

DRUG USE AND HIV/AIDS IN THAILAND IN THE YEAR 2000



Aaron Peak
Asian Harm Reduction Network
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TABLE OF CONTENTS

EXECUTIVE SUMMARY	3
OVERVIEW OF HIV/AIDS SITUATION	11
SITES VISITED	12
OVERVIEW OF DRUG USE IN THAILAND	13
I. WESTERN THAILAND	
MAE SOT	14
RANONG	17
II. NORTHERN THAILAND	
CHIANG MAI	19
CHIANG RAI AND MAE CHAN	22
MAE SAI AND FANG	24
III. NORTHEASTERN THAILAND	
KHON KAEN AND YASOTHORN	27
IV. BANGKOK	31
V. SOUTHERN THAILAND	
PATTANI, YALA, NARATHIWAT, SATUN, SONGKLA	36
VI. CONCLUSIONS AND RECOMMENDATIONS	40
Appendix A	44
Persons and organizations interviewed and visited	

EXECUTIVE SUMMARY

HIV/AIDS

In Thailand, estimates indicate that 984,000 persons have been infected since 1988 with HIV and that approximately 289,000 people have died of AIDS. Over 695,000 persons are now living with HIV. At the end of 1999, national HIV sentinel surveillance showed that prevalence had declined among Army conscripts, female direct/indirect sex workers, and pregnant women, but had increased among injecting drug users, from 39% in 1989 to 54.1% by June 1999.

Harm reduction for drug users has been a notable gap in AIDS initiatives. To date there is only one program located among Akha villages in Chiang Rai province. In addition, although a link between use of methamphetamine (or ATS)¹ and HIV risk has yet to be clarified, ATS use has increased dramatically and has the potential to create serious health consequences. Research is critically needed to examine the mechanisms by which ATS use, or ATS and alcohol use combined, could lead to HIV infection. Currently no educational materials on ATS and HIV exist for fishermen, factory workers, and agricultural farmers.

DRUG USE

According to the Office of Narcotics Control Board (ONCB), methamphetamine, known as *yabaa* in Thailand, comprises 75% of the drugs in use, heroin 10%, and others, 15%. Similarly the proportion of new heroin users (1993 to 1999) has declined steadily with a consistent increase of methamphetamine use during the same period. Other drugs such as ecstasy, opium, marijuana, glue and solvents are available and usage has remained stable over the same period. There has also been a decline in heroin injecting and snorting and an increase in *yabaa* ingesting and 'chasing'².

The Medical Services Division of the Ministry of Public Health (MoPH) stated that there are 301 different types of *yabaa* tablets from 50 provinces. Analysis of tablet contents several years ago indicated many had 20 to 25 milligrams of methamphetamine, 45 to 55 milligrams of caffeine and 40 to 60 milligrams of starch or sugar.

¹ ATS or amphetamine-type stimulants. A group of substances, mostly synthetic, with closely related chemical structure which have, to varying degrees, a stimulating effect on the central nervous system (CNS). Based on the predominant pharmacological effect (at common dose levels), the group comprises (1) CNS stimulants such as amphetamine, methamphetamine and methylphenidate; (2) anorectics (appetite suppressants) such as phenmetrazine, amfepramone (diethylpropion); and (3) entactogens or 'ecstasy'-type substances such as MDMA ('Ecstasy') and MDA. (WHO, Lexicon of Alcohol and Drug Terms, Geneva, 1994.)

² When using *yabaa*, the common practice is to take the foil off a gum wrapper, fold it length-wise, add the crushed tablet, put a lighter underneath and inhale the smoke through a tube ('chasing'). Same method used for heroin.

ONCB identified that migrant populations are lacking services due to language barriers. Pilot programs are needed, working through NGOs, to provide targeted migrant populations with measures to reduce harm associated with drug use. Further research is needed to establish the mechanisms of presumed sexual transmission due to use of *yabaa*.

I. WESTERN THAILAND

MAE SOT

In Mae Sot the present population is estimated to include 50,000 to 60,000 Burmese and 18,000 to 20,000 Thais. There are approximately 200 to 250 drug users with many more living in the surrounding countryside. The trend of injecting has diminished because heroin is difficult to obtain and prices are high. Drug users have switched from injecting heroin to ingesting *yabaa*. There are approximately 100 street children, among whom sniffing rubber cement is common. In the past there was very little drug use among the sex workers, however with the emergence of *yabaa*, estimates from local leaders and HIV/AIDS projects indicate 70% of sex workers now use *yabaa*. In addition, an estimated 90,000 workers, mostly Burmese, work in the area's factories, at which, it is alleged, the owners put *yabaa* in the drinking water to assure greater productivity.

There are three NGOs working on HIV/AIDS: 1) HIV Karen Working Group, working with Karen in refugee camps; 2) National Health and Education Committee (NHEC), and 3) Burmese Medical Association (BMA) have a joint project that provides education to eight factories and one health facility – Mae Tao Clinic. Similarly there are three international non-government organizations (INGOs) working in Mae Sot: 1) Open Society Institute/Soros Foundation, dealing with human rights issues, but not HIV; 2) Medecins Sans Frontieres (France), dealing with TB among migrant laborers in refugee camps, and 3) World Vision. World Vision began HIV/AIDS programs six years ago with three primary target groups: 1) factory workers, 2) Burmese living in the community, and 3) sex workers.

RANONG

According to World Vision there are currently about 10,000 drug users, mostly of *yabaa*. As of June 2000, HIV sero-surveillance statistics indicate HIV rates among fishermen of 7.95%, Thai and Burmese sex workers 26%, and factory workers 5%, all presumably through sexual transmission. After the economic crisis many fishermen switched from heroin to *yabaa* for two basic reasons: 1) heroin was too expensive for their reduced income, and 2) heroin was difficult to obtain. According to various reports, Thai boat owners force their fishermen to take *yabaa* every morning before going out to fish. To ensure fishermen take *yabaa* the owners watch them take it and if they refuse they are fired from their

job. Presently there are few NGOs and INGOs in Ranong. World Vision and CARE International are two INGOs working among the Burmese.

II. NORTHERN THAILAND

CHIANG MAI

According to the Northern Drug Dependence Treatment Center (NDTC) admissions breakdown, 39% from the lowlands use *yabaa* compared to 3% in hill tribe areas. In contrast, hill tribe patients account for 18% of opium admissions and 18% for heroin. Opium use among lowland patients is low (3%) whereas heroin use is higher (13%). The remaining 6% are admitted for use of other drugs. The ages of patients vary; *yabaa* users are 16 to 25 years and opium users are older, 31 to 40 years old. Currently 260 out of 3,149, or 8% of IDUs admitted to NDTC during 2000 have tested HIV positive.

There are many NGOs and community-based organizations (CBOs) in Chiang Mai. Most notable is AIDSNet, umbrella organization supporting CBOs implementing HIV prevention programs. Other agencies include the Asian Harm Reduction Network, having a regional focus and primarily promoting advocacy in the field of policy and harm reduction. UNICEF also has a branch office in Chiang Mai and is currently showing interest in developing HIV programs targeting youth and drug use. HIV infected individuals are very active, for example, the New Life Friends Center. At Chiang Mai University there are a Thai Youth AIDS Prevention Project and a Johns Hopkins University (JHU) project. The JHU project has been on-going for several years and has documented both prevention experiences and infection levels among opioid users in the north, particularly hill tribe populations.

According to the CDC 10, there is a need to up-grade the capacity of the management sector throughout the HIV/NGO community, as this is the weakest link overall in these programs. Other issues not adequately covered by government or donor agencies are: drug use and HIV in prisons; drug use and HIV in the juvenile detention centers; the creation of a network for drug users; and a study of *yabaa* and high risk behaviors among sex workers, agricultural laborers, factory workers, construction workers and both short and long-distance fishermen.

CHIANG RAI AND MAE CHAN

In the last 5 years there have been approximately 1,500 to 2,000 new AIDS cases and 500 to 800 AIDS-related deaths per year. Official reports state that sexual transmission accounts for 92.2% of all infections followed by mother-to-child transmission (5%), then injecting drug use (.05%). Chiang Rai province has more drug users than any other province in Thailand and it is fairly certain that the IDU category is under-reported because medical personnel only ask about sexual practices, not drug history. In the past opium (smoking) was the drug of choice, especially among the hill-tribe population. Until heroin was introduced,

injecting did not exist. In the last 5-7 years, *yabaa* has become available. *Yabaa* is inexpensive in this region compared to elsewhere in Thailand, only 12 Baht near the border and across the border, only 8 Baht.

Most support for general HIV/AIDS educational materials excludes the drug user population. Hospitals in Chiang Rai Province have been requested by government to initiate treatment and prevention programs targeting drug users and HIV. However, only two hospitals comply, as most do not have specialists to operate these programs. In the last five years the Director of CDC 10, has allocated funds for HIV prevention within the drug treatment centers. One NGO, the Hill Tribe Education Center (HTEC) works in 48 villages in Mae Fa Luang, Mae Sai, Chiang Khong, Mae Chan, Chiang Saen and Mae Suai districts. Drug use, including *yabaa*, is widespread in all these villages, and particularly in three Akha villages where heroin injecting is highly prevalent. The Mae Chan Harm Reduction Project has been on a decline since external funding ceased. Government considered the program too costly for its own budget because salaries had been paid to all village workers. Local leaders believe that detoxification is more sustainable than methadone maintenance treatment. Recently 6 out of 9 village projects discontinued activities due to lack of sustainability. Now only three villages still provide methadone maintenance treatment, however this has been temporarily suspended. The Provincial Health Office requests support for developing and implementing seminars on harm reduction and capacity building for the local NGO community, an issue made more critical since the closure of the Mae Chan Harm Reduction Project.

MAE SAI AND FANG

The switch from heroin to *yabaa* started 10 years ago and today very few heroin users are left, many having died as a result of AIDS, overdose, or violence. On average in Fang, 40% to 50% of families have one or more members using *yabaa*. The average price is 40 Baht locally per tablet and 25 Baht if purchased from hill tribe villages. Most laborers in Fang use *yabaa* voluntarily to work longer hours in the field, and thus earn more money. Approximately 90% of users inhale ("chase") the fumes of *yabaa*, while 10% ingest them orally.

Fang is in the agricultural belt with many Burmese (majority Shan) migrant laborers. Whereas, Mae Sai is a border town and the main industry is import and export of Burmese, Chinese and Thai supplies. Presently Fang has no NGOs working on HIV or drug use. HIV infected patients go to the only hospital for treatment and there are no private or government drug treatment programs. Mae Sai has 16 to 17 NGOs, mainly working with street children, of which four have HIV prevention and care components.

III. NORTHEASTERN THAILAND

KHON KAEN AND YASOTHORN

The Northeast region has a population of 21 million, 35% of the national population. There are 19 provinces of which nine have borders with Cambodia or Lao PDR. The AIDS cases in the Northeast account for 17% of all national cases. According to the Ministry of Public Health, Epidemiological Division Sentinel Sero-Surveillance report, HIV prevalence has increased among IDUs in the northeast.

Yabaa is frequently used by truck drivers and young people, and occasionally used by others. Because heroin is currently scarce and expensive, only those with enough money and over 25 years or older continue to use it.

