

HARM REDUCTION POLICIES AND INTERVENTIONS FOR INJECTION DRUG USERS IN THAILAND



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THE WORLD BANK GROUP



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1.0 BACKGROUND

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Thailand has received international recognition for its successful interventions to reduce the transmission of HIV among female sex workers and military recruits^{1,2}. It is looked upon as a role model for HIV education and awareness campaigns that include the extensive promotion and wide acceptance of condoms as an HIV prevention strategy³. Thailand has the most progressive and comprehensive antiretroviral program in the region with a reported coverage of over 80% of eligible individuals⁴. In 2001, it embarked on a progressive universal health care program that provides free access to a wide array of health care diagnostics and therapeutics for the people of Thailand⁵. With these impressive achievements, it is remarkable how poorly Thailand has responded to the HIV epidemic among injection drug users (IDUs). From available data, it appears that the HIV prevalence rates among IDUs have remained high and stagnant over the last decade⁶. Failure to provide effective interventions to reduce HIV transmission among drug users has resulted in unnecessary suffering, and for many, HIV-related death. Continued inaction threatens to undermine successful HIV prevention efforts in the country through ongoing HIV transmission among injection drug users and their sexual partners.

At the root of this failure has been the pursuit of an aggressive drug enforcement policy to reduce drug supply and provide “compulsory treatment” to illicit drug users. This “abstinence-at-any-cost” approach has effectively silenced repeated calls to provide effective interventions that could actually reduce HIV transmission, improve health outcomes, and engage drug users into effective treatment and recovery programs. It is concerning that the 2008 Annual Report from the Office of the Narcotics Control Board (ONCB) does not mention HIV or draws any distinction between injection drug use and other forms of illegal drugs⁷. Although governments around the world have pursued law enforcement strategies, Thailand’s 2002 “war on drugs” will go down as one of the most regressive and repressive responses to drug use ever attempted at a national level⁸. While no longer official government policy, the harassment and brutal enforcement practices aimed at illicit drug users persist⁹. Not only are these approaches ineffective in reducing the use of drugs, they serve to deepen the isolation of drug users and severely limit programs that can prevent HIV transmission.

The increase in the production and use of Amphetamine-Type-Stimulant (ATS) drugs in Thailand, and throughout South East Asia, has driven drug policy in recent years. Following decades of poppy eradication and crop substitution programs throughout the Golden Triangle, along with very aggressive enforcement policies, the supply of heroin has been greatly reduced. However, one of the unintended consequences of this “success” has been the emergence of other psychoactive drugs, most notably ATS. These substances include “crystal meth” or methylamphetamine hydrochloride (“ice”, “glass”, “yaba”, “crazy medicine”), amphetamines, and 3,4-

¹ There is a linkage between this report and the 2010 report *Revitalizing HIV Prevention in Thailand: A Critical Assessment*, which was prepared under the Country Development Partnership in Health (CDP-H), a joint partnership between the Ministry of Public Health and the World Bank. The work examines the changing pattern of HIV infections in Thailand. It reconfirmed injecting drug users as a key population most at risk of contracting HIV. The study assesses the effectiveness as well as cost-effectiveness of the current HIV prevention program, and identified mismatches, recommending policies to help public health officials reorient prevention efforts and to sustain the strengths and minimize the programmatic and financial deficiencies.

methylenedioxymethamphetamine (MDMA, ecstasy)¹⁰. As a result, the drug control and treatment paradigm has become focused almost exclusively on ATS. The people of Thailand have been told by the media and the government that ATS use is a national threat that must be aggressively confronted. There is a widely held belief that ATS use among young people is rampant and could produce a new wave of HIV infections. The proposed route of HIV transmission is through unsafe sexual practices that occur through heightened sexual risk taking under the influence of stimulant drugs. Although the use of drugs and unsafe sex are very legitimate concerns that require innovative public health interventions, there is no evidence that there is an ongoing HIV epidemic among the general youth population of Thailand. This is despite the high prevalence of ATS use that has been reported for well over a decade. Further, although the injection of ATS may occur in a small proportion of users, the drugs are primarily taken in pill form or inhaled, with little or no risk of HIV transmission through these routes of administration. The preoccupation with ATS has diverted attention and resources away from the most vulnerable injection drug users. The groups at most risk for HIV infection have always been the poly-drug users who continue to inject, inhale, and ingest a range of illegal drugs, including heroin¹¹. These drug users have largely been driven “underground” due to a lack of services and the ongoing threat of incarceration and/or compulsory treatment programs that do not offer any real opportunities to successfully address addiction. This is the very population that continues to be infected with HIV and who require harm reduction interventions.

The future trajectory of the HIV epidemic in Thailand rests largely on the response to HIV transmission among IDUs. Although valuable time has past and many preventable HIV infections have occurred, the environment in Thailand may be improving. The future policies set out by the ONCB, the Ministry of Public Health (MoPH), and the Ministry of Justice are critical to leading reforms that could go a long way to improving the response to illicit drug use in Thailand. If just some of the fierce determination and massive resources that are currently used to “eradicate” drug use were channeled into proven HIV prevention interventions and effective addictions treatment, Thailand could lead the region in HIV control. A wide-range of stakeholders have voiced an openness to harm reduction strategies and this is a pivotal time to implement, scale-up, and evaluate efforts to reduce HIV transmission among IDUs. The past successes among sex workers should be used to educate and persuade policy makers that the spread of HIV among drug users can be stopped, even if illicit drug use cannot be.

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2.0 MISSION OBJECTIVES

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The World Bank initiated a review of HIV prevention among injection drug users in Thailand, with the objective of providing technical assistance to strengthen national capacity to develop state-of-the-art injecting drug use harm reduction interventions. This was to include assistance in developing effective needle-syringe programs, opiate substitution therapy, and antiretroviral treatment services. There have been numerous professional reports and comprehensive HIV prevention guidelines produced over the past decade that offer ways to address regional issues around HIV prevention, care, and treatment for injection drug users. It is recognized that the failure to act upon previous recommendations and support key stakeholders will not be reversed by yet another report. However, it is the intention of this mission to conduct a rapid situational assessment and provide specific recommendations in the areas that require urgent attention, in order to reduce the transmission of HIV among current and former injection drug users in Thailand. The specific details of how to develop, implement, scale-up and monitor harm reduction programs are beyond the scope of this report, but can be found in a number of excellent documents that are referenced. Thailand has a well-developed public health care infrastructure run by a motivated and a highly trained group of health care professionals. In addition, there are well placed NGOs, community organizations, and committed international agencies that can provide the expertise and capacity to implement harm reduction programs if supported to do so through the leadership of key government institutions.

²The mission was conducted during 18 January to 5 February 2010.

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3.0 REDUCING HIV TRANSMISSION AMONG INJECTION DRUG USERS

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The ongoing HIV epidemic among injection drug users in Thailand can be greatly reduced with the knowledge and strategies that are currently available. Unfortunately, there continues to be confusion and misinformation around the term “harm reduction”, and this has been very detrimental to implementing programs that could really make a difference. This has persisted despite over two decades of harm reduction initiatives around the world and numerous reports and position papers in support of harm reduction programs – some specifically developed for Thailand. It is important to work with a common definition of harm reduction. Most simply, harm reduction is a very practical response to drug use for those people who are unable or unwilling to stop using drugs. The immediate objective is to limit the adverse health consequences of such use and to prevent the transmission of blood borne infections such as HIV and Hepatitis B/C¹².

Although most of the key stakeholders can agree with this definition and support the basic concept of reducing HIV transmission, there are still some serious misconceptions that were expressed by some of the key decision makers. It should be clear that proponents of harm reduction: i) do not endorse or promote the use of illicit drugs; ii) do not make it easier for people to initiate illicit drug use; iii) do not promote drug injecting by providing needles/syringes; and iv) do not oppose abstinence from illicit drug use – in fact that should be the ultimate goal. It must also be understood that harm reduction strategies should be promoted in all environments where injection drug use is found. An ATS epidemic, for example, is not a reason to dismiss harm reduction interventions because there is no proven drug substitution therapy. In fact, in the environments where stimulant use and other patterns of injection drug use predominate, other harm reduction interventions become even more important.

