HIV/AIDS and Custodial Settings in South East Asia

An Exploratory Review into the Issue of HIV/AIDS and Custodial Settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam
Projects: “Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings” (TD/RAS/I09) and “Reducing HIV Vulnerability from Drug Abuse” (TD/RAS/G22)

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Regional Centre for East Asia and the Pacific

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This document was formulated by Ms. Sonia Bezziccheri, Project Manager, UNODC Regional Centre for East Asia and the Pacific, on the basis of the findings of the project with editorial support by Ms. Michele Legge, Development Studies Network, Australian National University.

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FOREWORD

Globally, ten million people are estimated to be held in a prison at any given moment, and each year about 30 million people pass through a prison and return home. A range of problems including overcrowding, violence, continued drug abuse, a lack of protection for the youngest and weakest inmates, a general lack of prevention services, but particularly the lack of HIV prevention and drug dependence treatment programmes, limited medical care including HIV and AIDS treatments along with mismanagement, make custodial settings places of significantly increased risk of HIV infection in any given country.

According to UNODC data, prisons are overcrowded in 111 countries, with 39 countries housing between one-and-a-half to three times more people than actual prison capacity. In many countries the majority of incarcerations are related to illicit drug taking or trafficking offences, yet little is done to address the problem of drug use or to treat drug dependence and there is evidence of first time use in prisons. On release, former inmates are highly likely to relapse and re-offend.

If people are not HIV infected before incarceration, they are at an extremely high risk of becoming infected while in prison: HIV infection rates are generally significantly higher in prisons compared to national averages, but availability of evidence based HIV prevention, including access to the means of protection, is much lower than in the general community. After discharge, former prison inmates may spread the virus to their sexual partners or to others through the reuse and sharing of needles and syringes. Given the high turnout due to short sentences, prisons relentlessly fuel the epidemic.

To curb the HIV epidemic, urgent action is needed in prison settings. UNODC, as a co-sponsor of UNAIDS since 1999 and in collaboration with the World Health Organization, is committed to providing HIV/AIDS prevention and care related to drug dependence, particularly injecting drug use, in prison settings and among people who are trafficked.

The UNODC Regional Centre for East Asia and the Pacific regional project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (RAS/I09) builds upon the operational structure of national working groups established by the regional project on ‘Reducing HIV Vulnerability from Drug Abuse’ (RAS/G22). By expanding these partnerships to include prison authorities, the project addresses HIV/AIDS in custodial settings including prisons, juvenile detention centres and compulsory drug treatment centres. The project assists countries in expanding efforts to provide more effective HIV/AIDS prevention and treatment responses in compulsory drug dependence treatment and rehabilitation facilities; the development of a comprehensive approach to HIV/AIDS prevention programmes in custodial settings; and, the introduction and adaptation of community policing models for improving cooperation between public security agencies and community based programmes for the alleviation of HIV vulnerability from drug misuse.

Akira Fujino
Representative
UNODC Regional Centre
for East Asia and the Pacific
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>vii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations</td>
<td>viii</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Key findings</td>
<td>1</td>
</tr>
<tr>
<td>Conclusions and Recommendations</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>5</td>
</tr>
<tr>
<td>Methodology</td>
<td>10</td>
</tr>
<tr>
<td>Regional overview: A matrix and a summary of the results of the questionnaire</td>
<td>12</td>
</tr>
<tr>
<td>Country profiles:</td>
<td></td>
</tr>
<tr>
<td>1. Cambodia</td>
<td>19</td>
</tr>
<tr>
<td>2. China</td>
<td>24</td>
</tr>
<tr>
<td>3. Lao PDR</td>
<td>31</td>
</tr>
<tr>
<td>4. Myanmar</td>
<td>36</td>
</tr>
<tr>
<td>5. Thailand</td>
<td>42</td>
</tr>
<tr>
<td>6. Viet Nam</td>
<td>51</td>
</tr>
<tr>
<td>Annex I: References</td>
<td>54</td>
</tr>
<tr>
<td>Annex II: UNODC/UNAIDS/WHO Policy Brief on HIV Transmission in Prisons</td>
<td>59</td>
</tr>
<tr>
<td>Annex III: Letter sent to gather information from the National Focal Points</td>
<td>62</td>
</tr>
<tr>
<td>Annex IV: Questionnaire for the UNODC Regional Centre executed Project on ‘Strengthening comprehensive HIV/AIDS prevention and care for drug abusers in custodial and community settings’ (AD/RAS/05/I09)</td>
<td>63</td>
</tr>
<tr>
<td>Annex V: Paper by Bezziccheri S 2005, ‘Scale up responses or scale up the epidemics? A summary of the opinion of experts on the concentrated HIV/AIDS epidemic among injecting drug users in Asia and the Pacific’, presented at the Drugs and Development Symposium, Australian National University, Canberra, Australia, 15-17 August 2005</td>
<td>70</td>
</tr>
</tbody>
</table>
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**Cover page picture courtesy of Alessandro Scotti, UNODC Good Will Ambassador.**
<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
<th>FULL NAME/DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>APCCA</td>
<td>Asian and Pacific Conference of Correctional Administrators</td>
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<td>ARV</td>
<td>Anti-retroviral treatment</td>
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<tr>
<td>ATS</td>
<td>Amphetamine-type stimulant (referred to as <em>yaba</em> [crazy drug] in Lao/Thai languages)</td>
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<tr>
<td>CSWs</td>
<td>Commercial sex workers</td>
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<tr>
<td>EIC</td>
<td>Education, information and communication</td>
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<tr>
<td>HIPP</td>
<td>Health in Prison Project (WHO Regional Office for Europe)</td>
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<tr>
<td>IDU/s</td>
<td>Injecting drug use/users</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MdM</td>
<td>Medecins du Monde</td>
</tr>
<tr>
<td>NNCC</td>
<td>National Narcotic Control Commission of China</td>
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<tr>
<td>NGO</td>
<td>Non-government organisation</td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
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<td>RTL</td>
<td>Re-education through labour</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<tr>
<td>UNODC RC</td>
<td>United Nations Office on Drugs and Crime Regional Centre for East Asia and the Pacific (Bangkok, Thailand)</td>
</tr>
<tr>
<td>UNAIDS/RST</td>
<td>United Nations Joint Programme on HIV/AIDS/Regional Support Team (Bangkok, Thailand)</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

INTRODUCTION

For the purpose of this study, the terms custodial/closed/prison settings are used to refer to prison, remand/pre-trial centres, juvenile detention facilities as well as compulsory drug treatment centres. Although not under the same legal structure as the other facilities, drug treatment centres are included here because they limit personal freedom by keeping individuals in a confined space.

As a co-sponsor of UNAIDS since 1999, UNODC mainstreams HIV/AIDS prevention and care in its worldwide, regional and country level activities. With the integration of its drug and crime programmes, UNODC assists governments to provide and implement HIV/AIDS prevention programmes in prison settings including pre-trial detention centres and juvenile detention centres as well as other closed settings. Prisons, where most of the world’s drug users are found, are a breeding ground for HIV/AIDS and other infectious and transmissible diseases. Each year, around 30 million people enter and/or leave prison somewhere around the world, meaning HIV prevention in closed settings is a critical component to clamping the HIV epidemic in wider society.

UNODC Regional Centre for East Asia and the Pacific (UNODC RC) has engaged in these initiatives through two concurrent regional projects in particular, ‘Reducing HIV Vulnerability from Drug Abuse’ (RAS/G22) and ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (RAS/I09). The countries involved in these projects comprise the signatories to the Memorandum of Understanding on Drug Control (1993) – Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam.

This report represents the first activity of the regional project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (RAS/I09); it aims to provide an exploratory overview of HIV/AIDS prevention, care and support in custodial settings in the project countries. The report is based on the results of a questionnaire and literature review. It is limited in scope by a lack of information, due to the sensitivity of the subject matter and to an historical lack of attention to the issue of health care in custodial settings in South East Asia. It is the foremost aim of this review to contribute to the mobilisation of public awareness on the issue of HIV/AIDS in custodial settings.

KEY FINDINGS

- Drug dependent people are being increasingly incarcerated in compulsory drug treatment facilities, which, in turn, are increasing in number in most of the countries surveyed for this report. Structured and comprehensive drug treatment and after care in general appears to be provided in only a few countries. Furthermore, no research into the effectiveness of drug treatment in custody, or ‘compulsory drug treatment centres’ is available.

- There is a widespread lack of data on HIV/AIDS and drug use in custodial settings.

1 After the completion of this review, LAO PDR decided not to participate in the project ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (RAS/I09) for domestic reasons.
Overcrowding in custodial settings was widely reported, and this is linked to a lack of facilities alongside increasing drug related crime and drug misuse apprehensions.

Most countries identified under- and unqualified staff, alongside a modest HIV/AIDS budget within custodial settings (if reported at all) as major obstacles to the provision of appropriate health care in these settings.

AIDS and the transmission of HIV are generally acknowledged as major health concerns in custodial settings due to the high risk behaviours common to these settings including men who have sex with men (MSM), injecting drug use (IDU), sharing of injecting equipment, tattooing, and blood splatters (via rape and other violent acts). The incidence of HIV and AIDS in custodial settings was reported by most countries. Skin infections, contagious diseases, respiratory and gastro intestinal infections, and mental illness were other commonly reported health issues. Tuberculosis (TB) and AIDS accounted for the majority of deaths in custodial settings. Apart from a few exceptions, however, AIDS patients in custody were not provided with anti-retroviral treatment (ARV).

HIV education material – such as posters, booklets, audio visual material and training for staff and inmates – was reported as being the most useful tool for increasing HIV awareness and changing discriminatory attitudes towards AIDS patients.

Collaboration between prison authorities, non-government organisations (NGOs) and civil society was generally limited across the region. This lack of cooperation has important implications because the continuum of care is limited, making the chance of re-incarceration high.

Although a general lack of data and programmes for HIV prevention in custodial settings was common, government policies for HIV/AIDS prevention and a general willingness on the part of the authorities to improve conditions in these settings was reported in each of the countries under review.

CONCLUSIONS AND RECOMMENDATIONS

The policy of incarcerating drug users in prison, and particularly in compulsory drug treatment centres, is not only terribly expensive and apparently largely ineffective (with relapse rates of 80 per cent or more), it also negatively impacts public health (Burris and Strathdee 2006:117-118). HIV/AIDS, TB, hepatitis and other infectious diseases are endemic to closed settings especially when these settings are overcrowded, damp, unhygienic, poorly ventilated, and house inmates who are not adequately fed – all common conditions in South East Asia’s prisons. For these reasons, fewer people should be incarcerated for drug use, and alternative sentencing and restorative justice initiatives should be considered to address the public health needs and human rights of drug dependent people. The apprehension of drug dependent people occurs today despite inadequate and ineffective health care responses.

All surveyed countries, apart from Cambodia (and Viet Nam where authorities did not complete the questionnaire) reported that a large number of people were housed within compulsory drug rehabilitation centres. Addressing drug dependence as a chronic and relapsing health condition should constitute an essential component of a comprehensive HIV/AIDS strategy within the community and within closed settings.

Given the popularity of compulsory drug treatment centres around the region, these should be adequately equipped with structured and comprehensive drug treatment modalities. The impact of these treatment options should also be properly evaluated.
Community based voluntary drug treatment and rehabilitation options, along with a comprehensive HIV/AIDS prevention package for IDUs should be provided as an alternative to incarceration. Treatment for amphetamine-type stimulant (ATS) dependence needs to be tested and developed. Young people comprise the majority of drug related apprehensions and national house surveys indicate that they also comprise the majority of drug dependent people. Hence, youth specific approaches to drug treatment and rehabilitation in custodial facilities are critical; within this framework, the UN Convention on the Rights of the Child needs to be considered: ‘imprisonment of a child shall be used only as a measure of last resort and for the shortest appropriate period of time’.

Further research is required to gain a better understanding of the situation of infectious diseases in custodial settings in South East Asia, so that preventative solutions can be developed. Increased and harmonised data collection among relevant departments would greatly facilitate adequate responses and appropriate monitoring.

Judicial systems need to be strengthened and drug policy must evolve an enhanced understanding of drug dependence as a chronic relapsing health condition. Overcrowding in custodial settings appears to indicate that incarceration is viewed as an easy and ‘quick-fix’ solution to eliminating the drug problem in society.

Greater financial and human resource capacity must be provided to prison staff and inmates for the prevention, care and treatment of HIV/AIDS.

HIV prevention, care and treatment needs to be implemented in the prison system specifically to address the main transmission modes – MSM, IDU, tattooing and violence. This is not a great leap as national prison authorities already tend to recognise HIV and AIDS as major health concerns, along with the high risk behaviours which transmit HIV.

Free ARV should be provided to all those in custody who require it; access to ARV should be facilitated by the relevant authorities in closed settings and upon release. Prisons should link such services with NGOs and government services in the community to provide a continuum of care and a meaningful involvement of civil society, with the overall aims of decreasing re-incarceration and enhancing rehabilitation.

Inmates themselves, along with people living with HIV and AIDS (PLWHA), should be encouraged and involved in the design and distribution of information and education material, that is, posters, booklets and audio visual materials. For example, prisons in Bangkok have TVs, which are a useful medium for disseminating information of relevance to people in such settings.

NGOs should be brought on board to complement the burden of work of prison authorities; they should be involved in the provision of HIV/AIDS services and after care upon release across the region. PLWHA support workers should have a more visible presence in prison settings to provide both in-prison and post-release support. The international community should actively promote and support civil society and government partnerships for the provision of HIV/AIDS services in custody.

Stronger, high level policy commitment is required to recognise IDUs and prisoners as populations in need of HIV prevention, care and treatment. The human rights of drug dependent people, including and particularly injectors, along with inmates in general should be protected.
Women specific approaches are needed to adequately respond to the particular issues faced by women in prison with regards to HIV/AIDS prevention, care and treatment as well as drug dependence treatment and rehabilitation. Women face greater stigma and discrimination than men especially upon release if they are HIV positive, and/or have AIDS, and a history of drug dependence.

Urgent action is required to cease the detention of people without trial for long periods of time; not only this is a human rights violation but it constitutes a great risk to public health (Burris and Strathdee 2006). An expedited due process of law, and appropriate supervision in these settings should be ensured in order to prevent large numbers of remand prisoners engaging in high risk behaviour.

AIDS, TB and other infectious diseases in prison settings need to be urgently addressed in order to stop these centres being breeding grounds of disease from and to society. AIDS and TB patients should be able to apply for early release and receive adequate medical treatment, care and support.

Who is part of society?

Prison populations are an integral part of society and as such they are entitled to be provided with the same level of health care available to the wider community. In prison settings, however, high risk behaviour, lack of support services and short sentences among other shortcomings, mean inmates are at a much higher risk of being infected with HIV/AIDS and other diseases, and are at risk of infecting their social networks upon release.

For this reason, inmates have to be protected not only for their own wellbeing but also for the wellbeing of the wider society. As this review indicates, however, prison populations are currently not viewed as a part of society. Their vulnerability to contagious and infectious diseases while in custody is not being appropriately addressed, as evidenced by a widespread lack of data and monitoring mechanisms.

Although much more political will at the highest policy level is required to provide HIV/AIDS prevention, care and treatment in custodial settings, including the provision of ARV, South East Asian prison authorities have indicated a general willingness to review, and consequently to upgrade prison systems’ programmes to respond to the challenges of HIV and AIDS. As prison authorities’ capacity to respond to this situation is improved, and more data is more efficiently and effectively produced, the monitoring and provision of adequate responses to an international standard will become more evident.

Strong and sound partnerships across the international and national spectrum must be pursued to tackle the challenge of HIV/AIDS in custodial settings. No government, UN agency, or NGO/INGO can act alone as the wellbeing of all members of society is at stake.

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2 For example, in Europe, the incidence of HIV/AIDS is 20 times higher, and hepatitis C is 100 times higher in prison compared to the non-prison population. Furthermore, mental illness is two to four times higher in prison, suicide rates are up to five times higher. Around ten per cent of all HIV infections are caused by needle sharing; between 30-50 per cent of incarcerated people continue using drugs in prison, while five-ten per cent begin to inject drugs while behind bars. The prevalence of drug and alcohol use in prison is considerably higher – around 40 per cent – than in general society, and so are additional risks of contracting illness such as TB and STIs (Stover 2005).
BACKGROUND

Prison populations are increasing in many parts of the world; such populations are on the rise in 73 per cent of countries included in an International Centre for Prison Studies survey of 2005 (in 64 per cent of African countries, 79 per cent of states in the Americas, 88 per cent of Asian nations, 69 per cent of countries in Europe, and 69 per cent of the countries of Oceania). HIV/AIDS in prison settings is a global phenomenon and while some inmates have been infected outside the prison system, many have acquired HIV inside as a result of the high risk environment and behaviours endemic to these settings. Violence, unsafe sex, IDU, tattooing, lack of protection for the youngest and weakest inmates, overcrowding, corruption, poor prison management and health care as well as little or no access to condoms are all factors which contribute to the increased vulnerability of inmates the world over to HIV, TB, hepatitis C and sexually transmitted diseases.

At any given time around the world there are ten million people in prison, but 30 million are estimated to go in and out of the prison system every year on short term sentences. Epidemiological studies indicate that about three-quarters of prisoners have alcohol and other drug problems, more than one-third may be drug dependent, while another one-third are imprisoned for drug related offences (UNODC n.d.). Drug use may continue in prison settings and puts users at a higher than usual risk of acquiring HIV.

How do prison settings fuel HIV/AIDS?