The Northeastern Drug Dependence Treatment Center, which opened in 1992 as the regional drug treatment facility, became fully functional three years ago. There are few NGOs, including those composed of people living with HIV and AIDS (PLHA), working on HIV issues. AIDSNet identified one NGO, the Foundation for Children and Youth Development in Yasothorn, directly working with drug users and nine working indirectly with drug users. These may have the potential of providing harm reduction. Most of these organizations and groups presently have few skills with which to develop and provide sustainable projects.

IV. BANGKOK

Klong Toey district exemplifies the current common trend in drug use, i.e. the switch from heroin to *yabaa*. According the Duang Prateep Foundation Director, older IDUs have HIV or have died of AIDS and now the younger generation uses *yabaa*, mostly for pleasure, and for selling.

According to Lt. General RTA Dr. Aroon Showanasai, every year 30,000 urine analysis tests for drug consumption are conducted on Army personnel and if positive, they are tested for HIV. Each year 800 to 1,200 are admitted to drug treatment. Only 5 to 6% of these are heroin injectors, and the rest are *yabaa* 'chasers'. Dr. Showanasai stated that prevention programs have to be re-conceived and new data collected in order to understand the real situation.

The Bangkok Metropolitan Administration (BMA) has had a narcotics department that operates 15 drug treatment centers under the Ministry of Public Health. The main drug treatment modality has been a 45-day methadone treatment regime with emphasis on rehabilitation and reintegration. Currently 20,000 to 30,000 clients are admitted per year in the 15 centers, including 80 to 90% heroin users. There are also two drug treatment facilities belonging to the Medical Services Division within the Ministry of Public Health and Alden House, offering a choice of out-patient care or a live-in therapeutic community for those unable to remain abstinent once leaving treatment.

V. SOUTHERN THAILAND

PATTANI, NARATHIWAT, YALA, SONGKLA AND SATUN

Heroin use started more than 20 years ago in the south with most people smoking, then switching to injecting in the early 1970s. Two to three years ago ONCB estimated that there were 5,000 drug users in Yala Province. According to the Young Muslims Association of Thailand (YMAT), Narathiwat currently has the biggest drug user population in the south followed by Pattani, then Yala. Heroin is still the drug of choice and injecting is common, although *yabaa* is becoming more prevalent, especially in southern cities. Heroin use in the south has not decreased as in other parts of Thailand and heroin is readily available. One dose (0.6 mg) of heroin costs 100 to 200 Baht and a tablet of *yabaa* costs 120 Baht, depending on the availability. It is estimated that 80% of the older drug use generation is HIV infected, many contracting the disease while in prison. Overall HIV statistics for the south indicate 20% of infections are due to injecting and 60% to heterosexual transmission, including partners of IDUs. Narathiwat reportedly has low HIV transmission rates in sex workers.

In Pattani, the Southern Drug Dependence Treatment Center estimates 50% of heroin users admitted are HIV infected. Narathiwat has registered 1,157 AIDS cases and 255 deaths due to HIV in the last 10 years. Most deaths occurred in 1999 in a 3:1 (male:female) ratio. The highest HIV prevalence per capita is in Sungai Go Lok, located on the Malaysia/Thai border. In Yala Province, heroin is plentiful and users can purchase heroin at teashops for 100 Baht. In the past, groups of drug users injected together but since learning about HIV, many opt to inject alone, without sharing equipment. At the Satun Drug Treatment Center residents report feeling more comfortable than at a government facility because the director was a former drug user for 20 years and spent two years at Baan Iqram Drug Treatment Center before opening the Satun center. Drug users are more familiar with heroin than with *yabaa*, thus many simply guess at *yabaa* dosage. Death from overdose has been reported. Many injectors report they thought *yabaa* would have the same effects as heroin, but it did not diminish craving for heroin. When injecting heroin, many mix it with “Red Bull”, which gives a better effect. *Yabaa* use as a recreational drug is found mainly among high school or university students.

YMAT and the Provincial Health Departments of Narathiwat, Yala, Songkla and Pattani have successful collaborations with the four northern states in Malaysia. The success of this cross-border collaboration is attributed to having Islamic values in common.

According to the project director of Baan Soon Ruam Nam Jai PLHA Project, most HIV home care initiatives have originated with hospital staff in the south due to lack of NGOs to provide needed coverage. NGO support is lacking due to the intense stigma associated with HIV/AIDS. It is also difficult for other Thais to

come south and work as they do not know the local dialect and cannot communicate effectively.

VI. CONCLUSIONS AND RECOMMENDATIONS

The situation in Thailand is in flux. It appears that approximately half of the living IDUs are already infected with HIV and the remaining half, except among Akha hill tribes and heroin users in the southern portion of the nation, are rapidly switching to 'chasing' or ingesting *yabaa*.

Where injecting is continuing to take place, harm reduction measures are needed, complemented by adequate treatment regimes. Current opiate treatment consisting of detoxification, often with methadone, for 45 days, has low efficacy. High relapse rates are common. Improved treatment modes are required, and where they may already have been implemented, need documentation with long-term follow-up. In order to have an impact in the reduction of the spread of HIV from already infected IDUs, voluntary counseling and testing (VCT) programs need to identify them and bring them under treatment if possible, with adequate counseling for them, their partners and families.

Yabaa use (chasing and ingesting) is now dominant but, of itself, does not constitute a risk of HIV acquisition or spread. If, however, *yabaa* facilitates increased sexual risk taking, there may be linkages to HIV. Proper qualitative sexual research is needed to determine if this is true, followed up with behavioral surveillance surveys (BSS) to determine the extent of these practices or situations. Interventions could then be designed based on the information gathered. This is particularly important for sex workers and youth.

Numerous small NGOs and CBOs requested help with supporting people living with HIV and AIDS (PLHA). Home and community-based care is the most cost-effective option. To develop such a program, coordination with local health facilities is required, and staff and volunteers will require training. Investments in home care kits may be needed (soap, sugar, etc.). Such programs require considerable partnering among NGOs capable of implementing micro-credit, orphan care, grandparent support and other components of a full package. Where the epidemic is advanced and communities are experiencing high levels of death and dying, such an investment helps people cope and move forward to the future. Conducting such a program in communities in which infections were largely acquired through drug injecting would reach a group avoided by others due to the strong stigmatization of IDUS in society.

As the current drug and HIV situation in Thailand is complex, drug use pattern monitoring is a high priority. Further shifts in price, in response to massive seizures of *yabaa* shipments into Thailand by police, could lead to increased *yabaa* injecting and a return to IDU-related HIV risk levels. Or, changing factors

at the source of supply could cause a reverse in the relative price of heroin vs. *yabaa* and a concomitant shift to heroin use, probably injecting. If the past is any lesson about the future, drug use patterns are likely to change again and Thailand, along with a great many other of the world's nations, must invest in readying itself for dealing with the phenomenon for a long time to come.

OVERVIEW OF HIV/AIDS IN THAILAND

Introduction

To date, there are approximately 289,000 people who have died of AIDS nationwide and over 695,000 individuals now living with HIV. Many experts have applauded the national response towards the HIV epidemic, for its demonstrated political leadership and financial commitment. In 1988 the government and donor community allocated USD 684,000, which rose to 82 million by 1997 of which the Royal Thai Government financed 96%. Since the economic crisis there has been a reduction in allocated funding for HIV/AIDS.

Current Situation

By the end of 1999 prevalence declined sharply among Army conscripts, pregnant women and sex workers. The only at-risk population that has not seen a decline is injecting drug users. In June of 1989 it was estimated that 39% of injecting drug users were infected with HIV. Five years later that figure dropped to 34.3%; however, HIV prevalence climbed to 51.1% in June of 1999. The results of the national HIV sentinel surveillance for the year 2000 show that IDUs had the highest prevalence at 54.1%, followed by female direct prostitutes at 16.7%, and female indirect prostitutes at 6.6%. Prevalence among antenatal women was 1.8%.

The Royal Thai Government to date has only permitted one pilot harm reduction program to proceed. This program was implemented in Akha villages in Chiang Rai province and provided only a fraction of the coverage required nationwide. This weak response for IDUs is due to the lack of government conviction in harm reduction approaches and fear the public will view these as condoning injecting drug use.

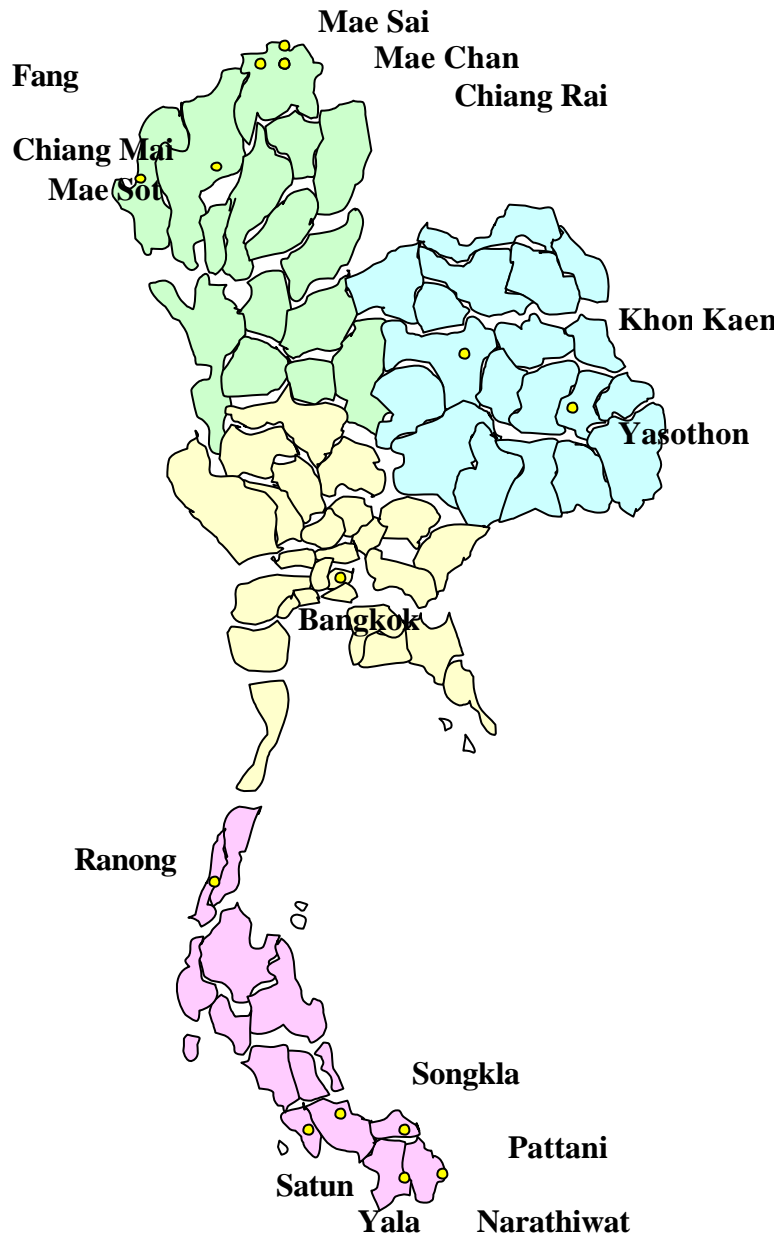
Schools in northern Thailand have now integrated drug and HIV education into their curricula, with participation from teachers, students and provincial authorities. The Ministry of Education has developed HIV/AIDS prevention materials for secondary schools, targeting youth from 14 to 15 years of age, including those in non-formal education programs. The latter is designed for those living along the borders of Thailand, including fishermen and migrants. Needle distribution programs for IDUs are conspicuously lacking. These could be undertaken by INGOs, with proper documentation of effectiveness. Currently there are no educational materials for fishermen, factory workers, and agricultural farmers. The STD Division is responsible for the sex worker community and the Ministry of Public Health is responsible for the drug using community.