Debates around the effectiveness of harm reduction interventions continue in many countries and Thailand is no exception. These debates are based mainly along ideological lines, as the actual evidence regarding the effectiveness of harm reduction is overwhelming. It is beyond the scope of this report to provide a critique of the studies that support each intervention, however there have been literally thousands of articles published that show the positive impact of harm reduction interventions. These studies, along with many “natural experiments” within cities, show that HIV transmission can be successfully prevented when drug users are offered strategies to avoid HIV exposure¹³. Although the prevention of HIV and Hepatitis C transmission is the driving force behind these interventions, there are many other health related benefits that have implications for both the drug users themselves and society at large.

Harm reduction should be thought of as a continuum of care - from engagement to abstinence. It must be recognized that some people will never progress through this continuum and make it all the way to abstinence, despite access to harm reduction interventions, state-of-the-art drug treatment, and long-term recovery programs. However,

it should also be recognized that without engagement, people who are dependent on illicit drugs would never have the opportunity to become abstinent.

The following strategies are recommended as part of a harm reduction continuum, and together make up a comprehensive approach to reducing HIV transmission among IDUs. Although the actual strategies proposed are not unique, the recommendations and priorities are designed to address some of the specific challenges facing injection drug users and health care providers in Thailand that were observed during the mission.

3.1 NEEDLE AND SYRINGE PROGRAMS (NSP)



Although a comprehensive “tool-box” of prevention strategies is important, needle and syringe programs (NSP) are at the corner stone of harm reduction interventions. It is an evidence-based intervention that is absolutely necessary for reducing HIV transmission among IDUs. Outside of a few small community-led projects that supply needles, there remains a critical lack of clean injection equipment available to drug users in Thailand. In fact, even among community groups and health care professionals, there appears to be a reluctance to promote NSP. It should be known that even in countries where NSP are well established, and proven to be effective, critics of the programs persist. There is nothing particularly unique about the drug use situation in Thailand that would prevent a rapid scale-up of NSP.

A major concern among opponents to NSP is that by supplying needles to drug users there will be an increase in drug use, and that the availability of needles may even lead to injection drug use among people using drugs through other routes of administration. There are a number of reasons that people may choose to inject drugs, but the availability of injection equipment does not factor into it. The primary motivation for the drug dependent individual is to use the psychoactive drugs to get “high” and/or to avoid withdrawal symptoms, and the use is not driven by the availability of clean injection equipment. There have been many studies and reviews that have consistently shown that there is no increase in drug use or the number of drug users in communities where NSP’s have been established¹⁴. People

around the world inject drugs in the most precarious of circumstances and knowingly take serious risks with contaminated equipment. Given the opportunity to use clean injection equipment however, drug users will readily accept a clean alternative.

Another concern is that drug users will simply discard the dirty needles in public places and this could pose an HIV infection risk to the general public through inadvertent needle stick injury. Although there is a theoretical risk of HIV transmission by this type of exposure, it is extremely remote due to the minimal amount of blood that is involved. In fact, there has never been a published case of HIV infection occurring through accidental community exposure. It has also been found that IDUs will safely dispose of used needles if given the proper facilities and opportunities to do this. Plastic disposal containers should be widely available as part of an NSP. Needle and syringe programs should not be delayed because of concerns around litter or the theoretical threat of accidental HIV infection to the general public.

One of the most important impacts of NSP is the connection to drug users who are otherwise difficult to contact. Within the current environment in Thailand, there is very little reason to come forward for addiction-related services, when the prospect for compulsory treatment and/or imprisonment is the likely outcome. The provision of clean needles and syringes are an excellent way to engage drug users in services that could ultimately lead to social engagement, addiction treatment, and the reduction or elimination of drug use. NSP programs should be low threshold without restrictions on the number of needles, or expectations that the participants in these programs will agree to stop using drugs. Limits to the number of needles have been shown to reduce the effectiveness of NSP and strict one-to-one exchanges reduce program effectiveness. Ideally the programs should be collaborative between health care professionals and community workers who can provide supports that are at the level of the drug users. Following initial engagement, it is reasonable to provide a graduated program that may include addiction treatment services, such as OST and drug detoxification, but the time line for this must be made on a case-by-case basis. Many people who are engaged in harm reduction programs will take months or even years to get to a place where abstinence from illicit drug use is realistic. In the meantime, NSP can effectively prevent HIV transmission among those not infected. Further, the impact of clean needles and syringes are extremely important for individuals who are already HIV positive, so that they can prevent transmission of HIV to others, and avoid the myriad of adverse health consequences associated with injection drug use. Those who are already immunosuppressed are at a heightened risk of serious bacterial infections contracted through the use of contaminated needles and poor injection techniques.

There are a number of considerations to setting up an effective NSP. Fixed site NSPs may be appropriate for some communities but most will require an outreach component. Law enforcement can seriously limit the distribution of needles and syringes at a fixed site, merely by establishing a police presence around the NSP. Therefore, when there is an environment of heavy law enforcement, the provision of outreach NSP is particular important. Further, it is critical that both drug users and outreach workers are not harassed or arrested by police officers for carrying clean injection equipment. A number of innovative distribution strategies have been successfully launched, including vending machines,

mobile health vans, community health center programs, and pharmacy dispensing. Each community should be assessed to determine the most appropriate distribution strategy, however in most communities a variety of distribution programs are most successful. There are practical and detailed guides available for setting up the NSP. For example, *Guide to Starting and Managing Needle and Syringe Programs* (2008), produced by WHO/UNAIDS/UNODC is an excellent reference¹⁵.

It is unacceptable to delay the introduction of NSP while HIV transmission continues in Thailand. There is overwhelming evidence that NSPs reduce HIV infections that is supported by rigorous scientific studies¹⁶. Further, there have been dramatic reductions in HIV incidence where NSP has been implemented, even in communities where there is high HIV prevalence and poly-drug use. In New York City the estimated incidence of HIV among injection drug users has fallen from 4.0% per year to 0.3% per year between 1994 and 2008, mainly due to NSP and other HIV prevention programs¹⁷. In Vancouver, the incidence of HIV among injection drug users has fallen by 80% with the implementation of a needle distribution program along with a range of other prevention programs and services¹⁸.

The promotion of condoms to prevent the sexual transmission of HIV can be viewed much like the promotion of clean needles and syringes to prevent the transmission of HIV through needle sharing. Like illicit drug use, commercial sex work is an illegal activity and the harms associated with the sex trade include the transmission of HIV. It would clearly be unacceptable for governments to deny condoms to women in the sex trade, while they focused on the elimination of the sex trade industry. At some level, denying clean injection equipment to drug users is equivalent to denying condoms to sex workers – like condoms, the provision of clean needles and syringes have been shown to prevent HIV transmission. Although the elimination of sex work and injection drug use would ultimately stop HIV transmission in these groups, the continued spread of HIV must not be allowed to continue while society waits for this to happen.

Recommendations / Priorities

1. Needle distribution programs should be set up urgently. This should be a combination of strategically placed fixed NSP sites as well as distribution through peer-networks. Established community groups should be encouraged to participate and take leadership roles. Population Services International (PSI) has the mandate and resources to push NSP forward and should do so.
2. Police should be informed that possession of clean needles and syringes is not illegal in Thailand, and therefore people who are distributing the needles should not be harassed or tested for drugs. This type of activity can be used to educate the police about NSP and potentially engage the police in facilitating the use of NSP by drug users.
3. Communities who are directly impacted by the needle distribution should be informed, but there is no time to delay this program while awaiting community endorsement. It has been shown that NSP will gain acceptance by the larger community when it is shown to be effective.

4. The NSP should be a distribution program. Exchanges, where clients must return used needles in order to get new ones, are not as effective as distribution programs in preventing HIV transmission.
5. Innovative ways to safely dispose of needles and keep them out of the community should be developed. NSP should not be held up because of community concerns around “litter”. Drug users can be given plastic “sharps” containers that can be used to deposit used needles and syringes. These can be returned to a centralized drop-off for safe disposal. Larger containers can be placed in “high-traffic” areas and collected on a regular basis. In some communities peer-volunteers have been trained and equipped with equipment to go through the community and pick up any discarded needles.
6. NSP is the main strategy to reach those in need and there should be minimal barriers. These are referred to as “low-threshold” programs. For example, needles should be distributed anonymously and strict one-for-one needle exchanges should be discouraged.
7. Although NSP should be part of a comprehensive program of addiction services including OST, detoxification, and long-term rehabilitation programs, the main goal of the NSP is to prevent the transmission of HIV. Therefore the uptake of other programs should not be a requirement of those using the NSP.
8. Information should be provided to health professionals and politicians through evidence-based publications and information sessions in order to educate them on the importance of NSP to HIV prevention and encourage them to support the programs.

