Despite this success, HIV prevention among people who inject drugs (PWID) has been insufficient, as evidenced by prevalence rates among PWID that have remained consistently 30–50% over the past two decades.

In 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Round 8) provided a grant to Population Services International (PSI) to help prevent new HIV infections among most-at-risk populations (MARPs) in Thailand. Supported by this grant, the CHAMPION IDU Programme includes a significant component to address the HIV epidemic among PWID by scaling up a range of harm reduction services across the country. In order to obtain the information needed to develop these services, rapid assessment and response (RAR) studies were conducted at eight sites in southern, northern and central Thailand during February–April 2010.

The ultimate goal of the CHAMPION IDU Programme is to reduce HIV incidence among PWID in Thailand. This is to be accomplished through strengthening and scaling up the delivery of comprehensive HIV prevention services, while also building a strong enabling environment for equitable and sustainable delivery of HIV services for PWID. Establishment of strategic information systems, which include the RARs, was considered necessary for the development of programmes, services and policy for PWID. A baseline survey (the Integrated Biological and Behavioral Survey, or IBBS) and end-term evaluations are also being conducted to monitor progress and to evaluate outcomes.

The focus of the RARs was on illicit drug use and injection drug use in particular. Although misuse of alcohol and prescription drugs is a significant problem in Thailand, these topics were not included under the scope of the current research.

The Asian Harm Reduction Network (AHRN) partnered with the Northern Substance Abuse Centre (NSAC) and the Administrative Committee for the Substance Abuse Academic Network (ACSAN) to implement the eight RARs. Three academic teams (all members of ACSAN) were formed in the north, south and in Bangkok to conduct fieldwork and write site reports, which are available for all eight sites in Thai and English.ⁱ

The findings of these RARs are summarized in this consolidated report and presented alongside recommendations (both general and region-specific) for the realization of a comprehensive harm reduction approach to addressing the epidemic of HIV among PWID in Thailand. In order to provide a context in which these findings and recommendations might be better understood, this report also presents an overview of drug use in Thailand, its history, patterns of use, impacts, policies and harm reduction efforts.

The responses recommended in this report include scaled-up opiate substitution, needle syringe programmes, access to voluntary counselling and testing, provision of adequate primary health care for PWID and improved access to antiretroviral therapy (ART). Recommendations are also made about policy related to drug use and harm reduction, and about crucial areas for research. Considering the fragility of the political and social environment where implementation of harm reduction services takes place, this report also makes recommendations about the continued need to foster an enabling environment between networks of PWID, outreach teams, health sector workers and the law enforcement community.

Global Fund assistance for the CHAMPION IDU Programme heralds the possibility of developing a government supported enabling environment for harm reduction services in Thailand. Government endorsement and implementation of the harm reduction policy currently under review, remains extremely important.



ⁱ The RAR site reports can be found under “New publications in the library” on the AHRN website: www.ahrn.net

II Methods

AHRN partnered with the NSAC and ACSAN to implement the RARs. The Research Manager, Dr Mark E Barrett and the Technical Advisor, Dr Nicholas Thomson developed the research design and data collection tools on behalf of AHRN. Under the leadership of Dr Apinun Aramrattana, ACSAN formed three teams, in the north, centre (Chulalongkorn University) and south (Prince of Songkla University) to implement data collection and analysis. These teams had considerable research experience, and several members had participated in the last RAR on injection drug use (IDU), which was conducted in 2005 by the AIDS Projects Management Group (APMG).¹

Site selection

At a meeting on 12 October 2009, attended by representatives from the National AIDS Management Centre (NAMC), Thai US Collaboration on Disease Control (TUC), the Ministry of Health Bureau of Epidemiology (BOE), the Joint United Nations Programme on HIV/AIDS (UNAIDS), Population Services International (PSI) and AHRN, eight sites were selected for the RARs based on the following principles:

- ⊙ RARs should cover some new sites where no programme activity has taken place and about which little is known, and some existing sites with large PWID communities. In sites with no existing IDU programme activity, sites should be chosen where programming is scheduled to begin in the year 2010, so that the results of the RAR will still be valid for those programmes.
- ⊙ RARs should be conducted in a mixture of sites that have drop-in centres (DIC) and outreach programmes, and sites that have outreach only.
- ⊙ In provinces covered by the IBBS, the RAR will avoid overlap or interference with IBBS sampling of PWID communities.ⁱⁱ



Table 1 lists the eight sites selected for RAR and their characteristics regarding the principles described above.

Location	Site characteristic	Programme activities	Activities start	IBBS
Bangkok area	Large PWID community	DIC and outreach	Existing	Yes
Ratchaburi province	New site	Outreach	Year 1	No
Chiang Mai	Large PWID community	DIC and outreach	Existing	Yes
Fang	New site	DIC and outreach	Year 1	No
Mae Hong Son province	New site	Outreach	Year 1	No
Surat Thani	New site	DIC and outreach	Year 1	No
Songkla	Large PWID community	DIC and outreach	Existing	Yes
Satun	New site	DIC and outreach	Year 1	No

Source: The authors

Table 1: RAR sites

ⁱⁱ The decisions about how RAR sampling of PWID and data collection would be conducted in IBBS sites were made in consultation by BOE, PSI, TUC, UNAIDS and representatives of implementing partners collaborating as the Technical Working Group.

Data collection, methods and instruments

Data collection began following a design workshop, which was a consultative meeting of partners and stakeholders held on 22 November 2009. The methodology for RARs was different at each site ⁱⁱⁱ, based on whether there were already DICs or outreach programmes in place, and whether or not the IBBS planned to collect data in that area. The use of quantitative surveys of large numbers of PWID was avoided in Bangkok, Chiang Mai and Songkla; whereas quantitative surveys were possible at the new sites: Ratchaburi, Fang, Mae Hong Son province, Surat Thani and Satun.

World Health Organization (WHO) guidelines for conducting RAR on PWID were used to develop the methodology data analysis plans. ² Data was collected through interviews with PWID and other key informants, as well as a structured questionnaire for PWID.

Figure 1 provides a diagrammatic view of the RAR process. Secondary data sources, such as on treatment and arrests from the Office of Narcotic Control Board (ONCB), and on the epidemiology of drug use and HIV from the Ministry of Public Health (MOPH), were very useful. Also, surveys on PWID in Bangkok and Chiang Mai (conducted in 2008 and 2009) provided good descriptive data on injection drug use and HIV risk behaviors.

The timeframe for the RARs included three months for planning (October, November and December, 2009) and three months for data collection and analysis (January, February and March, 2010).

Limitations

Conducting RARs on IDU in Thailand is extremely challenging due to the illegal nature of drug use and the harsh law enforcement climate; accordingly, there were several limitations that must be acknowledged regarding this study. The RARs accessed only a limited amount of qualitative data at most sites. The report would have been greatly enhanced by conducting observational fieldwork, mapping harm reduction services

and IDU ‘hotspots’, and collecting a wider array of qualitative data from interviews with key informants, PWID and focus group discussions. This would have enabled a much deeper enquiry into issues such as methamphetamine injection and female IDU. There were also restrictions on accessing PWID due to a requirement that RAR teams should not interfere with ongoing research studies targeting PWID at the sites. Thus, it was not possible in most locations to conduct quantitative surveys using structured questionnaires. Finally, the timeframe for data collection was short, and given the number of sites that each investigator was responsible for covering – three in the south, three in the north, and two in the central region – there were limitations on community preparation activities and in-depth data collection at all sites.

Reporting

The eight site reports were provided to PSI at the end of March 2010 for use in planning services for CHAMPION IDU Programme sites. This consolidated report was derived from those site reports, but also includes a general review of literature on IDU and harm reduction in Thailand. The summary of findings presents a general picture of IDU across the sites, regional findings (for the south, Bangkok and the north) ^{iv} and the need for scale-up of harm reduction services. Both general and site-specific recommendations are made for the realization of a comprehensive harm reduction approach to addressing the epidemic of HIV among PWID in Thailand.

ⁱⁱⁱ The eight site reports give a detailed description of data collection methods for each site. These can be found under “New publications in the library” on the AHRN website: www.ahrn.net

^{iv} The northeast of Thailand was not included in this RAR.