Access to medical care for HIV and AIDS varies considerably throughout Thailand. The big hospitals, medical schools and universities have excellent care programs and prophylactic regimes for opportunistic infections. However, in the rural areas of Thailand, the quality and extent of care depends largely on hospital

budgets and attitudes of hospital directors. In many cases patients pay for some expenses, regardless of what level of care is provided.

In 2001 the government plans to complete the national guidelines on the treatment of opportunistic infections. At present 5 to 10% of infected persons can be offered anti-retroviral treatment (ART) in Thailand. These individuals are selected according to medical status and past compliance. In 2002, an estimated 2,000 individuals will be treated, free of charge, with the Northern region receiving 500 of those slots. Priority will be given to post-natal mothers who have participated in ante-natal prevention programs. There is also a concerted effort to promote alternative care for patients, such as herbal medication, nutritional programs, and community and home-based care, including hospices.

Sites Visited in Thailand



OVERVIEW OF DRUG USE IN THAILAND

Current Drug Situation

At present methamphetamine, or *yabaa*, accounts for 75% of all drugs used in Thailand, with heroin accounting only for 10%. The proportion of new drug users entering treatment between 1993 and 1999 using heroin steadily declined from 76.4% in 1993 to 21.2% in 1999, with a brief rise to 84.6% in 1995. The opposite trend occurred with respect to *yabaa* use during the same period of time. In 1993, 1.2% of new drug users entering treatment identified as *yabaa* users. This rose steadily to 58.4% by 1999. Other types of drugs such as ecstasy, opium, marijuana, glue and solvents are still on the market; use of these has remained stable over the same period of time.

Similarly, injecting and snorting as modes of drug administration have declined in the same time period. In 1993 ONCB calculated that there were 24,654 IDUs and 1,202 individuals that preferred snorting. By the end of 1999, the numbers who injected and snorted declined by more than half (12,123 and 907 respectively). In the same period, persons who ingested and 'chased' *yabaa* increased from 1,315 and 19,705 to 2,284 and 22,167, respectively.

Government Structure on Drug Control

The government structures associated with the Office of Narcotics Control Board (ONCB) are multiple and cover all aspects of narcotic drugs. The Ministry of Public Health and ONCB are the main entities for supply and demand reduction. The role of the Food and Drug Administration is to cover all aspects of law, including regulations. The Department of Medical Service is in charge of all treatment and rehabilitation and is represented by the Secretary of Public Health. Each of these entities has its own organization and committee. These committees are represented at the provincial level by the provincial health offices and are housed in the Office of the Permanent Secretary. The Communicable Disease Center is responsible for all HIV/AIDS related to drug use as well as other routes of infection. However, the Division of AIDS has the over all responsibility for HIV/AIDS prevention and treatment throughout the nation. HIV/AIDS as a consequence of drug use is one small part of the overall activities of the ONCB and this is usually carried out by Ministry of Public Health, whose work is mainly geared to policies on AIDS prevention. Many activities are done through the Ministry of Education, utilizing the same concepts and guidelines, but focusing on life skills.

Targeted Populations

Messages for prevention and care of drug users have been increasing in the last few years. There are four main groups targeted: 1) in-school youth, including all school levels; 2) community; 3) workforce, and 4) special groups such as inmates, conscripts, Muslims, hill tribe and street children. For those persons at-risk, counseling is provided and for those who are already using drugs, treatment

options are offered, i.e. detoxification, rehabilitation, and psychological counseling.

A national survey was conducted in 1999 among students, sampling 35,000 students out of the 9 million student population from 50 provinces. The result estimated the number of students involved in drug use. The highest proportion of drug users reported use of methamphetamine (7%), followed by marijuana (2.7%), and inhalants (2.4%).

Within the workforce, there are five main targeted groups: 1) transport drivers; 2) entertainment workers, such as sex workers, bar workers; 3) seafarers and fishermen; 4) industrial farms, and 5) factories. It is the responsibility of each target group to develop the kind of message that will be understood by its population and the appropriate mode of dissemination.

Drug Treatment

The drug treatment sector is the responsibility of the Medical Services Division under the Ministry of Public Health. Since the laws were amended, all hospitals are responsible for providing drug treatment. The newest approach is the MATRIX model, currently being used in three regional drug treatment centers in Chiang Mai, Khon Kaen and Songkla and two provincial centers, Pattani and Mae Hong Son, primarily for hill tribe communities. Currently there are 640 drug treatment centers registered throughout Thailand. Of these there are 561 public institutions and 79 private facilities. The main treatment for heroin is methadone and this is usually administered in a 45-day program.

Identified Gaps in Services

Due to language barriers, the migrant population remains without services. A five-day train-the-trainer course was held, supported by ONCB, concerning the dangers of drugs. Far greater work is needed with this population to reduce drug use and its harms.

I. WESTERN THAILAND

MAE SOT

Industry

Mae Sot is known for its factories and at present there are approximately 70 registered factories employing about 90,000 workers, mostly Burmese migrant laborers, who live and work within the factory compounds. These workers are not allowed outside the factory and there are no health programs available to them in the compounds.

Drug use and at-risk populations

When the government implemented the opium eradication scheme in Mae Sot, drug use patterns switched from opium smoking to heroin use, first 'chasing' then

injecting. Currently there are approximately 200 to 250 drug users in Mae Sot but there are many more that live in the countryside surrounding the town. In recent years the trend toward injecting has diminished as heroin became difficult to obtain and prices began to rise. Many drug users have switched from injecting heroin to ingesting *yabaa*.

Similarly, in the past there was very little drug use among the sex worker community. However with the emergence of *yabaa*, it is reported that many sex workers are now taking the drug so that they may work longer hours, see more customers and earn a higher income. It is estimated that at present 70% of all sex workers in Mae Sot engage in *yabaa* use.

In Mae Sot there is a minimum of 100 direct and 200 indirect sex workers. Many of the indirect sex workers are employed in restaurants, bars and factories. Seventy percent of the sex workers are Burmese, 15% Karen and 15% Thai. Most of the customers are Thai. In the factories there are workers who provide sexual services, both male and female, to earn more money. It is said that, on average, sex workers have 10 customers per day and condom use is low. The rates of sexually transmitted diseases have reportedly remained steady.

Another dimension to injecting among the Burmese and Karen ethnic groups is the practice of injecting in the penis. It is said these men they think they have small penises and wish to enlarge them so as to satisfy their women. The practice of injecting hair oil into the penis began 15 years ago in Mae Sot and has spread to Ranong. Reports state that two to three fishermen or prisoners get together and inject this oil into five to six different places. One syringe is often used.

Service Providers

The majority of NGOs primarily work with the Burmese refugee population, focusing on health issues. There are three NGOs working in the field of HIV/AIDS. The HIV Karen Working Group works on HIV prevention in the refugee camps, primarily for the Karen ethnic group. The remaining two organizations, National Health and Education Committee (NHEC) and Burmese Medical Association (BMA) have a joint project with two programs, one for eight factories and the second providing HIV information to other organizations. The three-person teams that provide outreach to these factories are called 'flying teams'. These teams also work with the Mae Tao Clinic. AusAID is currently funding this project, which reached completion at the end of November 2000.

World Vision began implementation of HIV/AIDS programs six years ago along the Thai and Burmese border. In Mae Sot, World Vision collaborates with other NGOs in Mae Sot and has relationships with UNDP and the Red Cross in Burma.

In Mae Sot there is one private drug treatment center, with a religious orientation, providing only unmedicated detoxification. Detoxification is available in the

hospitals, and used to be free of charge. Now the government has decided to charge as there was such a high rate of relapse and it is felt that if the person has to pay for treatment, they will not relapse. Thai nationals are required to pay B 500 per treatment and persons of Burmese origin are required to pay B 3,000 per treatment.

The Mae Tao clinic is one of the most active medical facilities for Burmese in Mae Sot. This clinic has many different departments, units and activities, as the demands for services from the Burmese community are extensive. Located on the premises is a library, outpatient and inpatient departments, laboratory, trauma unit, eye clinic, child care and supplementary food program, obstetrics and gynecology, malaria program, tuberculosis program, training and knowledge exchange center, Back Pack Health Workers Team office and reproductive health program.

Identified Gaps in Services

Mae Sot at present does not have HIV prevention programs that focus on the drug using population, as most people infected with HIV have gotten the disease through sexual transmission. The main problem is with the people in the prisons as many people can become infected with HIV, hepatitis and tuberculosis. They are at double risk as many will have sex in prisons and drugs are also available if one can afford them.

The best option is to incorporate the HIV and drug use program into existing programs where basic infrastructure already exists. There will also need to be collaboration with the local authorities, factory workers and existing NGOs. Most of the workers should be Burmese as many among the drug user population are from Burma.

Appropriate educational materials are also needed, as to date there are none available targeting drug users. This material needs to be in several languages. In addition there needs to be more capacity building of the existing infrastructure and training on a wide range of counseling and care for persons with HIV and AIDS, as more people are now becoming sick. At this clinic, medical training could be provided on HIV related illnesses for the Back Pack Health Worker Teams so that when they travel into Burma they can assist the drug users that have HIV and AIDS.

Summary

Presently it is estimated that the population of Mae Sot includes 50,000 to 60,000 Burmese and 18,000 to 20,000 Thais. Efforts need to be made to address the Burmese population. One of the most innovative approaches has been the backpacker outreach scheme. Even though its primary aim is train Burmese community volunteers – from Burma not Thailand – to provide primary health care in the assorted town and villages where they come from, adapting this outreach method to reach the Burmese migrants in Thailand, and integrating HIV

prevention messages geared towards drug users would be beneficial and cost effective.

Heroin is still considered the drug of choice out in the countryside surrounding Mae Sot. At present there are no programs reaching these injecting farmers. Even in Mae Sot, the HIV prevention initiative is predominately focused on sex workers, factory workers and the migrant population. There are injectors or people affected by injecting drug use in all of these categories.

In order to initiate a project in Mae Sot, the committee, consisting of the Chief of Mae Sot District Office, Committee on Drug Abuse for Tak province, World Vision, and the chief of the government organizations, should be contacted.

Many persons met in Mae Sot favored the harm reduction approach, but have had very little information or training in what this approach entails. It would be beneficial to bring together national experts throughout Thailand to develop and present an orientation on harm reduction. This orientation might include other at-risk populations such as sex workers, factory workers, prison staff and local officials. It would also provide a forum for discussions on the development of tools needed to implement activities and assess the capacity and commitment of existing organizations.

One of the most visible gaps is the absence of appropriate communications materials on HIV and drug use for the drug using community in and around Mae Sot. Since the drug scene is somewhat varied, i.e. in Mae Sot more *yabaa* use and in the countryside more heroin use, materials should be developed in collaboration with a variety of drug users and service providers before field testing and production. These materials should be in Burmese, Karen and Thai and take into consideration the low levels of education of most of the drug users.