Two models are commonly used to explain the cross cultural/national mingling that occurs in the prison system and results in the spread of HIV. The ‘carburetor’ model demonstrates how natural geographic or socio-economic barriers within a country, as represented by diverse networks of people, have an opportunity to mingle in prison. In this model, inmates who continue to inject in prison share and use drugs and injecting equipment with other prisoners. When the inmates return home, they share equipment with associates and/or have sexual relationships with their partners thereby passing on any infection acquired whilst in prison.

The second model describes how the risk of HIV transmission considerably rises as the quota of HIV-infected inmates increases, due to the frequency of violence, unprotected sex, IDU and tattooing in prison settings (Vumbaca 2005:10).

Prisons and HIV/AIDS

The 2004 UNAIDS 4th Global Report on the AIDS epidemic reported extremely high incidence of HIV/AIDS among the world’s prison populations. In South Africa, for example, HIV prevalence among inmates is twice as high as that in the general population; in the US, it is four times higher. Extremely high incidence of high risk behaviours fans the epidemic in prisons. The Centre for Prison Studies estimated, for instance, that 65 per cent of male prisoners in South Africa have sex with other male prisoners. As most women are imprisoned for sex or drug related crime, they are even more at risk of being HIV positive than are men, as observed in Brazil, the US and Canada.

Prison authorities around the world are investing in programmes that protect prisoners from HIV. Many EU countries provide free access to condoms, substitution treatment and needle and syringe exchange programmes in prisons. In Spain, for instance, 60 per cent of incarcerated
drug users receive methadone. Some European prisons are also providing ARV treatment. However, as a UNAIDS report (2004:82) on the global epidemic pointed out:

_Ultimately … some of the most effective interventions for this group will be those aimed at breaking the vicious circle of drug use, crime and punishment. These include expanded substitution treatment for drug users in general, and increased use of non custodial sentences._

Uganda is considered a leader in providing HIV prevention training for prisoners and staff, and has shared its experience with South Africa’s prison authorities.

**International experience and instruments**

At least half of the prison population in the EU, comprising about 356,000 people, have a drug history and many have a severe drug problem. Not only do prisons not stop drug problems, they do not address the needs of problem drug users either. While HIV, hepatitis, TB and other infectious diseases are easily spread in closed settings, a return to drug dependence and crime is also very common. Therefore, addressing the needs of drug users in prison settings is a challenge for both public health and crime reduction policy (EMCDDA 2001). The following are some initiatives that have emerged in response to the clear need to implement sound public health practice in prisons:

- WHO Health in Prison Project (HIPP) Declaration in 2004, a follow up to the Project’s ‘Prisons, Drugs and Society’ Consensus Statement issued by the WHO and Council of Europe in 2002 (see [http://www.hipp-europe.org/background/0020.htm](http://www.hipp-europe.org/background/0020.htm)).
- European Monitoring Centre of Drugs and Drug Abuse Annual Report 2003 on prisoners’ human rights; and
- EU Drugs Strategy 2000-2004, which pledged to reduce over five years the incidence of drug related health damage (such as HIV, hepatitis C and TB) as well as decrease drug related deaths, including in prison settings.

The international instruments and guidelines particularly relevant for HIV/AIDS in prison include two sets of guidelines and one declaration:

- WHO’s 1993 ‘Guidelines on HIV Infection and AIDS in Prison’;
- UNHCR’s 1997 ‘International Guidelines on HIV/AIDS and Human Rights’; and

More recent international instruments include:

- ‘Warsaw Declaration: A Framework for Effective Action on HIV/AIDS and Injecting Drug Use’ (November 2003);
- ‘Moscow Declaration on Prison Health as part of Public Health’ (WHO Europe, October 2003), which encourages governments to take action to include penitentiary health in the public health system;
- ‘Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia’, which states that treatment and care for prisoners should be equivalent to that available outside the prison setting (February 2004);
UNODC, WHO, UNAIDS Policy Brief: Reduction of HIV Transmission in Prisons’ (2004), found in Annex II of this report; and

‘Status Paper on Prisons, Drugs and Harm Reduction’ (WHO Europe May 2005).

Legal obligations under the United Nations:

- ‘Prevention of Crime and Treatment of Offenders 9th and 10th Congress, Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment’ (General Assembly resolution 43/173 of 9 December 1988); and
- ‘Standard Minimum Rules for the Treatment of Prisoners’ as approved by the Economic and Social Council, 31 July 1957 (Resolution 663 C I [XXIV]); which provides for a legal obligation to maintain the health of inmates under international conventions on crime and on human rights.

UNODC policy context:

UNODC’s mandate on drug dependence and HIV/AIDS prevention is guided by four policy documents:

1. ‘The Declaration on the Guiding Principles of Demand Reduction’ (1998) which states that activities should cover all areas of demand reduction, from discouraging initial use to reducing the negative health and social consequences of drug dependence for the individual and society as a whole. HIV/AIDS is also recognised here as constituting one of the serious potential harms of drug dependence. This declaration, an accompaniment to the most recent UN General Assembly Special Session on Drugs (UNGASS), explicitly identifies prisoners as a population for drug demand reduction activities.

2. The UN System Position Paper on ‘Preventing the Transmission of HIV among Drug Users’ which recommends a comprehensive package of prevention and care for IDUs, including outreach services, HIV/AIDS education, the provision of condoms, drug dependency treatment (including substitution treatment and rehabilitation), needle and syringe programmes, voluntary HIV testing/counseling, and psychosocial support.

3. The June 2001 UNGASS ‘Declaration of Commitment on HIV/AIDS’ that provides general targets for Member States on HIV prevention and specific targets for groups with high or increasing rates of infection, including IDUs.

4. ‘The Commission on Narcotic Drugs Resolution E/CN.7/2002/L.3/Rev.1’ which calls upon UNODC to continue to cooperate with the United Nations Joint Programme on HIV/AIDS (UNAIDS) and other relevant United Nations entities to introduce and strengthen programmes that address HIV/AIDS.

UNODC HIV/AIDS programmatic areas

UNODC has been a co-sponsor of UNAIDS since 1999. As guided by the Global Task Team Recommendations, UNODC focuses on three programmatic priorities in 2006 and 2007. Under the UNAIDS United Budget and Work Plan, UNODC addresses HIV/AIDS prevention and care as it relates to drug use, especially IDU, prison settings and trafficked persons.

With regard to prison settings, UNODC is to ‘develop a globally agreed strategy on HIV/AIDS prevention, care and support in prison settings, and establish national HIV/AIDS prevention
and care programmes in prison settings of selected countries’. As outlined in a UNODC brochure (2005), the types of initiative within the global strategy include:

1. The right to health care and HIV/AIDS prevention, care and treatment for inmates should be equivalent to that available in the general community;
2. HIV/AIDS information and education is to be provided to inmates, wardens and prison staff;
3. Confidential and voluntary counseling, testing, and psychosocial support should be provided together with HIV/AIDS education and provision of HIV prevention;
4. The internal and external monitoring of general prison conditions and operating secure, safe and orderly prisons in order to reduce violence and the spread of HIV;
5. The classification and separation of juvenile from adult prisoners, and use of maternity wards;
6. The organisation of meaningful rehabilitation activities in prisons, including pre-release integration and after care programmes;
7. The training of prison staff on prison management and on the needs of HIV infected inmates;
8. The provision of antiretroviral therapy and improved hygiene, sanitation and diets for HIV infected prisoners;
9. The active involvement of civil society organisations in prisons and after care services; and
10. Drug dependence treatment as an alternative to imprisonment.

UNODC is also developing a toolkit for the prevention of HIV/AIDS in prisons and it is strengthening its capacity to provide adequate support at global, country and regional levels. In South East Asia, UNODC will post specialised HIV/AIDS advisors in China, Indonesia, Thailand and Viet Nam.

Universal access

Based on the commitments made at the 2005 World Summit and the Gleneagles G8 Summit, to support countries achieving as close as possible ARV treatment for all those who need it by 2010, the UNAIDS Secretariat and its co-sponsors plan to facilitate the process towards universal access to ARV. Building on the 2001 UNGASS Declaration of Commitment, scaling up towards universal access by 2010 will work as a midpoint to achieve Millennium Development Goal Number 6, to halt and reverse the epidemic by 2015.

ARV treatment access for IDUs, prisoners, commercial sex workers (CSWs) and MSM is of paramount importance particularly in South East Asia where the HIV epidemics are concentrated on these vulnerable populations. Greater civil society partnership and protection of vulnerable populations are crucial aspects for assuring greater ARV access for those who urgently need it both for treatment and prevention. While ARV specific protocols for IDUs are under preparation by WHO, prisons or closed settings in general represent an important opportunity to advance ARV treatment among ‘captive’ groups where many IDUs are found.
The UNODC HIV/AIDS strategy in South East Asia: Regional projects

UNODC’s entry point into HIV/AIDS and drug misuse in custodial settings has been to establish, support and assist national working groups on drugs and HIV/AIDS through a regional project that started in 2003, ‘Reducing HIV Vulnerability from Drug Abuse’ (RAS/G22). As a follow up, the project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (RAS/I09) was initiated in 2005. Both projects cover the countries which are signatories to the Memorandum of Understanding on Drug Control (1993), that is, Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam.

Partnership work

UNODC is to provide countries with assistance to implement comprehensive and large scale interventions to prevent HIV, and to care and give support to people with HIV in prison-like settings. UNODC is the principal body for this work in partnership with UNAIDS co-sponsors, particularly WHO\(^3\), civil society organisations, PLWHA organisations, and through UN Theme Groups on HIV/AIDS, the UN Implementation Support Plan, and national technical working groups. UNODC advocates for all relevant stakeholders – law enforcement, drug control, health and criminal justice sectors as well as civil society organisations and PLWHA – to be included in specialised national working groups to comprehensively and effectively address prevention, care and treatment of HIV and AIDS in prison settings.

\(^3\) WHO, as a partner to the UNODC mandate and a specialised provider of technical expertise, has developed guidelines and protocols on the comprehensive prevention of HIV/AIDS from drug abuse and regionally adapted tools for HIV/AIDS in closed settings. These include:

1. ‘Advocacy Guide for Effective HIV Prevention Among Injecting Drug Users’;
2. ‘Training Guide for HIV Prevention Outreach to Injecting Drug Users’;
3. ‘Policy and Programme Development Guide for HIV Prevention and Care Among Injecting Drug Users’;
4. ‘Technical Guide to Rapid Assessment and Response’;
5. ‘Second Generation Surveillance for HIV: Compilation of Basic Material’ (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance); and
METHODOLOGY

The research presented in this study was gathered between October 2005 and March 2006 with an aim to inform the UNODC regional project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (RAS/I09).

For the purpose of this study, the terms custodial/closed/prison settings are used to refer to prison, remand/pre-trial centres, juvenile detention facilities as well as compulsory drug treatment centres. Although not under the same legal structure as the other facilities, drug treatment centres are included here because they limit personal freedom by keeping individuals in a confined space.

This study was initiated by a letter sent to all UNODC field and project offices in the countries under review specifying the objectives of the project and requesting information on HIV/AIDS in custodial settings. The letter was also sent to UNAIDS, WHO and UNICEF offices, and to the wider regional UNODC RC networks and counterparts.

A very limited amount of information was received in response to the letter, however, reflecting the scarce attention given to such issues in South East Asia. In response to this gap the project team, with the assistance of experts, compiled a 19-item questionnaire on HIV/AIDS and drugs in custodial settings (as defined above). Discrete results were gathered, though they did not fully satisfy the questionnaire objective. The letter and questionnaire are included in this report (Annex III and IV, respectively).

Cambodia and Myanmar filled the questionnaire as requested. Thailand, reflecting an enhanced data collection capacity, was the only country that completed separate questionnaires for prisons, juvenile detention centres and compulsory drug treatment centres. Lao PDR and China filled the questionnaire only with regard to compulsory drug treatment centres; no information was received on prisons. No response was received from Viet Nam.

In addition to the questionnaire results, the project team reviewed the literature on existing assessments, projects and more general information provided by national and international organisations on conditions, health and management in such settings. Information for the review was also gathered via journal material, occasional papers and expert interviews. A modest amount of information was obtained via internet searches.

This report is organised by alphabetical country order; each country profile comprises eight sub-sections:

1. HIV/AIDS and IDU in the community and in prisons;
2. The prison department;
3. Prison reform;
4. International support;
5. Major problems;
6. Health care;
7. Health conditions in prisons; and
8. Results of the project questionnaire.
The first sub-section incorporates HIV prevalence among IDUs in the community as a comparative indicator of what may be occurring in prisons. This is because a large number of inmates are locked up for drug related offences – 70-80 per cent in some cases – and prisons mirror social trends. In addition, the HIV epidemics in South East Asia are driven by IDU and multi-partner sexual relations, both considered socially unacceptable and criminal acts in the eyes of the law, and consequently punishable by the deprivation of liberty. Thus prisons are closely yoked to the HIV social equation. Unfortunately, this cycle stigmatises the most vulnerable and hampers HIV prevention and treatment in South East Asia, at times simply because clients will not come forward for fear of apprehension.

The first section of this report is based on an earlier paper written by the author, ‘Scale up responses or scale up the epidemic?’, a summary of expert opinion on the concentrated HIV epidemic among IDUs in Asia and the Pacific (see Annex V). The paper was written for the Australian National University’s Development Studies Network’s Drugs and Development conference, held in Canberra, Australia, 15-17 August 2005. The paper was also a background document for the inaugural meeting of the Reconstituted United Nations Regional Task Force on IDU and HIV/AIDS, held in Kunming, China, 9 November 2005.

Illicit drug trafficking trends for each country were included here because of the clear links between drug availability and drug use. Underlying the take up of drug use is human kind’s innate search for altering consciousness as a way to numb emotional and physical pain. To cope with pain, humans can go a long way and try everything they lay their hands on, including illicit drugs, to prevent madness. Most factual recounts of prison life make reference to this kind of situation, describing the formation of a world quite different to the world outside prison walls. Lack of food, risk and incidence of rape and violence, lack of medical attention, absence of family and friends, at-times pervasive cruelty, the injustice of unjust sentences, corruption, and antiquated judicial systems create dangerous and depressing environments full of potent emotional stressors. In short, prisons are a hothouse for emotional and physical pain. In countries where illicit drugs abound, due to porous borders around fertile production regions, people will readily turn to drugs, licit as much as illicit, if they suffer unbearable pain. And, where there is demand, there is always a ready supply.


Finally, this report provides a regional analysis matrix outlining results of the project’s country questionnaires. Due to the dearth of information gathered via this method, however, the matrix is substantiated, wherever possible, by data gathered elsewhere.
Regional overview: A matrix and a summary of the results of the questionnaire

Questionnaire results at a glance

The information reported here refers to prisons proper in 2005 unless otherwise specified.

<table>
<thead>
<tr>
<th>Country</th>
<th>Cambodia</th>
<th>China</th>
<th>Lao PDR</th>
<th>Myanmar</th>
<th>Thailand</th>
<th>Viet Nam(^5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Ministry</td>
<td>Ministry of Interior</td>
<td>Ministry of Justice</td>
<td>Ministry of Interior(^6)</td>
<td>Ministry of Home Affairs</td>
<td>Ministry of Justice</td>
<td>Ministry of Public Security</td>
</tr>
<tr>
<td>Prison administration</td>
<td>Prison Department</td>
<td>Prison Administration Bureau</td>
<td>Prison Department</td>
<td>Myanmar Correction Department</td>
<td>Department of Corrections(^7)</td>
<td>Department of Correctional Services</td>
</tr>
<tr>
<td>Prison population rate (based on 100,000 of national pop.)(^8)</td>
<td>47</td>
<td>118</td>
<td>69</td>
<td>120</td>
<td>264</td>
<td>71</td>
</tr>
<tr>
<td>Juvenile (% of prison pop.)</td>
<td>Not reported</td>
<td>1.3%(^9)</td>
<td>Not reported</td>
<td>529 (2005)</td>
<td>1,800 (2005)</td>
<td>3,500(^12)</td>
</tr>
<tr>
<td>Official capacity of prison system</td>
<td>5,700</td>
<td>Not reported</td>
<td>Not reported</td>
<td>67,017(^13)</td>
<td>110,900</td>
<td>Not reported</td>
</tr>
<tr>
<td>Prison population total</td>
<td>7,484 (including 2,351 on remand)</td>
<td>1,548,498(^14)</td>
<td>4,020(^15)</td>
<td>64,699 (2005)</td>
<td>174,542 (2005)</td>
<td>55,000(^16)</td>
</tr>
</tbody>
</table>

\(^4\) The information presented here was obtained from the project questionnaire (see Annex III); however, where no information was supplied or available, supplementary data from the International Centre for Prison Studies (http://www.prisonstudies.org) was used.

\(^5\) The information provided for Viet Nam is entirely based on a literature review and the International Centre for Prison Studies because a project questionnaire was not returned.

\(^6\) All other detention facilities are under the Ministry of Public Security; the Office of the Public Prosecutor has an oversight and monitoring role for all such facilities as well as a responsibility for maintaining records of offenders and juvenile crime.

\(^7\) The youth detentions centres are, however, under the Department of Juvenile Detention and Observation, while compulsory drug treatment centres are under the Department of Probation.

\(^8\) The data provided for the prison population rate is based on http://www.prisonstudies.org.

\(^9\) Ibid.

\(^10\) Ibid.

\(^11\) This number refers to young detainees awaiting trial.

\(^12\) This number refers to youth in training centres.

\(^13\) While this number was provided by the authorities in the project questionnaire, the official capacity of prisons in Myanmar reported by www.prisonstudies.org is 26,100.

\(^14\) www.prisonstudies.org.

\(^15\) Ibid.