Measurement and Evaluation

1. The launch of any NSP should be rigorously evaluated using consistent methods and tools in order to collect reliable outcome measures that can lead to improvements in the programs and provide evidence for program effectiveness.
2. Local and National counts of the numbers of needles/syringes distributed and returned for safe disposal should be tracked through a centralized database.
3. Surveys should be conducted among drug users on a regular basis to prospectively determine obstacles to accessing clean needles/syringes.
4. Surveys should be conducted on a regular basis to track reported needle/syringe sharing in different communities in order to evaluate the impact of the NSP on the risk of HIV transmission.
5. Community sweeps should be organized to document discarded needles/syringes in public spaces and appropriate programs should be established to eliminate this.
6. Community surveys should be conducted both before and after a community NSP has been established to document concerns and track changes in community attitudes.
7. Ongoing monitoring of police activities with regards to NSP should be collected in order to prospectively document the enforcement response to the NSP.

3.2 OPIOID SUBSTITUTION THERAPY (OST)



OST is a highly effective intervention to reduce or eliminate opiate use among people who are dependent¹⁹. Historically, in Thailand, heroin has been the predominant drug injected. With input from many of the key stakeholders in Thailand, there are conflicting estimates about the actual amount of heroin use in the country. It appears that there are regional differences in heroin availability with the north and south having the most access and Bangkok having the least. Although reliable data is lacking, it appears that the general trend over the past decade is for decreasing heroin injecting, mainly due to high prices. As in other countries, the use of heroin is largely supply-driven and can have wide fluctuations in both price and availability. Whatever the actual number of heroin-dependent people turns out to be, it is known that heroin is still injected by some drug users and it would be the drug of first choice by many, if availability and price were to change.

Methadone has been legal and available in Thailand for decades but was officially approved for opiate substitution therapy in the year 2000. There are 20 methadone clinics in Bangkok, with 17 found within public health centers, 2 in regional hospitals, and one clinic as a stand-alone facility. Pharmacies are not permitted to dispense methadone, although there are some private clinics that do provide methadone. Although no official counts are available, it is estimated that less than 1000 people are receiving methadone maintenance in all of Bangkok. Although it is generally recognized by health professionals that long-term methadone maintenance treatment (MMT) is effective, there appears to be few active programs that actually provide comprehensive MMT. During visits to four of

the larger Methadone clinics, there were no consistent or standardized guidelines being followed. The two “maintenance” programs reviewed were essentially MMT “carry” programs where the methadone was given to the clients to self-administer at their homes. In all cases, the dosing appeared to inadequate to prevent withdrawal symptoms and there was a high risk for diversion and misuse. It could be argued that the programs are doing more harm than good. In one clinic, there were 23 patients on a maintenance program who picked up 350 mg of methadone on Fridays (equivalent to 50 mg per day). The clinic staff was well aware that there could be some diversion of the methadone to others and that there was also the potential for methadone injecting. The main reason for the weekly methadone distribution was the great distance that the clients had to travel to get to the clinic, and this made daily pickups extremely inconvenient. This practice of weekly methadone “carries” would not be supported by international guidelines and certainly has the potential to do harm. Stand-alone methadone clinics are not appropriate for clients who are living in more remote areas and either the clients need to move closer to the clinic, or other strategies to deliver the methadone must be established. There are clearly major resource implications for a distributing methadone to more remote locations and it may not be practical to offer MMT to people in all regions of the country.

The program at Jana Hospital was the only real daily dispensing methadone maintenance program that was visited. Again, the program was very small (under 50 clients) and the methadone dosing appeared to be inadequate for the majority of participants, leading to ongoing use of other opiates. Despite a high level of staff commitment and genuine support from the hospital leadership, there appeared to be a lack of technical know-how and resources to make the program more effective. In general, the MMT programs seemed severely under-funded and run by health care staff from other departments who had many other responsibilities in addition to the methadone program.

The clinics visited focused primarily on short-term “methadone detoxification” programs. In fact, some clinics required that clients “failed” the methadone detoxification on a number of occasions before they were considered for maintenance. In essence these methadone detoxification programs set people up for failure by providing them with low methadone dosing at the outset and then rapidly reducing the methadone dose over 15 to 60 days. Although no statistics were available, it was widely recognized by the clinic staff that there were extremely high dropout rates during these rapid methadone tapers. This would be expected, as withdrawal symptoms would occur early into the taper and there would be little reason to continue. There is no clinical evidence for the use of short-term methadone detoxification, unless it is accompanied by other treatment and support services. Even within a comprehensive treatment program, it is necessary to continue methadone for a number of months at a minimum. One of the barriers to longer-term methadone was the cost of the program. The few clients who wanted to receive MMT voluntarily, were required to pay for the programs themselves. The clients who were referred to the programs through a compulsory order could receive short-term methadone detoxification covered through government funding, but were not eligible for long-term maintenance.

The staff training at the methadone clinics was quite variable. Nursing staff ran most of the programs, and many had responsibilities in addition to the methadone program. The main training for methadone prescribing and monitoring was conducted out of the Thanyarak Institute on the outskirts of Bangkok. Although the Institute has a long history of addiction treatment programs with a large inpatient population (700 inpatient beds), at the time of the visit there were only 2 patients on methadone detoxification and essentially no outpatient methadone program. The exposure to active programs is essential to fully understand the complexity of MMT.

Other forms of OST are being evaluated in Thailand and may offer benefits over methadone maintenance for some individuals. There are currently large randomized trials being conducted using Buprenorphine and Suboxone (buprenorphine/naloxone). One of the major advantages of these alternative substitution medications is the dosing schedule. Buprenorphine is a long-acting partial mu opiate receptor agonist that does not produce the same intense “high” or dangerous side-effects as heroin. However, there are a number of countries where diverted pharmaceutical buprenorphine has been injected and resulted in high rates of overdose as well as HIV transmission²⁰. The diversion of buprenorphine and the associated harms however are largely due to inadequate programs and poor monitoring. The use of Suboxone addresses the issue of using the capsules for injection, as the naloxone component causes withdrawal symptoms. The high cost of Suboxone is currently a limiting factor for more widespread use in many countries. It is encouraging that these trials are being carried out in Thailand and this indicates a willingness to expand OST. However, in discussions around these trials it was concerning that there was no provision to supply clean needles and syringes to the trial participants.

There is global interest in pharmaceutical agents that can be used for stimulant substitution therapy. In an environment where stimulant use predominates, this is clearly a priority for Southeast Asia. Unfortunately, there are currently no stimulant substitution therapies available for clinical use and the research around this area is not particularly encouraging. Clearly, Thailand should be at the forefront of studies to assess promising pharmaceuticals that could safely replace ATS. It should be emphasized however that the prevention of HIV among people using stimulant drugs has been successful even without substitution therapy.

With the scale-up of antiretroviral treatment (ART) in Thailand, those who are working in MMT programs must be aware of possible drug interactions. As with most of the world, first-line ART consists of Nevirapine, or in some cases Efavirenz. These drugs act as inducers of specific liver enzymes that can increase the metabolism of other drugs, including methadone. Therefore, some people who are started on ART will require an increase in their methadone dosage. As there are so few people in methadone maintenance programs currently, and even fewer drug users on antiretroviral therapy, this only applies to a small number of individuals. As the OST and ART programs are expanded however, this information should be part of the training provided to methadone providers.

Although OST is a critical component to any harm reduction program, determining the prevalence of heroin dependency within a community is critical before expansion of OST can be accurately planned. Therefore, data on patterns of injection drug use is a priority in Thailand, as the paucity of data severely limits the ability to plan for OST. According to many of the health professionals consulted, heroin dependency is not common in the major cities and OST should not be a priority. However these observations are based on drug users who are presenting to OST services and there may well be large “hidden” populations of heroin users who are not accessing any services. In addition, many opioid dependent individuals are not interested in the rapid methadone tapers commonly offered, and may have already experienced failed methadone substitution. Establishing new methadone programs in Thailand and enhancing existing ones should follow internationally recognized guidelines. These programs should be sponsored by the government and offered at no cost to the participants. There are a number of published guidelines that have been developed along with comprehensive training programs. An excellent resource is the, “WHO/UNODC/UNAIDS position paper “Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention” ²¹.