RANONG

Industry

In the Ranong areas, there are an estimated 10,000 migrant workers, 27,000 fishermen and 500 sex workers (200 Burmese and 300 Thai). Migrant workers usually work in the canning factories, as fishermen, or at the port. The majority of the Burmese sex workers are located at the port, while Thai sex workers are located in the town. Police raid both drug users and sex workers on a regular basis. There are about 250 men who have sex with men (MSM) in Ranong town but not many are considered sex workers. There do not seem to be many street children in Ranong.

Drug Use and At-risk Populations

From 1994 to 1996 the fishing industry was very prosperous and many of the fishermen were earning substantial salaries (especially those who used dynamite in the fishing techniques) and heroin was very prevalent and affordable. After the

slump in the fishing industry due to the economic crisis in Thailand many of the fishermen switched from heroin to *yabaa*. There were many overdoses during that time as drug use was sporadic. Currently it is estimated that Ranong has 10,000 drug users throughout the various populations. The police periodically check the fishermen, primarily the Burmese, to see if they are using drugs. It was reported that, even if they have no drugs on them, but do have track marks, they are arrested.

When a person switches from heroin to *yabaa*, it is common practice to inject heroin once in the morning and, when the effect starts to wear off, around lunchtime, then *yabaa* is used. After three days, the heroin dosage is reduced by half using the same procedure. This procedure is repeated until *yabaa* is the only drug used.

At the beginning the general knowledge of the drug-using community was that heroin was more effective than *yabaa* and gave a better high. However, when heroin started to become scarce and *yabaa* was tried, most found that *yabaa* was more potent than heroin with fewer complications in administration. In addition the effects lasted longer and there were fewer symptoms of withdrawal. Many of those who discovered that *yabaa* was better than heroin started using it continuously for 10 days straight until the body wore out. More recently, when a person starts out with *yabaa*, he/she will take ½ to 1 tablet per day and when the body is used to it, this amount will gradually be increased to 5 or 6 tablets per day.

In Ranong, it is alleged that Thai boat owners force fishermen to take one tablet of *yabaa* every morning before going out to fish. In order to ensure that the fishermen take their tablet it will be handed to them, with water, and the owner watches them take it. The fishermen have no right to refuse and if they do, they are fired from their jobs.

There may be reason to believe that sex workers are at risk of contracting sexually transmitted infections (STIs), including HIV, in association with *yabaa* use. If a customer is using *yabaa*, erectile difficulties are said to impair condom use, making it difficult to put on and keep in place. As of June 2000, Ranong surveillance statistics indicated 8.0% prevalence among fisherman, 26% among Thai and Burmese sex workers, and 5% among factory workers.

There are always more people infected with HIV than the services can accommodate. One option offered is consultation and spiritual guidance from Thai Buddhist monks. Many of these monks have been trained and supported by the government, national or international agencies. Burmese monks, even though they are very supportive of persons living with HIV/AIDS, have not been trained and do not have any opportunities to gain skill in caring for and supporting people with AIDS. They have requested that training in counseling and care be provided but to date there has been no response from the donor agencies or national NGOs.

Service Providers

NGOs operated by Burmese find it very difficult to register, and Thai-operated NGOs usually are hampered by language and cultural differences. The only NGO working in Ranong is World Vision. The main objectives of the World Vision HIV program are to reduce the spread of HIV and to increase the care and support of persons with HIV/AIDS, through peer educators, social networking and educational materials in Burmese, H'mong and Mon. Their target groups are families in the fishermen's communities, sex workers, MSM, spiritual leaders, non-formal doctors and traditional health care workers. They plan to identify, develop and organize a community steering committee that will support the project after its completion in nine months.

Identified Gaps in Services

Treatment for drug addiction is scant. The only doctor who will provide drug treatment is located in the World Vision Clinic. Care for AIDS patients is limited within the Thai population and the Burmese Buddhist community has not received the support requested for skills-building in care and support of PLHA. There is a lack of educational materials focusing on drug use and HIV, even in the Thai language. The meager information on drug use is primarily targeted toward heroin injectors, of whom few exist. There are no informational materials in non-Thai languages spoken such as Mon, Burmese, Salone, Tawai, and Vate.

Summary

It does not appear that heroin injecting is as widespread as it was earlier. *Yabaa* use has spread widely and is alleged to place many persons at risk. Certainly other health, including mental health, consequences of *yabaa* use could become considerable. Research is needed to demonstrate a link, if one exists, between the acquisition of HIV through sexual transmission and *yabaa* use. A qualitative study of the contexts and patterns of *yabaa* use could clarify the messages required in developing educational materials for fishermen, factory workers, sex workers and all migrants.

Caring for people with HIV is inadequate, particularly within the Burmese community. Technical support could be offered to Burmese Buddhist monks who seek training for the support and care of persons with HIV and AIDS.

II. NORTHERN THAILAND

CHIANG MAI

Industry

The main industry in Chiang Mai is tourism, which generates employment for a wide variety of businesses. Besides the hotels, restaurants and tour companies, Chiang Mai presents a venue for Thais and the Hill Tribe population to sell their crafts. As the second largest city in Thailand, Chiang Mai has a great amount of

commerce and the standard of living is higher than that of other regions in Thailand.

Drug Use and At-risk Populations

According to the Northern Drug Dependence Treatment Center (NDTC) admissions breakdown, 39% from the lowlands use *yabaa* compared to 3% in hill tribe areas. Hill tribe patients account for 18% of opium admissions and 18% of heroin admissions. Opium use among lowland patients is low (3%); by contrast, heroin use is higher (13%). The remaining persons are admitted for use of other drugs. The ages of patients vary; *yabaa* users are 16 to 25 years and opium users are older, 31 to 40 years old. Of all IDUs admitted to NDTC during 2000, 260 out of 3,149, or 8% have tested HIV positive.

Of the heroin injectors, 26.9% were infected as opposed to 18.8% who injected opium. Out of the 1,366 *yabaa* users, 28 reported injecting of whom five individuals tested positive for HIV.

Four to five years ago approximately 40% of all admissions were *yabaa* users. Since that time this has increased slightly, by 2.5%. Many of those who use *yabaa* do so because of economic reasons and work as fishermen, agriculture laborers, factory and construction workers.

There are three levels of care for persons with HIV. The hospital director decides which level would be more appropriate at the time of admission. Most of the patients coming to the hospital with HIV are from the lower economic class and are treated for free. If a person is symptomatic, then primary prophylactics for opportunistic infections are given.

Service Providers

The NDTC provides services for 17 provinces in northern Thailand and has a staff of 3 doctors, 40 nurses, one pharmacist, two psychologists, and two social workers. At the center, counseling and drug treatment are provided for those drug users referred by other organizations. The NDTC has out-patient and in-patient services and can accommodate 240 to 300 patients who come to the center voluntarily. The cost per treatment visit is 1,000 Baht, which will cover medication, laboratory costs including x-rays. Research programs create information and statistics disseminated to the wider community.

The national AIDS budget for next year will allow anti-viral drugs to be given to 700 persons in the CDC10 region. Patients will be selected by committees in accordance with medical criteria.

There is a myriad of NGOs and community-based organizations (CBOs) in Chiang Mai. One of the more notable is AIDSNet that works with CBOs in implementing HIV prevention programs with support of the European Commission. UNICEF also has a branch office in Chiang Mai and is currently

showing interest in developing HIV programs targeting youth and drug use. The Asian Harm Reduction Network produces advocacy materials.

HIV infected individuals are very active in the north compared to other regions of Thailand. In Chiang Mai there is the New Life Friends Center and at Chiang Mai University there is a Thai Youth AIDS Prevention Project. Johns Hopkins University (JHU) is also very active and is based in Chiang Mai. The JHU program has been on-going for several years and has documented both prevention experiences and infection levels among opioid users in the north, particularly hill tribe populations.

Identified Gaps in Services

Even though there are many organizations that target at-risk populations, there is still a need to up-grade the capacity of the management sector, considered the weakest link in prevention for IDUs.

Some other issues that are not adequately covered by the government or donor community and are urgently needed within HIV and drug use prevention are:

- Drug use and HIV in prisons

- Drug use and HIV in the juvenile detention centers

- The creation of a network run for and by drug users

- Research on use of *yabaa* and high risk behaviors among

- Sex workers
- Agricultural laborers
- Factory workers
- Construction workers
- Fishermen (short and long distance)

Summary

Presently Chiang Mai has actively responded to the HIV epidemic for many at-risk groups. However, services for drug users are less developed and coverage is not adequate. One of the weakest aspects of the overall response is the lack of capacity to manage and coordinate programs. It should be noted that a number of the organizations and NGOs who are based in Chiang Mai focus their activities in other northern areas.

The most pressing need is to up-grade the capacity of the management sector. This could be achieved with several management workshops, which bring together national experts throughout Thailand to train management staff. There are also experts in Chiang Mai, such as AIDSNet, CDC 10 and PLHA groups, who could assist in the training.

Chiang Mai would be a good location to trial the development of self-run projects by drug users and ex-drug users, thus empowering them to voice their needs, and acquire resources and skills to manage some of their own activities. These networks have proved to be valuable advocacy bodies elsewhere, such as in

India, and push for the advancement of treatment options and prevention programs.

There is also the potential within Chiang Mai to undertake social and behavioral research to assess HIV risk among *yabaa* users from various social, industrial and economic backgrounds.

CHIANG RAI, MAE CHAN AND HILL TRIBE COMMUNITIES

Drug Use and At-risk Populations

Chiang Rai Province at present has a population of approximately 1,200,000 persons of which 13% are from the hill tribe communities. The first case of HIV was detected in Chiang Rai in 1988 and cases increased sharply till 1993. For the last 5 years there have been approximately 1,500 to 2,000 new cases of AIDS per year and approximately 500 to 800 AIDS-related deaths per year.

This province also has more drug users than any other province in Thailand. In the past opium was the most popular drug, especially among the hill-tribe population. Many in the hill-tribe communities who smoked opium switched to injecting when heroin was introduced. In the last 5 to 7 years *yabaa* appeared on the scene. Unlike heroin users, *yabaa* users are much younger, have more frequent sexual encounters and do not associate risk of HIV with *yabaa* use. HIV risk has been associated in the local people's minds with sex workers, and younger men are more often opting for casual, non-commercial sex. It is purported that condom use among younger users, those between 15 and 19 years old, is less common than among the older drug users.

In the province, sexual transmission is the most common route of infection currently reported at 92.2% followed by mother-to-child transmission 5%. Transmission by injecting drug use only accounts for .05%, but this likely to be under-reported as medical personnel only ask individuals about their sexual practices and not their drug history.

Hill Tribes

Hill Tribe Education Center works in 48 villages in Mae Fa Luang, Mae Sai, Chiang Khong, Mae Chan, Chiang Saen and Mae Suai districts. People over 35 years of age are usually injecting opium or heroin, whereas those under 35 'chase' *yabaa*, and seldom inject. Three of the Akha villages have high levels of injecting. In the 12 Akha villages where opium smoking and heroin injecting are prevalent, trained Akha staff and volunteers provide counseling to drug users. Needle exchanges are not permitted and only information can be offered.