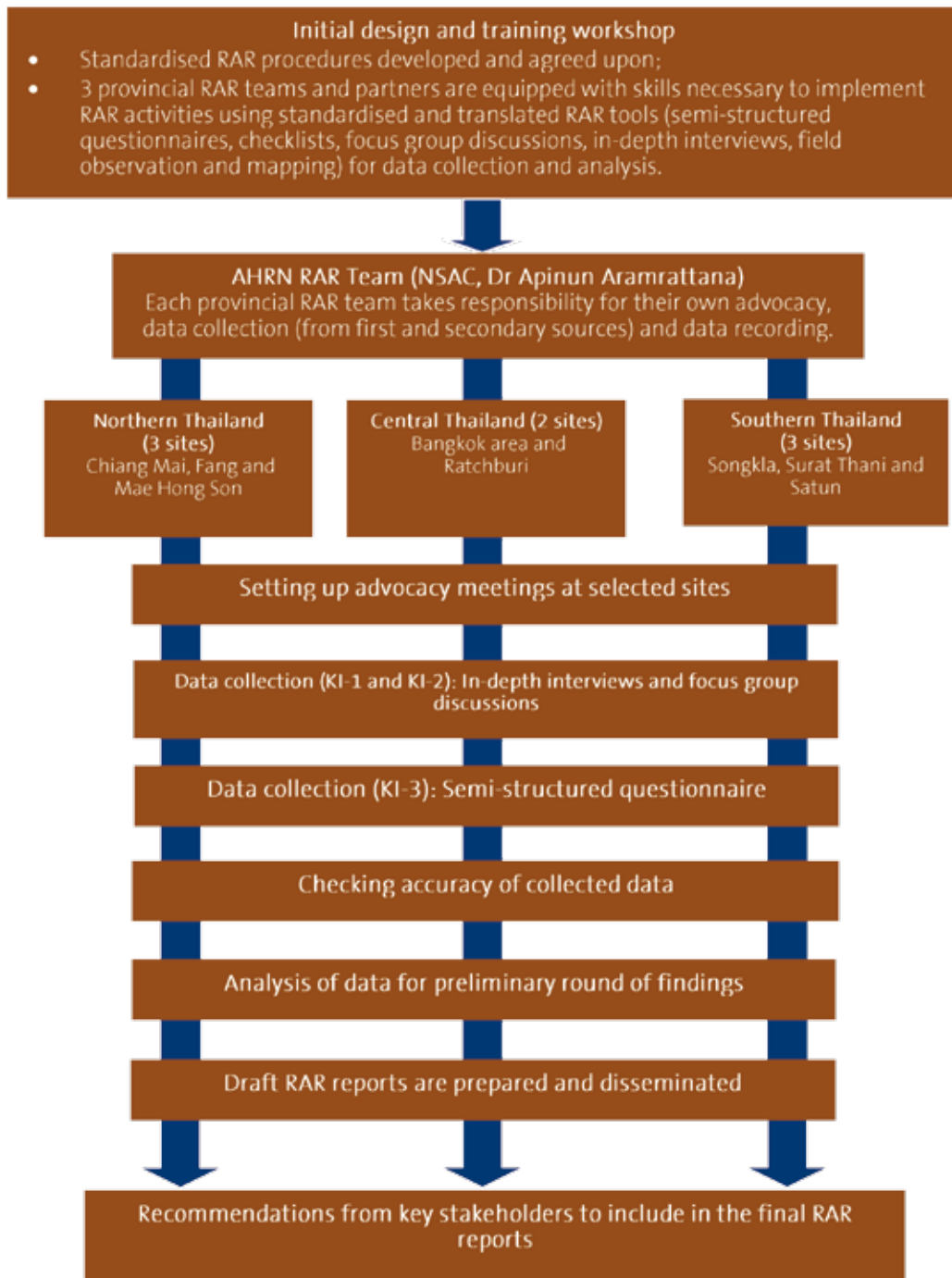


Figure 1: RAR planning and implementation
Source: The authors



III Background and literature review

In order to understand the needs and challenges of scaling up harm reduction services in Thailand it is important to understand the historical, policy and public health context. This background section summarises the literature and documents harm reduction efforts implemented in response to drug use. Through an examination of the history of drug availability, patterns of use and the interventions of government and non-government actors, we illustrate the current needs of drug users, particularly with regards to HIV.

From opium to methamphetamine: A brief history of the drug trade in Thailand

The history of drug trade in South-East Asia is convoluted and complex. Many authors have mapped the history of the trade in opium across the Bengal Sea, from the Ganges in India to the ports of Nan King in China. A number of accounts have documented the rise of the British East India Company and its role in the opium trade into China. The full historical significance of the trade in opium is outside the scope of this report, but it helps to contextualise the current trade in heroin and methamphetamine in South-East Asia.

Three centuries of opium trade cultivated mass demand across South-East Asia and the economic prosperity of many nations was derived largely from the taxes gained from opium dens. International and national attempts at suppression of opium were met with the emergence of smugglers willing to meet the demand of users. In many instances, the suppression of opium led to the widespread production of morphine and heroin. While multinational efforts at drug suppression were able to reduce the overall availability of opium and heroin, this was short-lived as the trade became increasingly the domain of transnational crime syndicates.

During the Second World War, the illegal opium trade routes were blocked from Persia and India into China. In response the French encouraged Hmong farmers to expand opium production across the mountainous regions of South-East Asia.³ When Burma gained independence from Britain at the end of the Second World War, opium cultivation and trade flourished in the Shan States.

The political ideologies of the Cold War converged in the Golden Triangle region of South-East Asia. The communist party of China eliminated the world's major opium market within a decade and forced remnants of the Nationalist regime into the geographical margins of South-East Asia. This played a significant role in the development of the region's drug trade. In addition, the efforts of the United States (US) government to contain the spread of communism involved forging alliances with tribes and warlords in the Golden Triangle. In return for siding with the US,

rebel groups were provided with arms and air transport, supporting the production and sale of opium.⁴

1973 saw the creation of the US Drug Enforcement Agency and the beginning of significant investments in bilateral anti-drugs operations between the US and Thailand, targeting opium and heroin production and trafficking in the Golden Triangle. While heroin transportation to the US from South-East Asia declined after the fall of Saigon in the mid-1970s, opium production increased as the military junta took control of Burma in 1988.

Since the early 1970s, opium production in Burma's Shan States had been dominated by the warlord Khun Sa. He had built a strong army with finances gained from the narcotics trade and was able to conduct his activities, seemingly immune from the Burmese military. As the Thai army bombed his bases on the Thai-Burmese border, his army protected him and he simply went deeper into Burma. In 1996, a peace deal brokered between Burma's ruling military and Khun Sa led to a temporary closure of the heroin trade. It was at this critical juncture that methamphetamine took hold. The parties that took over the heroin trade also realized the profitability of methamphetamine production. When heroin eventually returned to the market place, so did the relatively inexpensive methamphetamine tablets, known locally as "ya ba".^v

Methamphetamine production and trafficking in the autonomous zones of Burma continued to flourish. Drug trafficking networks, long established through the opium and heroin trade, adapted with ease to the new methamphetamine market. A shift of investment from heroin to methamphetamine, rather than pressure on opium farming is suggested as the main reason that methamphetamine began flooding the Thai market post-1996. Thai officials estimated that in 1997, 100 million tablets were distributed in Thailand; by 2000 this had increased to 400 million. In 2004, the US State Department estimated that about 800 million methamphetamine tablets were being produced in Burma, of

^v Throughout this report references to methamphetamine are to the tablet form of the drug, unless stated otherwise.

which approximately 80% were being consumed in Thailand.⁵

Epidemiology and patterns of drug use in Thailand

The first attempt at estimating the numbers of drug users in Thailand was in 1921, when it was estimated that there were 200,000 opium users. It is thought that the opium using population remained steady until 1959 when the government banned the smoking and selling of opium and required that addicts register themselves. Within six months, 70,000 opium addicts had been registered.⁶ Since then many attempts have been made to accurately reflect the number of people who use drugs, including three national household surveys.

There have also been a variety of surveys using different methodologies to estimate the total number of PWID. In 1993, the Thailand Development Research Institute estimated that there were between 100,000 and 250,000 PWID. Since then estimates of the numbers of PWID have varied widely from between 40,000⁷ to 240,000⁸.

There is little doubt that the banning of opium contributed to the production of heroin in the region. Some sources suggest that Bangkok became one of the largest heroin production centres in world⁹. During the early 1960's, the most common method of using heroin was to smoke it. However, by the late 1960s reports emerged of a more pure form of heroin spreading throughout Thailand; this was accompanied by the earliest reports of heroin injection. In 1976, it was

reported that Thai adolescents were injecting heroin and that 24,000 had sought treatment. This number had increased to 35,000 by 1988 and it was felt that heroin injection was entrenched in many parts of the country¹⁰.