\(^16\) Ibid.
<table>
<thead>
<tr>
<th>Country</th>
<th>Cambodia</th>
<th>China</th>
<th>Lao PDR</th>
<th>Myanmar</th>
<th>Thailand</th>
<th>Viet Nam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory drug</td>
<td>No</td>
<td>140,000(^{15})</td>
<td>1,319 (2004)/644 (2005)/3 centres</td>
<td>1,490 (2004)/1,492 (2005)/69 centres</td>
<td>9,781 (2004)/2,358 (2005)/49 centres</td>
<td>About 100,000 clients – 1,000/1,500 per centre – are believed to be in the ‘05-06’ centres/80 centres(^{19})</td>
</tr>
<tr>
<td>rehabilitation centres</td>
<td>(clients/number of centres in the country)</td>
<td>516 centres</td>
<td>3,500 youth in ‘training centres’/17 centres</td>
<td>844 (2005)/1,492 (2005)/2,358 (2005)/49 centres</td>
<td>1,492 (2005)/2,358 (2005)/49 centres</td>
<td>2,358 (2005)/49 centres</td>
</tr>
<tr>
<td>Involvement of NGOs</td>
<td>Yes</td>
<td>No NGOs were reported</td>
<td>No NGOs were reported</td>
<td>Yes</td>
<td>Yes</td>
<td>Not reported</td>
</tr>
<tr>
<td>HIV/AIDS is a major</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>health concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug related cases</td>
<td>5,027(^{20})</td>
<td>Not reported</td>
<td>Not reported</td>
<td>4,918</td>
<td>100,511 (2004)(^{21})</td>
<td>Not reported</td>
</tr>
<tr>
<td>HIV cases</td>
<td>28 (2004)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>610 including 351 females</td>
<td>869 (2004)(^{21})</td>
<td>~20% (study based on 48 state prisons, July 2000)(^{22})</td>
</tr>
<tr>
<td>ARV provision</td>
<td>No</td>
<td>Not reported</td>
<td>Not reported</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Availability of drug</td>
<td>No</td>
<td>Peer education(^{23})</td>
<td>Not reported</td>
<td>Peer education</td>
<td>Yes (but no pharmacological)</td>
<td>Not reported</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major barrier to the</td>
<td>Lack of support to health services in prisons</td>
<td>Lack of education about HIV/AIDS for both staff and inmates result in fear and discrimination of HIV positive people</td>
<td>Not reported</td>
<td>Inadequate resources and illiteracy</td>
<td>Lack of knowledge and understanding. Attitude of staff; and a high inmate turnover especially for youth</td>
<td>Not reported</td>
</tr>
<tr>
<td>provision of HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>prevention, care and</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{17}\) Because authorities did not return a completed project questionnaire, the information provided for Viet Nam is entirely based on a literature review and data from the International Centre for Prison Studies.

\(^{18}\) The Ministry of Public Security manages health care in the compulsory drug rehabilitation centres, while the prisons and RTL camps are under the Ministry of Justice.

\(^{19}\) ‘UNODC Brief on the 05/06 Treatment Centre System in Viet Nam’, 2004, unpublished document.

\(^{20}\) This number refers to drug abuse cases, it includes 420 apprehensions for drug trafficking.

\(^{21}\) Of these, 22.12 per cent were drug use cases and 77.88 per cent for drug dealing. The Department of Juvenile Observation and Protection reported 2,640 apprehensions for drug related offences, 790 drug dealing and 68 drug use/possession cases.


\(^{23}\) ‘Peer education’ was reported as the most effective drug education method.
Regional overview:

This section presents a summary of findings from the project questionnaire and literature review. Each key point is presented with an overview of each surveyed country’s response.

High rates of incarceration for cases related to drug offences and drug dependence:

- **Cambodia** reported a prison population of 7,484 inmates; 5,027 of these were incarcerated due to drug misuse – including 420 persons apprehended for drug trafficking – representing 67 per cent of the total prison population.
- **China, Lao PDR and Viet Nam** did not report on this type of apprehension.
- **Myanmar** reported 4,918 inmates for drug related offences out of a total prison population of 64,699 or 7.6 per cent.
- **Thailand** reported that 77.8 per cent of inmates were incarcerated for drug offences, (36 per cent for selling and 41 per cent for possession with intent to sell). Twenty-two per cent of inmates were specifically incarcerated for drug misuse. The Thai authorities estimate that 60-80 per cent of inmates in prisons proper have some drug use history.

Compulsory drug rehabilitation centres:

- **Cambodia** is the only surveyed country that apparently does not have compulsory drug rehabilitation centres.
- **China** reported 140,000 clients attended one of its 516 compulsory drug rehabilitation centres in 2005.
- **Lao PDR** reported 1,319 clients in 2004, and 844 clients in 2005, attended one of three of the nation’s compulsory drug rehabilitation centres.
- **Myanmar** reported 1,490 clients (2004) and 1,492 (2005) in a compulsory drug treatment centre. They also reported 26 major and 40 minor treatment centres around the country.
- **Viet Nam** did not report. It is reported elsewhere, however, that prisons proper house 55,000 people, while almost double that amount (100,000 people) are in the nation’s 80 so-called ‘05-06’ rehab centres, which include drug treatment facilities.

Provision of drug treatment:

Drug treatment or after care appears to be provided in few countries. Only China and Myanmar reported on the provision of peer drug education. Thailand provided a greater range of options, though it lacked pharmacological options such as substitution drugs for opioid dependence.

Data collection:

A lack of data on HIV/AIDS prevalence in custodial settings was common for all countries. For this reason, no proper aggregate analysis could be provided.
Overcrowding:

Prison settings' overcrowding was observed in Cambodia and Thailand according to the reported data. Thailand, with a current population of 3,500 in its youth training centres and an official capacity of 500, has an overcrowded incarcerated youth population too.

Capacity for the provision of HIV/AIDS prevention, care and treatment:

Under- or unqualified staff and a meagre HIV/AIDS budget for prison settings, when reported at all, was identified by four out of six countries (Cambodia, China, Myanmar and Thailand) as the main obstacle for the provision of HIV/AIDS prevention, care and treatment among inmates and prison guards.

AIDS as major health concern:

Three out of six countries (Lao PDR, Myanmar and Thailand) identified AIDS and the transmission of HIV as a major health concern in prison settings due to MSM, IDU and sharing of injecting equipment, tattooing, and blood splatters (rape and violence).

ARV provision in prisons settings:

ARV provision was reported only in Thailand and Myanmar, but the extent of coverage for prison inmates was not made clear.

HIV/AIDS education material:

Posters, booklets and audio visual material and tailored training programmes for staff and inmates were identified by all countries as the most useful HIV prevention and awareness raising tools, and for contributing to attitudinal change aimed at decreasing stigma and discrimination of AIDS patients among inmates and prison staff.

HIV and AIDS cases in prison settings:

HIV cases among inmates were reported in Cambodia (28 cases, 0.37 per cent), Myanmar (610, including 351 women, 0.94 per cent) and Thailand (869, 0.49 per cent). AIDS related deaths were reported also by Cambodia (ten, 0.13 per cent), Myanmar (184, including 19 women, 0.28 per cent) and Thailand (331, 0.18 per cent).

Civil society involvement in prison settings:

NGO collaboration with prison authorities for health related service provision was reported by Cambodia, Myanmar and Thailand only.

Policy for HIV/AIDS in prison settings:

All countries except Viet Nam reported the existence of a policy for HIV/AIDS in prison settings.

Incarcerated youth:

Data for youth in detention was provided by Myanmar, 529 (0.8 per cent), and Thailand with 1,800 young detainees awaiting trial and 3,500 youth in training centres (three per cent).
Women in prison settings:

Women populations were reported by Myanmar with 8,638 (13.3 per cent) and Thailand with 40,520 for 2004 (18.5 per cent) and 30,207 for 2005 (17.3 per cent).

Remand prisoners:

Cambodia reported 2,351 remand prisoners (31 per cent), and Myanmar with 4,741 in 2004 (7.3 per cent) and 5,867 (nine per cent) in 2005.

Major health threat in prison settings:

Cambodia reported skin infections, contagious diseases, respiratory and gastro intestinal infections; Myanmar reported infectious diseases; and Thailand reported HIV/AIDS and TB as well as general high risk behaviour and mental illness.

Main cause of death in prison settings:

Cambodia and Thailand reported these as TB and AIDS; Myanmar only reported TB (accounting for 33 per cent of deaths).
COUNTRY PROFILES
### 1. CAMBODIA

<table>
<thead>
<tr>
<th>Cambodia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Ministry</td>
</tr>
<tr>
<td>Prison administration</td>
</tr>
<tr>
<td>Prison population rate (based on 100,000 of national pop.)(^{24})</td>
</tr>
<tr>
<td>Female prisoners</td>
</tr>
<tr>
<td>Juvenile (% of prison pop.)</td>
</tr>
<tr>
<td>Official capacity of prison system</td>
</tr>
<tr>
<td>Prison population total</td>
</tr>
<tr>
<td>Compulsory drug rehabilitation centres (clients/number of centres in the country)</td>
</tr>
<tr>
<td>Involvement of NGOs</td>
</tr>
<tr>
<td>HIV/AIDS is a major health concern</td>
</tr>
<tr>
<td>Drug related cases</td>
</tr>
<tr>
<td>HIV cases</td>
</tr>
<tr>
<td>AIDS deaths</td>
</tr>
<tr>
<td>ARV provision</td>
</tr>
<tr>
<td>Drug treatment is available</td>
</tr>
<tr>
<td>Major barrier to the provision of HIV prevention, care and support</td>
</tr>
</tbody>
</table>

**HIV/AIDS and injecting drug use in the community and in prisons:**

Despite a successful 100 per cent condom campaign during the '90s, Cambodia is facing the threat of a resurgence of cases due to prevention complacency and an underlying disregard for targeting specific populations such as drug users.

Sentinel surveillance indicated 1.9 per cent HIV prevalence among the adult population in 2003. The country is also experiencing a steep increase in drug use, particularly ATS use and heroin injection. In 2004, nearly one million ATS pills were seized, a fourfold increase from 2003. Furthermore, a June 2005 rapid assessment indicated that IDU is rising and syringe sharing is common. High HIV risk is also associated with heightened sexual drive caused by ATS use; 40 per cent of illicit drug users reported irregular use of condoms when engaging in sex under the influence of drugs. The sale of blood for money to buy drugs was also reported. A recent report by NGO Mith Samlanh/Friends asserted that HIV among drug users in Cambodia is on the rise.

Cambodia has around 600 IDUs. The highest HIV prevalence was, however, recorded among sex workers: a 2002 study found 18.5 per cent of direct sex workers had HIV and 13.8 per cent indirect sex workers. In 2003, around 170,000 people were living with HIV/AIDS and

\(^{24}\) The data provided for the prison population rate is from http://www.prisonstudies.org.

\(^{25}\) This number refers to drug abuse cases, and it includes 420 apprehensions for drug trafficking.
15,000 were reported to have died from AIDS related causes. Heterosexual intercourse, especially between spouses, is the main recorded transmission route for the virus, along with mother to child transmission. Gender inequality is a major factor fuelling this situation (WHO and UNODC 2006).

There is no data on HIV/AIDS or IDUs in prisons.

**The prison department:**

Following a Royal Decree in March 2000, the Cambodian Prisons Department was separated from the National Police Force. The Department is an independent unit under the General Administration Department of the Ministry of Interior. The Department is responsible for the management of 22 municipal-provincial prisons and three national facilities; there are 25 prisons nationwide. *Prakas* (Proclamation) 217 provides direction to the department on prison administration.

**Prison reform:**

The Ministry of Interior in collaboration with other ministries are in consultation to improve the prison system. Problems of the prison system overlap the different authorities: reasons for overcrowding, for instance, are linked to National Police crackdowns on crime which resulted in increased arrests; a slow legal progress has left people lingering in prisons for a long time.

In 2002, health management procedures were updated due to precarious health conditions, and prison medical staff received training on the new guidelines. In 2003, new guidelines and training for prison officers was provided.

Under- and unqualified staff are serious issues in Cambodia’s prisons. As the department was united with the National Police until 2000, personnel in the department are primarily former police officers. Such problems place a strain on personnel management. To overcome this deficiency, new recruiting plans have been in place since 2004/2005.

**International support:**

In its efforts to improve the criminal justice and legal sectors, the Royal Government of Cambodia receives assistance from foreign donors including Australia (with a second five-year phase of the Cambodia Criminal Justice Assistance Project), the French Government (supporting the development of criminal laws and a Royal School of Magistracy), and the Japanese Government (providing assistance to the National Police and Ministry of Justice).26

The Global Fund on AIDS, TB and Malaria has approved the two-year US$16.6 million project, ‘Partnership for going to scale with proven interventions for HIV/AIDS, Tuberculosis and Malaria’. No part of this project is focused on custodial settings, however.

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26 For more information, see http://www.apcca.org/News&Events/Discussion%20Papers%20-%20agenda%201/Cambodia.htm. The Asian and Pacific Conference of Correctional Administrators is an annual conference of correctional administrators employed by Governments in the Asian and Pacific Region. Other papers can be found at http://www.apcca.org/23rd%20APCCA%20Discussion%20Papers/Cambodia/Discussion%20Paper%20(Cambodia).PDF.
Major problems:

The majority of prisons were built in 1920, many are old and decrepit and this facilitates escape.

A lack of facilities, slow judicial process, inadequate laws to permit non-custodial sentencing, large backlog of outstanding warrants, poverty, and lack of legal representation for the poor leads to overcrowding in prisons. Overcrowding contributes to poor health standards, tension, stress, and violence.

Food shortage in prisons is also a reported concern. According to a report by NGO Lichado, the prison in Kompong Thom Province, built under French rule in 1905, is one of Cambodia’s oldest prisons. The Ministry of Interior allocates this prison US$15 per month for food supplies, or US$0.25 per prisoner per day (The Cambodia Daily 2003).

Health care:

At present, six prisons have established health care facilities that provide primary health care. According to a report of the 23rd Asia and Pacific Conference of Correctional Administrators, held in Hong Kong in 2003, ten more clinics have been established but they lack appropriate equipment. The Prison Department is working with the Ministry of Health and provincial health authorities to establish health clinics in prisons that meet the Ministry’s standards; these will be recognised health centres that can compete for Government funding. Training is to be offered for health care providers at these centres.

Health conditions in prisons:

It is reported that heat, humidity and close physical proximity among the prisoners creates the perfect breeding ground for bacteria and disease; all prisoners appear to have skin disease and most suffer diarrhoea, malaria and malnutrition.

Results of the project survey:

<table>
<thead>
<tr>
<th>Number of prisons: 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prisoners: 7,484</td>
</tr>
<tr>
<td>Number of remand prisoners: 2,351</td>
</tr>
<tr>
<td>Juvenile and women prisons are known as Correctional Centre No. 2</td>
</tr>
<tr>
<td>While the official capacity of the 25 prisons is 5,700, 7,484 people are currently interred</td>
</tr>
</tbody>
</table>

Policy:

Cambodia has a Government policy for health in custodial settings, the Prison Health Operating Manual, which was prepared in consultation with various ministries in 2003-2004. Cambodia also published ‘Prevention and Management for HIV/AIDS’ for custodial settings.

NGOs:

Cambodia has currently three NGOs working in custodial settings, they are:

1. The Prison Fellowship which provides for vocational training, health education and counseling for hospice services in three national prisons and selected provincial ones.
2. The Sunrise NGO which provides for health education and emergency medication in Kompong Cham Prison.

3. The Cambodia People Living with HIV/AIDS Network which provides counseling, advocacy and medication in 12 provinces.

**Responsible department:**

The Health Department, Health Office of the Prison Department of the Ministry of Interior, is the responsible party for health in custodial settings.

**Capacity:**

With regard to health providers for the above custodial facilities, Cambodia reported 28 nurses, 31 primary health providers and two medical assistants.

**HIV/AIDS and major health concerns:**

The Government does not recognise HIV/AIDS as a major health issue in custody and as a consequence there is no devoted HIV/AIDS budget. Twenty-eight HIV cases have been confirmed and there were ten AIDS related deaths in prison in 2004.

HIV/AIDS related services exist only in the form of information distribution. For the most advanced AIDS cases, there is the possibility of applying for medical amnesty.

The major health threats in custodial settings appear to be related to skin diseases, contagious diseases, respiratory and gastro-intestinal infections. The most common cause of death, however, appears to be related to TB and AIDS.

No drug treatment or ARV provision is supplied; pain relief is provided.

**Drug related cases:**

The total number of drug related cases was 5,027, including 420 sentenced for drug trafficking.

**Health care provision:**

When first apprehended, a person is required to be assessed for psychological problems and drug dependence. Hence induction, assessment, basic health care and referral are provided.

**Drug dependence treatment:**

With regard to drug dependence treatment, while a limited assessment takes place, only information material is distributed.

**Training provision and needs:**

First aid, including HIV/AIDS training, is provided to new custodial staff and refresher training is provided every three years.

Training on drug management, as prepared by the National Committee on Drugs and Mental Health of the Ministry of Health, is provided to all staff in custodial settings. The training is, however, very basic.
Training programmes for HIV/AIDS prevention and care for health workers and guards are coordinated through the National AIDS Authority and the National Centre for HIV/AIDS and the Prison Department, with certification from the Ministry of Health.

Health workers require enhanced training capacity in the treatment and management of patients; while guards require training in the handling of prisoners suffering from AIDS.

**Barrier:**

Lack of support for prisoner health services is the greatest identified barrier to HIV/AIDS prevention, care and treatment in custodial settings.