One recently developed program focused on HIV/AIDS along the Thai, Burma and Lao borders, but its funding from AusAID is now completed. HTEC feels that programs focusing on drug use and HIV in these border villages are very

necessary, but suffer when funding is channeled through government in which a high proportion is spent on administrative costs.

Service Providers

Most support for HIV/AIDS educational materials excludes the drug user population. Every hospital in Chiang Rai province has been requested by the government to initiate a treatment and prevention program targeting drug users and HIV. However there are only two drug treatment centers in operation, located in the north. Similarly in the 15 community hospitals in the province only 50% actually provide various forms of drug treatment.

Most medical staff perceive that working with drug users is difficult, even after the provincial health office conducted harm reduction orientation training for hospital personnel. The general opinion is that drug users can go to Bangkok, Chiang Mai or Mae Hong Son for drug treatment. Health workers recognize the high failure rates of the available treatment programs and wish to have community support before embarking on other harm reduction strategies. The Minister of Interior has launched a program aimed at drug-free villages, in contradiction to a harm reduction approach. This further exacerbates policy contradictions.

The Mae Chan Harm Reduction Project has been on a decline since external funding reached completion. The government felt that the program was too costly for their budget because salaries had been paid to village workers. Local leaders believe that detoxification is more sustainable than methadone maintenance treatment. With the closure of 6 out of 9 village projects, only three villages still expect to provide methadone maintenance treatment, although current funding problems have led to suspension.

Another project, supported by a Christian organization for the last ten years, is called the Dawn Project, and targets the hill tribe population. Persons requesting treatment must agree to stay in the program for three years. The Dawn Project does not interact with the community nor do they provide primary prevention. In Mae Fa Luang there is another detoxification program operating in the Chinese community.

At present there are activities focusing on HIV and drug use in 9 hill tribe villages within Chiang Rai province. The HTEC currently employs four hill tribe staff in its programs focusing on health. These campaigns are promoted by non-formal education mobile teams, which travel to the villages on a regular basis. In addition to the HTEC, the Non Formal Education Center and the Public Health Office also collaborate in providing training for staff on HIV and counseling and to assist children whose parents have HIV or AIDS with education scholarships.

Identified Gaps in Services

The provincial health office is supportive of developing and implementing orientation seminars on harm reduction for the local NGO community.

In the past the government developed policies with instructions to hospitals to provide care for opioid users who were HIV infected, in addition to drug treatment. More recently, the government has revised the policy that all drug users have to be provided with prevention and treatment. However, there is still no program for drug users to receive AZT even though 20% of the drug users that come to the Mae Chan Hospital are infected with HIV. AZT is made available to pregnant women and female sex workers.

Summary

Throughout Thailand heroin injecting has diminished among the older male population, as some have switched to *yabaa* and others have become ill and died of AIDS. *Yabaa* use is now very prevalent throughout the country and the overall age of drug users is decreasing. However there are a few pockets in Thailand where heroin/opium injecting is still the main choice of drug and mode of administration. One of these areas is within the Akha hill tribe communities, which are scattered throughout the Chiang Rai Province.

The entire northern region is at a critical juncture in regard to harm reduction strategies and initiatives. Even though harm reduction has been implemented in hill tribe communities, it failed to equip these communities with the skills to maintain their programs. There are some individuals and agencies that are taking advantage of this oversight to express their views that harm reduction does not have a successful impact. Therefore it is crucial that more effort be made in orienting all concerned parties on the benefits of providing comprehensive harm reduction measures.

The development and implementation of an up-to-date orientation workshop on comprehensive harm reduction measures is a priority. AIDSNet could host this workshop for the lowland population and the HTEC for the hill tribe communities. One of the major goals of this workshop would be to involve the community in selecting appropriate components of the harm reduction repertoire so that implementation would be in a timely manner and sustainable where needed. Research, including behavioral surveillance surveys (BSS), among hill tribe IDUs and lowland *yabaa* smokers would be valuable in order to inform intervention efforts.

MAE SAI AND FANG

Industry

Mae Sai is a border town and the main industry is import/export of supplies to and from Burma and Thailand. Along the main street there are many vendors that sell items, primarily of Chinese origin that come across Burma. There is also a small tourist industry and many tourists go to Mae Sai to obtain a visa or to visit Burma.

Fang is in the agricultural belt and many migrant laborers come over from Burma to work the fields. The majority of these workers are Shan, with a history of injecting, but have steadily been adopting the 'chasing' of *yabaa*.

Drug Use and At-Risk Populations

Mae Sai is experiencing a high rate of HIV. Almost every week there are four to five deaths related to AIDS. Most of those who have HIV or AIDS are former sex workers who have moved back to their homes after earning money, have married and had children. Since the Mae Sai hospital cannot accommodate all those requesting admission for illnesses related to HIV, many travel to Mae Chan to access services.

The switch from heroin to methamphetamine started 10 years ago and today there are very few heroin users left. Many of them have since died of AIDS, overdoses or violence. *Yabaa* is very easy to buy, whereas heroin is extremely difficult to find most of the time. *Yabaa* does not produce the same withdrawal symptoms as heroin and therefore appears less dangerous to consumers.

Service Providers

At present there are no NGOs working on HIV or drug use in Fang and all those infected with HIV go to the only hospital for treatment. Similarly, there are no private or government programs for drug treatment, including detoxification. In the past there used to be many heroin IDUs, but most of these persons have since died of AIDS. Currently the drug of choice is *yabaa*. Drug users, mainly Thai, purchase *yabaa* from the hill tribe villages.

The Hill Tribe Education Center (HTEC) provides, with collaboration from the Non Formal Education Center and the Public Health Office, non-formal education for the street children in Mae Sai, as well as classes on the weekends for students living in Burma. The street children who attend the non-formal education classes only make up about 20%; the other 80% have parents working as migrant laborers in the town. Many of these children do not have proper education because they are as mobile as their parents and therefore difficult to access.

The Daughters Education Program (DEP) began in 1989. From the beginning it was conceived as a community-based initiative aimed at preventing girls being coerced into the sex industry. The staff works with Akha and other hill tribe groups to provide girls under the age of 20 with alternatives to prostitution in the way of education, job training and assistance in finding employment. From the initial group of 19 girls, the center has grown to sponsor over 300 girls in school and over 100 in vocational training in regional centers.

At the DEP facility in Mae Sai there are 60 to 70 children whose parents have died. In addition there are two other DEP sites located in Doi Luang District and Vien Khen District. Altogether DEP presently houses 197 children, with over 700

children having resided at these facilities. Within DEP there are four primary groups; 1) children who live at the facility and go to school in town, 2) vocational and non-formal education students, 3) children who live in the community and go to school at DEP and 4) the teenage group that lives and works in the surrounding area but comes to DEP for activities. DEP, however, does not admit any child who is HIV infected. These are referred to another facility or DEP helps connect them to the hospital for support.

Mae Sai presently has 16-17 NGOs, mainly working with street children, of which four work in HIV prevention and care.

World Vision works with HIV infected individuals, mostly those who are symptomatic, by meeting with them every month at the Mae Sai hospital for monthly check-ups.

The Sem Pring Puang Kea Foundation helps children whose parents have died of HIV-related diseases or those with children who have contracted HIV. These children are provided with education or scholarships to attend schools.

One woman, Ms. Janram, who has an office in Mae Sai. often works in Mae Chan. She has worked for many years for other organizations and has just recently started her own organization. This organization teaches hill tribe children how to prevent HIV, and tries to prevent them becoming a sex worker or a drug user. This is part of the Learning Center Project for hill tribe communities with the main office located in Bangkok.

Identified Gaps in Services

The only program focusing directly on issues of drug use and HIV is the Learning Center Project for hill tribe communities, but Mae Sai branch has been newly formed. The hospital does not have the capabilities to care for all those who are symptomatic with opportunistic infections or are in the final stages of AIDS.

Informational materials for drug users are not available. There is, however, information targeted towards sexual transmission among young females or returning women who have worked in the sex industry.

Summary

Mae Sai has a limited amount of external support for HIV prevention initiatives and none for work with drug users. Drug use in Mae Sai is primarily of *yabaa* with occasional reports of injecting. Most NGOs working in Mae Sai are focused on street children, the children of migrant laborers, women returning from larger cities, and the prevention of sex work among young girls.

In Fang there are no active programs or organizations working with drug users. *Yabaa* is very common and is primarily used for work-related tasks. Those drug

users who used to inject heroin have either switched to *yabaa*, died of AIDS or are HIV positive.

III. NORTHEASTERN THAILAND

KHON KAEN AND YASOTHORN

Drug Use and At-Risk Populations

The Northeast region of Thailand has a population of 21 million, which is 35% of the national population. There are 19 provinces within the region of which 9 have borders with Cambodia or Lao PDR. The total number of AIDS cases in the northeast make up 17% of all cases reported in Thailand. Many HIV infections are directly linked to the low level of economy in the northeast resulting in high levels of migration to Bangkok and the south. After the economic crash in 1997 many who were working outside of the northeast returned home, bringing HIV into the community, and spreading it to family members. As a result, a very high percentage of women and children are presently infected.

According to the MoPH Epidemiological Division sentinel sero-prevalence surveillance report for the northeast, there has been an increase in HIV infection among IDUs. The national prevalence rate was 40% in 1996, 40% in 1997, 47.5% in 1998 and 51.1% in 1999, whereas in the northeast the rates were 20%, 14.3%, 20.2% and 32.3% in the same years.

In the past heroin was more common and *yabaa* was only used by truck drivers. Now heroin is far scarcer and only used by those people, 25 years old and up, who have plentiful money. *Yabaa* is now being used by students and out-of-school youth who sell it among themselves. Many use *yabaa* before going to nightclubs or sell it in order to earn more money to buy modern consumer goods. The price for *yabaa* varies between about 50 Baht and 120 to 200 Baht per tablet. Most who take *yabaa* use it for periods of extended labor; a smaller proportion of people 'chase' it for pleasure and parties. Those who take *yabaa* primarily to enhance labor buy more during the rice planting and harvesting seasons. On some occasions, landowners put it into the water, as it is crucial to get the crops in or out on time.

Although a high prevalence of *yabaa* use is reported throughout the northeast, it is particularly high in Maha Sarakham and Kalasin, where levels of drug use are among the highest nationwide. In the provinces of Amnat Charoan and Surin, *yabaa* is reportedly used by the fishing community. Other populations at-risk are:

Youth - There are a high number of NGOs that work with the youth in the northeast, mainly providing capacity building and life skills.

Sex workers - In Sakon Nakhon there are two NGOs that provide services for sex workers. It should be noted that not all the sex workers are of Thai nationality and some come from Lao, Vietnam, Russia and Central Asia. Migrants. Even though the northeast has a high level of migrant laborers, there is no NGO that only focuses on migration. Currently AIDSNet and PATH are developing training on HIV prevention in the migrant population. Very hard to reach groups, such as those in juvenile detention centers, youth in discos/night clubs, and cross border migrants. There has been a project started in Ubon Ratchathani addressing cross border issues with Lao PDR.

Disadvantaged groups – This would include PLHAs and their families, children affected/infected with HIV, people living in remote areas.