The Thai authorities believed they had stamped out the last remaining heroin refineries in Thailand by 1998¹¹. The ONCB reported that in 1996, 405 kg of heroin was seized from 25,347 cases and in 2000 386 kg was seized from 4,184 cases.¹² Since then they report a steady decline in the amount of heroin seized – outside of a significant spike in 2005, of 954.6 kg from 491 cases. In 2009, the ONCB reported that heroin seizures had dropped to 113.9 kg from 222 cases.¹³

The availability and use of methamphetamine increased from 1996 onwards and hit a peak in 2003. A reported decline was attributed to the increased suppression efforts of the “War on Drugs”.¹⁴ Recently however, the availability of methamphetamine has increased to pre-2003 levels and crystal methamphetamine, also known as “ya ice”, is increasingly available in Thailand.¹⁵ As is the case with heroin, methamphetamine is largely produced in Burma and trafficked into Thailand, then re-exported from Thailand into other countries including Brunei Darussalam, Hong Kong, Indonesia, Japan, Malaysia, the Philippines and Singapore.¹⁶

Estimates of the size of the population of people who inject drugs

Attempts to estimate the size of the population of PWID in Thailand have been conducted using various methods including capture–recapture, case numbers of PWID seeking treatment, adjusting rates based on PWID-related HIV case reporting and through the systematic review of secondary data.¹⁷ Between 1991 and 2002, the reported number of PWID attending Bangkok’s drug treatment clinics declined from 7,500 to 4,000. At the same time, the number of non-injecting methamphetamine users (i.e. those smoking or swallowing the drug) seeking treatment far outweighed people seeking treatment for opiate dependence.¹⁸

Figure 2 illustrates the change in proportion of new drug users admitted to treatment, between 1992 and 1999. It shows a dramatic decline in the proportion admitted for heroin use (75%–20%) and a great increase in the proportion ad-

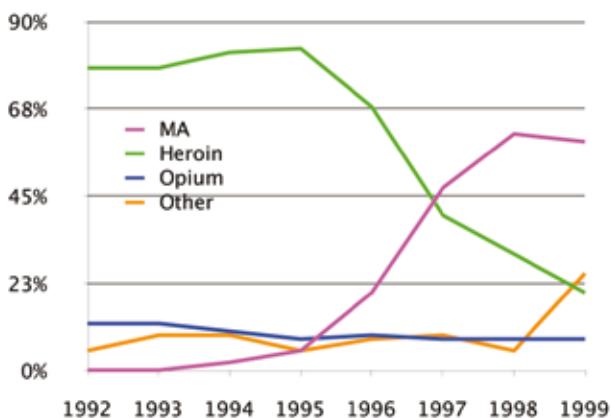


Figure 2: Proportion of new drug users admitted to treatment (1992–1999)

Source: Ministry of Public Health, Thailand, 2000.

mitted for methamphetamine use (0%–60%). In 2003, the number of PWID seeking treatment in Bangkok had dropped to 2,000 and by 2004 this number had fallen to 1,000 – leading the Bureau of Health Service System Development to note an 87% reduction.¹⁹ Explaining this drop in numbers is more difficult.

In 1991, Mastro et al conducted a capture–recapture survey among PWID in Bangkok and estimated that there were 36,000 PWID, of whom 89% were heroin injectors.²⁰ In 2004, Wattana et al used respondent driven sampling to recruit PWID in Bangkok and compared the numbers of PWID previously or currently in treatment with those who reported never being in treatment. Through this process they estimated that there were 3,595 PWID in Bangkok,²¹ a 90% reduction since 1991. Whilst it is reported that there are clusters of PWID in Chiang Rai, Chiang Mai and southern Thailand there is little direct information on the number of PWID outside of Bangkok.²² Despite the lack of real information, PWID numbers have been estimated based on the 1991 Mastro study and various adjusted estimates have been made from that original data.

In 2004, the United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries reported PWID numbers in Thailand as ranging between 20,000 and 76,000 with a mid-point estimate of 48,000.²³ In 2008, the Reference Group to the United Nations on HIV and Injecting Drug Use reported data from 2001 which estimated that there were 160,000 PWIDs.²⁴ This 2001 estimate has since been used by Chatterjee and Sharma in a 2010 paper estimating coverage of PWID populations by needle syringe programmes (NSPs) and opiate substitution therapy.²⁵ Furthermore, this was the figure used in estimating harm reduction scale-up needs for the CHAMPION IDU Programme.

In 2008, Family Health International (FHI) published an estimate of the population of PWID in Thailand as 38,380 in 2004, (based on the 1991 Mastro study and following a complex series of adjustments and variables).²⁶ Despite this, the two United Nations (UN) reference groups and the CHAMPION IDU Programme continue to use the 2001 estimate, which is four times higher than the FHI estimate. This could result in a distorted evaluation of coverage²⁷ and the cost of providing such services.²⁸

Confounding any estimate of the current number of PWID is the fact that none have attempted to include the numbers of PWID who are currently

incarcerated²⁹ within Thailand’s prison system. A recent study by Hayashi et al recruited 252 PWID from Bangkok, of whom 78.2% had reported ever being incarcerated. Whilst this sample size was small, the number of PWID in Thailand’s prison system is significant. In 2010, the Thai government is planning to conduct a national survey to estimate the size of the PWID population, and has scheduled a methodology planning meeting for June that year.³⁰

Estimates of the size of the population of non-injection drug users

The use of a variety of non-injection drugs is common in Thailand and includes cannabis, kratom, ecstasy and cocaine.³¹ But the illicit use of methamphetamine and more recently crystal methamphetamine poses the most significant issues for public health and law enforcement.

Since 1996, the availability and use of methamphetamine has escalated and it has become the most frequently used illicit drug in Thailand.³² Prior to 1996, the use of methamphetamine was predominantly associated with construction and labour industries and the drug was ingested to provide additional energy for work.³³ With an increased supply and deliberate marketing campaign, the recreational use of methamphetamine has escalated since 1997 and by 2002 the ONCB estimated there were 2.5 million methamphetamine users.³⁴ Methamphetamine tablets vary in chemical composition but in general, contain approximately 25% active methamphetamine.³⁵

The first Thai National Household Survey was conducted by the Academic Committee on Substance Use in 2001. It estimated that 3.49 million people aged 15–60 reported ever using methamphetamine. A second national household survey conducted in 2003, suggested that approximately 1 million people had used methamphetamine in the previous year. The survey also found that of the 450,000 people who reported using methamphetamine in the 30 days prior, 73% were aged 12–24.³⁶ Methamphetamine use recently increased to similar levels to those seen prior to the 2003 “War on Drugs”, and recent reports of a significant increase in the trafficking of methamphetamine from Burma into Thailand, has authorities concerned.³⁷

HIV prevalence among people who inject drugs

The first reported case of HIV infection in Thailand was detected in a male sex worker in 1984.³⁸ Subsequent serosurveys among male sex workers from 1985 to 1990, at various locations across Thailand, showed that the HIV seroprevalence did not surpass 4%.³⁹ The HIV epidemic escalated dramatically after this, characterized by a series of subepidemics affecting different groups including PWID, men who have sex with men (MSM) and female sex workers.

Throughout the 1990s, HIV prevalence among female sex workers was reported to be 33%, leading to one of the world's most successful HIV prevention campaigns, the 100% Condom Programme. This sustained campaign saw HIV prevalence among female sex workers drop to a reported 4% in 2008. Despite the widespread success of the 100% Condom Programme, the HIV epidemic has manifested itself particularly among MARPs. In 2007, HIV prevalence was found to be 30% among MSM in Bangkok, and among PWID HIV prevalence has only once dipped below 30% since 1988.

