Paper presented at the Australian Agency for International Development (AusAID) Special Seminar, November 22, 2000:

It's Everyone's Problem: HIV/AIDS and Development in Asia and the Pacific

Harm reduction: injecting drug use

Dr Nick Crofts[1]

[1] Director, the Centre for Harm Reduction. The Macfarlane Burnet Centre for Medical Research
crofts@burnet.edu.au

Until the mujahadeen began systematically producing opium and heroin through the late 1980s and into the present day, Burma had been the world's largest producer of heroin. Burma still accounts for over 80% of the heroin coming out of the Golden Triangle region of Burma, Thailand and Laos.

Burma's history of opiate production goes back to 1949, when generals from the defeated Kuomintang made common cause with their ethnic counterparts in northern Burma and began to systematically organise what till then had been a folk industry, that of growing opium poppies. Their motive (and is) was similar to that of the mujahadeen - this is the most profitable crop possible, and the profit is needed and used to purchase arms on the illegal market for their various armed struggles. Australia's heroin epidemic dates from the Vietnam War, when trafficking routes were opened up from the Golden Triangle to the west. Australia became a major staging point, and as always happens in these situations a local market began to develop.

Injecting of heroin was however uncommon in Asia until relatively recently; the smoking of opium, usually tightly socially controlled, was the more familiar method of opiate use. Several things changed this: the success of U.S.-French operations in breaking Mafia factories for the refining of opium into heroin in Sicily and southern France led to such refining factories relocating to Asia itself, especially Burma. This meant that increasingly what was exported from the Golden Triangle was increasingly heroin, which was increasingly injected, as opposed to opium, which was more often smoked. As well, joint U.S.-Thai operations had some impact on trafficking of heroin south-eastwards through the peninsula. In response, new trafficking routes sprang up across the south of China and through the northeast of India. These new routes exposed new populations to heroin, at a time when enormous social change associated with economic development was leading to social dislocation and social upheaval. Supply came together with vulnerable populations; the result was explosive growth in heroin consumption, mostly injected, throughout large areas of Asia.

In the mid-1980s HIV entered this picture. Some epidemics, such as that in Thailand, were relatively closely monitored from the start. Others, such as those in Ruili County of Yunnan Province in southwest China on the Burmese border, and in Manipur State in the northeast of India, again on the Burmese border, were only discovered after they were full blown epidemics. The first studies in Ruili, Manipur and in Burma itself found between 60% and 90% of the injecting drug users (IDUs) tested had HIV infection, as early as 1989.

Since then, the only change has been a worsening of the situation. Many countries in Asia now have suffered explosive epidemics of HIV infection among rapidly growing populations of IDUs. If there is a significant population of IDUs in a community, and if HIV enters that population, the community can go from having no HIV infection to having several thousands of people with HIV in a matter of months, as has been seen repeatedly in Asia and other regions (latterly especially Eastern Europe and Russia, and most recently Central and Western Asia). This provides a pool for continued transmission of HIV, as most of these heroin users are sexually active young men.

Despite repeated documentation of the situation, little action has been taken in regard to these epidemics, and what has been done has occurred on far too small a scale to have an impact on the epidemics. In some countries, such as Burma, the whole issue of HIV/AIDS has been ignored; in others, such as India, action to match rhetoric has been very slow in coming, but even where there is action it has not included prevention among IDUs. Even in countries where there has been a good response to HIV/AIDS, such as Thailand, little or nothing has

been done to control the epidemic among IDUs. Not only national governments, but also the U.N. agencies have steadfastly refused to get involved in or support prevention efforts among IDUs, or for that matter even to recognise these epidemics and their impacts.

Countries which have experienced or are experiencing major epidemics of heroin use, injecting drug use and HIV infection among IDUs include:
- Thailand, where prevalence of HIV reached 40% among IDUs by 1990 and has remained there since;
- Burma, where HIV prevalences among IDUs up to 90% have been recorded;
- Vietnam, where HIV is spreading rapidly among IDUs, firstly in Ho Chi Minh City and subsequently province by province until there are now few provinces which do not have significant epidemics;
- India, where government for a long time has been happy to recognise the massive epidemic in Manipur and neighbouring states, but utterly denied similar situations in the rest of India;
- Nepal, which despite having the first model harm reduction program in Asia, and despite repeated warnings, failed to mount a response to the threat of HIV among IDUs and since 1998 now has prevalences of 40-50% across the country among IDUs;
- China, an opium producer again for the first time since 1949, where similarly acknowledgment of the drug use and HIV epidemics among ethnic minorities in Yunnan was used to deny the existence of the problem elsewhere;
- Malaysia, where HIV among IDUs has been recognised since 1990, but where government has been steadfast in its refusal to do anything about the problem, seeing IDUs as expendable; and
- Indonesia, where denial is just, over the last two years, beginning to be replaced by concern.