**Material:**

Posters, booklets and audio visual training programmes for staff and prisoners would be most useful.
2. CHINA

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<tr>
<th>China</th>
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<tr>
<td><strong>Responsible Ministry</strong></td>
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<tr>
<td><strong>Prison administration</strong></td>
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<tr>
<td><strong>Prison population rate (based on 100,000 of national pop.)</strong>&lt;sup&gt;27&lt;/sup&gt;</td>
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<tr>
<td><strong>Female prisoners</strong></td>
</tr>
<tr>
<td><strong>Juvenile (% of prison pop.)</strong></td>
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<tr>
<td><strong>Official capacity of prison system</strong></td>
</tr>
<tr>
<td><strong>Prison population total</strong></td>
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<tr>
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<tr>
<td><strong>Involvement of NGOs</strong></td>
</tr>
<tr>
<td><strong>HIV/AIDS is a major health concern</strong></td>
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<tr>
<td><strong>Drug related cases</strong></td>
</tr>
<tr>
<td><strong>HIV cases</strong></td>
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<tr>
<td><strong>AIDS deaths</strong></td>
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<tr>
<td><strong>ARV provision</strong></td>
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<tr>
<td><strong>Drug treatment is available</strong></td>
</tr>
<tr>
<td><strong>Major barrier to the provision of HIV prevention, care and support</strong></td>
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</table>

**HIV/AIDS and injecting drug use in the community and in prisons:**

In 2003, there were an estimated 840,000 people living with HIV/AIDS – this number could increase to ten million by 2010 if no preventive measures are taken<sup>32</sup> – among which 80,000 are AIDS patients. According to the United Nations Reference Group on Injecting Drug Users, there are an estimated 1,928,000 IDUs in China and 85 per cent live in rural areas. Estimated HIV prevalence among IDUs is up to 84 per cent depending on geographical areas (United Nations Reference Group 2004).

According to the 2005 Annual Report of the National Narcotics Control Commission of China, accumulated registered drug users amount to 1,160,000; while current drug users number around 780,000, and 78 per cent of them use heroin.

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<sup>27</sup> The data provided for the prison population rate is from http://www.prisonstudies.org.
<sup>28</sup> Ibid.
<sup>29</sup> Data from www.prisonstudies.org.
<sup>30</sup> The Ministry of Public Security manages health care in the compulsory drug rehabilitation centres, while the prisons and RTL centres are under the Ministry of Justice.
<sup>31</sup> ‘Peer education’ was reported as the most effective method of drug education.
<sup>32</sup> This calculation is based on a 30 per cent increase observed since 1999 (UNAIDS/WHO Epidemic Update 2005).
According to a recent UNAIDS regional report, the concentrated epidemic among IDUs in China has ‘kick started’ the epidemic among sex workers and their clients, and national infection rates have skyrocketed. Recent studies show that unsafe injecting is commonly practiced among IDUs who also have multiple partners, and buy and sell sex, often without using a condom. In 2002, HIV was detected among drug users in all 31 provinces; and in 2001, 70 per cent of HIV infections were found in the IDU community. Compared to other countries in the region, the Government has reacted relatively urgently through a high level national multi-sector task force comprised of various ministries at decision making levels, formalised under the Prime Minister. As a result, 34 methadone maintenance clinics and 50 needle and syringe programmes were set up nationwide following preliminary pilot programmes. One hundred such clinics and 130 needle and syringe programmes were planned in 2005; and from 2006-2009 the Government aims to scale up such programmes to 1,500 methadone maintenance clinics and 1,400 needle and syringe programmes nationwide.

Geography plays a key role in recent increases in drug use in China. The mainland is adjacent to both of Asia’s major narcotic producing areas – South East Asia’s Golden Triangle and South West Asia’s Golden Crescent. The latter area is specifically responsible for the increasing volume of illicit drugs trafficked into Western China, particularly Xinjiang Province. China is also a major centre for ATS production. Reports indicate that ATS injecting practice is increasing. Generally, drug use in China continues to rise and as of 2004, there were 1.6 million registered drug dependent people, a 100 per cent increase from 1995. Youths made up 74 per cent of registered drug dependent people, the majority of whom use heroin.

Illegal drug use was recorded in 2,148 cities, counties, and districts across China. The Government has 25,000 recorded deaths of drug dependent people from overdose. Increasing drug misuse is also a result of the opening up of China over the last decade, as Chinese youth have come to enjoy increasing levels of disposable income and freedom. In Beijing and Shanghai a Western style rave culture has begun to take root, accounting for the increasing popularity of recreational drugs such as Ecstasy and ATS, particularly at local nightclubs.

With a large, developed chemical industry, China is one of the world’s largest producers of precursor chemicals, including acetic anhydride (AA), potassium permanganate, piperonylmethylketone (PMK), pseudoephedrine, and ephedra. China monitors all 22 of the chemicals on the 1988 UN Drug Convention watch list. The authorities claim to have seized over 96 tons of precursor chemicals from August through November 2004.33

Despite Government attention to IDU and HIV/AIDS, no action seems to have been provided in prisons which house a nationwide population of 1.5 million people. HIV prevalence among prisoners was recorded as between 0-4 per cent according to the most recent study of 1996; studies of persons apprehended for drug misuse in Sichuan Province showed that 48.8 per cent were listed as IDUs (1997), and five per cent were thought to be HIV positive. In Yunnan, the prevalence of IDUs among persons incarcerated for using drugs was 60 per cent (2003); and in Cai Yuan City, 42 per cent of IDUs in compulsory drug treatment centres were found to be HIV positive (Dolan et al. 2004).

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The prison department:

The Prison Administration Bureau under the Ministry of Justice is responsible for prisoners and the Ministry of Public Security for pre-trial detainees. Under their jurisdiction there are 679 centres (including 30 for juveniles).

Prison or custodial settings reform:

In order to comply with the Covenant on Civil and Political Rights (1998), a new legislation replacing RTL committees with minor offences or misdemeanour courts is being considered by the Standing Committee of the National People’s Congress. Such courts will guarantee the presumption of innocence, the right to a lawyer and other due process rights – all currently absent.

It is envisioned that eventually all custody and education, forced drug rehabilitation and legal education will also be brought into the system of misdemeanour courts (South China Morning Post 2004).

International support:

There is a very large component for prisons in China’s round four Global Fund proposal; authorities in the RTL camps are seeking international assistance to upgrade the system as they feel at present they are not ‘curing’ people. The Global Fund on AIDS, TB and Malaria approved a two-year US$32 million project submitted by China Comprehensive AIDS Response, a community based HIV treatment, care and prevention programme in central China; and a two-year US$23.9 million project aimed at reducing HIV transmission among and from vulnerable groups, and alleviating the virus’s impact in seven provinces (Anhui, Hebei, Shandong, Henan, Hubei, Shanxi, and Shaanxi).

The Yunnan Daytop, in collaboration with the Yunnan Institute of Drug Dependency Prevention and Treatment, runs two projects funded by China/UK AIDS Control and Prevention Programme dealing with HIV/AIDS in prisons: the Detoxification Centre for Drug Users and HIV/AIDS Prevention Peer Education Project, and the AIDS Care Project. The former uses Daytop trained peer educators to provide relapse prevention and HIV/AIDS counselling at ten detoxification centres and two RTL camps in Yunnan. This project started in 2001 in collaboration with Medicins sans Frontiers/Doctors without Borders Holland (MSF) in Kunming, Yuxi, Luoping, Chuxiong and Qujing. This project has to date conducted 111 training classes and six outreach activities, thus reaching approximately 3,000 members of the target community.

The AIDS Care Project provides occupational training for workers in detoxification clinics and camps along with education and counselling for inmates and community members. The project’s main focus has been voluntary counselling and testing, psychological care, basic medical care and support group activities for PLWHA. Project counselling activities have already served 700 people from the community and the centres as well as 200 HIV positive persons and more than 100 AIDS patients.

34 The Yunnan Institute of Drug Dependency Prevention and Treatment is the only specialised, comprehensive organisation under the Public Health Ministry which engages in drug dependency treatment, recovery and prevention as well as training and international cooperation on drug abuse issues. The Institute has received international recognition from the Economic and Social Commission for Asia and the Pacific and UNODC. Prestigious nationally as well internationally, the Institute was appointed sponsor of the Therapy League of Asia in 1999.
UNODC Regional Centre for East Asia and the Pacific

In 2003, UNODC RC began looking into drug dependence treatment offered in the Chinese compulsory drug treatment centres with the objective of introducing health oriented approaches to drug rehabilitation in China. A mission in 2004 revealed that recovery training – relapse prevention, group therapy, counselling, self help or the 12 step programme – was not offered.

UNODC RC published a Recovery Training Programme Manual for Enhancing Drug Dependence Treatment in China as part of the UNAIDS Programme Acceleration Funds 2002 national project ‘Destigmatisation of Injecting Drug Users’ (AD/CPR/H20). The Recovery Training Programme was subsequently delivered in a training session sponsored by UNODC RC and the National Narcotic Control Commission of China (NNCC) and took place in Guiyang City and Bei Hai City in July 2004. The training material was translated into Chinese.\(^{35}\) UNODC RC additionally established a Best Practices for Drug Dependence Treatment and Rehabilitation with specific recommendations for the compulsory drug treatment centres in China.\(^{36}\) The locations and the content of the training were decided through the Multisectoral Task Force on Drug Use and HIV/AIDS as assisted by the UNODC RC executed project on ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/03/RAS/G22).

The UNODC RC executed a regional project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (AD/RAS/I09) to build upon the political and operational structure of both the ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/03/RAS/G22) and one on ‘Destigmatisation of Injecting Drug Users’ (AD/CPR/H20) in order to continue and expand the work began in 2003. Through the project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (AD/RAS/I09), UNODC RC has for the first time established a professional position in Beijing, China, to closely monitor needs and responses as well as expand technical assistance and future cooperation to reduce HIV vulnerability in custodial settings.

From the UNODC RC work in compulsory drug treatment centres in China, the following actions were recommended (UNODC and NNCC 2004):

- To provide more awareness and education with respect to new approaches (especially psychological) to drug dependence treatment;
- To provide consistent training among the compulsory drug treatment centres throughout the country especially on relapse prevention, counselling and aftercare;
- To fund pilot projects to test the effectiveness of new approaches;
- To provide opportunities for Chinese officials to visit nearby centres (such as in Hong Kong, Malaysia, the Philippines, Singapore or Thailand);
- To develop a centre of excellence in China where drug dependence treatment alternatives can be offered together with training opportunities; and
- To encourage partnerships with institutions abroad, such as the therapeutic community project carried out in Kunming, Yunnan, in partnership with Daytop International.

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\(^{35}\) The Recovery Training Programme can be accessed at: www.unodc.un.or.th/drugsandhiv/publications.

Major problems:

No information was available on prisons.

The compulsory drug rehabilitation centres

According to Chinese law, drug takers must be rehabilitated; as a consequence, monitoring systems for drug misuse have been established throughout the country.

China has 746 compulsory rehabilitation centres and 168 treatment and RTL centres. According to data from 1999, every year around 220,000 drug users are treated at compulsory rehabilitation centres, and 120,000 are treated at RTL centres (Standing Committee of the National People’s Congress n.d.).

Establishing ‘drug free communities’ is one of the Chinese leadership’s visions and since 1994 the country has imposed this policy and achieved some results; Baotou City in the Inner Autonomous Region is a model for this national vision. The city has 2,169 help and education groups; its rehab success rate is over 70 per cent and it established 1,436 drug free communities and essentially realised a drug free target (ibid).

Not all communities return such positive results, however. What is more, China’s compulsory drug rehabilitation centres are suspected HIV breeding grounds. The Government estimates that about 70 per cent of the nation’s AIDS cases are found among heroin users.

Relapse prevention techniques are generally based on the idea that relapse is a normal aspect of dependence and recovery and that it may take many attempts until a drug dependent person achieves abstinence; in this context, relapsing should not be considered a failure and be punished. Punishment aggravates the mental state of the patient and will affect motivation and lead to the person resuming heroin use as the best possible escape from his/her misery.

The chemical club for China’s displaced

Amidst skyrocketing economic growth, and with drug use soaring in China, drug treatment centres offering a wide range of expensive alternative therapies, as well as not so successful remedies, have been established in various locations. Acupuncture, herbal pills, and manicures and methadone packages are offered at high prices; for example, in Guandong, American-style clinics have opened up offering drug users a manicure and methadone package. The price for a two-week stay is US$5,000 (ibid). Another voluntary drug rehab centre offers a new treatment called ‘therapy community’; operating out of the Ankang Hospital in Beijing’s outskirts it reported assisting 110 drug users. Peer education is also part of such therapy (China Daily 2005). The Shanghai drug rehabilitation centre, and the Baiyun Voluntary Drug Rehabilitation centre (which reported helping 3,000 drug users, with a 72 per cent success rate), are also among the plethora of new voluntary drug dependence treatment and rehab centres (China Daily 2004). China’s voluntary drug treatment centres are fast gaining a strong client base, and becoming more popular than traditional compulsory facilities.

Health care:

No information was found on the provision of health care in prison/custodial settings.
Health conditions in prisons:

It has been documented that epidemics such as TB can be a great problem in Chinese prisons due to overcrowding and unhygienic conditions. In fact, TB tops the list of infectious causes of death. One in every three person in China, equivalent to 400 million people, have TB. Each year, 1.3 million people in China develop active TB and 150,000 die as a consequence of the disease, ranking China second in TB deaths after India.

Results of the project survey:

Chinese authorities only addressed the questionnaire questions relating to compulsory drug treatment centres; no figures were reported on prisons proper or other closed settings.

| Number of compulsory drug treatment centres: 516 |
| Number of clients in compulsory drug treatment centres: 140,000 |

Policy:

China has a Government policy for health in the compulsory drug treatment centres.

NGOs:

No NGOs were listed.

Responsible department:

The Ministry of Public Security manages doctors in compulsory rehabilitation centres while the Ministry of Justice manages doctors in the RTL centres and prisons.

Capacity:

No information was reported.

HIV/AIDS and major health concerns:

The Government does not recognise HIV/AIDS as a major health issue in compulsory drug treatment centres and as a consequence there is no devoted HIV/AIDS budget.

Drug related cases:

No information was reported.

Health care provision:

When first apprehended, a person is required to be assessed for psychological problems but not for drug dependence. It is unclear what services are provided.

Drug dependence treatment:

Peer education is listed as the most effective drug education method.
Training provision and needs:

Health workers require enhanced training capacity in the treatment and management of patients; while guards require training in the handling of prisoners suffering from AIDS along with HIV prevention.

Barrier:

Lack of information on HIV/AIDS appears to be the greatest barrier to HIV prevention, care and support. Due to a lack of knowledge on HIV/AIDS, doctors and other staff fear HIV positive patients and discriminate against HIV positive drug users.

Material:

No information was reported.
3. LAO PDR

<table>
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<tr>
<th>Lao PDR</th>
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<tbody>
<tr>
<td>Responsible Ministry</td>
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<tr>
<td>Prison administration</td>
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<tr>
<td>Prison population rate (based on 100,000 of national pop.)$^{38}$</td>
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<tr>
<td>Female prisoners</td>
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<td>Juvenile (% of prison pop.)</td>
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<td>Official capacity of prison system</td>
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<tr>
<td>Major barrier to the provision of HIV prevention, care and support</td>
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</table>

HIV/AIDS and injecting drug use in the community and in prisons:

About 1,700 persons with HIV and AIDS were estimated to live in Lao PDR in 2002. The main route of HIV transmission is sexual intercourse. With a surge of ATS misuse, however, HIV and STI has increased among youth especially in urban centres. High risk behaviour associated with ATS use includes increased sexual promiscuity, multiple partners, and increased levels of self confidence and a sense of invincibility (hence low condom use if at all).

The number of IDUs in Lao PDR is estimated at 8,000 (United Nations Reference Group 2003). Two per cent of HIV cases were nevertheless identified among IDUs as reported in 2002 (Reid and Costigan 2002:124). Furthermore, as the transport system evolves in Lao PDR, the country’s border regions are coming in more contact with IDU and drug trafficking, as its neighbouring countries experience these problems at high levels. It is also at the border towns that CSWs and migration occurs. To exclude Lao PDR from the high prevalence HIV

$^{37}$ All other detention facilities are under the Ministry of Public Security; the Office of the Public Prosecutor has oversight and monitoring role of all such facilities as well as a responsibility for maintaining records of offenders and juvenile crime.

$^{38}$ The data provided for the prison population rate is from http://www.prisonstudies.org.

$^{39}$ Ibid.
among IDUs countries would be a mistake given the current rate of its infrastructure development.40

ATS (yaba) has increasingly flooded the streets of urban centres in the country since 1999. The Vientiane prefecture office reported that 2.5 per cent of youth aged 13-30 in the capital Vientiane use yaba, 3.5 per cent in Savannakhet and 2.8 per cent in Udomxay. Reflecting this trend, an increasingly number of youth have been treated at Mahosot Hospital Mental Health Unit or Somsangna Treatment and Rehabilitation centre in Vientiane.

Alongside increased use of yaba, there has been a rise in the incidence of crime such as violence and household burglary as well as an increase in motorcycle accidents. More and more youth are being held in detention centres sending the overcrowding figures to new heights. Families refer children who are problematic yaba users to detention facilities as neither they, nor the community, nor the schools, know how to handle yaba dependence. Treatment for yaba dependence is not available in Lao PDR.

Clearly there is the need to increase the capacity at multisectoral levels to deal with problematic yaba use in Lao PDR at district level hospitals (or health providers), at yaba case management level, and in regards to increasing the capacity of nurses and doctors to deal with mental health issues. Furthermore, information and general knowledge about yaba use and dependence needs to be disseminated among the country’s youth. In the absence of qualified psychiatrists or psychologists (only two currently appear to practice in Lao PDR) relapse rates are very high and adequate follow up does not exist.