Recommendations / Priorities

1. The existing methadone programs in Thailand need urgent evaluation and upgrades. Despite the best intentions and commitment of the clinic staff, the programs visited are at best ineffective and at worst harmful. International standards for methadone maintenance are not being followed in Thailand despite having methadone programs in operation for many years. There is no evidence that drug users in Thailand are exceptional in their response to methadone or that these therapeutic standards should not apply.
2. A National OST program should be established that follows international guidelines and has a central registry for participants.
3. Criteria for Opiate dependency must be established and maintained in order to identify drug users who would benefit from this intervention.
4. Voluntary OST should be provided free of charge. Although OST is actually part of a benefit package under universal coverage through the National Health Security Office, there is still a model of self-pay as part of clinic cost recovery. Charging the patients to enroll in OST programs is a major disincentive to the initiation of OST at some facilities.
5. Establishing guidelines for OST eligibility. People who are not actually dependent on opiates should not be put on substitution therapy.
6. There is no clinical evidence in support of rapid methadone tapers that essentially set heroin users up for early failure. These programs are widely promoted in Thailand and should be discouraged.
7. Police and law enforcement should not interfere with OST programs by intercepting drugs users who must visit OST providers on a daily basis.
8. OST is an excellent opportunity to engage with drug users and should be part of a comprehensive harm reduction program.
9. OST programs can provide an opportunity to extend antiretroviral therapy to those who are HIV positive and this should be considered at all OST sites.

10. A range of sites should be developed for the dispensing of OST. Clearly hospital based programs have limitations with regards to access. The wide network of smaller community based health centers already established in Thailand would serve as excellent sites for OST programs.
11. Training modules should be established to upgrade current staff on OST and associated service.

Measurement and Evaluation

1. A National registry of OST patients should be established to ensure that adequate standards of care are being maintained.
2. A database to track the number of people on methadone maintenance can be recorded along with outcomes.
3. Surveys should be conducted to assess OST needs in various regions of the country.
4. Various strategies to distribute methadone should be evaluated in the Thai context. For example, stand-alone methadone clinics, hospital-based methadone clinics, pharmacy distribution centers and out-reach delivery programs.
5. The availability of Buprenorphine and Suboxone (buprenorphine/naloxone) in Thailand provides a unique opportunity to compare and evaluate these other forms of OST. Comparative trials should be set up to evaluate the outcomes of these different substitution therapies.
6. Methadone dosing should be monitored closely in order to collect data to evaluate methadone dose with ongoing opiate use.
7. Monitoring of poly-drug use through urine screening should be developed and standardized.

3.3 HIV TESTING AND COUSLING (T&C)



There are both individual and public health imperatives to scale-up HIV testing in Thailand – especially among injection drug users. Although an acute HIV seroconversion illness may occur, the majority of newly acquired HIV infections go completely unnoticed and the diagnosis is made following the deterioration in general health or an opportunistic infection. By this time, immunosuppression is usually advanced and antiretroviral therapy may be less effective. Therefore, HIV testing needs to be widely promoted and easily accessible to people at most risk, and this includes injection drug users. It is recommended that people undergo HIV testing every 6 to 12 months if engaging in activities that could put them at risk of exposure. HIV negative tests are also very important from an individual's perspective. People with a history of injection drug use may assume that they are already HIV positive, and this can create or add to feelings of hopelessness and despair. Receiving an HIV negative test can be a real turning point for people and encourage them to reduce their drug use and/or needle sharing practices.

HIV testing is not readily available or promoted for drug users in Thailand. There are major barriers to testing from the perspective of the individual at risk for HIV infection, including the fear of prosecution and further isolation from family and friends. Another barrier is a belief among drug users that they would not be offered ART, even if they met the criteria for treatment. Linking testing to ART is critical to encourage people to undergo HIV testing.

There are also concerns that people using drugs in Thailand may be tested for HIV without adequate pre and post-test counseling, and in some cases, without their knowledge. Informed consent should always precede HIV testing and the results should be provided in person in a reasonable time frame. There must be safeguards put in place to ensure that HIV testing is kept confidential and not used by employers, governments or law enforcement to restrict activities or impose some form of punishment. As long as there is suspicion surrounding the ultimate use of HIV testing results, it will be difficult to convince drug users to be tested.

In some instances there appears to be a lack of interest on the part of health care workers in providing HIV testing under the guise of confidentiality. This was seen in some of the compulsory treatment centers where testing was not readily accessible. Ironically, in some of the centers one of the few services that required payment was HIV testing. This is unacceptable as it is essentially denying people the opportunity to receive life-saving treatment. It was also expressed by health care staff that people at risk for HIV did not want to be tested. In the right environment, including appropriate support and assurances of confidentiality, it is hard to come up with a reason for not receiving an HIV test. This should be what pre-test counseling is about.

The principles of Voluntary Counseling and Testing (VCT) are sound and should be adhered to following published guidelines²². They have been developed and implemented in order to provide consistent messaging around HIV and protect people against uninformed or secretive testing. Advances in testing technologies should also be incorporated into testing protocols. Rapid HIV tests that can be performed on “finger-prick” blood samples or saliva, can produce the results in minutes. This is a very useful way of testing people

who are not consistently engaged in care and may not return for test results that must be sent to other laboratories. The use of rapid tests require the same comprehensive pre and post test counseling strategies, but are extremely useful for obtaining quick results when an individual decides to be tested.

With free access to antiretroviral therapy and CD4 monitoring, everyone should have equal access to HIV testing. The outlook for people infected with HIV has changed dramatically over the past ten to fifteen years in countries where ART available. Developing strategies to make HIV testing more available, more informed, and more secure is critical.

Recommendations / Priorities

1. HIV testing and counseling should be widely available and promoted in Thailand – including injection drug users.
2. Campaigns directed to drug users should be developed that demystify HIV treatment and promote the benefits of knowing one's HIV status.
3. HIV testing must be secure and confidentiality respected and standardized voluntary counseling and testing programs should be followed.
4. Rapid HIV tests should be used as much as possible to optimize the opportunity to provide the test results and engage in long-term care and possible antiretroviral therapy.
5. HIV testing should be linked to ART treatment – this could be at specific treatment centers or incorporated into other health clinics.

Measurement and Evaluation

1. Surveys should be conducted among drug users to identify some of the barriers to HIV testing.
2. A database should be set up to determine the proportion of those testing HIV positive who return to pick up their test results and are subsequently followed.
3. Goals should be set and prospective databases established for HIV testing coverage – for example 90% of IDUs should be tested for HIV.
4. Goals should be set for regular testing among IDUs who have tested HIV negative in the past – for example 90% should be tested at least annually.
5. Follow-up of all HIV positive IDUs should be conducted to determine the proportion receiving ART. Goals to increase the proportion receiving ART should be established and prospectively followed.
6. Trends in HIV incidence should be monitored through the establishment of both rapid assessment and prospective cohort studies.
7. Measure the network structures that have been established both within smaller communities as well as between cities in order to collect more information on HIV transmission within Thailand.

3.4 ANTIRETROVIRAL THERAPY FOR INJECTION DRUG USERS



The introduction of highly active antiretroviral therapy (HAART) in 1996 and the subsequent improvements in tolerability, dosing schedules, and toxicities, have transformed HIV infection into a chronic and manageable infection for people who have access to treatment. Policy makers in Thailand are well aware of the major health and social benefits of offering free ART to its citizens, and programs to increase ART distribution are underway. Unfortunately, the scaling up of ART appears to have bypassed people who have a history of injection drug use or who are active drug users. Although data around antiretroviral distribution and specific risk groups is not readily available, it appears that very few drug users are receiving ART. It is a widely held view among health care providers in Thailand that IDUs are not candidates for ART. This reluctance to initiate ART for drug users is certainly not unique to Thailand, however there are many very successful programs in other countries that are designed specifically for supporting drug users on ART. There are now over 400 Comprehensive Care Centers (CCC) in Thailand that can distribute antiretroviral therapy. The main focus of these government programs are to increase the number of people receiving ART with less capacity for adherence support and monitoring outcomes. It is logical that these CCC's would favor patients who thought to be the most likely to adhere to therapy and follow-up with appointment. Because of this, these centers are not friendly to drug users and ART may be denied.