From 1997 to 1999 the Northeastern Drug Dependence Treatment center experienced a steady increase of heroin use and very little *yabaa* use. However that changed in mid-1999 and at present, the use of *yabaa* has dramatically increased as heroin use has declined. In 1997, when heroin use peaked, heroin cost 3,500 Baht per “pick” or dose; at the present time, heroin only costs 800 to 1,000 Baht per dose. *Yabaa*, however, is much cheaper. Many Thai youth take boats over to Lao PDR to use *yabaa*, as they fear arrest by the Thai police. A recent study has shown that 10% of school children have used *yabaa* in this region.

The center’s records indicate that the majority of clients are between the ages of 15 to 25 and unemployed. They are primarily *yabaa* users but qualify as poly-drug users. If *yabaa* is not obtainable, then these youths will use heroin, glue or opium. The center categorizes the clients into three groups; 1) methamphetamine users, 2) alcoholics and 3) poly-drug users such as opium, glue, heroin and marijuana. On average, there are 20 patients per day utilizing the out-patient program. For the in-patient unit, 90 beds are allocated at an occupancy rate of 80%.

Service Providers

At present there is a limited number of NGOs in the northeast working on HIV/AIDS. Many are focused on environmental issues. The most active area for HIV work is TAO where the Tambon Administration Office is located. In this area there are four groups (CBOs made up of monks, teachers and women) who are active in HIV prevention. There is still poor acceptance of programs aimed at drug use, sex work or HIV/AIDS and for this reason AIDSNet is committed to working with these groups and organizations.

There are approximately 60 registered NGOs, 50 CBOs and 70 PLHA groups consisting of 3,500 persons in the northeast and AIDSNet have identified 10 that have the potential of providing harm reduction measures to the community. These 10 were selected because most of them work indirectly with drug users through youth and community groups. There is only one NGO working directly

with the drug using population. The staff at AIDSNet plus key individuals attended a harm reduction workshop in Chiang Mai, after which they developed a workshop for Khon Kaen and invited these 10 NGOs. To date, only one NGO has initiated a harm reduction approach, whereas the others felt that working with HIV among other populations took preference over working with the drug using community.

Among these service providers, 79 projects are sponsored by the European Commission through AIDSNet of which 29 projects are prevention activities, 25 focus on care, counseling and support and 25 on capacity building. They are divided into three groups, which there are 31 small projects (under 50,000 Baht), 16 medium sized projects (50,000 to 100,000 Baht) and 32 large projects (100,000 to 500,000 Baht). With regard to capacity building, there have been 22 trainings implemented by AIDSNet covering the following topics;

- 3 – project management
- 7 – community behavior change
- 10 – project accounting and report writing
- 1 – working with children affected by HIV/AIDS
- 1 – regional AIDS strategy development, which was in collaboration with CDC 5,6 and 7, PHA network and NGO network utilizing the AIDS strategy guidelines.

The Northeastern Drug Dependence Treatment Center opened in 1992 as the regional drug treatment facility and became fully functional only three years ago. It was not until May 2000 that the center started accepting in-patients and providing a range of activities. During this time the government changed its policy on drug treatment and placed all drug treatment units within the hospital setting. The center reduced its responsibility from providing services for the region to Khon Kaen province. The center at present has 27 nurses and 14 assistants to provide services to the patients.

Many family members, as well as clients of the Northeastern Drug Dependence Treatment Center, worry about relapse once they leave the center. In the past, the ideas about the creation of support groups were discussed but this was deemed too difficult, as many of the clients come from different provinces or do not want to be identified while others, who belonged to the upper echelons, have families who do not want their sons attending treatment for fear of neighbors or colleagues finding out. To rectify this situation the center set up a 24-hour hotline, which is operated by the nursing staff but the coverage is not adequate.

The Foundation for Children and Youth Development in Yasothorn works with children who have left the family for various reasons. Many of these have left because of economic reasons or are abandoned or orphaned. In many cases they team up with youth in similar situations, often turning to drugs, then

becoming dealers or sex workers and may contract HIV. The Foundation works with these children and tries to connect them with families or relatives.

The foundation has conducted a rehabilitation youth camp in which 120 individuals participated. Some attended the camp on a volunteer basis, while others were given sleeping pills by their parents and when they woke up they were at the camp. The participants came from a variety of locations such as Yasothorn, Chiang Mai, Yala, Chiang Rai and Nonthaburi. The camp attendees were comprised of 60% males, primarily for drug use, and 40% females who were sexually abused or sex workers. The majority of HIV infections among youth are contracted sexually. Once the youth has returned home they are labeled by the community as “bad” and treated as such. Many of these youth will eventually leave home again due to such negative social processes, thus continuing to be at high risk acquiring HIV.

Identified Gaps in Services

There is a limited number of NGOs and PLHA organizations, although this has been recently increasing. Most of these organizations and groups have little capacity to provide good infrastructure through adequate management and program development, including outreach techniques. Many who work in these organizations are young and very action-oriented. This may be due to the nature of work, as the older, more established organizations tend to focus on poverty and environmental issues whereas the newer organizations focus on health issues. The more established organizations also tend to receive funding more readily and the issues that they represent are more palatable to the donor community.

According to key informants in Yasothorn, one major problem is that the government has separated sex education, drug use prevention and HIV prevention. This has fragmented the cohesiveness and provision of proper interventions throughout the northeast. The situation is compounded by the insufficient budget for each of these three initiatives. It is believed, that if the government would combine activities and funding in these three areas, sustainable programs could be implemented.

It would be beneficial to all concerned if the development and implementation of an up-to-date orientation workshop on comprehensive harm reduction measures were supported. AIDSNet has already moved forward on this issue and has provided training for 10 suitable NGOs. However, to date only one has taken up the harm reduction component. It would be advisable to re-engage the other nine NGOs to determine their reasons for not becoming involved in working with drug users. Such a workshop could involve the community as well in selecting appropriate components of the harm reduction repertoire so that implementation would be in a timely manner and sustainable.

Building relationships with NGOs and drug users may enable the execution of suitable qualitative and quantitative research into the relationship of current drug use patterns, HIV risk behavior and infection in the northeast. One of main obstacles to the prevention of HIV among youth is the lack of accessible condoms. In addition to engaging in casual sex with girlfriends and/or boyfriends, many of those who use drugs sell sex to buy their drugs. The local youth can go to the provincial health office and request condoms but many are too shy to approach the health workers for condoms. This issue needs immediate attention and more appropriate condom distribution facilities.

Summary

Many of the current HIV infections throughout the northeast were originally acquired when the individual migrated to Bangkok or the south. After the economic crisis in 1997, most of these migrant laborers returned home with HIV and infected loved ones. At that time those who were injecting heroin and became infected have either died of AIDS or are now symptomatic. This also holds true for their spouses and to a lesser extent their children.

Even though there appear to be numerous NGOs and CBOs in the northeast, most are working on environmental issues and only a few are engaged in HIV prevention. These few organizations work with target populations other than drug users because many either fear drug users or find the work too difficult. At present there is only one NGO working with potential, current and former drug users.

Yabaa use is now the most prevalent drug on the market in the northeast. Many use *yabaa* either for pleasure or labor-related economic reasons, for example, in agriculture. Although Injecting is not the most prevalent mode of administration, the situation bears monitoring. Shifts in price could lead to more frequent injecting of *yabaa* or, if the relative supply and cost of heroin and *yabaa* once again reverse, drug use patterns are likely to change again.

Local needs include 1) better access to condoms for youth; 2) technical knowledge and skills related to harm reduction; 3) the development of community-based approaches to demand reduction for *yabaa*

IV. BANGKOK

Drug use and at-risk populations

The Bangkok Metropolitan Administration (BMA) has had a narcotic department for the last 18 years. The main drug treatment modality has been the use of methadone for a 45-day treatment regime. The BMA places considerable emphasis on rehabilitation and reintegration into society. All persons in any of the programs are referred to as members and not clients or patients. An

example of one of the BMA's initiatives is The Winner House, modeled on the Day Top philosophy but modified for the Thai context.

Like other neighborhoods in Bangkok, the major drugs of choice in Klong Toey area used to be heroin and opium but has now changed to *yabaa*, which costs 50 to 100 Baht per tablet. This is primarily ingested, but there are some who 'chase' and very few who inject *yabaa*. Typically, these *yabaa* tablets include additives, such as caffeine or, it is alleged, even arsenic and pesticides. Most youth take *yabaa* for pleasure, but there are a few who sell *yabaa* and do not use it themselves. The IDU population used to have HIV, but most of them are already dead.

There is a rehabilitation center in La Mar District located in Chumphon Province, 600 kilometers outside of Bangkok, to which the Foundation sends drug users. The program is for boys, lasts for 3 years, and utilizes occupational therapy such as working on the rubber plantations. The youths have an opportunity to go to school or receive vocational training. They also have adult education classes where a diploma in environmental issues can be received. This program helps build self-esteem and teach responsibility.

There is not as much HIV infection as one would think in the Klong Toey area. A great deal of safe sex education with condom distribution has taken place and appear to have been successful. However, recently the Ministry of Public Health has stopped supplying the project with condoms, as they have no funding. Therefore sex workers who cater to sailors at the port sometimes do not use condoms, depending on their current economic situation.

Military

As a pioneer of drug use prevention for the Army, Lt. General RTA Dr. Aroon Showanasai recalls that in 1959 opium was outlawed and if a person was caught using it they were forced to join the Army to learn responsibility. In 1961 heroin was introduced to Thailand from Hong Kong and the use of opium decreased. During that same year the drug treatment program was started in the military hospital. Similarly in 1978 the first rehabilitation program was initiated in Rat Buri. Ten years later, the first HIV infected recruit (who happened to be gay) was found. During the Vietnam War the American soldiers introduced injecting. Dr. Wiloa started a program in 1982 to assess the extent of drug use by utilizing urine analysis, checking for track marks and also testing for HIV.

Each year there are approximately 800 to 1,200 persons admitted to the treatment center for heroin use. Five to six percent only are injecting drug users, as 'chasing' *yabaa* has become more popular. There are 7 military drug treatment centers throughout Thailand and the patients remain on average for 6 months. In 1988 the hospital started HIV prevention for Army personnel and was the first in Thailand to offer an in-patient department for drug treatment. At that time the drug treatment department tested 150 Army personnel in the center and found that 30% were HIV infected. Five years ago the prevention and counseling

program was initiated. Every year the center also conducts 30,000 urine analysis tests to see if there are drugs present in Army personnel. If they show positive results then the person is also tested for HIV using the ELISA test. The situation has changed dramatically and the drug of choice is now *yabaa*. This means that all the prevention programs have to be re-conceived and new data collected in order to know the real situation.

Service providers

The BMA presently has 15 drug treatment centers that are under the Ministry of Public Health. There are also two drug treatment facilities within Bangkok that belong to the Medical Services Division in the Ministry of Public Health.

Currently the program's clients are mainly heroin users. They comprise 80% to 90% of the 20,000 to 30,000 clients who go through the fifteen centers per year, down from virtually 100% twenty years ago. The programs consist of a 45-day methadone detoxification regime with the additional use of naltrexone. For those individuals that are newly addicted to heroin, the doctors are using Cloradine instead.