In 2008, UNAIDS estimated that there were 610,000 people (range of 410,000–880,000) living with HIV and a national prevalence rate of 1.4% (0.9%–2.1%) among the adult population aged 15–49. HIV incidence continues to be high in certain groups: Of new HIV infections nearly a third are found in married women, followed by MSM (26%) and PWID (7%).⁴⁰

Whilst the epidemic appeared to start slowly in some sentinel groups, PWID experienced an explosive spread of HIV. Rates of HIV among PWID were minimal until the mid-1980s (usually 0%–1%), however, a surveillance study conducted by the Thanyarak Hospital for drug treatment in Bangkok showed that HIV prevalence rose from 1% to 31% from January to July 1988, and to almost 40% in the ensuing 12 months.⁴¹ One of the early studies of HIV among PWID in Bangkok showed that in one year from 1987 to 1988, HIV prevalence jumped from

0% to 49%.⁴² The majority of PWID incidence and prevalence studies have been conducted in Bangkok with some studies conducted in northern Thailand but the highest reported prevalence was actually recorded in southern Thailand, where prevalence rose from 40% in 1995 to 57% in 2001.⁴³

Sentinel surveillance expanded across all provinces in Thailand in 1991 and by 2005 the prevalence of HIV among PWID had risen from 30% to 50%.⁴⁴ In the waves of sentinel surveillance conducted between 1989 and 2009, HIV prevalence among PWID only dropped below 30% on one occasion.⁴⁵ However, samples used in recent sentinel surveillance are too small to allow for reliable estimates; for example, the sample size for 2009 was only 223 PWID. The most recent estimates of HIV prevalence among PWID are 24% in Bangkok and 11% in Chiang Mai.⁴⁶

Figure 3 illustrates HIV prevalence among PWID between 1996 and 2009, as estimated through sentinel surveillance.

The upcoming IBBS will establish more reliable HIV prevalence estimates among PWID in 2010. This will be helpful in establishing a baseline for assessing trends in HIV among PWID and other MARPs. However, in order to really understand the behaviour of an epidemic, incidence estimates (number of new cases during a period of time) will be needed. There is a need for further incidence studies of HIV among PWID in Thailand, especially as PWID demographics are changing, many PWID are spending time in incarceration and drug trends are shifting.

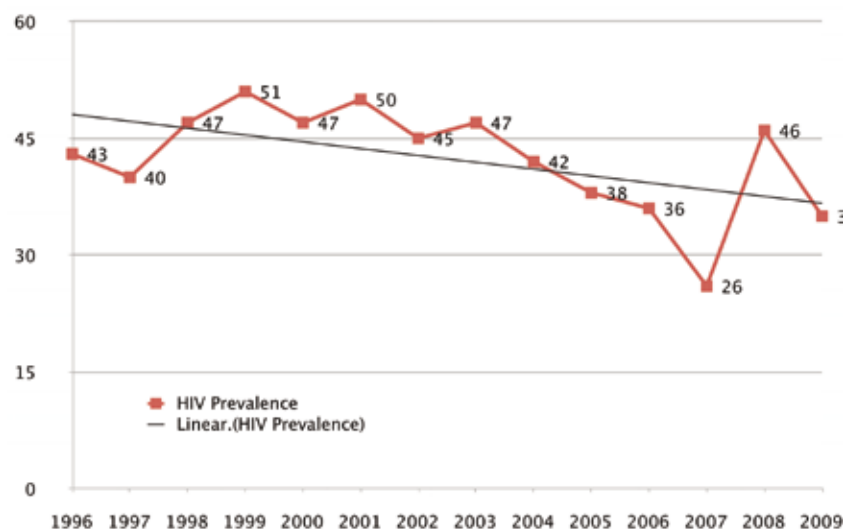


Figure 3: Sentinel surveillance on HIV among people who inject drugs
Source: Bureau of Epidemiology, Ministry of Public Health, Thailand

While the greatest risk of HIV infection is associated with IDU, non-injection methamphetamine use is also associated with significant risks. Non-injecting methamphetamine users engage in risk-associated sexual behaviours more frequently and have an HIV prevalence twice that of the general population. Furthermore, there appears to be a confluence of risks during interactions between MSM, female sex workers and other MARPs.

Risk behaviours and health implications for people who inject drugs

Needle sharing

Needle sharing practices and frequency of injection have been shown to be associated with HIV among PWID in Thailand.⁴⁷ One study showed that needle sharing among some networks of PWID was as high as 69%, and that 91% of PWID reported ever sharing needles.⁴⁸

Needle sharing is also associated with hepatitis C (HCV) infection. Studies have shown an HCV prevalence rate of greater than 90% among PWID in Thailand.⁴⁹ In addition, HIV/HCV co-infection has been shown to be as high as 99% among PWID in prisons in Thailand.⁵⁰ In fact, a history of incarceration continues to be highly correlated with HIV among PWID in Thailand.^{51 52}

The high rates of sharing of injection equipment indicate that awareness of the associated risks is still very low in Thailand.

Injection of other drugs

PWID in Thailand are not just injecting heroin: there has been a reported increase in injection of midazolam,⁵³ opium⁵⁴ and methamphetamine⁵⁵ among PWID. There is evidence that predominantly opiate injectors will inject methamphetamines⁵⁶ and there is also evidence that some people have injected only methamphetamine in the last month but it is not conclusive as to why.⁵⁷ A recent study has shown that the injection of methamphetamine was more common than both midazolam and heroin in the last 30 days.⁵⁸ According to a study conducted among methamphetamine users in Thailand, the Lao People's Democratic Republic and Cambodia, social net-

works of injectors and non-injectors mix and this may influence the transition to injection from methamphetamine smoking. However, the data does not distinguish as to whether the transition is to methamphetamine or other drugs.⁵⁹

More research is needed to explore the context of methamphetamine injection and potential harm reduction and public health responses to methamphetamine use, especially considering the large number of methamphetamine users in Thailand and the region.

Sexual risk behaviour

Among PWID, reported condom use at last sex varies across different study settings and depending on partner type. One study conducted in Chiang Mai, Samutprakan and Songkla reported condom use at last sex as 17%.⁶⁰ A study conducted among PWID, who were participating in the AIDS VAX B/E vaccine trial in Bangkok, 1999–2003, showed that condom use with live-in partners was 7.3% at the baseline and 46% with casual partners at baseline.⁶¹ A more recent study reported that among PWID in Bangkok, condom use at last sex with a steady partner was 21.6%, and condom use with casual partner was 75.6%.⁶²

Arrest and incarceration

Between 1996 and 2004, Thailand's prison population doubled. This has been attributed to both the criminalisation of methamphetamine in 1996 and a heavy-handed law enforcement approach to drugs issues, peaking with the "War on Drugs" in 2003.⁶³ The website of the Thai Department of Corrections notes that offences associated with narcotics currently account for 55% of all incarcerations.⁶⁴ In 2007, there were 84,073 methamphetamine related arrests.⁶⁵ Studies consistently show that drug users are particularly vulnerable to arrest and incarceration. A recent study conducted in Bangkok among PWID showed that over 75% of participants reported a history of incarceration.⁶⁶ HIV prevention efforts are almost nonexistent in Thailand's prison system: as of 2008, there was no access to HIV prevention materials inside prisons and access by community groups providing HIV education is very limited.⁶⁷ There are no opiate substitution programmes in Thai prisons and unsafe injection practices continue to be reported.⁶⁸

Government and non-government interventions

Mortality

Little mortality data is available on PWID in Thailand but one study showed an all-cause mortality rate of 39 per 1000 person years, compared to 14 per 1000 person years among non-PWIDs.⁶⁹

Individual and public health implications of methamphetamine use

Scientific research around issues of illicit drug use and public health in Thailand has traditionally focused on HIV risk behaviors and incidence rates among cohorts of heroin injectors.⁷⁰ As the number of heroin users tapered off in the late 1990s⁷¹ and the numbers of methamphetamine users increased, researchers began to explore patterns of methamphetamine use and its impact on individual and public health.

As research agendas expanded, it became clear that cohorts of methamphetamine users were significantly different from cohorts of opiate injectors. Between 1999 and 2000, researchers investigated the sociodemographic, sexual and drug use risk factors among methamphetamine users presenting for drug treatment in northern Thailand.⁷² In this cohort, methamphetamine users had markedly different sexual risk behaviors, and higher rates of sexually transmitted infections (STIs), when compared with heroin-using counterparts.

While HIV infection rates were found to be lower in non-injecting methamphetamine users, another study conducted over the same timeframe did confirm higher HIV-1 prevalence among methamphetamine users in central Thailand than among the general population.⁷³ Among 1,890 methamphetamine users who predominantly inhaled the drug, HIV prevalence was 2.4%, almost double the national prevalence rate.