Even if ATS has flooded the country and affected its youth, ATS production does not appear to occur in Lao PDR. China and Myanmar seem to be the source of the drug; it is trafficked through Lao PDR, Thailand and Viet Nam. With high intensity anti-drug crackdowns occurring around the region, especially in Thailand, ATS trafficking has moved to less policed and more vulnerable states such Viet Nam and Lao PDR.

The crisis that the ATS epidemic has sparked across South East Asia has severe consequences for law enforcement agencies and detention centres, which are increasingly overcrowded. It is usual that 70-80 per cent of inmates are incarcerated because of their drug use history, and health service providers are not equipped to face the mental health problems associated with synthetic drug taking. This is not only valid for Lao PDR but for China, Myanmar, Thailand, Cambodia, and Viet Nam.

Several studies have recommended ways of improving the outcomes of the Somsangna drug user detention centre in Vientiane in particular, as the policy of incarceration of drug users has almost no impact on cessation of drug use, but does have major health impacts including transmission of HIV, Chlamydia and TB. Economically as well, incarceration is much more expensive than treating drug users in the community.

Lao PDR was declared ‘opium free’ in 2006 although there are still opium users in the country.

No specific information was found on HIV or IDU in prison settings.

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40 See Burnet Institute Lao PDR 2005, ‘Drug use and HIV risk in Khamkeuth district (Borlikhamxay), Sing district (Louangnamtha), and Khua district (Phongsaly)’, Vientiane, Lao PDR, unpublished document.
The prison department:

The Lao prison department is administered by the Ministry of Interior. Other detention facilities come under the Ministry of Public Security, but the Office of the Public Prosecutor has an oversight and monitoring role over all such facilities as well as responsibility for maintaining records of offenders and juvenile criminals.

Prison or custodial settings reform:

No information was found.

International support:

The global fund on AIDS, TB and Malaria approved a two-year US$1 million project for partnerships to scale up prevention for the above diseases.

UNICEF has advocated for diversion programmes as an alternative to incarceration of juvenile ATS users, with a special focus on feasibility studies for community based treatment and rehabilitation initiatives. In August 2004, UNICEF funded a study of ATS use in Lao PDR which carried specific recommendations for community based policy responses as an alternative to juvenile detention.

In cooperation with Save the Children UK and Australia, UNICEF has advocated for juvenile justice system alternatives that could respond to the ATS epidemic and its consequences including the soaring number of youth held in detention centres.

Through two regional projects – ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/03/RAS/G22) and ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (AD/RAS/I09) – UNODC RC is advocating and supporting the implementation of a programme of work through new public health and related partnerships with the Lao National Commission for Drug Control and Supervision. The programme includes:

1. More research on the prevalence of HIV/AIDS transmission among drug users;
2. The creation of advocacy material to increase national awareness about the links between HIV/AIDS and drugs;
3. The introduction and implementation of HIV/AIDS prevention with drug treatment services;
4. Prevention of HIV among female commercial sex workers and other risk groups;
5. Prevention of HIV/AIDS among youth, including mass media mobilisation;
6. Drug counselling for peer youth and health workers in Vientiane’s youth centres; and
7. The Burnet Institute’s project to conduct further research and assessments to monitor the drug use/HIV situation, develop and disseminate education and information material, outreach activities, organise advocacy initiatives, and support intersectoral collaboration at national, provincial and district levels.

UNODC has directly supported the drug counselling for peer youth and health workers initiative, specifically with a proposal from the Vientiane Youth Centre for Health and Development, managed by the Lao Women’s Union, to support drug prevention activities.
provided regularly by the Centre and to extend such counselling to the Somsangna Centre in Vientiane. Furthermore, UNODC has supported the Burnet Institute’s project for more research to monitor drug misuse and HIV/AIDS as well as to provide education, information and communication (EIC) material for drug use prevention.

**Major problems:**

No information was found.

**Health care:**

*A matter of drug use*

Not much is known about health care provision in Lao prisons. An assessment supported by UNICEF and conducted by the People’s Supreme Prosecutor and Ministry of Public Security on Children in Detention Centres in Lao PDR (2003:27), however, identified that 65 per cent of the children were detained for drug misuse and three per cent for selling drugs. Furthermore, when committing offences, 80 per cent were under the influence of drugs, four per cent under the influence of alcohol, and 3.5 per cent under the influence of both drugs and alcohol. The most used drug was overwhelmingly identified as amphetamines; only one respondent identified glue sniffing.

The report also found no adequate drug detoxification, treatment or rehabilitation programmes for young people. Three of the recommendations of the study dealt with drug dependence and its prominent influence in the juvenile justice system (ibid:31):

- *Drug misuse is clearly a major problem relating to juvenile justice.* In many cases, parents or local authorities do not know what to do with drug offenders and place them in detention/re-education centres. There is clearly a need for community based rehabilitation programmes and information to parents on how to support a child who is drug dependent (since many of the children are put in custody by their parents).

- *Medical treatment for detoxification of children addicted to amphetamines is needed.* It is recommended that these services take place primarily within hospitals and health centres, allowing children to receive medical care whilst remaining within a structured environment but not detained in a closed facility. To achieve this, medical professionals’ training is urgently required.

- *Establishing effective drug prevention programmes would have a large effect on juvenile justice.* The study clearly shows that many youths try drugs because of peer pressure. As a consequence, peer to peer and life skills programmes could have a major effect in prevention of drug misuse.

The report further found that living conditions in juvenile detention centres in seven provinces did not meet the basic requirements of international regulations in terms of basic conditions such as lighting, ventilation, health care and adequate nutritional intake for children.

**Health conditions in prisons:**

No information was found.
Results of the project survey:

The questionnaire was only partially completed by Lao PDR authorities.

| Number of youth detention facilities: 6   |
| Number of compulsory drug treatment centres: 3 |
| Number of clients in compulsory drug treatment centres: 1,319 (2004)/844 (2005) |

Policy:

The Government reports the existence of a policy for health in custodial settings.

NGOs:

No NGOs were listed.

Responsible department:

The Ministry of Public Health has responsibility for providing health care in custody.

Capacity:

The Government reported one doctor and two nurses in youth detention centres; and three doctors and five nurses in compulsory drug treatment centres.

HIV/AIDS and major health concerns:

The Government does recognise HIV/AIDS as a major health issue in custody, however, did not specify a specific transmission mode.

No figure was provided for a dedicated HIV/AIDS budget in custodial settings.

Drug related cases:

No information was reported.

Health care provision:

No information was reported.

Drug dependence treatment:

No information was reported.

Training provision and needs:

No information was reported.

Barrier:

No information was reported.

Material:

No information was reported.
4. MYANMAR

<table>
<thead>
<tr>
<th>Myanmar</th>
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<tbody>
<tr>
<td><strong>Responsible Ministry</strong></td>
<td>Ministry of Home Affairs</td>
</tr>
<tr>
<td><strong>Prison administration</strong></td>
<td>Myanmar Correction Department</td>
</tr>
<tr>
<td><strong>Prison population rate</strong>&lt;br&gt;(based on 100,000 of national pop.)&lt;sup&gt;41&lt;/sup&gt;</td>
<td>120</td>
</tr>
<tr>
<td><strong>Female prisoners</strong></td>
<td>8,638 (2005)</td>
</tr>
<tr>
<td><strong>Juvenile (% of prison pop.)</strong></td>
<td>529 (2005)&lt;br&gt;1.6%&lt;sup&gt;42&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Official capacity of prison system</strong></td>
<td>67,017&lt;sup&gt;43&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Prison population total</strong></td>
<td>64,699 (2005)</td>
</tr>
<tr>
<td><strong>Compulsory drug rehabilitation centres</strong>&lt;br&gt;(clients/number of centres in the country)</td>
<td>1,490 (2004)/1,492 (2005)/26 major and 40 minor centres</td>
</tr>
<tr>
<td><strong>Involvement of NGOs</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>HIV/AIDS is a major health concern</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Drug related cases</strong></td>
<td>4,918</td>
</tr>
<tr>
<td><strong>HIV cases</strong></td>
<td>610 including 351 females (2004)</td>
</tr>
<tr>
<td><strong>AIDS deaths</strong></td>
<td>184 including 19 females (2004)</td>
</tr>
<tr>
<td><strong>ARV provision</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Drug treatment is available</strong></td>
<td>Peer education</td>
</tr>
<tr>
<td><strong>Major barrier to the provision of HIV prevention, care and support</strong></td>
<td>Inadequate resources and illiteracy</td>
</tr>
</tbody>
</table>

HIV/AIDS and injecting drug use in the community and in prisons:

Myanmar has one of the most alarming epidemics in Asia. IDUs record dramatic HIV infection rates and around a third of new HIV cases come from this high risk group (Aceijas et al. 2004). Between 1992 and 2003, for example, 45-80 per cent of IDUs tested positive for HIV in annual sentinel surveillance. In the same period, known cases of HIV in CSWs jumped from five to 31 per cent. Perhaps the most alarming trend is the transmission of HIV from IDUs and CSWs into the general population. Due to inadequate prevention efforts, the virus has passed through high risk groups and onto regular sex partners of IDUs and CSWs or their clients, prompting increases in HIV among women who report only one sexual partner; for example, in the towns of Pyay and Hpa-an, five per cent and 7.5 per cent of pregnant women, respectively, tested HIV positive. Identification of this transmission route presents opportunities for prevention efforts (UNAIDS and WHO 2004:42-43). The Government has committed to responding to the epidemic through the Joint Programme to Fight AIDS in Myanmar, a United Nations collaborative initiative which provides a framework for prevention efforts.

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<sup>41</sup> The data provided for the prison population rate is based on http://www.prisonstudies.org.

<sup>42</sup> Ibid.

<sup>43</sup> While this number was provided by the authorities in the project questionnaire, the official capacity of prisons in Myanmar, reported by www.prisonstudies.org, is only 26,100.
cooperative planning, resource mobilisation and advancing the ‘Three Ones’ principles. However, to date implementation of any such initiatives have been minimal.

It is unfortunate that despite early and clear warning signs, Myanmar had to experience a ‘spill-over effect’, from initial concentrated infections among vulnerable groups to a generalised spread, thereby placing millions of people at risk of disease and death.

**Drug use?**

Myanmar continues to be the largest regional source of production for ATS, but heroin is the first drug of choice. IDUs number around 195,000 (2003). Drug injecting also appears to be increasing and diffusing from urban to rural areas. The number of IDUs has increased in recent years with the drug preference shifting from opium smoking to injecting heroin. In 1991, in Myitkyina, 0.7 per cent of drug users used heroin, by 1997 this figure skyrocketed to 95 per cent. Specific geographical pockets can register 50-90 per cent HIV prevalence among IDUs. Heroin use predominates in Kachin State, in the Northern Shan State and in all the large cities. Opium use still predominates in the Eastern and Southern Shan State and in the Kayah State.

**The prison department:**

The Myanmar Correction Department is administered by the Ministry of Home Affairs.

**Prison or custodial settings reform:**

It appears that since 1994, there has been an effort to reform the prison system in Myanmar through an 11-points list (1997) and a 9-point guideline (1999). At present, there seem to be 6,500 staff responsible for the administration of about 60,000 inmates distributed in the following facilities:

- 41 prisons;
- two rehabilitation camps;
- seven agricultural camps;
- two livestock breeding camps;
- 13 quarry camps; and
- 13 regional development camps.

**International support:**

*UNODC Myanmar*

UNODC’s project ‘Reducing Injecting Drug Use and its Harmful Consequences in the Union of Myanmar’ (AD/MYA/03/G54) conducts drugs and HIV/AIDS awareness training for staff, family members and inmates in two prisons, Lashio in Northern Shan State and in Taung Lay Lone (Taunngyi) Southern Shan State. Funding (in the form of income generation) to support the prisons’ clinic in health care services for inmates and in particular, drug users and IDUs, is forthcoming.

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44 See Myanmar Correctional Department, http://www.myanmar.com/Ministry/Moha/PrisonsMain.htm.
45 Ibid.
UNODC’s counterpart national agency, the Central Committee for Drug Abuse Control (CCDAC), received funding assistance under round two of Funds for HIV/AIDS in Myanmar (FHAM) for 2004-2006. Activities to be conducted in seven prisons (in Yangon, Mandalay, Lashio, Kyaington, Taung Lay Lone, Monywar, and Myitkyina) are:

- Behavioural studies;
- Develop guidelines to introduce the comprehensive package for the prevention of HIV/AIDS among IDUs, education, training and intervention in prisons;
- Train selected staff members and inmates as peer educators (140) and provide peer education;
- Conduct training of trainers’ sessions for staff members and conduct multiplier courses (HIV/AIDS and drug use for inmates and prison staff members, 49 sessions);
- Conduct educational sessions for staff members and their families (28 sessions);
- STI treatment provided to 600 inmates;
- Access to detoxification provided to 400 drug users; and
- Provision of primary health care (including opportunistic infections) for 1,200 inmates through prison clinics.

Medecins du Monde

MdM has implemented general HIV/AIDS awareness training in Yangon and Myitkyina prisons since 1999 and 1996 respectively. Target populations include IDUs, CSWs and their respective communities.

The Asian Harm Reduction Network

AHRN has conducted a two-day workshop on ‘Prisons, Injecting Drug Use and HIV’. AHRN will also work with CCDAC under their FHAM round project for HIV/AIDS prevention in prisons.

Global Fund

The Global Fund to fight AIDS, TB and Malaria approved a two-year US$35.7 million project in support of strengthening prevention and control programmes on HIV and Malaria. Due to the country’s internal affairs and amidst international criticism, however, the Global Fund discontinued assistance to Myanmar in 2005.

Major problems:

No information was found.

Health care:

No information was found.
Drug use:

Male drug users end up in the Wet Hti Kan Rehabilitation Centre, where they are provided with arts and crafts, handicrafts and outdoor training such as agriculture, livestock breeding as treatment and vocational training.\textsuperscript{46}

Health conditions in prisons:

No information was found.

Results of the project survey:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prisons</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Number of prisoners</td>
<td>38,523 (2004)/37,395 (2005)</td>
<td></td>
</tr>
<tr>
<td>Number of remand prisoners</td>
<td>4,741 (2004)/5,867 (2005)</td>
<td></td>
</tr>
<tr>
<td>Number of youth detention centres</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Number of youth detainees</td>
<td>380 (2004)/529 (2005)</td>
<td></td>
</tr>
<tr>
<td>Number of women in prison</td>
<td>8,554 (2004)/8,638 (2005)</td>
<td></td>
</tr>
<tr>
<td>Number of compulsory drug treatment centres</td>
<td>26 major and 40 minor centres</td>
<td></td>
</tr>
<tr>
<td>Number of clients in compulsory drug treatment centres</td>
<td>1,490 (2004)/1,492 (2005)</td>
<td></td>
</tr>
<tr>
<td>Total number of custodial settings</td>
<td>90 (41 prisons and 49 camps)</td>
<td></td>
</tr>
<tr>
<td>Official capacity for custodial settings</td>
<td>67,017</td>
<td></td>
</tr>
</tbody>
</table>

Policy:

Myanmar has a Government policy for health in custodial settings, the Myanmar Jail Manual, whereby provisions for health are laid out.

NGOs:

Myanmar has two NGOs working in custodial settings:

1. The International Committee of the Red Cross which visits prisons and camps and provides assistance and material such as medicines and soap;
2. MdM which conducts HIV education sessions for prison staff and inmates at the Insein Central Prison.

Responsible department:

The Ministry of Health is responsible for providing health care in prison settings.

Capacity:

Myanmar reported 22 doctors and 22 nurses attending the prisons, with three doctors and five nurses in the youth detention centres. In the major drug treatment centres, consultant psychiatrists take responsibility while in the minor centres, township medical officers are responsible for drug treatment.

\textsuperscript{46} Ibid.
Increasing the capacity of health care providers as well as facilities would greatly facilitate appropriate care giving.

HIV/AIDS and major health concerns:

The Government recognises HIV/AIDS in custody as a major health issue. Furthermore, the Government acknowledges the major causes of HIV transmission in custody as MSM and IDU.

The Government has a specific budget devoted to the prevention of HIV in custody which covers health education on HIV/AIDS by the sexually transmitted diseases team under the Ministry of Health, and specialists from the civilian hospitals.

Voluntary counselling and testing (VCT), education, treatment and care (including ARV provision), peer support groups, counselling and early release options for the most advanced AIDS cases are provided.

The major health threat in custodial settings appears to be infectious diseases.

The total number of HIV positive people in 2004 was 610 (including 351 females); while there were 184 AIDS related deaths (including 19 females).

Drug related cases:

There are 1,289 people in jail on drug trafficking related charges, 1,248 men and 81 women. Drug possession charges have landed 2,285 in jail, of whom 2,206 are male and 779 are female. There are 4,140 men and 750 women in jail for drug misuse related offences.

Health care provision:

There is one doctor for each prison. General health screening is provided on entry, along with equal and free medical care, and continuing treatment from previously established health issues. New inmates are screened for mental health problems and drug dependence. Referrals and drug counselling are provided.

People living with HIV/AIDS:

PLWHA are quite involved in custodial settings and manage peer education programmes as well as HIV/AIDS counselling.

Those who are diagnosed with infectious diseases are isolated.

The most common cause of death (33 per cent) is related to TB; and the main reason to account for disease among inmates appears to be the absence of health education.

Drug dependence treatment:

Drug users appear also to be involved in providing peer education. Assessment, education, rehabilitation, follow up after release and pre-release medical check ups are the drug dependence treatment provisions.
Training provision and needs:

MdM has since 2003 conducted HIV education sessions for prison staff and inmates sentenced under the Narcotic Law and Prostitution Act at Insein Central Jail, Yangon. In addition, training programmes on management of drug dependence treatment are supplied in Shwe Pyi Thar and Shwe Pyi Aye Youth Correction Centres. Two centres for women (in Tonte and Mandalay) were established to provide life skills training particularly for women living with HIV/AIDS.