The Winner House admits individuals who are HIV infected or have TB. The staff include two nurses, two psychologists, four social workers at the therapeutic community program and two psychologists and one social worker at the re-entry program. Currently there are 60 members at the center of which 10% are in treatment for heroin use. Only Thai nationals are admitted into the program those who are not, receive only counseling and information. This entire program costs the individual 1,000 Baht per month.

There is also a narcotics anonymous program within the center to assist the members in helping themselves. This philosophy has not been present in many of the other government programs and is needed to assist the members with goals and values. Many drug users have negative behavior and are irresponsible when they enter the program. This stems from having spent much of their time stealing and committing unacceptable social behavior that is related to their drug use. The components of this program assist them in becoming responsible as well as accountable for their actions.

When the members first enter the program they will be briefed on the four major areas in which they will learn how to live without drugs. These areas include:

1. Shaping behavior
2. Intellectual development
3. Emotional development i.e. control emotion (act not react)
4. Vocational skill development

These four components take approximately one to one and a half years to complete depending on the individual. They will also move from the detoxification and rehabilitation center to the re-entry program.

Once they are graduates of the program they are often sent to universities and schools to be guest lecturers. This will not only help them build self-esteem, but also enlightens attending students. Similarly the graduates are followed up once a month to make sure that they are progressing smoothly.

Alden House, another option for therapy, was a result of the work of several committed individuals who met at a drug treatment center (one staff and one client). They decided to offer HIV infected drug users a choice of out-patient care or a live-in therapeutic community setting. The choice was considered necessary because many of those in recovery did not possess the necessary skills to remain abstinent with counseling alone, once they left traditional treatment. Alden House is open to all persons infected with HIV/AIDS and many travel from throughout Thailand to the House.

Alden House has two facilities staffed by 5 individuals, and caters to both men and women. One house is co-ed for the very ill that have nowhere to go and for those who are not terminally ill it offers an opportunity to provide an extended family structure that includes a normal life style i.e. through shopping, cooking and working. The second house includes the office for administration personnel as well as children of those who have died of AIDS. This came about when Medecins Sans Frontieres/Belgium requested that they take in those children with the most difficult emotional issues. This house also has a facility for meetings and training of staff and volunteers working in the field of HIV/AIDS and drug use.

This drug treatment initiative follows the Day Top model and philosophy i.e. therapeutic community, behavior modification and self-control. It aims at enhancing inner-dependence, and is based on a reward/punishment psychological regime. Given the deep-rooted socially stratified society of Thailand, in which punishment is accepted due to one's low status, it takes two years to re-train clients' behavioral patterns.

In the past, Alden House received 90% of its funding from the government but recently this has been dramatically reduced. The group has also actively advocated for access to anti-retroviral drugs for PLHA. Alden House is in need of support, as the current budget will be depleted soon. The main funding priority is to secure core funding for Alden House and once this is accomplished then development and implementation may proceed for the opening of two more houses, one in the northeast and the other in the south.

Duang Prateep Foundation is located in the Klong Toey area of Bangkok, which has a population of 100,000. This is considered one of the poorest areas in the city and many of the residents are elderly or young. Families have little security as many grandparents are left to care for grand children, as the parents have gone to find work or have died.

The Foundation is also a part of the Anti Drug Association, which is operated by the community itself. The general aim is to motivate youth with sports, education and group activities. There is no support from the local or national government or from the private sector.

There is also the “New Life Project” which houses young individuals of whom many have been sold by their families for economic reasons. These youths usually cannot go home and stay at the project center. When the center opened 13 years ago there used to be youth from professional families. The center has 90 young people now and several hundred on the waiting list.

Identified Gaps in Services

The Bangkok area is in need of scaling up the coordination and networking of programs involved in HIV and drug use, as agencies working in the same field do not know what the others are doing. Such coordination would include the government, international agencies and national NGOs located within Bangkok. The most strategic and productive way to move forward would be to have a seminar for all agencies and a study tour to projects within Bangkok.

There does not seem to be a shortage of drug treatment facilities in Bangkok. However many follow the same guidelines of minimal detoxification treatment, an unsuccessful approach entailing high levels of rapid relapse. One facility, The Winner House, emphasizes rehabilitation and re-entry into society. Even though this center claims to have a high success rate, the government feels that it is too expensive to reproduce throughout Thailand.

Bangkok is also the center for all HIV infected individuals who are active in the PLHA movement. Many individuals from around Thailand travel to Bangkok to receive treatment or request assistance from the PLHA network.

Summary

Inasmuch as the majority of donor agencies, NGO head offices, and the seat of government are based in Bangkok, FHI could make a greater contribution by supporting initiatives outside of Bangkok. However, with the support of FHI, a seminar could be hosted by the BMA to familiarize all agencies involved in HIV and drug use activities with each other and promote the complementary approaches of demand reduction and harm reduction, in accordance with UNAIDS recommendations.

V. SOUTHERN THAILAND

PATTANI, SONGKLA, YALA, SATUN AND NARATHIWAT

Industry

The southern area is known for its rubber plantations and many of the migrant laborers that work on these plantations are from the northeast of Thailand, seeking off-season work.

Fishing is another major industry. Many fishermen are migrants, sleep in temporary houses near the port, and are infected with HIV. These men need assistance in getting to the hospital. The hospital checks to see if the person is suffering from an AIDS-related disease, If this is the case, a Christian organization will assist in making sure they can return home, often supplying them with transportation and notifying the family. There is still injecting among the long-distance fishermen and unemployed youth.

Drug Use and At-Risk Populations

The use of heroin started more than 20 years ago in the south. At that time most people smoked heroin, but in the early 1970s the switch from smoking to injecting began. Many IDUs have since died of AIDS or are now symptomatic with the disease. Two to three years ago the ONCB estimated that there were 5,000 drug users in Yala Province. At present it is thought that Narathiwat has the biggest drug use population in the south, followed by Pattani, then Yala.

Unlike other parts of the country, heroin use has not decreased and heroin is readily available in this region. Among the new generation of drug users, *yabaa* is becoming more prevalent, especially in southern cities. Among the older generation of drug users, approximately 80% are HIV infected, many having contracted the infection while in prison.

In Pattani it is estimated 50% of heroin users admitted into the Southern Drug Dependence Treatment Center are HIV infected. The center offers medical treatment for opportunistic infections and prophylactic treatment if the person has a history of PCP or a CD4 count that is below 200.

In the past 10 years the Province of Narathiwat has registered 1,157 AIDS cases and 255 deaths due to HIV related causes. The highest rate of HIV per capita is an area called Sungai Go Lok, which is located on the Malaysia/Thai border.

Currently heroin is very plentiful in Yala. Users can purchase it easily at teashops for 100 Baht. Needle sharing is reported to be less common.

The Young Muslim Association of Thailand (YMAT), as well as the Provincial Health Departments in the four border provinces (Narathiwat, Yala, Songkla and

Pattani) have successfully collaborated with the four northern states in Malaysia. Muslim beliefs, held in common, affect HIV/AIDS messages. As commercial or illicit sex is more stigmatized than drug use, condom promotion is not seen as acceptable.

Service Providers

Heroin is still the most common drug used in Pattani, as reflected in seizure and arrest records 1996 to 1999. Heroin is also widely available and the drug use pattern has shown a slight, but steady, increase in heroin. However *yabaa* is increasing at a more rapid rate. Most heroin users inject two to four times per day and range from 15 to 40 years of age. The majority of persons admitted in 1999 to the treatment center are male (1,278) with very few females (8) requesting services. Relapse rates are high.

The Drug User Rehabilitation Center in Narathiwat was started four years ago for detoxification of heroin users, using religious counseling to motivate attitude and behavior change. A large number of individuals want to be admitted to the detoxification center but cannot afford the 1,000 Baht for the 45 day course of treatment. This 1,000 Baht covers two meals per day and the methadone that is needed for detoxification. Much training is needed for the staff. Another center offers training in agriculture and carpentry. The center also is a halfway house where individuals can stay, but work outside during the day. This center has not yet reached its potential utilization level, as there needs to be formalization of courses and utilization of the land allocated by the government.

YMAT was launched in October 1964 by a group of Muslim youths who had discussed the need for an Islamic organization representing all young Muslims in Thailand. The formation of YMAT united several Muslim youth groups in various communities and paved the way for concerted, nationwide effort based on their experience. YMAT presents Islam as the *deen*, which encompasses all aspects of human life. One of their projects is the rehabilitation of drug users from the southern border provinces. YMAT has further developed itself as a non-governmental organization since receiving its first grant from the Ministry of Public Health in 1992.

The Baan Iqram Rehabilitation Center for drug-addicted persons was established by YMAT (Yala Branch), using religious ways of rehabilitation, aimed at assisting Muslim youths wishing to cancel their drug addiction. Baan Iqram has been incorporated since September 1993, and is primarily supported by Yala Provincial Public Health Office.

Malaysian drug users often buy their drugs in Sungai Go Lok, which is on the Malay/Thai border, also familiar to some Thai drug users. Because Malaysia does not permit methadone, many drug users come to Yala for treatment. The majority of drug users that request treatment are from the four northern states of

Malaysia. Those who have money and do not want to be registered as a drug user in Malaysia come from other parts of the country, such as Kuala Lumpur.

NGOs start to play a role in home-based care. Baan Soon Ruam Nam Jai PLHA Project is an organization that provides services to people with symptomatic HIV disease. Home visits started one year ago and was supported by the local hospital from June to December 1999. Starting in April 2000, funding was provided by Rak Thai Foundation to support home visits to 28 individuals. Because there is only one full-time staff member, linkages have been made in 20 villages with PLHAs or former drug users. Counseling is also provided to the patients and families and once a month there is a health check day for people infected or affected by HIV.

HIV infected individuals are treated with herbal medicines that are collected in the local area. During home care visits many of the neighbors suspect that the person has HIV. To reduce discrimination, neighbors are also visited to enlighten them on basic HIV information. PLHAs come to the center to collect their herbal medication and receive counseling if necessary. Some prefer to come, as they do not want their neighbors to know of their status.

The next phase of Baan Soon Ruam Nam Jai PLHA Project is to raise awareness with the Muslim community and with religious leaders. One of the venues that has been proposed is on Fridays following the afternoon prayer.

The Drug Treatment Center in Satun provides detoxification and rehabilitation for drug users who are serious about stopping their drug habit. All clients are admitted free of cost. The center also takes in HIV infected persons who have nowhere to go. The center also conducts awareness-raising on drug use and HIV infection to the community, thus making it easier for those infected with HIV to be accepted into the community.

In the beginning, the center primarily catered to heroin users but has now started accepting those with *yabaa* as their drug of choice. Many users are unfamiliar with *yabaa* and inject it rather than 'chase' or ingest it. They are only able to inject for a maximum of 2 to 3 months before they became physically exhausted. There have been instances where drug users have died after a week of *yabaa* injecting. Most of those who inject do so individually and not in groups. However there is sharing of needles, as many know the locations where the needles are hidden and go to use them at different times. The center has discussed starting a needle exchange program with the local police, but the police did not agree and would not endorse this component.

The center has had limited support, not necessarily funding, from ONCB Center for Administration for the Southern Provinces, the local hospital and Rak Thai Foundation. On occasions the hospital staff visit the center to tend to ill clients or provide transport to the hospital for a client. Rak Thai Foundation only supports

home care activities for those with AIDS and community awareness and does not support any operational needs of the center. At present the center does not have enough food to feed the clients, nor a telephone, vehicle or sports equipment for the clients. Currently the staff consists of one full-time and 5 part-time members.