A recently completed five-year study investigating risk profiles and peer-based risk reduction strategies with methamphetamine users in northern Thailand showed that users aged 18–25 ($n = 1,189$) had multiple profiles concerning substance use and STIs, including HIV.⁷⁴ The cohort were frequent users of methamphetamine, but in addition: 50% self-reported alcohol abuse more than five days a week; Chlamydia rates were above 30%; 22% had ever been arrested, and of those 75% had been arrested at least twice; condom use at last sex was only 15%; and many females reported unplanned pregnancies and self-induced abortions.⁷⁵

Drug policies

Thailand did not formalize a ban on opium until 1959 when Prime Minister Sarit introduced the Harmful Habit Forming Drugs Act, which outlawed the production, sale and use of opium.⁷⁶ While this policy alone was slow to take effect, sustained international and national pressure has largely eradicated the opium crop in Thailand. Several decades of alternative development in the highlands, largely supported and subsidized by the Royal Family of Thailand, has contributed to Thailand currently being recognized as essentially free of opium production.⁷⁷

In 1975, Thailand became a signatory to the 1961 UN Single Convention, the 1971 UN Convention on Psychotropic Substances and in 2002 ratified the UN Convention against Illicit Trafficking in Narcotics.⁷⁸ In 1976, the Narcotic Control Act was passed and the ONCB was established, with the prime minister as chair. The ONCB is lead authority in coordinating anti-drugs efforts in Thailand.

The Narcotic Addict Rehabilitation Act BE 2545 (2002) provided a legal framework for government initiated treatment and rehabilitation of people suspected of drug abuse. Under this legal framework, Thailand has expanded the number of compulsory drug treatment centres (mainly managed by the military) from 35 to 84. People suspected of drug abuse are often detained by police and sent to prison for up to 45 days whilst their case is investigated by the provincial committee monitoring the Rehabilitation Act. Several reports have recently been written that examine the effect of the Rehabilitation Act and the administrative detention of drug users in closed settings.⁷⁹⁸⁰

As the use of methamphetamine escalated the government amended narcotics laws in 1996, criminalising the drug and placing it in the same category as heroin.⁸¹ This means that those convicted of trafficking heroin and/or methamphetamine may be sentenced to capital punishment. Methamphetamine availability and use continued to rise however and in 2003, the government launched the well-documented “War on Drugs”. This included mass arrests of those suspected of manufacturing or selling methamphetamine, as well as what human rights observers termed “extrajudicial executions” of more than 2,500 people.⁸² As a result, the number of people incarcerated in Thailand’s prison system doubled between 1996 and 2004.⁸³

In 2006, 75% of the 68,000 drug-related charges in Thailand were related to methamphetamine;

⁸⁴this number rose to 84,073 amphetamine-related arrests in 2007. ⁸⁵

Thailand's Department of Corrections states that offences related to narcotics account for 55% of all incarcerations. ⁸⁶

The Demand Reduction Policy 2006–2008 is the ONCB roadmap to a sustained reduction in the number of drug users in Thailand. The policy's essential guiding principles are to “monitor the drugs situation and ensure a timely response to establish a sustainable victory over drugs”. There is no mention of decreasing vulnerability to HIV or harm reduction principles but rather an underlying intention to coerce and compel drug users into treatment and rehabilitation programmes. ⁸⁷

This policy was supported by statements from the Thai prime minister in March 2009, who stated that the next phase of Thailand's “War on Drugs” was to get 120,000 people into rehabilitation programmes. ⁸⁸

The National Narcotics Control Policy on Five Fences Strategy is the most recent comprehensive law enforcement policy from the ONCB. This policy was formulated in response to the perception that drug availability and use has reached an all time high. The policy's main objective is to solve drug problems to improve the life of Thai people. The five fences refer to a harmonized drug control strategy that tackles drug availability and use in five distinct environments:

- ⊙ a border fence to strengthen drug law enforcement measures and prevent drug smuggling in target border areas;
- ⊙ a community fence to strengthen target communities against drugs;
- ⊙ a social fence to eliminate risk factors to protect society against drugs;
- ⊙ a school fence to strengthen schools and educational institutions against drugs;
- ⊙ a family fence to strengthen families against drugs.

As well as national enforcement, Thailand is actively engaged in regional and international drug enforcement. Since 1993, this includes cooperation in the United Nations Office on Drugs and Crime (UNODC) Regional Memorandum of Understanding on Drug Control and a commitment to the Association of Southeast Asian Nations (ASEAN) and China Cooperation on the Reduc-

tion of Drugs (ACCORD) project. The ONCB also has strong links to the US Drug Enforcement Agency and is actively involved in bilateral and multilateral law enforcement activities in South-East Asia. ⁸⁹

Drug policies and HIV prevention, treatment and care

Thailand does not yet have an official national harm reduction policy, although a sustained effort on the part of key officials from the Ministry of Public Health, the ONCB and civil society has resulted in the formation of a draft harm reduction policy. This policy push is the result of over a decade of sustained pressure from various national and international civil society groups (e.g., TDN, AHRN) and government institutions. The awarding of the Global Fund Round 8 grant to the CHAMPION IDU Programme has only heightened the need for a national harm reduction policy. Its adoption as a legal document is eagerly anticipated by civil society groups, programme implementers and the public health community of Thailand.

Methadone availability

The use of methadone in Thailand as a form of opiate detoxification has expanded over the last 30 years. During this time, many district hospitals have established methadone programmes, the majority of which are tapered detoxification programmes. The protocols in place to determine appropriate doses of methadone and detoxification schedules have been widely criticized by civil society groups and international drug treatment experts. Criticisms point to the fact that multiple structural barriers created within the programmes are limiting access, and that programmes are not established for long-term maintenance, even though evidence is overwhelming that maintenance is preferable to detoxification. An overhaul of the current system has been recommended. Priorities for improving methadone programmes include: becoming more client-centred, creating international best practice dosing and monitoring guidelines, improving support services and dispensing points, and providing ongoing staff training to support a workforce for the scale-up of effective programmes. ⁹⁰

Rehabilitation centres

The Narcotic Addict Rehabilitation Act 2545 (2002) that came into effect in 2002 paved the way for the forced treatment of thousands of people in military-style camps. The camps put a focus on exercise, life skills, discipline and reintegration. Access to the camp mostly follows arrest and prison detention. The number of camps has grown from 6 in the year 2000 to 84 in 2010. There has been no formal evaluation of the camps' effectiveness in preventing recidivism, and the ba-

sis on which many people are detained as “drug addicts” is without evidence. Methamphetamine users make up 81% of people in the camps, while heroin users make up just 1.4%. There is no medically supervised withdrawal for methamphetamine or heroin users offered by the camps.

Matrix model

Thailand’s district community health centres are meant to provide both methadone for detoxification and manage the Matrix programme, which uses a psychosocial model of abstinence from methamphetamine use. It is not clear how many of the district health centres provide these services or what the quality of such services is.

Provision of sterile injection equipment

The first NSP was set up in the hills of northern Thailand in November 1992.⁹¹ Opium eradication programmes in the north had left many ethnic minority opium users vulnerable to the refined heroin that was being trafficked throughout the Golden Triangle. The numbers of ethnic minorities seeking treatment in Chiang Mai for opiate dependence far outweighed the numbers of lowland Thais. Three Akha villages between Mae Chan and Mae Salong were selected to participate in the first NSP. The villages reported that many people had transitioned from opium smoking to injection drug use.

Through a series of formal and informal meetings between village representatives, government officials and technical experts, the programme began supplying needles and syringes to 46 PWID. Although the programme faced several challenges, it is an example of how NSPs can work in difficult-to-reach hill tribe communities in northern Thailand. Evaluation of the success of the programme was more difficult as records of needles distributed and injecting behaviour stopped after an initial effort. Also, there were other possible influences, such as community-based methadone maintenance programmes piloted in the same catchment area and ongoing programmes operated by a number of nongovernmental organizations and the United Nations International Drug Control Programme (UNDCP). Despite the limitations of the NSP, two HIV prevalence studies showed that over the time period, HIV prevalence did not increase among PWID in these villages but stabilized at 33%.⁹²

The few NSPs currently in operation are run exclusively by nongovernmental organizations and most are concentrated in the Bangkok area. The government health sector does not support or provide any programmes to provide sterile injection equipment. The programmes that do exist have been heavily subscribed in the few places where available, which indicates that there is a

strong demand for these services. A recent report from the 2009 Reference Group to the United Nations on HIV and Injecting Drug Use estimated that less than 1% of PWID are accessing sterile needles and syringes.⁹³

Working groups and policy positions

The Asian Harm Reduction Network convened a policy forum on the issue of HIV prevention among PWID in Thailand in the year 2000 and shortly thereafter the Thai Working Group on HIV and Drug Risk Reduction was formed. The working group established a national taskforce on IDU in Thailand and launched the first Joint Plan of Action on HIV/AIDS and Drug Risk Reduction, 2003–2005. By this stage the taskforce had become the Harm Reduction Working Group, which released a second Joint Plan of Action on HIV/AIDS and Drug Risk Reduction, 2006–2007. Whilst these efforts looked to be gaining momentum, during 2000–2007,⁹⁴ Thailand did not make any real progress towards implementing comprehensive harm reduction strategies. This period was punctuated by the well-documented “War on Drugs”.