There is a need to provide training on basic HIV/AIDS facts – modes of transmission, signs and symptoms, counselling, safe and sterile injecting techniques, life skills and condom use.

A training curriculum for health workers could be structured through active collaboration with the National AIDS Programme; as for prison guards, respective departments could provide training of trainers’ courses and subsequently conduct multiplier courses at work stations.

Barrier:

Inadequate financial and human resources as well as illiteracy, especially of detainees, were identified as the greatest barriers to providing HIV/AIDS prevention, care and support in custodial settings.

Material:

Material needs range from information on comprehensive HIV prevention connected to drug use, especially needle and syringe exchange programmes, as well as the proper use of condoms. Videos, pamphlets and posters would be most useful.
## 5. THAILAND

<table>
<thead>
<tr>
<th><strong>Thailand</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Ministry</strong></td>
</tr>
<tr>
<td><strong>Prison administration</strong></td>
</tr>
<tr>
<td><strong>Prison population rate</strong> (based on 100,000 of national pop.)&lt;sup&gt;48&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Female prisoners</strong></td>
</tr>
<tr>
<td><strong>Juvenile (% of prison pop.)</strong></td>
</tr>
<tr>
<td><strong>Official capacity of prison system</strong></td>
</tr>
<tr>
<td><strong>Prison population total</strong></td>
</tr>
<tr>
<td><strong>Compulsory drug rehabilitation centres</strong>&lt;br&gt;(clients/number of centres in the country)</td>
</tr>
<tr>
<td><strong>Involvement of NGOs</strong></td>
</tr>
<tr>
<td><strong>HIV/AIDS is a major health concern</strong></td>
</tr>
<tr>
<td><strong>Drug related cases</strong></td>
</tr>
<tr>
<td><strong>HIV cases</strong></td>
</tr>
<tr>
<td><strong>AIDS deaths</strong></td>
</tr>
<tr>
<td><strong>ARV provision</strong></td>
</tr>
<tr>
<td><strong>Drug treatment is available</strong></td>
</tr>
<tr>
<td><strong>Major barrier to the provision of HIV prevention, care and support</strong></td>
</tr>
</tbody>
</table>

* The figures for the year 2005 are only to March of that year

### HIV/AIDS and injecting drug use in the community and in prisons:

As of January 2004, 231,712 AIDS cases have been reported in Thailand, and nearly 80 per cent of these were people aged between 20-39 years. The male-to-female ratio of reported AIDS cases is 8:1. Sexual intercourse accounts for most of the HIV transmission (88 per cent), followed by IDU (six per cent) and prenatal (five per cent). Total HIV/AIDS cases amounted to 570,000 and deaths to 58,000 (WHO and UNODC 2004).

Thailand and Cambodia were among the countries that implemented 100 per cent condom campaigns in the late 1990s and have successfully slowed the epidemic especially among CSWs, their partners and clients. Drug users and especially IDUs, however, were not

<sup>47</sup> The youth detentions centres are under the Department of Juvenile Detention and Observation, while compulsory drug treatment centres are under the Department of Probation.<br>
<sup>48</sup> The data provided for the prison population rate is from http://www.prisonstudies.org.<br>
<sup>49</sup> This number refers to young detainees awaiting trial.<br>
<sup>50</sup> This number refers to youth in the training centres.<br>
<sup>51</sup> Of these, 22.12 per cent were drug use cases, and 77.88 per cent for selling drugs. The Department of Juvenile Observation and Protection reported 2,640 apprehensions for drug related offences, 790 for drug dealing and 68 drug use/possession cases.
explicitly targeted by such campaigns and hence continued to show high prevalence rates of HIV infection. In Thailand, HIV prevalence among IDUs is still at around 54 per cent – the population with the highest HIV/AIDS prevalence in the Kingdom. IDUs are estimated to number around 57,000 and they account for a fifth of new HIV cases (Aceijas et al. 2004).

HIV infection among IDUs in Bangkok rose from two to 43 per cent between 1987 and 1988. Several studies assert that this epidemic started in prisons because the prevalence suddenly jumped in the wake of an amnesty, on the King’s birthday, when hundreds of prisoners – among them supposedly many IDUs – were released. Indeed, six studies of HIV infection among drug injectors in Thailand found that a history of imprisonment was significantly associated with acquiring HIV (Dolan et al. 2003; 2004). A recent study concluded that ‘IDUs in Bangkok are at significantly increased risk of HIV infection through sharing needles with multiple partners while in holding cells before incarceration’ (Buavirat et al. 2003:308). The Government estimates that 60-80 per cent of inmates have a drug use background.

Drug use?

Five per cent of the population is dependent on illicit drugs especially ATS, locally known as yaba. It was first detected in Thailand in 1996-1997, and in 1990 misuse of the drug skyrocketed as the price for heroin increased tenfold (due to domestic changes in Myanmar) and the pill form of yaba found a receptive market.

Yaba is widely consumed for recreational purposes by youth but also by occupational workers such as drivers of tuk tuksa (three-wheel taxis) who take it to cope with their everyday life and in a bid to earn more money as yaba can prolong the working day by eight to ten hours. Yaba, previously known as yama (horse drug) is still considered an energizing pill that helps one focus, work more, become stronger and more confident – appealing effects for the shy natured Thais. ATS in many parts of Myanmar and Lao PDR (as it was in Thailand some ten years ago) is perceived as a vitamin.

Those caught in possession of any (even only one) yaba pill can be sentenced to four years in jail if the suspect is arrested with intent to sell. If a suspect is found with less than six pills but no intention to sell, however, he/she will be sent to a compulsory drug treatment centre for an initial six months and will have to appear in front of a subcommittee (composed of police, psychologists and the court) before being released.

The War on Drugs in 2005

On 11 April 2005 Thai authorities re-launched for three months the forth phase (third operation) of their War on Drugs. This phase focused on reducing the demand for drugs; hence the war aimed to increase the chances for drug dependent people to be treated in compulsory drug treatment facilities as well as assist their communities to accept and provide them job opportunities.

During the previous campaign, 300,000 drug dependent people were forced into treatment. And since then, the number of treatment clients has decreased alongside the prevalence of drug use, hence the campaign was perceived as a success, despite widespread criticism by human rights advocates such as Amnesty International, Human Rights Watch and the United Nations High Commissioner for Human Rights. This attention spotlighted international concern of extra judicial killings and the disappearance of about 2,500 people. When Hina Jilani, the Special Rapporteur on Human Rights Defenders, visited Thailand in May 2003,
civil society confirmed that the reported disappearances and killings were a direct result of the extreme anti-narcotics campaign.

So far, reports of violations of human rights have not surfaced during the forth phase of the War on Drugs, although unclear policy continues to hamper effective HIV prevention for IDUs in Thailand.

**The prison department:**

1. The Department of Probation is responsible for compulsory drug treatment centres;
2. The Department of Corrections for adult prisons; and
3. The Department of Juvenile Detention and Observation for youth detention centres.

**Prison or custodial settings reform:**

*A human approach to incarceration*

To cope with rampant overcrowding and meet the needs of prisoners, the Department of Corrections has introduced a few changes. For example, the Drug Addicts Rehabilitation Act treats minor drug offenders as patients rather than criminals and provides judges with a larger pool of options for sentencing. In 2004, the Director General of the Corrections Department Natthee Jitsawang initiated a new programme for women prisoners whereby they could work during the week and take care of their family, and on the weekend they had to return to custody to serve out their jail sentence.

Other innovations under this Act include permission to conduct wedding ceremonies, to organise soccer matches, to practice meditation and traditional massage, and sing in choirs. In addition, elderly prisoners can enjoy reduced sentences, and more family visits are allowed than in the past (*Bangkok Post* 2004).

These are all encouraging steps; the Department of Corrections is open to innovation, improvement and change. With the outstanding overcrowding problem that Thailand prisons experience, however, what is needed first and foremost is figuring out a way to send less people to prisons.

**International support:**

The Global Fund on AIDS, Tuberculosis and Malaria approved a two-year US$61.2 million project for strengthening national prevention and care programmes on HIV/AIDS, TB and Malaria.

The UNODC ‘Regional Project on Reducing HIV/AIDS Vulnerability from Drug Abuse’ (AD/RAS/02/G22), over the course of several years, promoted and supported the establishment of politically sound and operational national working groups on drugs and HIV/AIDS in Cambodia, China, Lao PDR, Myanmar, Thailand, and Viet Nam. The project also guided the members of these working groups to establish integrated work plans to commit the authorities over time and across various sectoral responsibilities to the reduction of HIV/AIDS vulnerability from drug misuse. The project has successfully reigned the national task force on drugs and HIV/AIDS under the leadership of the Bureau of AIDS, TB and STI, in partnership with UNAIDS Thailand, the United Nations Theme Group on HIV/AIDS of
Thailand, the World Health Organization, as well as civil society groups and stakeholder representatives such as the Thai Drug Users Network and the Thai AIDS Treatment Action Group.

Gaining momentum from the International AIDS Conference, held in July 2004 in Bangkok, as well as the commitment of Thailand’s former Prime Minister Thaksin Shinawatra, to treat drug users as patients rather than criminals, the Thai Working Group on Drugs and HIV/AIDS has followed through on its commitments to implement the integrated work plan developed with support from UNODC and other partners. The work plan includes activities and coordinated inputs of UN agencies and focuses on issues of situation assessment, policy clarity (for the comprehensive HIV/AIDS prevention approach from drug use), advocacy for public support on drugs and HIV/AIDS responses, national guidelines for drug substitution treatment, operational guidelines and studies related to outreach services, and drug related HIV infection among prison populations for adults and juveniles. The UNAIDS Programme Acceleration Fund (PAF) for Thailand – a mechanism at country level designed to facilitate the implementation of the United Nations Implementation Support Plan (UNISP) 2005-2006 – has supported, as per Thailand’s national work plan on drugs and HIV/AIDS, five different proposals on various aspects of comprehensive HIV/AIDS prevention from drug use among juvenile detainees and adult prisoners as well as outreach activities.

With the UNODC project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (AD/RAS/I09), a renewed opportunity beckons for continuing the inspiring work initiated by Thailand’s Department of Corrections and Department of Juvenile Detention and Observation through the National Task Force on Drugs and HIV/AIDS. Indeed, this new project strategically plans to build upon the political and operational structure of the national working groups established by the regional project on ‘Reducing HIV Vulnerability from Drug Abuse’ (AD/RAS/02/G22). Furthermore, the project on ‘Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings’ (AD/RAS/I09) plans to expand partnerships of such national mechanisms to include the Ministry of Justice, in order to effectively address HIV/AIDS related risks and vulnerabilities in custodial settings including prisons, juvenile detention centres and compulsory drug treatment centres.

The above project will also assist countries to expand their efforts through the existing national working groups to: provide more effective prevention and treatment responses in compulsory drug dependence treatment and rehabilitation facilities; develop a comprehensive approach to HIV/AIDS prevention programmes in custodial settings; and introduce and adapt community policing models for improved cooperation of the public security sector with community based programmes for the alleviation of HIV vulnerability from drug misuse (Brenny and Bezziccheri 2005).

**Health care:**

It is important to note that the numbers of doctors and nurses reported by the Thai authorities in prison settings refer to full time staff only of the Department of Corrections. In addition, the Thai system has a functional referral system whereby inmates, patients and juveniles can be sent to nearest Government hospital or health station for medical services.
Health conditions in prisons:

A recent study conducted by Family Health International Thailand on HIV/AIDS high risk behaviour in four prisons – a remand centre, a maximum security prison, a drug treatment centre, and a young offenders prison – in Bangkok in 2005, found a link between sexual intercourse among inmates and HIV transmission, and links between needle sharing and HIV. Condom distribution was perceived by prison staff as essential for preventing HIV transmission together with related education and information material in the prison. Tattooing, rape, penis modification and their implications for the spread of blood borne viruses, including HIV, were also observed in the surveyed prisons (FHI Thailand et al. 2006).

Results of the project survey:

<table>
<thead>
<tr>
<th>Number of prisons: 130</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of remand prisons: 4</td>
</tr>
<tr>
<td>Number of remand prisoners: Information not reported.</td>
</tr>
<tr>
<td>Number of youth detention centres: 32 (2004)/34 (2005)</td>
</tr>
<tr>
<td>Number of youth detainees awaiting for trial: 1,800 (2004/2005)</td>
</tr>
<tr>
<td>Number of youth training centres of the Department of Juvenile Detention: 17</td>
</tr>
<tr>
<td>Number of youth detainees in training centres: 3,500 (2004)/3,500 (2005)</td>
</tr>
<tr>
<td>Number of women prisons: 6</td>
</tr>
<tr>
<td>Number of compulsory drug treatment centres: 35 (2004)/49 (2005)</td>
</tr>
<tr>
<td>Number of clients in compulsory drug treatment centres: 9,781 (2004)/2,358 (March 2005)</td>
</tr>
<tr>
<td>Total number of custodial settings: 223 (2004)/240 (2005)</td>
</tr>
<tr>
<td>Official capacity of youth training centres: 500</td>
</tr>
<tr>
<td>Official capacity of youth detention centres: 105</td>
</tr>
</tbody>
</table>

* The figures for the year 2005 are only to March of that year

Policy:

Thailand has a Government policy for health in custodial settings.

NGOs:

Thailand has several NGOs working in custodial settings. For the Juvenile Observation and Protection Department, PATH provides education on safe sex practice in Baan Kanchanapisek and Baan Pranee training centres.

For the Department of Corrections, Medicins sans Frontiers/Doctors without Borders provides health care for HIV/AIDS patients in Minburi Special Prison and Bang Kwang Central Prison. The NGO ACCESS provides training for the prevention of HIV/AIDS in Klong Prem Central Prison. Furthermore, Flame Ministries International provides a prevention and solution to HIV/AIDS problems programme in Pattaya Special Prison.
UNAIDS, together with other UN agencies, provides HIV/AIDS prevention from drug misuse education in juvenile and adult facilities through the Bureau of Justice System Development and the Health Care Service Division.

**Responsible department:**

The Ministry of Public Health and the National Health Security Office are jointly responsible for the prevention of HIV in the prison system of Thailand.

**Capacity:**

Thailand reported 17 doctors, 289 nurses and 26 primary health care providers in the state’s adult prisons, and two doctors and 45 nurses in the youth detention centres. There are no doctors in the women’s prisons; instead, there are nine nurses and three primary health care providers. In the compulsory drug treatment centres, there are 49 primary health care providers, at least one for each centre.

In total, Thailand reported 19 doctors, 356 nurses and 78 primary health care providers in its custodial facilities. However, it is important to note that patients are also referred to nearest hospital on case by case bases.

**HIV/AIDS and major health concerns:**

The Government recognises HIV/AIDS in custody and as a major health issue.

Furthermore, the Government acknowledges the major causes of HIV transmission in custody as MSM, drug use including drug injecting, tattooing, blood splatters and violence.

The Thai Government has a specific budget devoted to the prevention of HIV in custody. The table below outlines the budget in Thai Baht for different HIV/AIDS activities:

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV prevention</th>
<th>Treatment and care</th>
<th>Education development and research on HIV/AIDS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>244,101,000</td>
<td>1,312,978,000</td>
<td>72,687,000</td>
<td>1,629,766,000</td>
</tr>
<tr>
<td>2005</td>
<td>214,116,700</td>
<td>1,329,673,400</td>
<td>57,826,100</td>
<td>1,601,616,200</td>
</tr>
</tbody>
</table>

The most recent national budget devoted to health care services in custodial settings allocates THB136 per person per year provided by the Department of Corrections. The Department of Corrections does not receive the budget allocation for HIV/AIDS but it receives THB880,000 (US$21,500) per year from the National HIV/AIDS Prevention and Problem Solving Work Plan.

Similarly, the Department of Juvenile Observation and Protection receives THB910,000 (US$22,250) per year from the National HIV/AIDS Prevention and Problem Solving Work Plan. Both departments implement HIV/AIDS prevention programmes with the aim of increasing prisoners’ knowledge and understanding on HIV/AIDS transmission.

Within the above budget the Department of Corrections spends THB430,000 (US$10,500) on drug dependence treatment in prisons.
In 2004, there were 869 HIV positive people in prison, and 331 people died of AIDS related causes while in custody. The total number of people in custodial settings for drug related offences was 100,511. No data was available for hepatitis C cases.

_Drug related cases:_

<table>
<thead>
<tr>
<th>Type of drug offences</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug use</td>
<td>1,311</td>
<td>858</td>
<td>2,169</td>
<td>2.16%</td>
</tr>
<tr>
<td>Drug possession</td>
<td>10,479</td>
<td>3,096</td>
<td>13,575</td>
<td>13.51%</td>
</tr>
<tr>
<td>Use and possession</td>
<td>5,032</td>
<td>1,454</td>
<td>6,486</td>
<td>6.45%</td>
</tr>
<tr>
<td><strong>Total drug use cases</strong></td>
<td>16,822</td>
<td>5,408</td>
<td>22,230</td>
<td>22.12%</td>
</tr>
<tr>
<td>Dealing</td>
<td>25,644</td>
<td>11,022</td>
<td>36,666</td>
<td>36.48%</td>
</tr>
<tr>
<td>Possession with intent to deal</td>
<td>30,233</td>
<td>11,203</td>
<td>41,436</td>
<td>41.23%</td>
</tr>
<tr>
<td>Other (production/trafficking)</td>
<td>128</td>
<td>51</td>
<td>179</td>
<td>0.18%</td>
</tr>
<tr>
<td><strong>Total dealing cases</strong></td>
<td>56,005</td>
<td>22,276</td>
<td>78,281</td>
<td>77.88%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>72,827</td>
<td>27,684</td>
<td>100,511</td>
<td>100%</td>
</tr>
</tbody>
</table>

* There are 709 drug selling and 68 drug use and possession cases in the Department of Juvenile Observation and Protection.