The first challenge for any ART program is to identify the people who are in need of HIV treatment. This requires HIV testing and counseling along with some baseline laboratory data (e.g. CD4 count) that is often done prior to the referral to the CCC. Clearly active drug users who are not engaged in any medical care will not be started on HIV treatment. Fortunately, many of the harm reduction strategies proposed will enable health care professionals to engage with drug users and provide a starting point for HIV testing, care, and treatment

A major concern around prescribing ART for active drug users is the risk of developing HIV resistance. It is known that the development of resistance is strongly associated with adherence to the daily ART medications and that instability in housing and other social factors, along with ongoing drug use, may reduce adherence. Although it is important to encourage all those receiving ART to maximize adherence, the potential to develop resistance to first-line medications is not unique to drug users. Clearly, it is very beneficial to optimize the social circumstances for anyone initiating ART. Short delays in starting ART while housing is found or a drug treatment program is completed can be justified in order to enhance success. However, it is unacceptable to exclude IDU from access to ART programs or to expect abstinence before initiating ART. This is especially true in situations when many drug users are diagnosed relatively late in the course of their HIV infection, and there is a small window of opportunity to initiate ART. It should be acknowledged that adherence to ART is more difficult in the face of drug dependency, and that heightened efforts and more resources are required for monitoring and follow-up. However the response to treatment is usually good and drug users can become very engaged in improving their lives and focusing on their health.

There is good evidence that even people who are actively using drugs can successfully adhere to ART and have good therapeutic outcomes²³. Further, it has been demonstrated that engagement in ART programs may have very positive impacts on changing drug use patterns. ART programs can be integrated into comprehensive HIV care and treatment models that provide a range of services, including drug dependency treatment. Programs that encourage participants to have regular contact with health care workers in order to monitor tolerance and adherence to ART can lead to very positive outcomes with regards to general improvements in health and social situations. Linking the daily dispensing of OST with ART can be a very successful model for those who qualify for OST.

The role of ART in the prevention of HIV transmission has also gained momentum in recent years²⁴. By reducing the HIV plasma viral load through ART, the transmission of HIV can be greatly reduced. From a public health standpoint, this is an extremely important consideration when advocating for the inclusion of injection drug users in ART programs. In the case of sexual transmission, the risk of HIV transmission by an individual with undetectable levels of virus is thought to be close to zero. Although the risk of transmission through the sharing of needles may not be quite as dramatic, the risk of transmission is strongly influenced by the HIV plasma viral load. Therefore, the uptake of ART by active and former drug users are especially important from a public health standpoint. This is the very population where there is increased mobility, increased contact with law enforcement and health facilities, and a high potential to transmit HIV to others. Increasing ART coverage to drug users is extremely important in reducing the rates of HIV transmission in Thailand.

Recommendations / Priorities

1. An urgent scale-up of HIV testing is needed for IDU in order to determine the numbers of drug users who require ART.
2. Active and former drug users must not be excluded from the current scale-up of ART.

3. Special clinics should be established in certain “high-density” locations, where services specific to drug users can be offered that will support ART uptake and adherence. This might include daily dispensing programs that can enhance adherence and supply other supportive services.
4. Programs and training modules should be offered to health care providers who will be prescribing and monitoring ART to drug users as this requires additional skills.
5. Closer monitoring of CD4 and plasma viral load may be required to prevent HIV resistance.
6. The establishment of patient education programs and modules around ART is critical to promote engagement and ensure commitment to taking the medications.

Measurement and Evaluation

1. Centralized ART databases should be established to track the uptake of ART among those who identify as former or current drug users.
2. Adherence measures should be tracked both through medication distribution databases along with self-reporting surveys.
3. Outcomes should be tracked through a standardized database that includes CD4, plasma viral loads.
4. ART toxicity should be monitored in a standardized fashion and any changes in ART due to drug toxicity should be collected.
5. ART uptake through OST programs should be monitored and adherence measures for these programs reported.
6. Those on ART should be encouraged to self-report illicit drug use to determine changes in injection practices among those starting ART.

3.5 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI)

In many communities, there is an intersection between sex work and drug use, where the exchange of money for sex is used to support the purchase of drugs. In this environment, sexually transmitted infections (STIs) are common, and harm reduction programs should include educational materials around the recognition and prevention of STIs. The actual prevalence of STIs and the types of infections that are currently being transmitted among IDUs in Thailand are not readily available. Collecting epidemiologic data around STIs is important for the planning of programs. In addition to the serious medical consequences of untreated STIs, they are known to promote the transmission of HIV. This is particularly relevant for STIs that cause genital ulcerations such as syphilis and herpes. This has been well documented for both women and men and is an important link for the transmission of HIV beyond drug users themselves. Concurrent sexual partnerships, non-consensual sex, and anal sex are other important drivers of STI transmission that should be addressed through educational programs. Condoms are the primary method of STI prevention and are clearly an important component of harm reduction.

In addition, harm reduction initiatives should be designed to promote awareness of STI signs and symptoms, and if there is an infection, the provision of diagnostic testing and treatment. In the case of drug users, specialized STI clinics may be required if barriers to accessing hospital and community health clinics exist. There is a long history of STI information campaigns and STI treatment programs in Thailand. There is an excellent opportunity to increase awareness of HIV testing and treatment through existing STI programs. The emphasis of these prevention programs has traditionally focused on female sex workers and men-who-have-sex-with-men (MSM). Modifying these programs to include IDU would be an effective strategy. STIs may well be a first point of contact with people using injection drugs. Anyone who presents with an STI, should be offered HIV testing as this is a marker for possible sexual exposure to HIV. Enquiring into the use of injection drug use should be part of routine assessment in this situation.

STI prevention and treatment aimed at IDUs should be developed along with the other harm reduction interventions – specifically NSP. In Thailand, it will be much easier to gain support for programs aimed at STI prevention and treatment compared with other harm reduction initiatives. While reducing the adverse health consequences of STIs is important, and may even reduce the sexual transmission of HIV, it will not significantly influence the spread of HIV among injection drug users without the other components of harm reduction in place. Simply supplying condoms to injection drug users will have very little impact on HIV transmission in the absence of clean needles and syringes.

Recommendations / Priorities

1. Development and distribution of STI information and education aimed at IDUs.
2. Increased provision of condoms through outreach programs, community organizations and health care facilities.
3. Distribution of information regarding safer sexual practices and the reduction of concurrent sexual partnerships.
4. Training of health care workers to recognize and treat STIs through syndromic algorithms that would group STIs into vaginal/urethral discharge; genital ulcers; etc.
5. Introduction of rapid diagnostic technologies that can be used on site and be linked to appropriate antimicrobial treatment.
6. Development of contact tracing programs whereby sexual partners can be identified and have easy access to diagnostics and treatment.

Measurement and Evaluation

1. Surveys of condom access among injection drug users should be conducted and prospectively followed.
2. Baseline STI rates among IDUs in Thailand should be collected through standardized reporting systems. Much of this would have to be done through “syndromic” diagnostic algorithms.
3. Diagnostic testing facilities should be established in key locations that can monitor trends in the incidence of various STIs based on laboratory diagnosis and perform antimicrobial sensitivity testing.

4. Baseline and prospective counts of condom distribution should be collected along with information on where the condoms are being distributed.

3.6 TARGETED INFORMATION, EDUCATION AND COMMUNICATION (IEC)



The transmission of HIV among injection drug users is largely preventable if the drug users themselves adhere to some very basic practices. Explosive outbreaks of HIV generally occur in communities that do not have the basic information about how HIV is transmitted and knowingly share needles and injection equipment. The current state of knowledge about HIV prevention among IDUs in Thailand is not known. The severe marginalization of drug users through enforcement policies has limited contact with community groups and health care professionals who could educate IDUs around safer needle use and other safer injecting practices. In communities where there are opportunities to engage with drug users, unsafe practices can be greatly diminished through simple instruction, information sessions, and written materials. There has been a wide range of educational materials developed to educate drug users around safer practices and these need to be more widely disseminated. The first step is to contact people who are using injection drugs in order to provide them the opportunity to learn about safer practices. Community groups are in the best position to do this.

There are many other advantages to having a well-informed drug using community. Often other drug users are the first to find victims of inadvertent drug overdose and should know how to react in this situation. In addition, local knowledge around the types of drugs that are being used in the community is very helpful. Information around contaminated drug supplies or particularly high-purity drugs that are being sold should be quickly disseminated in the community, and this comes about through good lines of communication. For younger drug users, a basic lack of understanding around the expected physical response to psychoactive drugs can lead to serious outcomes. For example, information around the dangers of mixing different substances, and the concurrent use of alcohol, should be provided through targeted information programs.