Civil society led service provision

In response to the “War on Drugs”, the Thai Drug Users Network (TDN) was established; firstly, as an organized forum where human rights concerns could be expressed and secondly, to further advocacy to push through the legal reforms necessary to foster an enabling environment for comprehensive harm reduction programmes and services. The formation of TDN and its brave stance on the issue of human rights and the need for harm reduction resulted in the awarding of a Global Fund Round 3 grant, given outside of the normal country coordinating mechanism.

The Global Fund Round 3 grant was the genesis of a civil society led response to HIV prevention and care among PWID populations in Thailand. In 2004, under the auspices of the Raks Thai Foundation (the principal recipient of the Global Fund grant), TDN established four DICs in Chiang Mai, Bangkok, Satun and Samut Prakarn, which included the provision of clean injecting equipment. It was reported that over 1,500 PWID were reached by through activities of these DICs.

In addition, PSI established three DICs in Bangkok, Chiang Mai and Chiang Rai under the “O-zone” model. Peer-based outreach has been an underlying feature of all of the DICs. Training was provided to peer educators to help them access networks of PWID and raise awareness of harm reduction principles and the types of activities and services available.⁹⁵

Harm reduction and prisons

Many PWID report a history of arrest and incarceration, and there is evidence that the imprisonment of PWID was one of the catalytic events that led to the rapid increase in HIV prevalence among PWID. Despite this, harm reduction services remain scant in prison settings in Thailand and PWID continue to report that they have spent periods of time in Thailand's prison system. In 2005, research conducted on behalf of the Department of Corrections of Thailand and supported by FHI highlighted that multiple HIV risk behaviours were prevalent in the Thai custodial system, including consensual and non-consensual sex, injection and non-injection drug use, penile modification and tattooing.

In response to HIV in the Thai prison system, Médecins Sans Frontières has been able to initiate a small ART programme in two prisons, and Alden House has been able to support a limited peer-education programme to conduct HIV education activities in the Central Correctional Institution for Drug Addicts. Condoms are available in a small number of prisons but structural barriers exist that prevent their widespread dissemination and therefore use. Widespread harm reduction programmes in the Thai correctional system remain non-existent.

It is believed that the CHAMPION IDU Programme will include the initiation of methadone in prison settings but the details are unclear. Furthermore, the provision of sterile injecting equipment has not been mentioned as being part of any potential harm reduction activity in Thailand's prisons.

Provision of antiretroviral therapy for people who inject drugs

A recent estimate by the 2009 Reference Group to the United Nations on HIV and Injecting Drug Use suggests that only 1 in 50 PWID in Thailand is receiving ART.⁹⁶ This is in stark contrast to the estimate that 80% of people requiring ART are receiving it under the government's Universal Access Programme. It was reported that in 2008, 95% of hospitals were providing ART and 116,747 people were enrolled in ART programmes.⁹⁷ It was only in 2004 that the government revoked a previous policy explicitly excluding PWID from ART programmes.⁹⁸

This indicates that reaching PWID with ART has only recently become a priority for the Universal Access Programme.

Overall service coverage

Comprehensive harm reduction programmes include the provision of sterile needles and syringes, flexible opiate substitution programmes, access to voluntary counselling and testing, and provision of ART and other primary health care services. To have an effective impact in prevention of new HIV infections and to provide equitable health care in society, it is estimated that coverage of these services needs to reach 60%. High rates of coverage are seen in countries where services are provided through a combination of outreach, mainstream health services and DICS. In addition, the adoption of policies and practices that allow these programmes to operate effectively and promote positive relationships with other sectors, including law enforcement, is essential.

The awarding of the Global Fund Round 8 grant to the CHAMPION IDU Programme should pave the way for the adoption of such policies and practices and allow for scaled-up provision of services. The recent paper from the 2009 Reference Group to the United Nations on HIV and Injecting Drug Use estimates that Thailand falls well below the required minimum 60% coverage in all areas of harm reduction, including HIV prevention, treatment and care. The Reference Group estimates that:

- ⊙ less than 1% of PWID are accessing sterile needles and syringes
- ⊙ 2%–5% of PWID are accessing opiate substitution therapy
- ⊙ 1%–4% of HIV positive PWID who require ART are receiving it.⁹⁹

In view of the almost complete absence of coverage of harm reduction services for PWID it will take some time to build momentum, particularly since NSPs rely on a chain referral case finding system.

IV Summary of findings

Drug use in Thailand

During this RAR, it was reported that heroin use had declined across the sites. It has become scarce and expensive in most places (with the possible exception of Fang in Chiang Mai province and in Mae Hong Son province, both of which border Myanmar in the north). In some locations in the south, such as Surat Thani and Satun, it was reported that heroin is very difficult to find and that users must travel to other provinces to buy it. The scarcity and cost of heroin was reported to have led to the injection of other drugs as substitutes (or to enhance the effects of heroin), such as methadone, midazolam (and other benzodiazepines), opium or methamphetamine depending on what is available.¹⁰⁰

Figure 4 shows that from 2005 to 2009 treatment admissions from methamphetamine more than doubled (32,240 to 76,921), whereas heroin admissions declined by 34% (from 1,659 to 1,097) (see Figure 5). An increase in treatment admissions does not by itself indicate an increase in prevalence, but when combined with data on arrests and seizures and population use data from the series of household surveys, it is clear that the use of methamphetamine has surpassed the use of heroin and most other substances.

The use of methamphetamine and opium, and especially the injection of these drugs, has significant implications for harm reduction programming in Thailand. Injection of midazolam has been shown to be associated with many deleterious health consequences, such as abscesses, collapsed veins, respiratory failure and the risk of overdosing due to the amnesic effects of the drug.¹⁰¹ Some of the adulterants in methamphetamine (or in crude opium) have serious health consequences.

It was reported that PWID in rural areas of Chiang Mai and Mae Hong Son provinces inject opium when heroin is not available; however, this depends on proximity to heroin trafficking routes. Methamphetamine injection was not reported to the RAR team in these rural areas in the north but other studies have reported the injection of methamphetamine in northern Thailand. Opium was also used as a substitute for heroin in Bangkok, although PWID reported a preference to inject midazolam and methadone, often in combination. Midazolam and methadone are both reported to be available from clinics that service PWID in Bangkok.

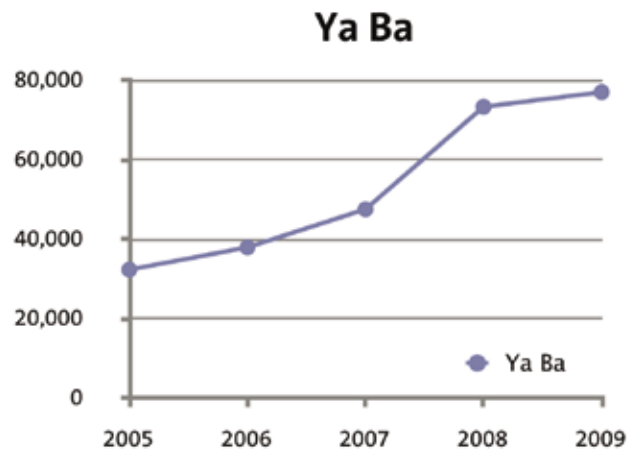


Figure 4: Number of people admitted to treatment for methamphetamine in Thailand, 2005–2009

Source: ONCB

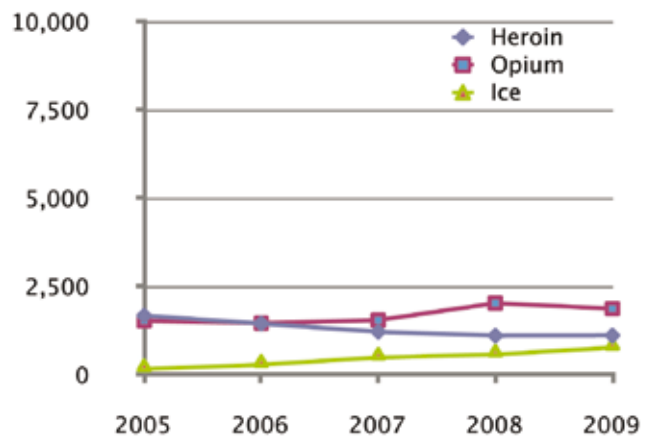


Figure 5: Number of people admitted to treatment for heroin, opium and crystal methamphetamine in Thailand, 2005–2009

Source: ONCB

Site-specific findings

Ratchaburi

No active PWID were found in Ratchaburi province. Methamphetamine was the most common drug found in the province: 98% of arrests were due to methamphetamine. There were 913 treatment admissions for methamphetamine and only one for heroin. Methamphetamine was reportedly smoked but not injected. It was recommended by the RAR team that harm reduction efforts in Ratchaburi should focus on preventing methamphetamine smokers from transitioning to injection.