The major health concern for the authorities is HIV/AIDS and TB, risky behaviour, as well as mental illness. However, inmates consider drug treatment and rehabilitation as the most important health concern in prisons, followed by health and HIV/AIDS education.

The most common cause of death in custodial settings was reported to be AIDS and TB. While the most common cause of disease is respiratory and skin disease.

_Health care provision:_

A general health screening on entrance is provided to all inmates for psychological problems and drug dependence. Specifically, induction, assessment, basic health care and referral are provided. As for drug dependence treatment, assessment, education, drug counselling, rehabilitation and pre release medical check ups are provided. Drug substitution maintenance treatment is not provided in custodial settings.

VCT, education, treatment and care (including ARV provision), peer support groups and early release for the most advanced AIDS cases are provided.
People living with HIV/AIDS:

Thailand did not report any involvement of PLWHA or ex-drug users in custodial facilities services for the provision of specialised health care.

Drug dependence treatment:

There appear to be drug counsellors or so-called ‘treatment working groups’ which are composed of nurses, psychologists, academics, social workers and teachers who take care of all children and youth.

Training provision and needs:

Therapeutic community courses are provided for staff at adult prisons. A training programme for the development of HIV/AIDS staff in juvenile detention centres and training centres is also provided. Specifically, staff undergo training on how to use the Department of Juvenile Observation and Protection manual for treatment of drug users/risk persons; a few staff members at each centre attend this training course. The Department of Juvenile Observation and Protection runs the courses and has distributed two to three copies of the manual to each juvenile detention and training centre.

A training curriculum for health workers could be better structured by providing:

1. AIDS counselling for individuals as well as groups;
2. Prevention of HIV/AIDS training among drug users;
3. Care for HIV/AIDS patients;
4. ARV; and
5. Training on project management skills.

A training curriculum for guards could be better structured by providing:

1. HIV/AIDS information with the aim of behaviour and attitude change toward HIV positive individuals; and

In regard to most useful training, Thailand reported that the health workers would benefit from training on:

1. Caring for drug users;
2. Peer education;
3. In depth counselling (e.g. a group of about 30 people for a period of two weeks); and
4. Techniques for effective prevention of HIV/AIDS transmission (e.g. a group of 80 people for two to three days).

As for the guards, they would benefit from training on:

1. Rehabilitation of drug users;
2. Measures for the prevention of HIV/AIDS in prisons;
3. Knowledge and understanding of HIV/AIDS and drugs (e.g. a group of 80 people for three days); and
4. Adjustment of attitudes towards HIV positive people and drug users (e.g. a group of 80 people for three days).

**Barrier:**

The greatest barriers identified for HIV/AIDS prevention, care and support in custodial settings are:

1. Knowledge, understanding and attitudes of staff as they all have different professional backgrounds;
2. Attitudes of staff towards the operation of HIV/AIDS prevention programmes in custodial settings; and
3. Due to high turnover, especially of children and youth in juvenile detention centres, information cannot be properly provided.

**Material:**

Material needed to increase health awareness among inmates includes:

- Media to provide information on risk reduction of re-using and/or sharing needles or other injecting equipment;
- Media to provide information on safe sex practices among MSM; and
- Media to provide visual information on study tours and other education material.

As with regard to management needs, Thailand reported that in order to provide adequate HIV/AIDS prevention and care in its custodial settings, the following were needed:

1. Political commitment, specifically, including HIV/AIDS prevention and care within the policy mandate of each concerned agency; and
2. Providing knowledge on HIV/AIDS and adjusting the attitudes of everybody to be fully aware of facts and the importance of preventing HIV transmission.
### 6. VIET NAM

<table>
<thead>
<tr>
<th>Viet Nam(^{52})</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Ministry</strong></td>
<td>Ministry of Public Security</td>
</tr>
<tr>
<td><strong>Prison administration</strong></td>
<td>Department of Correctional Services</td>
</tr>
<tr>
<td><strong>Prison population rate</strong> (based on 100,000 of national pop.)(^{53})</td>
<td>71</td>
</tr>
<tr>
<td><strong>Female prisoners</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Juvenile (% of prison pop.)</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Official capacity of prison system</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Prison population total</strong></td>
<td>55,000(^{54})</td>
</tr>
<tr>
<td><strong>Compulsory drug rehabilitation centres</strong> (clients/number of centres in the country)</td>
<td>About 100,000 clients, 1,000-1,500 per centre, are believed to be in the ‘05-06’ centres/80 centres(^{55})</td>
</tr>
<tr>
<td><strong>Involvement of NGOs</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>HIV/AIDS is a major health concern</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Drug related cases</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>HIV cases</strong></td>
<td>~20% (study based on 48 state prisons, July 2000)(^{56})</td>
</tr>
<tr>
<td><strong>AIDS deaths</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>ARV provision</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Drug treatment is available</strong></td>
<td>Not reported</td>
</tr>
<tr>
<td><strong>Major barrier to the provision of HIV prevention, care and support</strong></td>
<td>Not reported</td>
</tr>
</tbody>
</table>

### HIV/AIDS and injecting drug use in the community and in prisons:

In 2001, HIV prevalence was highest among IDUs (22.3 per cent) in Hanoi. From behavioural surveys, 28 per cent of IDUs were reportedly sharing injecting equipment. Hai Phong City reported a 70 per cent prevalence of HIV among IDUs in 2001. HIV/AIDS cases amounted to 220,000 in 2003 and deaths to 9,000 in the same year.

Any intervention to prevent HIV among IDUs and other drug users has to take into consideration the need to raise awareness about high risk behaviour of sharing needles and unsafe sexual practice with their partners.

The nexus of IDU and sex work skyrocketed HIV infection rate to above 80 per cent among IDUs in 2003-2004, and to 50 per cent among sex workers especially in the country’s north. The Government responded to the problem and AIDS spending increased from US$7-8 million in 2003 to a projected US$50 million in 2006. One development has been the gradual

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\(^{52}\) The information provided for Viet Nam is entirely based on a literature review and the International Centre for Prison Studies, since no response to the project questionnaire was received.

\(^{53}\) The data provided for the prison population rate is based on http://www.prisonstudies.org.

\(^{54}\) Ibid.


replacement of the highly stigmatising ‘social evil’ approach to substance misuse and sex work in favour of prevention efforts based on sound and effective public health practices (UNAIDS 2005).

Any intervention to prevent HIV among IDUs and other drug users has to take into consideration the need to raise awareness about sexual protection. Indonesia, like China and Viet Nam, has now committed to scaling up comprehensive prevention and treatment approaches at all levels; these commitments now need to be adequately monitored and guided.

According to the Police Department of Prison Management, the problem of drug misuse and infection of HIV/AIDS and fatal diseases in prisons is increasing: 25,608 prisoners were identified as drug users; 6,750 were infected with hepatitis B, C, D; 11,962 with HIV/AIDS; and 7,520 with TB. The rate of HIV/AIDS infection in some prisons reached 40 per cent of total inmates. Between October 2003-2004, 1,202 prisoners died of AIDS (Phap luat 2005).

There are about 113,000 IDUs (2003) in Viet Nam, and the estimated prevalence among IDUs is close to 90 per cent in some areas (WHO and UNODC 2004). Although opium has mostly been eradicated – some cultivation still exists in the Northern part of the country – opioids continue to dominate drug misuse and injection in Viet Nam. Around 65 per cent of drug users in the country are IDUs, with 42 per cent HIV prevalence. An increasing number of deaths associated with IDU was reported in 2004. Although ATS misuse is much less common, there has been an increase in 2003 and 2004, with reports of drug users switching from other drugs to ATS.

There has also been increase in the supply and purity of ATS in 2005. According to Police Department reports, the seizure of ATS increased five times (210,800 tablets) in 2005, compared to 39,500 tablets in 2004. Heroin seizure rates have remained the same. In 2003, there were 18,260 recorded offences related to illicit drugs – apparently a 21 per cent drop from 2002 (UNODC RC 2005).

The prison department:

The Department of Correctional Services is administered by the Ministry of Public Security.

The ‘05-06’ centres

Apparently the prison population is much smaller (55,000) than the population of the so-called ‘05-06’ centres for CSWs and drug users. At least one ‘05’ and one ‘06’ centre exists in every province of Viet Nam. According to the drug law, the Ministry of Labour, Invalids and Social Affairs (MOLISA) is in charge of drug treatment and rehabilitation and thus directly responsible for supervising and managing the ‘05-06’ centres. Various centres are also now run by the Youth Union. The ‘05-06’ centres are named after the Government’s Decree No. 05 and Decree No. 06 or Trung tam Cai nghieng Phuc hoi (Detox or Treatment and Rehabilitation Centre).

There are about 80 such centres countrywide with an average population of 1,000-1,500 per centre, for a total of around 100,000 people. Ho Chi Minh City has the largest population of drug users, 18 ‘05-06’ centres with a total of about 30,000 clients. Among them, 25-30 per cent are voluntary clients. There are also many provincial treatment centres (‘06’) having an admission capacity of 100-200 drug users.
In principle, all CSWs and drug users arriving at the centres should be tested for HIV but in practice there are not enough resources to test all of them; the proportion of tests carried out varies from 100 per cent to 40 per cent, on average about 73 per cent were tested for HIV in 2002. Apparently one of the dilemmas of the ‘05-06’ centres is shortage of medical staff and high relapse rates (70-80 per cent in the first year after release, and 90-100 per cent after two years).

The minimum time in the centre is six months but clients can extend. Given increasing drug misuse prevalence, however, in 2003 Ho Chi Minh City began a pilot project to detain recovering drug users for three more years in addition to the two year compulsory drug treatment original and official period.

There is also a rather high probability of escape; depending on the specific centres, from one to 30 per cent of the clients can attempt a joint breakout. On average, about two per cent of them escape each year (UNODC 2004).

As the problem of HIV/AIDS continues to grow among high risk groups, namely CSWs and IDUs, in late 2001 the Government resolved to send all 100,000 registered drug users to the compulsory drug treatment centres for two years. The occurrence of high risk behaviours including unprotected sexual intercourse in these settings is presumed. The UNODC RC executed project on ‘Reducing HIV Vulnerability from Drug Abuse’ (RAS/G22) currently supports the undertaking of a rapid assessment on HIV/AIDS related high risk behaviours in the ‘05-06’ centres.

**Prison or custodial settings reform:**

In March 2003, the Prime Minister instructed the Public Security Ministry to upgrade prisons and detention facilities. No apparent improvement has been observed, lack of food and medical care has continued (Human Rights Watch 2003:6).

**International support:**

The Global Fund to Fight AIDS, Tuberculosis and Malaria approved US$10 million for a two-year project for strengthening care, counselling and support to people living with HIV/AIDS, and related community services.

**Major problems:**

No information was reported.

**Health care:**

No information was reported.

**Health conditions in prisons:**

No information was reported.

**Results of the project survey:**

No response was received.
ANNEX I

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- UNODC, 
  <www.unodc.org>
- UNODC Regional Centre for the East Asia and the Pacific, 
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- United Nations Reference Group, Imperial College, London, 
  <http://www.idurefgroup.org>
- WHO Health in Prison Project, 
  <http://www.hipp-europe.org>
- WHO, 
  <http://www.who.org>
**BACKGROUND**

The rates of HIV infection among inmates of prisons and other detention centres in many countries are significantly higher than those in the general population. Examples include countries in Western and Eastern Europe, Africa, Latin America and Asia. The available data on HIV infection rates in prisons cover inmates who were infected outside the institutions before imprisonment and persons who were infected inside the institutions through the sharing of contaminated injection equipment or through unprotected sex. Certain populations that are highly vulnerable to HIV infection have a heightened probability of incarceration because of their involvement in behaviours such as drug use and sex work.

**PREVENTION PROGRAMMES IN PRISONS**

In 1993 WHO issued guidelines on HIV infection and AIDS in prisons [1].

They included the following paragraphs. “All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.”

“Drug-dependent prisoners should be encouraged to enrol in drug treatment programmes while in prison, with adequate protection of their confidentiality. Such programmes should include information on the treatment of drug dependency and on the risks associated with different methods of drug use. Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons.”

“In countries where bleach is available to injecting drug users in the community, diluted bleach or another effective viricidal agent, together with specific detailed instructions on cleaning injecting equipment, should be made available in prisons housing injecting drug users or where tattooing or skin piercing occurs. In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.”

Since the early 1990s, various countries have introduced prevention programmes in prisons. Such programmes usually include education on HIV/AIDS, voluntary testing and counselling, the distribution of condoms, bleach, needles and syringes, and substitution therapy for injecting
drug users. In 1991, 16 of 52 criminal justice systems surveyed in Europe had made bleach available, and by 1997 about 50 per cent had done so. Various countries provide clean needles and syringes to inmates and implement substitution treatment. However, many of these programmes are small in scale and restricted to a few prisons. None of the countries where evaluations of such programmes have been carried out have reversed their policies.

**EVIDENCE**

Four elements of prevention programmes in prisons have been studied extensively: the provision of bleach for cleaning needles and syringes; needle and syringe programmes; methadone maintenance treatment; and the provision of condoms.

Although many countries make **bleach** available to injecting drug users in prisons, inmates do not consistently use it before they inject. Studies showed that between 4 per cent and 85 per cent of prisoners always used bleach to clean their injection equipment and that some inmates used inappropriate methods to clean needles and syringes.

Programmes providing **clean needles and syringes in prisons** were satisfactory in all studies reported. Usually, clean injection equipment was provided by prison health personnel or through automatic distribution machines. Drug consumption by inmates participating in such programmes was stable or decreased over time. Reported sharing of needles and syringes declined dramatically and was virtually non-existent at the conclusion of most pilot studies. No cases of inmates acquiring HIV, hepatitis B or hepatitis C were reported in any prison with a functioning needle and syringe programme. No serious unintended negative consequences were reported. There were no reported instances of initiation of injecting by inmates who did not inject before the introduction of a programme. The use of needles or syringes as weapons was not reported, contrary to what had been feared. Staff attitudes were generally positive but response rates in surveys varied [2].

**Substitution treatment programmes** in prisons are relatively easy to carry out and appear to have benefited drug-dependent inmates. By 1992 more than 10 countries had established such programmes [3, 4]. They reported a reduced frequency of illicit drug use in prison and reduced involvement in the prison drug trade. The literature also indicates that methadone maintenance reduces the frequency of injecting among drug-dependent inmates. Significantly fewer injections per week were reported than in injecting drug users not participating in a methadone programme. Self-reported syringe sharing was also lower among those receiving methadone in comparison with a control group, indicating a significant reduction in the risk of HIV transmission. Various other drug-dependence treatment modalities are being implemented in prison settings, including therapeutic community methods and group counselling. Evaluations of such programmes have also yielded promising results with respect to high-risk behaviour among drug-dependent inmates [5].

Where **condoms** are made available in prisons, this usually involves the use of automatic distribution machines. The evaluation of such programmes indicated that inmates use the machines. Studies have revealed low levels of harassment of users of the machines by other inmates and few incidents of improper condom disposal. The reported level of safer sex was high among those who had sex and there was no evidence of any unintended consequences as a result of condoms being available. Most of the data on HIV prevention in prisons have been collected in developed countries, and are, strictly speaking, only valid for the countries where they were obtained. However, there is no evidence indicating that interventions implemented
in developing countries or in countries with economies in transition would yield different results. Interventions would have to be adapted to the specific cultural circumstances of each country in which they were implemented.

**POLICY AND PROGRAMMING IMPLICATIONS**

The prevention of HIV transmission in prisons is mostly hampered by the denial of governments of the existence of injecting drug use and sexual intercourse in prisons, rather than by a lack of evidence that key interventions work. There is ample evidence that drug use in general, injecting drug use in particular and sexual intercourse between inmates are widespread in such institutions. Furthermore, there are data indicating that the risk of HIV infection in prisons is usually higher than in the general community: prisons are a high-risk environment for HIV infection. Once this has been accepted, governments have a wide range of programme options for preventing HIV transmission in prisons.

The evidence shows that such programmes should include all the measures against HIV transmission which are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment. All these interventions have proved effective in reducing the risk of HIV transmission in prisons. They have also been shown to have no unintended negative consequences. The available scientific evidence suggests that such interventions can be reliably expanded from pilot projects to nationwide programmes.

For further information, contact: World Health Organization, Department of HIV/AIDS, 20, avenue Appia CH-1211 Geneva 27 Switzerland, E-mail: hiv-aids@who.int, http://www.who.int/hiv/en.


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Letter sent to gather information from the National Focal Points

RE: DESK REVIEW FOR REGIONAL PROJECT ON HIV/AIDS PREVENTION & CARE IN CLOSED SETTINGS IN THE MOU COUNTRIES

Dear Colleagues,

In view of the beginning of UNODC regional project on ‘Strengthening comprehensive HIV/AIDS prevention and care for drug abusers in custodial and community settings’ (AD/RAS/I09), a desk review of the current HIV/AIDS situation in prison-like settings is necessary.

The review will cover the six MOU countries and will attempt to provide a review of HIV/AIDS in:

- Prisons
- Juvenile detention centres
- Compulsory drug treatment centres (especially for Viet Nam and China)

You are very kindly invited to send whatever contact, study, paper, comments, assessment, opportunity for interviews, etc. to this e-mail Sonia.BEZZICCHERI@unodc.org and cc: Sujitra.SAMNGAMNOI@unodc.org at your convenience and preferably no later than 1 November 2004 if feasible. Please also pass this note to anyone who could contribute.

The review is to provide a summary of the situation on HIV/AIDS in closed settings in China, Cambodia, Lao PDR, Myanmar, Thailand and Viet Nam, and an important chance to advocate the social needs associated with such situation in the region.