Recommendations / Priorities

1. Obtain feedback from drug users regarding the strengths and weaknesses of the currently available materials so that modification can be made.
2. Develop targeted information around safer drug use, the dangers of drug mixing, and overdose prevention.
3. Determine the drug combinations and other use patterns in different communities.
4. Programs to access the most marginalized drug users in the community.

Measurement and Evaluation

1. Surveys to determine basic levels of knowledge around HIV transmission through injecting practices and drug preparation. These should be conducted on a regular basis (e.g. annually) to estimate the impact of the programs.
2. Surveys to determine the knowledge with regards to overdose prevention and response to overdose situations.
3. Studies to estimate the proportion of drug users being reached with education materials.

3.7 CO-INFECTIONS INCLUDING HEPATITIS C VIRUS AND TUBERCULOSIS

Around the world outbreaks of HIV among injection drug users has been preceded by outbreaks of Hepatitis C virus (HCV) infection. The force of transmission of HCV is several-fold higher than HIV, and therefore the majority of HIV positive IDU are also HCV infected. These viruses appear to act synergistically to worsen clinical outcomes. For example, the course of liver disease among HCV positive individuals who are also HIV positive is accelerated. Likewise the course of HIV infection may be accelerated among those who are also HCV infected. This is another reason that ART should be offered to injection drug users.

There is a need to scale up HCV treatment among drug users in Thailand and around the world, as liver disease becomes a more common cause of illness and death among IDUs. Unfortunately there are currently a number of obstacles to providing HCV treatment on a larger scale. The current therapy consists of interferon that must be given by subcutaneous injections, plus daily ribavirin pills. The duration of treatment is currently at least 6 to 12 months long, and there are a number of drug toxicities that make therapy a real challenge to complete. Although potentially curative, the overall success rate is estimated to be from 30% to 70% among those co-infected with HIV using standard treatment²⁵. Finally, the cost of treatment is currently prohibitive for most of those who could benefit from treatment. There are currently a number of new HCV medications being developed and studied, leading to some optimism that future therapies will be better tolerated, more effective, and potentially more affordable. For the time being, efforts to provide HCV therapy for drug users should be pursued using standard treatments as newer agents are introduced. Education around protecting the liver through diet, reducing or eliminating alcohol use, and treating HIV should be priorities.

Tuberculosis is endemic in Thailand and is commonly associated with HIV infection. The spread of tuberculosis is closely tied to poor living conditions and crowding. These are the very environments that are common to IDUs in Thailand and elsewhere. Tuberculosis acts much like other opportunistic infections, in that reactivation of previous tuberculosis infection occurs when there is immunosuppression due to HIV. Unlike most other HIV-related opportunistic infections however, it can develop with relatively modest immunosuppression and commonly occurs in people who are not HIV infected greatly increasing the likelihood of exposure. Tuberculosis requires long-term antimicrobial treatment that should be administered under close supervision. Without intensive follow-up and attention to adherence, TB can become resistant to first-line treatment²⁶. Early diagnosis is associated with better outcomes and screening through skin testing and chest x-rays are an important part of preventative tuberculosis programs. Tuberculosis is also a major problem in closed settings such as prisons, where many injection drug users are confined. Harm reduction programs can be instrumental in detecting potential cases of tuberculosis and referring them to the appropriate tuberculosis care and treatment programs. The WHO has developed specific guidelines for the prevention and management of tuberculosis among IDUs²⁷.

Recommendations / Priorities

1. There needs to be a scale-up of HCV testing among drug users. This is important information for individual drug users and can also help to predict the future trajectory of HIV infection in communities.
2. Tuberculosis screening, care and treatment should be scaled up for drug users who are at particularly high risk.
3. IDUs should not be excluded from ongoing national TB control programs.
4. Special outreach programs should be developed to deal specifically with TB among IDUs with regards to screening, care and treatment.
5. Specific training is necessary for health care providers who will be prescribing and monitoring medications for both HCV and tuberculosis.

Measurement and Evaluation

1. Determine the number of IDU who are HCV antibody positive and develop a data system that can estimate the incidence of HCV among IDUs.
2. Determine the number of IDU who are TB positive based on skin-testing, chest X-rays, and/or sputum testing and develop a data system that can estimate the incidence of TB among IDU.
3. Measure the proportion of IDU that receive HCV and/or TB treatment.
4. Measure the adherence to HCV and/or TB treatment through clinic-based data systems.
5. Measure the outcomes of treatment to both HCV and TB among IDU and determine factors associated with success.

3.8 INJECTION RELATED INFECTIONS AND DRUG OVERDOSE

Injection-related infections cause serious morbidity and mortality among IDUs worldwide. In environments with poor sanitation, contaminated injection equipment, and lack of medical facilities, it is difficult to avoid skin and soft tissue infections. In fact, without very sterile injection environments and proper injection techniques these infections are almost inevitable. In many cases, skin infections become chronic and are a source of ongoing pain and suffering. Even more serious, is the development of deeper bacterial infections including abscesses, osteomyelitis (bone infections), and endocarditis (infection of the heart valves and tissue) that can be fatal. The diagnoses of these infections are often delayed or even missed, as they require more complex diagnostic testing and imaging procedures that may not be readily accessible. Even if correctly diagnosed, the medical expertise and long-term antibiotic therapy required for successful treatment may not be available. It is unlikely that a rapid change in the ability to diagnose and treat these infections will be improved in the short term, so that prevention remains the main goal. The provision of clean needles and syringes can have a major impact on reducing infection rates and saving lives.

Although there is a paucity of available information as to the rates of antibiotic resistant pathogens among injection drug users in Thailand, it is likely that many of the infections are not susceptible to standard antimicrobial therapy. In other settings, the increase of methicillin resistant *Staphylococcus aureus* (MRSA) infection has greatly complicated the approach to treatment of the infections commonly seen among IDUs. With easy access to antibiotics through community pharmacies in Thailand, it is very likely that MRSA is common. MRSA infections are often aggressive and are associated with the deeper bacterial infections. The main challenge with MRSA is the limited availability of antibiotics that are able to effectively treat the bacteria. A commonly used antibiotic, Vancomycin, is only available in an intravenous formulation and this generally requires an inpatient clinic or hospital setting to administer the drug. Besides MRSA, there are a number of other aggressive bacteria that cause infections among IDUs that require specific antibiotics. The selection of the most appropriate antibiotic is best made with the guidance of bacterial cultures and antibiotic sensitivity testing. Again this is expensive and requires specialized laboratories that may not be easily accessible to marginalized groups.

Injection drug use is associated with both fatal and non-fatal overdoses. Heroin or other opiates cause drug overdose due to central nervous system and respiratory depression. The actual numbers of overdoses are difficult to estimate, and even fatal overdoses may go unreported. In an environment with heavy enforcement policies, drug users may be less willing to report overdoses among other IDUs in their community due to the fear of arrest. The fluctuations in heroin availability may also contribute to higher rates of overdose, as heroin users may experience repeated cycles of opiate use followed by periods of opiate withdrawal. This makes it difficult to determine the appropriate dosing and overdoses commonly occur following the re-introduction of heroin following a period of abstinence. Further, street heroin purchases are characterized by fluctuations in drug

purity and this also makes it difficult for users to determine dosing. Multiple overdoses may occur in a particular community over a short period of time when a high-purity influx of heroin is brought to the street market. One successful approach to overdose management is Naloxone administration. This drug has an extremely high affinity for opioid receptors and is a competitive opiate antagonist that can quickly reverse the effects of heroin overdose. However, it must be administered relatively early to avoid irreversible central nervous system damage and therefore relies on a rapid response by emergency medical services. To deal with these inevitable delays, some communities have launched programs that train community members, including other IDUs, to administer Naloxone. The initial findings from these pilot programs are encouraging. In San Francisco, there were no deaths among 20 opiate overdose cases that received Naloxone and/or CPR from another drug user trained in the program²⁸. This may be a very appropriate intervention for Thailand, where most opiate use is very hidden and the chance of a rapid medical team response is unlikely.

The use of ATS and other stimulant drugs may also be associated with drug overdose. In most cases, the overdose symptoms are characterized by agitation, aggression, paranoia, and movement disorders. For most ATS users, these are relatively common features of their drug use. More severe symptoms may occur including seizures, cardiac arrhythmias, and coma. These are managed by supportive care and by treating the specific symptoms. Outcomes can be fatal if not managed under experienced medical supervision. The inability to recognize ATS overdose when it does occur can lead to delays in treatment, and the education of medical staff is critical to improving outcomes.