Bangkok

As elsewhere in Thailand, methamphetamine has become the most commonly used drug in the Bangkok area, and users come from all backgrounds and age groups. This is reflected by household survey findings (2007), treatment admissions, arrests and seizures. Many PWID reported in interviews and focus groups that heroin has become scarce and this has led to injection of substitute drugs, such as midazolam and methadone, which are reportedly available from some clinics. PWID also report injecting opium and methamphetamine. The Bangkok RAR found that some methamphetamine users have transitioned directly from smoking to injecting (i.e. without having had a heroin injection background). This was also reported in the last RAR conducted in Thailand by APMG, ¹⁰² where it was also mentioned that HIV prevalence among methamphetamine injectors was an alarming 64% in the year 2004. ¹⁰³

The changing pattern of PWID using multiple drugs is shown in the findings of a 2009 study conducted by TUC on IDU in Bangkok and Chiang Mai. ¹⁰⁴ In Bangkok, PWID are currently injecting methamphetamine and midazolam at a higher rate than heroin. In Chiang Mai, only about one third reported injecting heroin (34%), and nearly as many reported injecting methamphetamine (32%) (see Table 2).

Harm reduction centres and services provide relatively good coverage for heroin injectors in the Bangkok area, as compared to other parts of the country, with availability of DICs and methadone clinics in most areas. The main challenge will be to tailor and deliver prevention programmes for methamphetamine injectors and to prevent transition to injection for non-injecting methamphetamine users.

Southern Thailand

The RARs conducted in southern Thailand reported different drugs being used than in Bangkok and the north. For example, midazolam use was not reported in the south, but other benzodiazepine drugs, such as manozolam and alprazolam, were injected as substitutes for heroin. As in Bangkok and Chiang Mai, heroin injectors reported injecting multiple drugs, such as methamphetamine, methadone and manozolam. Methamphetamine is prevalent, although reported to be more expensive than at other sites. Users reported that one tablet costs around 500 baht; the lowest was 300 baht per tablet. Some heroin users reported that they could not find

Injection (past 30 days)	(Bangkok n = 746)	Chiang Mai (n = 309)
Heroin	34%	34%
Midazolam	42%	4%
Methamphetamine	63%	32%
Opium	NR	14%
Methadone	13%	6%

Table 2: Drug use in the past 30 days: Findings from a TUC respondent driven sampling study on injection drug use

Source: Yongvanitjit K et al. 2009

heroin and have switched to injecting methamphetamine instead. There were also reports of methamphetamine users that have transitioned to injection. However, reasons for transitioning are not yet understood and will require ethnographic investigation.

According to the RAR, kratom juice, ^{vi} and cocktails that include kratom, cough syrup, coca cola, and sedative-hypnotic or tranquillizer tablets (sometimes referred to as “4 X 100”) are popular among young people. There were reports of a range of other substances being sometimes added to these cocktails, including the scrapings from the inside fluorescent light bulbs and mosquito coils. Cannabis and inhalants are also commonly used. “Club drugs” (such as ecstasy and ice) were reportedly used by more affluent people who go night clubbing.

Northern Thailand

The situation in Chiang Mai city is similar to Bangkok, although the use of midazolam is reported to be less prevalent (4% in a recent survey of PWID; see Table 2). ¹⁰⁵ In the rural, mountainous areas of Chiang Mai province, such as Om Koi and Fang districts, and the nearby provinces of Mae Hong Son and Chiang Rai, there is more injection of opium than heroin in some places, depending on proximity to trafficking routes. Some drug users have access to and prefer to use heroin, whereas in some areas they can find only opium. The RAR in Mae Hong Son presents a case study of opium injectors in the province.

As in Songkla, harm reduction services are available in Chiang Mai city but are either nascent or nonexistent in rural areas, especially in difficult-to-reach mountainous districts. In Fang, people requiring methadone have to travel to the Fang Hospital Methadone Clinic, which is open only one day per week. To expand harm reduction services in remote areas, implementers will need to explore multiple approaches. For example, the Ozone harm reduction centre is mapping PWID networks, case by case, which appears to be an effective way to work with different ethnic networks.

^{vi} Kratom (*Mitragyna Speciosa*) is a plant native to the south that has mild stimulant properties. It can also have hallucinogenic effects in high doses.

A special feature of the north is that there are many drug trafficking routes from Myanmar and this has made opium, heroin and methamphetamine abundant and inexpensive. For example, methamphetamine is only 50 baht a tablet, and heroin is much cheaper and relatively purer than elsewhere in the country. This may explain why there is little reported injection of substitutes like midazolam in this area.

Harm reduction service and programme scale-up needs

Harm reduction has only begun to address the needs of PWID in Thailand. Sharing of needles, syringes and injection equipment was reported to be prevalent at all sites. The one exception is possibly Bangkok, where PWID are better educated due to harm reduction programmes that have been in place for several years. For example, recent surveys of PWID have shown that sharing of injection equipment is not as frequent in Bangkok as it is in Chiang Mai.¹⁰⁶ However, these harm reduction programmes have primarily targeted heroin injectors, whereas key informants and interviewees in focus groups describe methamphetamine injectors as being very different in terms of age, gender, health and sexual and social behavior. It is likely that there are many of these who have not been reached by harm reduction services (as suggested by the finding of 64% HIV prevalence among methamphetamine injectors in 2004). This would also be true in Chiang Mai, and possibly other areas where methamphetamine smokers have transitioned to injection.

Harm reduction services are needed in places where there are active PWID networks and where there has been no penetration of services. The RAR reported extensive PWID networks in sites such as Fang and Om Koi in Chiang Mai province, Pai in Mae Hong Son province, and Mae Suay in Chiang Rai province that have not received any harm reduction services, other than limited access to methadone clinics at hospitals. These are areas where opium was formerly grown and used, and where heroin became prevalent following opium eradication. Working in these areas requires travel to distant locations and passage through frequent military checkpoints near the border, and harm reduction staff may need to speak languages other than Thai. The work being done by the PSI Ozone Centre in Fang uses PWID peer educators to map networks and has succeeded in finding more than 50 PWID within Jin Haw, Muse

and other ethnic groups in the six months from inception. Mapping of PWID networks seems to be an efficient way to find individuals in order to introduce them to harm reduction services, especially in the current climate of drug suppression campaigns by the government. However, protocols related to the use of this technique will need to be developed to prevent PWID networks being targeted by overzealous law enforcement officials.

Harm reduction programmes have only begun to scratch the surface in the southern provinces. According to the RAR, Chana district in Songkla province has the most developed harm reduction services, with a range of services available on referral. These include a methadone clinic that is connected to HIV services and other health services and to the Ozone Drop-in Centre, located nearby the hospital. However, these services cover only Chana and a few adjacent districts. There are many other districts that have no coverage despite widespread reports from key informants of PWID networks, particularly in Songkla city, Hat Yai city, Singhanakorn, Thepa and Natawee. Likewise Satun, Kuan Ka Long and Kuan Don are in need of service coverage. Surat Thani, Ampur Muang and Ko Samui also have reports of PWID, but no harm reduction centres or programmes. Extensive PWID networks were also reported by informants in provinces further to the south, such as Yala, Pattani and Narathiwat. Whilst this area is politically tense, this should not stop attempts at establishing harm reduction services for PWID in these provinces.