Thank you very much in advance for your attention to this matter; your insight is appreciated.

With best regards, Sonia Bezziccheri
Questionnaire for the UNODC Regional Centre executed Project on ‘Strengthening comprehensive HIV/AIDS prevention and care for drug abusers in custodial and community settings’ (AD/RAS/05/I09)

HIV/AIDS in Custodial Settings

Strengthening Comprehensive HIV/AIDS Prevention and Care among Drug Users and in Prison Settings (AD/RAS/I09)

Survey to be distributed to country coordinator as prepared by UNODC Regional Centre

Dear Colleagues,

In view of the beginning of UNODC project to strengthen comprehensive HIV/AIDS prevention and care among drug users in prison settings, including prisons, juvenile detention centres and compulsory drug treatment and rehabilitation centres, UNODC Regional Centre wishes to gather preliminary information to influence the direction of the project’s future activities. The immediate objective of the project, run over a two year period, will be to increase the capacity of government agencies responsible for public security, compulsory drug abuse treatment and rehabilitation, and correctional services to reduce HIV vulnerability from harmful drug abuse.

In this regard, UNODC is conducting a survey that will provide a regional overview of what is known on HIV/AIDS prevalence in custodial settings. The results of such a survey will be used for the preparation of a background document to facilitate a better understanding of the regional and national issues as well as the challenges around comprehensive HIV prevention and drug abuse in custodial settings in order to appropriately assist countries.

With this objective, UNODC Regional Centre would like to ask you to answer the following questions about custodial settings in your country.

As provider of such information, UNODC Regional Centre is pleased to invite you (or your nominee for this project) to present the results of the survey for your country to a major advocacy campaign event whose date and venue will be communicated in due course.
Your cooperation on this survey is much appreciated in anticipation of future activities to improve access to health services and HIV/AIDS comprehensive prevention in custodial settings.

Please fax the responses to: Ms Sujitra SAMNGAMNOI at +66 2 288-3040/
Tel: +66 2 288-2620/E-mail: Sujitra.Samngamnoi@unodc.org for any inquiry about sending your responses.

Please contact Sonia Bezziccheri if you have any questions at:
Tel: +66 2 288-2099/Fax: +66 2 288-3040/E-mail: Sonia.Bezziccheri@unodc.org

UNODC Regional Centre for East Asia and the Pacific

Definition of Custodial Settings: A custodial setting includes any site where adult prisoners, juvenile criminals and/or drug abusers are locked in for a determined period of time without the possibility of free exit. Defined as such, ‘custodial settings’ include prisons, juvenile detention centres and compulsory drug abuse treatment and rehabilitation centres.

Section 1:

<table>
<thead>
<tr>
<th>Country........................</th>
<th>2004</th>
<th>2005 (if any change occurred)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prisons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of prisoners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of remand prisons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of prisoners in remand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of youth detention centres</td>
<td></td>
<td></td>
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<tr>
<td>Number of youth detainees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of women prisons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of women prisoners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of compulsory drug abuse treatment centres</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clients in compulsory drug treatment centres</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of custodial settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Official capacity for custodial settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population in custodial settings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2:

1. Is there a government policy for health in custodial settings? .................
   a. If yes, please attach a copy of the policy and specify the programmes that support it. .................
   b. Does the implementation and support of the above policy/programmes include the participation of NGOs – Non-Governmental Organisations?
      □ Yes
      □ No
   c. If “Yes”, please name the NGOs, the services that they provide and the custodial setting where they work. (See table):

<table>
<thead>
<tr>
<th>Name of NGOs</th>
<th>Services provided</th>
<th>Name of the custodial setting where they work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Which department or ministry has responsibility for managing the health of people in custodial settings? .................

3. If applicable, please provide the approximate number of health workers in custodial settings. (See table):

<table>
<thead>
<tr>
<th>Custodial Settings</th>
<th>Number of doctors</th>
<th>Number of nurses</th>
<th>Number of primary health care providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisons</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Remand prisons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth detention centres</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women prisons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compulsory drug abuse treatment centres</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Does the government recognise HIV/AIDS in custodial settings as a major health issue?

☐ Yes
☐ No

a. If “yes”, what does the government believe are the major risk behaviours for the transmission of HIV/AIDS inside custodial settings?

☐ MSM
☐ Tattoos
☐ Blood splatters (violence)
☐ Injecting drug use/drug use
☐ Others, please specify …………..

5. What is the approximate and most recent total national budget for the prevention and treatment of HIV/AIDS in your county? (Please specify to which year this budget refers: 2004 or 2005?) ……………

a. What is the most recent national budget devoted to health services in custodial settings? ……………

b. Within the above budget (a), how much is devoted to HIV/AIDS? ……………

b.1. What programmes does this funding provide in custodial settings?

………………
………………

c. Within the above budget (a) how much is devoted to drug abuse treatment?

………………

c.1. What programmes does this funding provide for in custodial settings?

………………
………………

Section 3:

6. Please tell us how many people are in custodial settings for drug offences; are known to be HIV positive; have hepatitis C; and have died in 2004 (or the most recent available year; please specify)? (See table):

<table>
<thead>
<tr>
<th>Custodial Settings</th>
<th>Number of people in custody for drug offences</th>
<th>Number of known HIV positive cases</th>
<th>Number of people infected with hepatitis C</th>
<th>Number that have died in 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisons</td>
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<td>Remand prisons</td>
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<tr>
<td>Youth detention centres</td>
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<td></td>
</tr>
<tr>
<td>Women prisons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compulsory drug abuse treatment centres</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
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</tbody>
</table>
7. If applicable, within the people that are in custodial settings for drug offences, please tell us how many are in for: drug trafficking, production, possession and use for the year 2004 (or the most recent year, please specify). (See table)*:

<table>
<thead>
<tr>
<th>Custodial Settings</th>
<th>Number of cases for drug trafficking</th>
<th>Number of cases for drug production</th>
<th>Number of cases for drug possession</th>
<th>Number of cases for drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisons</td>
<td></td>
<td></td>
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<tr>
<td>Remand prisons</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth detention centres</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Women prisons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Multiple responses possible

Section 4:

8. What do the relevant authorities consider to be the major health concerns and therefore health priorities in custodial settings? .................
   a. What does the prison health staff consider to be the major health concerns and therefore priorities? .................
   b. If applicable, what do the people in custody consider to be the major health concern/s? .................

9. What is the most common cause of death among people in custodial settings?
   .................

10. What is the most common cause of disease among people in custodial settings?
    .................

11. When someone enters a custodial setting, could you describe if any, the basic health checks/assessments that are conducted?
   a. Are people assessed for mental health problems? .................
   b. Are people assessed for drug dependence? .................
   c. From the following health care services, please choose those that are provided:
      - Induction
      - Assessment
      - Basic health care (including access to condom and sterile injecting equipment)
      - Health care referral (including specialised department for women)
      - Other (please describe): .................
   d. Drug abuse treatment
      - Assessment
      - Education, information and communication material, and distribution
      - Drug Counselling (Individual)/Therapeutic community
Substitution drug therapy; e.g. Methadone
Rehabilitation
Follow up after release
Pre release medical checks, advise, treatments, referrals
Other (please describe): ……………

e. HIV/AIDS prevention and care

VCT
EIC material, and appropriate distribution
Treatment and Care (including ARV provision)
Peer support groups; group/individual counselling
Early release for most advanced AIDS cases
Other (please describe): ……………

Section 5:

12. What is the involvement of People Living with HIV/AIDS (PLWHA) or drug users or drug counsellors in the provision of specialised health care services in custodial settings? (Please specify):

PLWHA; if yes please explain: ……………
……………………

Drug users; if yes please explain: ……………
……………………

Drug counsellors; if yes please explain: ……………
……………………

13. Could you please describe any training programmes on HIV/AIDS prevention and care which all staff in custodial settings may undergo before active duty?

……………………
……………………
……………………

a. Could you please describe any training programmes on management of drug abuse treatment which all staff in custodial settings may undergo before active duty?

……………………
……………………
……………………

14. How could a training programme for HIV/AIDS prevention and care for a) health workers, b) guards, best be structured. (Please explain and specify):

a. Health workers: ……………
……………………

b. Guards: ……………
……………………
15. Could you describe the training needs of health workers and guards which may be most useful with regards to HIV/AIDS prevention and care and drug abuse treatment? (Please explain and specify):
   a. Health workers: ……………
      ……………
   b. Guards: ……………
      ……………

16. What do you think are the main barriers to HIV/AIDS prevention and care programmes in custodial settings? (Please explain):
    ……………
    ……………

17. What kind of Information, Education and Communication (IEC) materials would be most important in improving health among people in custodial settings, (i.e. information about the ways HIV is transmitted and ways to reduce it, e.g. harm reduction information about needle and injecting equipment sharing? (Please explain):
    ……………
    ……………
    ……………

18. Could you please provide viable solutions on the management needs in order to provide HIV/AIDS prevention and care in custodial settings in your country?
    ……………
    ……………

19. Please provide any relevant documentation related to the above questions (e.g. in the form of specific assessments, studies, survey, etc.)

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Paper by Bezziccheri S 2005, ‘Scale up responses or scale up the epidemics? A summary of the opinion of experts on the concentrated HIV/AIDS epidemic among injecting drug users in Asia and the Pacific’, presented at the Drugs and Development Symposium, Australian National University, Canberra, Australia, 15-17 August 2005

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Scale up responses or scale up the epidemics?*

Introduction

In 2004, Asia was home to 3.3 million injecting drug users (IDUs) and 8.2 million people with HIV and AIDS, while over half a million people in Asia died of AIDS-related complications. More than one million new infections – accounting for 24 per cent of new infections worldwide – are contracted in Asia each year, and this rate is likely to increase. Worldwide, five to ten per cent of infections are due to injecting drug use (IDU) through sharing of needles and syringes, and commercial and non-commercial sexual contact. In Asia, however, IDU is responsible for 20-30 per cent of new HIV infections. In Thailand, for example, IDU accounts for 20 per cent of new HIV cases, while in Myanmar IDU contributes to 30 per cent (Aceijas et al. 2004).2

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

However, only five per cent of IDUs in Asia have access to HIV prevention services. In South East Asia, only around one per cent can access such services. Often facing double public stigma for both HIV and drug addiction, IDUs are usually not considered part of mainstream society. Heavy crackdowns by police around the region have intensified users’ marginalisation through fear of arrest and harassment.
Most regional authorities understand the importance of intensifying HIV prevention and access to treatment to curb the disastrous effects of the disease. The issue is addressed at various levels of governance including the economy and social stability. However, commitments made by governments still require much to be honoured in practise to have any real impact on the course of the concentrated epidemics in Asia. And if there is no concrete impact, the HIV epidemics will continue to scale up.

**Overview**

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

Despite successful 100 per cent condom campaigns that considerably slowed the epidemic in the 1990s, Cambodia and Thailand face a threat of a resurgence of cases due to complacency regarding prevention as well as an underlying disregard for targeting specific populations such as injecting and other drug users. Thailand is a case in point. An acclaimed best practice model for past efforts, the country still reports about 50 per cent HIV prevalence among its IDU population.
In Cambodia, sentinel surveillance results showed 1.9 per cent HIV prevalence among its adult population in 2003. At the same time, the country is also experiencing a steep increase in drug abuse, particularly amphetamine-type stimulants (ATS) and injecting of heroin. In 2004, nearly one million ATS pills were seized here, a fourfold increase from 2003. Furthermore, IDU is rising and sharing of needles and syringes is common practice among IDUs (UNODC et al. 2005). High HIV risk is also associated with heightened sexual drive caused by ATS use. For example, 40 per cent of illicit drug users reported irregular use of condoms or none at all when engaging in sex under the influence of drugs. They also reported that they were selling blood for money to buy drugs. A recent report by NGO Mith Samlanh/Friends (2004) shows that HIV among drug users in Cambodia is rising.

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

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

The lucky ones

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

Sex and drugs: China, Indonesia and Viet Nam

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

In China, reports show unsafe injecting is common practice among IDUs who also have multiple partners, and often buy and sell sex without a condom. In 2002, HIV was found among drug users in all 31 provinces; in 2001, 70 per cent of HIV infections were observed among IDUs. Compared to other countries in the region, the Government has reacted relatively urgently through a national multi-sectoral task force comprised of various ministries at decision-making levels, formalised under the prime minister. As a result, 34 methadone maintenance clinics and 50 needle and syringe programmes were set up nationwide following
preliminary pilot programmes. The Government plans to have 100 such clinics and 130 needle and syringe programmes by the end of 2005; and in the next three years it will have scaled up such programmes to 1,500 methadone maintenance clinics and 1,400 needle and syringe programmes nationwide.

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

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

Breakthroughs

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

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

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

In Malaysia, the government realised punishing and locking up drug dependents was not constructive, neither for the users nor for the state, after HIV rates increased – estimates indicated that 75 per cent of infections were attributed to IDU. Subsequently, the Government, under pressure from NGOs, adopted a health approach and gradually introduced the comprehensive package to HIV prevention from drug abuse. In 2003, after pilot methadone and buprenorphine programmes showed good results, the Government provided US$10.3 million of support to scale up interventions. An additional US$1.5 million was allocated to NGOs last year to continue such activities.
Similarly in Bangladesh, there exists a striking association between adherence to needle and syringe programmes and a decrease in needle sharing, as well as an increase in reporting and seeking treatment for STI. In three rounds of serological surveillance carried out at the needle and syringe programmes sites in 1999-2000, not one of more than 400 IDUs tested positive for HIV (MAP 2005:11). These results show Bangladesh has successfully responded to the concentrated epidemics, due in part to pressure from NGOs. If the Government had stood by idly, HIV prevalence could have reached ten per cent among sex workers and two per cent among their clients in 2005, considerably higher than the one per cent currently reported in each group.

Understanding injecting drug users

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

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

Illicit drug use in most Asian countries is criminalised. As a consequence, a large number of IDUs can be found in confined settings including juvenile and adult prisons, where drug users can comprise half the population. High risk behaviour – rape, violence, injecting drug use, tattooing, men who have unprotected sex with men – in such settings is well documented and a source of international concern. UNODC estimates 10 million prisoners worldwide, while the annual prison turnover is about 30 million individuals a year.

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

Risk of HIV infection is often not an overwhelming concern of IDUs, who perceive that they face other more immediate life threatening situations on the street. This may help explain why in Kathmandu Valley, Nepal, 37 per cent of male drug injectors acquired HIV in one year or less of their injecting career, while 70 per cent become HIV positive within two to five years. By the time users have injected for five or more years, it is estimated that 81 per cent will be infected with the HIV virus. In ‘high-prevalence settings, drug injectors need to adopt very high levels of safe injecting practices right from the start of their injecting careers if they are to be confident of avoiding infection’ (MAP 2005:7).
Yet what real incentives and chances do drug users, or for that matter, vulnerable people, have to protect themselves against HIV when they are the prey of structural disadvantages stemming from in-egalitarian societies? As President of the AIDS Society of Asia and the Pacific Dennis Altman (2005) said at a recent conference:

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

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

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

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

Money talks, or does it?

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

Then there is the economic loss. In 2001, Asia was down an estimated US$7.3 billion through productivity losses as a result of the epidemic. If Asia simultaneously brings HIV treatment and prevention to scale as soon as possible, the region could save annual AIDS-related costs of US$4 billion by 2010, and over US$10 billion by 2015 (ADB and UNAIDS 2005:1). Notwithstanding donors’ increased pledges from US$300 million in 1996 to US$6.1 billion in 2004, Asian nations must show intent and willingness to address the epidemic in order to gain much-needed confidence from donors.

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

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

Removal of the causes of stigma and discrimination and of human rights violations of drug dependent people is essential. The 2005 UNAIDS policy paper places respect for human rights at the top of the list of both the Principles of Effective HIV Prevention and the Essential Policy Actions for HIV Prevention. Fear of arrest and harassment by the police has been recognised as an obstacle for effective HIV prevention for IDUs. Police should be trained in public health approaches and encouraged to view drug addiction as a mental and physical condition that needs medical care and appropriate ‘structural interventions’.

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

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

Undoubtedly, what needs to be done is widely known.

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

Notes

* This is an internal document of the UNODC Regional Centre for East Asia and the Pacific. The views expressed in this paper are those of the author and do not necessarily reflect the views of the United Nations and UNODC. The designations employed and presentation of the material in this work do not imply the expression of any opinion whatsoever on the part of UNODC concerning the legal status of any country, territory, city or area of its authorities, or concerning the delimitation of its frontiers and boundaries. Quoted statistics are not UNODC based.
1. This paper has been written by Sonia Bezziccheri, UNODC. Burkhard Dammann, UNODC, and Swarup Sarkar, UNAIDS, have provided advice on and revisions of the paper.

2. This data is from the United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries, which seeks to advise on the international epidemiology of HIV transmission associated with IDU and on effective HIV prevention and care interventions targeting IDU. The Reference Group is steered by UNAIDS, WHO and UNODC. Its objective is to enhance an evidence-based approach to HIV prevention among IDU. The Secretariat team of the Reference Group is based at The Centre for Research on Drugs and Health Behaviour in the Department of Social Science and Medicine, Imperial College London. Background papers can be accessed at http://www.idurefgroup.org.

3. At the same time, the global attention to AIDS treatment has caused some neglect of HIV prevention, a problem which can be addressed best if HIV treatment and prevention are recognised as equally important and supportive of each other and their synergies are harnessed programmatically, in policy as well as in advocacy (UNAIDS 2005c).

References


UNAIDS 2005d, *Global Task Team on improving AIDS coordination among multilateral institutions and international donors*, final report, 14 June, Geneva.