Prevention of drug overdose must be the driving force behind the design and implementation of harm reduction strategies. Drug users can be educated around the safer use of drugs in order to avoid overdose. Testing out a small amount of drug prior to the injection, avoiding poly-drug use, injecting with a trusted friend, understanding individual drug tolerance, are just some of the messages that can be incorporated into educational materials. Periods immediately following release from incarceration or compulsory treatment centers are particularly high-risk for overdose when tolerance for “normal” opiate doses may be reduced.

Recommendations / Priorities

1. Creating injection environments where there is sterile equipment and the availability of clean water and skin cleaning facilities.
2. A consistent supply of clean needles/syringes and injection equipment as one of the primary ways to reduce injection related infections.
3. Education around proper injection techniques and the proper cleaning of skin for drug users.
4. Determining the rates of MRSA and other bacterial infections seen in drug users and supply appropriate antimicrobial therapy.
5. Training health care staff to recognize serious bacterial infections early on and refer for appropriate diagnosis and treatment.

6. Establishing safe places where drug users can be housed for short periods to have detoxification supports.
7. Education of health care providers and emergency response teams to recognize and properly manage drug overdose.
8. Develop a discharge plan with prisons and compulsory treatment centers in order to connect people with ongoing detoxification or other drug treatment supports.
9. Pilot projects to train and equip community members and drug users to administer Naloxone for overdose management.

Measurement and Evaluation

1. Determine baseline rates of MRSA and other bacterial infections and monitor the trends over time.
2. Determine the rates and outcomes of serious bacterial infections and their complications of injection drug use through access to clinic and hospital records.
3. Develop a centralized system to report drug overdose deaths and monitor this over time. Determine the situations and other factors that are associated with overdoses.

3.9 COMMUNITY LEADERSHIP AND INVOLVEMENT



The involvement of community is critical to the design and uptake of harm reduction strategies. There are many community groups that are already established that have the expertise and capacity to develop and implement harm reduction interventions. Health care professionals may have a more difficult time to access drug users and can work effectively along side current or former drug users to gain access to hidden populations. In addition, the use of trained “peer-researchers” can be an effective way to generate data to evaluate harm reduction interventions. Another very positive outcome of this type of partnership is the capacity building that can occur among active and former drug users who feel part of the solution.

Community organizations often establish an office to conduct their operations. These offices provide a centralized location to store materials, conduct training workshops, hold support groups, and serve as a drop-in for drug users for information and support. These offices should be well situated so that drug users can easily access the facilities. Some of the community interventions seen in Thailand may fail to reach the most vulnerable populations of drug users due to the location.

It is clear that Thailand has a culture of including grass-roots organizations and community groups in the planning and implementation of HIV prevention programs (e.g. TTAG, Raks Thai Foundation). The input from these groups is critical in order to develop the programs that will actually have an impact.

Recommendations / Priorities

1. Community initiatives through user groups are critical to moving the harm reduction forward. The 12-D group appears to be at the forefront of uniting different community groups and moving harm reduction programs along in Thailand.
2. There is a difference between drop-in centers for active drug users (e.g. Ozone) and drop-in centers focused on vocational training and other supports for former drug users (e.g. Thanyarak Institute). Both serve very important but potentially different functions. Both models should be supported.
3. Provide training and support for community workers who can be involved with outreach and other education and support programs.

Measurement and Evaluation

1. Determine the number of active and former drug users participating in these community centers around Thailand.
2. Conduct surveys to determine the strengths and weaknesses of these community groups and identify barriers to access.
3. Conduct outreach studies to estimate the proportion of drug users in the surrounding community that actually access the services.

HARM REDUCTION POLICIES AND INTERVENTIONS FOR INJECTION DRUG USERS IN THAILAND

4.0 DETERMINANTS OF DRUG USE

4.0 DETERMINANTS OF DRUG USE

There are many factors that influence the use of psychoactive substances within societies. A discussion around the determinants of drug use is well beyond the scope of this report. However, it is important to recognize that there are a number of modifiable factors involved in the initiation into illicit drug use, and the subsequent trajectory into long-term drug dependency and addiction. It is a very complex social, environmental, and genetic process and requires interventions that go far beyond simple supply reduction and the criminalization of drug use. While much attention has been given to the “outbreak” of drug use among the youth of Thailand, there has not been enough attention given to the social and environmental determinants of drug use in the country. As in most countries, problem drug use is concentrated with the poor and the marginalized. The use of drugs only perpetuates the social disadvantages that contributed to drug use in the first place. There is an urgent need to put more focus on the determinants of drug use and the development of comprehensive and accurate educational materials around illicit drugs.

For many drug users, their use of illicit drugs is associated with an underlying mental illness. By focusing on drug dependency and ignoring the mental illness, many individuals never receive an appropriate diagnosis and are denied treatments that could help them manage. Like most other countries, the approach to mental illness in Thailand is poorly developed and certainly contributes to drug misuse in the country. Thailand, like many countries, does not provide enough support for mental illness diagnosis, care and treatment. Mental illness is perhaps one of the most poorly recognized and managed areas and is very closely linked to drug use.

The devastating impact that addiction can have on individuals, families and societies is impossible to measure. Many families are left with few options to help their relatives and friends deal with their addictions. Having an educated population is one of the most effective means of dealing with drug use.

HARM REDUCTION POLICIES AND INTERVENTIONS FOR INJECTION DRUG USERS IN THAILAND

5.0 APPROACHES TO DRUG TREATMENT AND PUNISHMENT

5.0 APPROACHES TO DRUG TREATMENT AND PUNISHMENT

The approach to problem drug use in Thailand has focused largely on enforcement. This includes the criminal punishment of drug production, drug trafficking, drug use, and drug possession. Although there is a general consensus that “drug users are patients that should be offered treatment and not criminals that should be punished”, there is very little evidence that this is being practiced in Thailand. The punitive approach to drug use has resulted in over-crowded prisons, the expansion of compulsory treatment centers, and the unintended consequence of persistent HIV transmission. The ongoing global debate around “decriminalization” of drug use and possession is a topic that has not received much attention in Thailand.

The “war on drugs” policy adopted by the government of Thailand in 2003 was perhaps the most brutal and regressive response to drug use ever launched. Not only did this policy have a deadly impact on people using illicit drugs during 2003 and 2004, the negative effects remain. The reported numbers of people using drugs, by the law enforcements own admission has only increased in the past decade. A current program of drug control is sponsored by the Ministry of Interior and is called the “Clean and Seal” program, whereby villages would receive a designation of being “drug-free”. They would prove this by “turning in” potential drug users in their communities to the authorities. The likely result would be the removal of the suspected drug user from their community and the transfer to a compulsory treatment facility. This type of program further marginalizes and isolates drug users from their families and other supports and exposes them to ineffective and potential harmful “treatment”. The direct impact on HIV transmission is unclear, but it is certainly a regressive program with regards to dealing with drug users.

With the long history of drug misuse and addiction in Thailand it is surprising that so little efforts have been made to train medical professionals in dealing with this issue. While the government continues to invest large amounts of money in law enforcement and compulsory treatment, the level of training available to health care professionals is inadequate. This is especially concerning when so many people are forced into compulsory treatment programs. By the ONCBs own estimates, over 600,000 people are sentenced to compulsory drug treatment in Thailand annually. With so few doctors with training in addiction medicine and seemingly no academic training offered through University programs, the poor outcomes reported by these programs is not surprising.

5.1 COMMUNITY LAW ENFORCEMENT

An emphasis on law enforcement invariably results in a lack of over-sight to adequately control the behaviors of police in their dealings with suspected drug users. Although it is often difficult to verify police misconduct complaints drug users and community groups have expressed a number of concerns. These include unnecessary drug urine testing,

physical abuse, extortion, and unlawful arrest and confinement. Although it may not be possible in the short-term to have an official endorsement of harm reduction strategies by community law enforcement officers, it is critical to have some cooperation. In countries with successful harm reduction programs, the police are knowledgeable about the programs and are discouraged by their superiors from interfering. This does not mean that the police are always supportive of harm reduction, but in many cases will see the advantages of engaging drug users and directing them to supportive services. With a heavy enforcement presence, harm reduction programs cannot operate effectively. Excessive drug enforcement is not only ineffective, but further exacerbates the illicit drug use problem by driving up profit margins for drug dealers, and undermines the very programs that could help reduce drug use.