Methadone is the cornerstone of the harm reduction strategy for heroin users in Thailand. However, methadone treatment is inconsistent and does not follow best practice guidelines.¹⁰⁷ This RAR revealed problems with inadequate dosing, the possibility of registering at multiple clinics (reported in Chiang Mai), take home supplies leading to overdose (reported in Satun) and the use of detoxification schedules that have been shown to be ineffective. For example, in Fang in Chiang Mai, doses as low as 10 milligrams of methadone are being used to detoxify opium addicts. Also, the policy of requiring that PWID fail three times while attempting detoxification before becoming eligible for admittance to methadone maintenance should cease and a full range of substitution therapies be expanded.

V Recommendations

General

For areas with established harm reduction programmes, such as Bangkok, Chiang Mai and Songkla the key issues will be:

- ⊙ Finding ways to create an enabling environment where PWID can come to receive services without fear of police harassment and arrest. There have been reports of cases where police have planted drugs on PWID, and conducted random urine screening at checkpoints, which makes it difficult to travel to some hospitals or centres. ¹⁰⁸ Sensitization and training for law enforcement officers will be necessary to bring about an enabling environment.
- ⊙ Adapting services for methamphetamine injectors and developing strategies for implementing those services, including a review of peer-outreach techniques that have been found effective for methamphetamine users.
- ⊙ Developing capacity, interventions and information and education materials on methods to reduce harms related to injection of specific drugs, such as midazolam, methamphetamine and other drugs that are now commonly used by PWID.
- ⊙ Developing specific programmes and services that address the needs of female PWID and the female partners of male PWID.

In order for harm reduction services to meet the needs of PWID in Thailand, action will need to be taken in the research, policy, programme and service arenas. Detailed recommendations on the development and scale-up of harm reduction are made in the following section.

1. Promote the immediate enactment of the tabled government harm reduction policy, which would allow for advocacy and implementation of harm reduction programmes in Thailand. In addition, reinstitute a national harm reduction working group made up of representatives from the Ministry of Public Health, ONCB, civil society and the United Nations to oversee the implementation of harm reduction services.
2. Support efforts by the Government of Thailand to review the efficacy of the Narcotic Addict Rehabilitation Act, to promote cooperation between the law enforcement and drug treatment sectors and to drastically reduce the number of PWID in compulsory treatment and prisons. ONCB will need technical assistance in its efforts to recommend evidence-based alternatives to criminal justice approaches to providing treatment and rehabilitation.
3. Provide harm reduction services in closed settings (e.g., prisons, jails, detention centres and compulsory drug treatment centres). Given the substantial time spent by drug users in such institutions, there need to be harm reduction programmes, such as provision of condoms and access to sterile injection equipment in closed settings. There should also be access to medical detoxification for those who are drug dependent. This is in keeping with UN guidelines regarding treatment of prisoners and detainees. It also makes good public health sense to prevent the spread of HIV from incarcerated people to the community.
4. Expand and scale up harm reduction programmes to areas with active PWID networks, to provide a full range of services in line with WHO/UNODC/UNAIDS technical guidelines. These would include outreach; provision of sterile needles, syringes and injection equipment; referral to substitution therapies; voluntary counselling and testing; and provision of ART.
5. Create an enabling environment where PWID can receive services without fear of police harassment and arrest. Sensitization and training for law enforcement officers will be necessary to bring about an enabling environment.

6. Provide sterile needle, syringe and injection equipment to prevent the spread of HIV among methamphetamine injectors for whom substitution treatments are not an option.
7. Reassess harm reduction strategies, build capacity, provide tools and redesign programmes to respond to the injection of midazolam (and other benzodiazepines), opium and methamphetamine. In addition, harm reduction strategies need to focus on the harms associated with methamphetamine use including preventing the transition to injection.
8. Consider the use of strategic mapping of PWID networks as a case finding strategy, both to access hard-to-reach groups in rural settings and to mitigate against stigma and the heavy-handed law enforcement approach that currently pervade. Protocols related to the use of this technique will need to be developed to protect PWID from overzealous law enforcement officials.
9. Build capacity of staff operating DICs and outreach programmes to better manage cooperation with methadone clinics, other health services and the law enforcement community.
10. Immediately revise methadone programmes using evidence-based guidelines, including a national registration system of clients, proper dosing and detoxification schedules and use of proper criteria for entry to methadone maintenance.
11. Expand methadone programmes to reach distant rural communities through innovative outreach approaches. (These same approaches may prove useful in urban settings as well.)
12. Develop specific programmes and services that address the needs of female PWID and the female partners of PWID.
13. Use non-PWID as management staff along with PWID as peer-outreach workers. In addition, improve management techniques to mitigate difficulties with PWID that have alcohol problems, or display violent or other inappropriate behavior.

Research related

14. Initiate a focused study to investigate factors surrounding methamphetamine injection and explore harm reduction strategies and interventions that can: i) help methamphetamine injectors, and ii) target non-injecting methamphetamine users to prevent transition to injection drug use and other harms associated with methamphetamine use, including STI/HIV risk reduction and treatment. Interventions would then need to be trialed and reviewed for scaling up to a national level.
15. Set up multisectoral surveillance teams in each region to do ongoing assessments of the drug use and harm reduction situations.
16. Conduct a study to estimate the total number of PWID countrywide and at specific locations. This will be useful as a baseline for evaluating coverage of harm reduction services.
17. Promote research on the causes and conditions of initiation and continuation of substance use among youth. In light of the general failure of national prevention efforts to decrease youth using methamphetamine, there is an urgent need to revisit primary prevention approaches, which have relied mainly on anti-drug slogans and campaigns as opposed to the provision of neutral and factual information on the use and consequences of drug use.

Bangkok area

18. Pilot harm reduction strategies that include DICs and outreach services targeting young methamphetamine users and PWID. This would provide the opportunity to assess and develop ways to reach this target group before scaling up.
19. Implement midazolam interventions targeting PWID, nongovernmental organizations and health services in Bangkok. A special training course to provide harm reduction guidelines and treatment of midazolam withdrawal is urgently needed for harm reduction centres and health programmes working with drug users.

20. Establish tighter regulations on the distribution of midazolam (and other benzodiazepines) and methadone, which were reported to be available in clinics in Bangkok.

North

21. Expand harm reduction programmes in areas with active PWID networks. ONCB data and respondent driven sampling studies have identified PWID networks in several districts in Chiang Mai, Chiang Rai, Mae Hong Son, Tak and Lampang provinces.
22. Develop active outreach programmes that use mapping of IDU networks to reach PWID in rural communities, such as in Fang (PSI Ozone). Peer educators can encourage PWID to access voluntary counselling and testing, harm reduction, and drug treatment and rehabilitation services.
23. Assess methadone dosing guidelines used at clinics and hospitals in rural areas in the north and bring them into line with international best practices as well as piloting outreach methadone services to remote communities.

South

24. Expand harm reduction programmes into areas with active PWID networks outside the Chana area in Songkla. This could be done through use of a van that travels to districts that have been identified as having PWID.
25. Conduct a reconnaissance mission to explore reports that IDU is rampant in some provinces to the south (Yala, Narathiwat and Pattani). This could also be handled by multisectoral surveillance teams (see number 15, above).



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The RAR site reports that informed the findings and recommendations of this consolidated report are available in both English and Thai.

The RARs for Ratchaburi; Bangkok; northern Thailand (Chiang Mai, Fang and Mae Hong Son); and southern Thailand (Songkla, Surat Thani and Satun) can be found under “New publications in library” on the Asian Harm Reduction Network (AHRN) website: www.ahrn.net

Rapid assessment and response:
Preparation for the scale-up of
comprehensive harm reduction
services in Thailand



This consolidated report is based on eight rapid assessment and response (RAR) studies conducted in Thailand to investigate injection drug use in order to inform the development of harm reduction services. The report provides a thorough analysis of the background and context of injection drug use and of harm reduction efforts in Thailand and presents a summary of findings from the RAR studies. Some findings of interest include the increasing trend towards injection of methamphetamine and the switch to alternative drugs among heroin injectors (such as midazolam, other benzodiazepine drugs, opium and methadone) in response to the short supply and increasing cost of heroin. What is evident across all sites is the urgent need for harm reduction services to prevent the spread of HIV. The report concludes with recommendations for the development and scale-up of harm reduction efforts across the country.

A report by AHRN, Thailand



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