Identified Gaps in Services

There are few NGOs in Pattani and in the south generally because local communities are conservative and do not easily accept activities in support of marginalized persons. It is also difficult for other Thais to come to the south and work as they often do not know the local dialect, as well as the Yavi language, and cannot communicate effectively. Staffing locally is difficult because the NGO sector cannot offer secure and steady employment.

Local interpretations of Islam condemn those who acquire HIV as sinners, thus raising levels of stigma higher than found elsewhere in Thailand. This is one reason that there are no PLHA groups in the south. Very few people want to be associated with HIV infection and many have not disclosed their status to family members or the community.

This differs greatly from the north as many have gotten infected through sexual contacts when they left their villages for cities to make money for their families. In the south many of those infected with HIV contracted the disease through the use of contaminated syringes and not through helping the family. As a result they are more vulnerable to stigma and discrimination.

In these communities, the greatest need is to diminish attitudes of blame and punishment and to promote forgiveness, in order to create a better life for those infected or affected by HIV/AIDS. This should also include wives that have been infected by their IDU husbands, as well as parents of children caught in the spiral of drug use and HIV. Exposure to HIV infected IDUs who have family support networks from the north would be a useful experience for those in the south.

Summary

The southern region has very few HIV projects implemented by NGOs or funded by international donors. Despite this gap, there is a strong commitment among specific organizations in the Islamic community. The projects in Satun, Narathiwat and Yala all stem from individuals associated, on a voluntary basis, with the Baan Iqram Rehabilitation Center.

Purportedly, due to the Islamic beliefs, condom use is not promoted in this region, as sex outside of marriage is prohibited. Compared to elsewhere in Thailand, there is also a greater amount of discrimination and stigma placed on sex workers as well as drug users. If someone has HIV or has died of AIDS this is usually hidden lest they not receive a traditional Muslim burial.

This region is one of the only areas left, beside the northern Akha hill tribe communities, where injecting is the preferred mode of administration for heroin and is common for *yabaa* as well.

One of the more important suggested activities is to target the religious leaders with information and open up a discussion concerning mercy and care for those with HIV.

In Yala the YMAT requires assistance in evaluating the effectiveness of its activities. In addition the Baan Soon Ruam Nam Jai PHA Project is in need of support for the care and counseling of HIV and AIDS clients. A networking meeting for PLHAs and families to meet with their peers from the Bangkok area might be beneficial. Medicinal herbs are now the only medication being utilized, as they are relatively inexpensive and locally grown. Exploration of other prophylactic measures as well as pharmaceutical medication may be necessary to prolong the lives of the clients.

The Narathiwat Drug Treatment Rehabilitation Center does not have running water, despite government promises, or screened windows. Longer-term (5 years) assistance is needed in building capacity among the staff members as well as supporting the existing infrastructure of the center. This would include counseling and care for HIV/AIDS clients, outreach and general harm reduction measures.

The Drug Treatment Center in Satun requires support for their detoxification and rehabilitation program. This would include the building of capacity among the staff, funding of operational costs, training for outreach, primary health care, care for persons with HIV and AIDS and information on harms associated with *yabaa* use.

VI. CONCLUSIONS AND RECOMMENDATIONS

The current situation with regard to drug use patterns and HIV in Thailand is complex, under rapid change, and bears monitoring. It appears that approximately half of the living IDUs are already infected with HIV and the remaining half, except among Akha hill tribes and heroin users in the southern portion of the nation, are rapidly switching to 'chasing' or ingesting *yabaa*.

HIV transmission is associated with injecting drug use, which, in Thailand, has been the most common mode of administration of heroin for the past few decades. As needle exchange or open distribution systems have not generally been permitted, drug treatment programs have been the main activity with the potential to have an impact on HIV infection levels among IDUs. Thailand has invested in numerous treatment centers and appears committed to developing expertise in this area. However, treatment regimes based on short-term

detoxification, with or without methadone, have been shown to be ineffective in all settings. High rates of relapse are the norm. More comprehensive treatment programs with adequate counseling, long term pharmacotherapy, skills training, housing and health care, if needed, are usually more successful. These, however, must be sustained over long time periods in order to be effective and require back-up after-care in the community with support groups made up of persons in recovery. Improving knowledge of the scientific principles of opiate dependence treatment among policy makers, government health and NGO workers would be a valuable investment for Thailand. Where heroin injecting continues, as in scattered Akha hill tribe villages and the southern region, a complementary mix of demand reduction and harm reduction methods, including scientifically sound treatment options, should be designed for trials and implemented through selected NGOs. Programs to increase the use of sterile injection equipment, such as syringe exchange programs, should be expanded. These programs do need to be complemented by increased long-term treatment programs for drug addiction. HIV infected IDUs are often anxious to give up the habit and need a program geared to manage their infection and dependence in a way that will reduce the likelihood they will continue to transmit the virus to others. Proper documentation with long-term follow-up of patients must be seen as an investment of the highest priority. The current confusion of drug treatment methods in place reflect the lack of scientific knowledge and testing of treatment modalities in the Thai context.

It should be noted that, although demand reduction is politically and socially far more acceptable in all nations, few programs of demand reduction have demonstrated success anywhere. Shifts in social norms regarding drug use do occur, however, and injecting has increasingly become associated with low status, death from HIV, alienation from family, criminality, personal impoverishment and ill health-i.e. an identity to be avoided. School-based education about drugs, in association with school-based sex education, requires openness, honest factual information and well-trained teachers. Developing effective youth education to reduce the demand for drugs will be a challenge in societies, such as Thailand, where the availability of illicit drugs is very great.

Methamphetamine use is now very common in a variety of groups, defined by occupation, age and locale. As the form of methamphetamine available (tablet as opposed to 'crystal') is less frequently injected than 'chased' or ingested orally, the risk of acquiring HIV or other blood-borne viruses is drastically reduced. Under this scenario, neither needle distribution systems nor methadone treatment regimes are appropriate. Although craving for amphetamine-type stimulants can develop, dependence is not characterized by severe withdrawal symptoms. Therefore, treatment of methamphetamine dependence is more dependent on behavioral modification than pharmacotherapy at the present time. As the phenomenon of methamphetamine dependence is new to Thailand, the development of scientifically sound educational materials, both for the specialist and the lay person, would be highly useful. Consultant specialists from both

Europe and the USA could share knowledge and experience with Thai treatment specialists as well as NGOs wishing to work on the problem of *yabaa* use. More specifically pertinent to HIV prevention, the possibility exists that *yabaa* use facilitates risky sexual behavior. In-depth research by professionals with experience in qualitative sexuality research methods will be required to examine the contexts and meanings of *yabaa* use and sexual behavior among different groups. This is particularly important among sex workers and youth. Should specific issues be revealed that demonstrate heightened risk, quantitative surveys would be important in order to reveal the extent of such risk. In order to determine, however, if the risk of HIV transmission through sex is in fact greater among *yabaa* users than among similar people who do not use *yabaa*, a prospective cohort study would be required. The Johns Hopkins University Substance Use and HIV/AIDS Research program based at Chiang Mai University would be an excellent site for such a study. In the end, sexual risk of HIV transmission, with or without the use of *yabaa*, is substantially reduced with consistent condom use and the main prevention messages remain the same. A situational analysis of such risk taking among *yabaa* users could provide insights with which to develop properly targeted communications and messages.

Throughout this assessment, NGOs and CBOs working in HIV affected communities have requested support for caring for infected and affected people. The burden of advanced HIV disease and AIDS is increasing in Thailand as the epidemic matures. Home and community-based care is the most feasible option but requires well-informed caretakers and a cadre of trained people in each region to support such a system. Exploring the possibilities of developing an integrated home-based care system in a selected locale heavily affected by HIV among IDUs is a worthwhile investment. Implementation may require funding at different levels. Government health facilities, multiple donors and implementation agencies would need to be involved. Voluntary counseling and testing (VCT) in such locales must also be available. Equipping people with the skills to handle widespread serious disease and death is a humane investment in ameliorating the impact of this epidemic on families, allowing them to handle these deaths and move on to the future.

As the situation is complex, drug use pattern monitoring is a high priority. *Yabaa* use is now the most prevalent drug on the market in the west, north, northeast, and in Bangkok. This shift occurred very rapidly and portends continued change. Further shifts in price, in relation to massive seizures of *yabaa* shipments into Thailand by police, could lead to increased *yabaa* injecting and a return to IDU-related HIV risk levels. Or, changing factors at the source of supply could cause a reverse in the relative price of heroin vs. *yabaa* and a concomitant shift to heroin use, probably injecting. If the past is any lesson about the future, drug use patterns are likely to change again. Investing in helping Thailand ready itself for the long-term management of illicit drug use, conducting the needed research in order to devise the best methods for mitigating its impact on the health of the

population and reducing the demand among potential new users is a challenge and opportunity for important cooperative aid.

Appendix A. Persons and organizations interviewed and visited

UNAIDS Drug Use and HIV Vulnerability Advisor
Dr. Anupong Chitwarakorn – Director of Division of AIDS, MoPH
Office of Narcotics Control Board
Medical Services Division - MoPH
United Nations Drug Control Program
World Vision
Mae Sot drug user
Mae Sot HIV/AIDS Experts
Htun Htun Oo – Head of Trauma Unit at Mae Tao Clinic
Site visit to NHEC/BMA HIV/AIDS Office
Dr. Cynthia Muang – Mae Tao Clinic
Meeting on Current Gaps in HIV/AIDS Prevention with Dr. Cynthia Muang
Site visit to fishing port in Ranong
World Vision Office - Ranong
Sex worker cum drug user
President of the Burmese Women’s Union
Northern Drug Dependence Treatment Center
Dr. Kriengkrai – CDC 10
Dr. Chawalit Natpratan– CDC 10
Dr. Somsak Supawitkul – Chiang Rai Provincial Health Office
Hill Tribe Education Center – Chiang Rai
Dr. Pornpimol Saksoong - Pharmacist at Mae Chan Hospital
Yabaa user in Fang
Fang Hospital Doctor
Daughter’s Education Program – Mae Sai
AIDSNet Northeast Office – Khon Kaen
Yabaa/HIV+ couple/baby - Yasothorn
Northeast Drug Dependence Treatment Center – Khon Kaen
Foundation for Youth and Development - Yasothorn
Site visit to the BMA drug treatment facility – The Winner House
Site visit to Alden House for People Living with HIV/AIDS
Site visit to Duang Prateep Foundation – Klong Toey District
Lt. General Dr. Aroon Showanasai and site visit to Pramongkulklae Army
General Hospital drug treatment facility
Dr. Boonrawd Prasithiphol – Director of Drug Prevention Division, BMA
Site visit to the BMA drug treatment facility – The Winner House
Site visit and interview with the Young Muslims Association of Thailand - Yala
Site visit and interview with Drug User Rehabilitation Center - Narathiwat
Interview at Southern Drug Dependence Treatment Center - Pattani
Site visit and interview with the Drug Treatment Center - Satun
World Vision Volunteer – Songkla Fishing Port
Site visit and interview with Baan Soon Ruam Nam Jai PHA Project - Yala