Another major concern is the precarious circumstances faced by suspected drug users after their arrest, but prior to sentencing. A period of up to 60 days, and in some cases longer, may elapse. This time is spent in a makeshift detention facility where the risk of HIV transmission appears to be high. A study from Bangkok concluded that there are significant risks associated with these holding cells, where lower levels of security provide the opportunity to secure drugs, but without access to clean injection equipment. Used needles are likely to be used over and over dramatically increasing the risk of HIV transmission. Further, many of the inmates endure serious withdrawal symptoms without appropriate medical supports²⁹. There is an urgent need to expedite the sentencing procedures and provide adequate care for those awaiting transfer to other facilities.

5.2 COMPULSORY TREATMENT CENTERS

Compulsory Treatment Centers is the main governmental response to illicit drug use in Thailand. Thai drug users, who have been through these centers, describe the over-arching attitude at these facilities as “buck-up and stop using drugs”. There is no attempt to address the underlying problems that perpetuate the addiction, or offer any real psychological or pharmacological treatments. There are no harm reduction programs despite the presence of illicit drugs that find their way into the Centers. There is no methadone offered to the inmates even if they were taking methadone prior to their arrival at the Center. For the few drug users who are receiving antiretroviral therapy there is no ongoing access offered. The staff are largely unqualified to deal with drug dependency and there is no attempt at providing any care following release. The inmates of these Centers are a mixture of long-term drug addicts and younger people who, in most cases, are not actually addicted to drugs at all. This is a dire situation, especially for the young people who are required to stay in the Centers. In fact, the main victims of compulsory treatment appear to be “youth” who have been using methamphetamine. A recent review of compulsory drug treatment in Thailand by the Canadian HIV/AIDS Legal Network provides an in-depth perspective³⁰.

The Centers came about in response to the serious over crowding of jails, especially during the “war on drugs”. Despite some pull back on the regressive policies of the war of drugs,

these facilities continue to operate and in fact are increasing quite rapidly in Thailand. In 2004, there were 34 Centers and in 2009 there were 94. This rapid expansion appears to be disconnected from any evidence of effectiveness. The Centers do not provide any sustained reduction in drug use and it is widely accepted that the majority of people who are released from the Centers go back to using drugs. A study found that 95% of the people who were released from similar Centers in China relapsed within 6 months. An assessment sponsored by the WHO on the compulsory programs in Cambodia, China, Malaysia and Viet Nam, provides a comprehensive look at the limitations of this approach to drug use³¹.

Outcome measures should be rigorously collected and a proper evaluation of these Centers should be conducted. The resources required for the operation of these Centers should demand that there is some accountability. There are potential ways to make these Centers more acceptable, even if the compulsory nature of the Centers were continued. It is clear that harm reduction strategies could be incorporated into the Centers as well as drug treatment interventions that could actually address drug dependency. The sentencing should also be more transparent and standardized and a transition from the mandatory time in detention to release must be organized in a way that allows the individual to access ongoing care and treatment.

5.3 PRISONS

The “war on drugs” and the ongoing drug enforcement policies have had a profound impact on the prison population in Thailand. It is estimated that 60% of people are in prison for drug-related offences. Like in other countries with large incarcerated populations, law enforcement authorities are reluctant to acknowledge that drug use occurs in the prisons. However, prisons are known to be environments where HIV transmission through both injection drug use and sexual encounters are serious problems. This has been recently demonstrated in Thailand prisons³². The unintended consequences of placing drug users in prison are the networks that invariable form, and the subsequent HIV transmission with even limited opportunities to use drugs. It is the responsibility of the prison administration to ensure that HIV infection does not occur by providing the necessary tools to the prison inmates.

As a general approach to reducing the transmission of HIV in prison settings, health authorities have called for harm reduction interventions that would be equivalent to that found in non-prison environments. Unfortunately this is not the case for most countries and there is a reluctance to include needle and syringe programs in prisons. While this debate is continuing, other interventions should be introduced. Many prisons have introduced HIV testing programs, OST, and ARV therapy.

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6.0 RESEARCH PRIORITIES

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The majority of stakeholders contacted during this consultation agreed that there was a need to increase research capacity and collect relevant information in order to plan new programs and evaluate existing ones. Research can fill critical gaps in knowledge and evaluate the impact of harm reduction strategies. However, it is important to emphasize that waiting for more “research” to be conducted is not a reason to delay a rapid scale-up of comprehensive harm reduction programs in Thailand. Research and evaluation should be an integral component of the harm reduction initiatives and modifications can be made as the scale-up proceeds.

There are currently large gaps in knowledge around drug use patterns and the numbers of people who are actually drug dependent in Thailand. Accurate data around drug use is critical to establishing the most appropriate interventions and the cities that these interventions should be focused. There is an urgent need to establish a comprehensive research agenda that can guide HIV prevention and care programs for IDUs. All research needs to be closely linked to programs, with the ability to use the information to expand HIV prevention where it is most needed, and modify programs that are not meeting expectations. This requires government funding and the recruitment of trained investigators to carry out the research. Even a modest percentage of the money currently used for enforcement and compulsory treatment could be used for research and evaluation. The NGO community also must play an important role in the research agenda. Funds currently being designated for program and policy work should have a research and evaluation component. There is already good potential to establish community-based networks where common studies could be conducted. Population Service International (PSI) currently holds the funding for the latest Global Fund grant and is in a strong position to lead the research component.

Research Priorities

1. Epidemiological surveys should be conducted to determine the prevalence of injection drug use. Regional differences are anticipated, but standard survey instruments can be developed that capture this. Studies can be conducted that incorporate both rapid assessment methods and prospective cohort methodologies. It is critical that better data be collected around patterns of drug use in the major centers of Bangkok, Chiang Mai, Chiang Rai Songkhla and deep south provinces. Specifically the prevalence of ATS injection, the prevalence of heroin injection, and the prevalence of diverted pharmaceutical injection.
2. The “treatment” strategies used within compulsory treatment centers should be evaluated. Specifically, the Matrix Model that is widely practiced in Thailand should be formally assessed. Initially developed as therapeutic counseling model for stimulant dependency in the 1980’s, the effectiveness remains unproven³³. The impact of the Matrix Model in the context of compulsory treatment may be especially compromised. As a first-step, a prospective follow-up of people who have gone through the program should be conducted.

3. NSP programs require rigorous evaluation to ensure that they are meeting pre-determined targets and that injection drug users are accessing clean needles and syringes. This should go beyond just counting the number of needles distributed and include access for the more marginalized drug users, frequency of sharing needles with others, and the uptake of other services by NSP participants.
4. The existing OST programs require formal evaluation. This would include the evaluation of adherence to the programs, the use of concurrent opiates and other illicit drugs among participants, and impact on social and medical well-being. Those programs that are found to be deficient should be modified.
5. Surveys of drug users need to be conducted in order to identify the major barriers to accessing harm reduction programs, medical care and social services.
6. Research into the impact of prisons, compulsory treatment centers, and other forms of detention should be evaluated. This would include studies into HIV transmission risks in these settings and the potential role of harm reduction programs in these settings.
7. Studies should be conducted into the role of law enforcement in preventing safer injection practices and interference with harm reduction programs.
8. Research into the transition of drug users from prison and/or compulsory treatment centers back to society with a focus on overdose prevention, drug treatment programs, and HIV care.
9. Studies to determine the prevalence of associated infections including Hepatitis C, tuberculosis and STIs should be conducted using appropriate diagnostic testing. Outcomes from these programs should be prospectively tracked.
10. HIV testing prevalence among IDUs should be measured and programs to scale-up access to HIV testing should be rolled out and evaluated.
11. ART treatment uptake, adherence and outcomes for current and former injection drug users should be measured, and programs designed to increase the number of IDU receiving ART should be established.

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7.0 SUMMARY

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The current focus on enforcement and punishment, along with the reliance on compulsory drug treatment centers, has done little to control drug use in Thailand. The unintended consequence of this approach has been to push drug users into precarious and dangerous environments that have directly led to risky drug using patterns and persistently high rates of HIV transmission. Adopting a harm reduction approach to deal with injection drug use could have a major impact on reducing HIV transmission as well as engaging drug users into better health care and effective drug treatment. This will require strong leadership in key government Ministries and related agencies so that the central stakeholders can roll out harm reduction programs. Thailand has the potential to greatly reduce the transmission of HIV among injection drug users and become a regional leader in harm reduction.

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HARM REDUCTION POLICIES AND INTERVENTIONS FOR INJECTION DRUG USERS IN THAILAND

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