In every case, government inaction has been fuelled by the devastating newness of these problems and ignorance or lack of experience in handling them; by universal perceptions of IDUs as people who do not matter, as expendable; and by ill-founded advice from bodies such as UNDCP, often exporting U.S. or Swedish domestic drug policy, that harm reduction policies and activities encourage drug use and worsen the drug problem.

Let me give but one example. One of the two major HIV vaccine trials globally is going on in the methadone clinics of the Bangkok Municipal Administration (BMA). Why there? Because the IDUs in Bangkok cycle repeatedly through these clinics, and are available for testing and monitoring on a regular basis. The incidence of HIV infection among these IDUs has remained at between 6% and 10% per year since 1987; a perfect population for trial of a vaccine to demonstrate its impact on preventing infection. But why do these IDUs cycle through the methadone clinics so regularly, and why is the incidence so high when Thailand is so proud of its record in controlling the sexual transmission of HIV? Because, with U.S. policy support, Thailand has refused to accept harm reduction, and continues to be committed to abstinence oriented approaches which have failed everywhere they have been used. The methadone clinics do not provide methadone maintenance, which has been shown in multiple studies to bne effective in preventing HIV transmission, but methadone detox, in which people are started on methadone and then weaned off it over a 45-day period. 100% of these people return to using street heroin, until they are next admitted to the clinic. There are no needle exchange or peer education programs functioning in Bangkok. We know exactly how to stop this HIV transmission among IDUs; rather than doing so, the epidemic is protected and provides an excellent site for vaccine trials. IDUs are expendable.

Australia has a proud record in this regard; I for one describe the prevention of the HIV

epidemic among IDUs in Australia as one of the public health triumphs of the century. And it has been Australians who have been at the forefront of attempts to introduce effective policy and programs for HIV prevention in Asia, generally with very little support. There are harm reduction programs in many Asian countries, a dozen or so needle exchange programs, perhaps half a dozen methadone and buprenorphine maintenance programs, but these are reaching a tiny proportion of the at-risk populations.

In 1996, with a small grant from AusAID, we started the Asian Harm Reduction Network (AHRN) to bring these programs together and boost support for them. UNAIDS around that time became the first UN organisation to openly support harm reduction as the only effective approach to prevention of HIV among IDUs. Gradually other organisations, including USAID and UNDCP, are adopting this stance. With AHRN, we produced the first Manual for Reducing Drug Related Harm in Asia; we received some funding from the Commonwealth Health Department for this, but they did not want their name associated with it because of the political sensitivities of espousing harm reduction in Asia.

Change is happening; slowly it is being recognised that having one or two small pilot or demonstration programs is not nearly adequate, as the example of Nepal tragically demonstrates. Slowly some countries or regions are preparing responses commensurate with the scale of the epidemics - notably Manipur, Bangla Desh and Nepal. But it is far too late, and far too slow. The realisation that these are major HIV epidemics in sizeable populations, in most Asian countries key to the evolution of the national AIDS epidemic, has been far too slow in coming and has really not yet penetrated - among governments here and in Asia, among UN agencies and programmes, and in the aid sector in general. There is a reluctance to deal with the twin threats of drug use and HIV.

The efforts to scale up are creating their own new problems: for instance, disposing of a few hundred used needles and syringes from a small program in Kathmandu, Ho Chi Minh City or Cebu City in the Philippines is one thing; disposing of hundreds of thousands or even millions creates very special problems. This is another area Australia may have much to offer.

This is also a rapidly evolving problem. Just over the last few years, amphetamines have exploded throughout Asia, bringing new populations, especially of youth, into illicit drug use, and posing new threats of HIV transmission because of their impact on sexual behaviour. Indonesia is becoming not only a major staging post for these drugs into Australia, it has become one of the major consumers in the region in a very short space of time and now increasingly a producer. This can only continue to grow, given the social and economic problems there. And the first few, small studies which have been done in Indonesia have shown that we have to date seen the very small tip of a very large iceberg in relation to heroin injecting; HIV prevalences among the few IDUs who have been tested are 40-90% already.

It is not too late to take effective action. But the reality of the situation must once and for all be recognised, and responses designed accordingly. This is, regionally and country by country, an enormous but still much hidden problem. It is a problem which is continuing to worsen. It is a major part of national AIDS epidemics, kickstarting and fuelling the other facets of the epidemic, among sex workers and others. Without addressing these epidemics seriously, we will not adequately address the national and regional epidemics.

And the other reality is that of all the different types of HIV epidemics, spread in different

ways among different population groups, we know more about how to effectively intervene among IDUs - it is technically easier and more effective - than in any other population group. What is continually lacking is political will.

Dr Nick Crofts is Deputy Director at the Macfarlane Burnet Centre. He established the UNAIDS-endorsed Asian Harm Reduction Network (1996), the Centre for Harm Reduction (1998) and edited the Manual for Harm Reduction in Asia (2000). He was awarded the International Rolleston Award for Harm Reduction in 1998. The Centre for Harm Reduction is active in Vietnam, India, Nepal, Indonesia and in regional and global projects.