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**Demand reduction strategies in closed
settings in China, Indonesia and Viet Nam**

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DEMAND REDUCTION STRATEGIES IN CLOSED SETTINGS IN CHINA, INDONESIA AND VIET NAM

Sarah Larney and Kate Dolan

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ACRONYMS

05/06	Commonly used name for Social Education and Labour Centres in Viet Nam
AIDS	Acquired Immune Deficiency Syndrome
ARHP	Asia Regional HIV/AIDS Project
ATS	Amphetamine-type stimulants (includes amphetamine, methamphetamine, ecstasy)
BNN	National Narcotics Board (Indonesia)
CBT	Cognitive-behaviour therapy
CDRC	Compulsory detoxification and rehabilitation centre (China)
DSEP	Department of Social Evils Prevention (Viet Nam)
HIV	Human Immunodeficiency Virus
IDU/s	Injecting drug use/rs
KE	Key expert
LVEP	Living Values Education Program
MOLISA	Ministry of Labour, Invalids and Social Affairs (Viet Nam)
MDMA	3,4-Methylenedioxymethamphetamine; also known as ecstasy
MMT	Methadone maintenance treatment
NGO	Non-government organisation
RELC	Re-education through labour centre (China)
SELC	Social education and labour centre (Viet Nam)
TC	Therapeutic community
UNAIDS	United Nations Joint Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

1. INTRODUCTION

1.1 Injecting drug use and HIV transmission

Injecting drug use (IDU) is a global concern. Over 130 countries have reported drug injection within their borders and there are an estimated 13.2 million IDUs worldwide, 80% of whom live in developing countries (Aceijas, Stimson, Hickman, & Rhodes, 2004; Wodak, Ali, & Farrell, 2004). Harms associated with IDU include involvement in criminal activity, imprisonment, overdose and mortality (WHO/UNODC/UNAIDS, 2004). However, one of the most prominent harms associated with IDU is HIV infection, which can be spread via sharing of injecting equipment. In many countries, particularly in South and South-East Asia, IDU is the leading mode of HIV transmission (UNAIDS, 2005). IDU accounts for half of new HIV cases reported in China (Ministry of Health China, 2006) and as much as 90% of new cases in Indonesia (Ford, Wirawan, Sumantera, Sawitri, & Stahre, 2004). IDUs have the highest HIV prevalence of all risk groups in Viet Nam, with one-third of all IDU infected (Ministry of Health Vietnam, 2005).

The potential for HIV to spread from IDUs to the wider community is great. IDUs are usually sexually active and may have multiple sex partners (Pisani, Dadun, Suchaya, Kamil, & Jazant, 2003; M. Zhao, Wang, Lu, Xu, & McCoy, 2005). Furthermore, many IDUs engage in sex work (UNAIDS, 2006). Infected sexual partners of IDUs and sex workers may then further transmit the virus to other sexual partners. Mother-to-child transmission of HIV can also occur. Addressing injecting drug use with effective interventions is vital for stemming HIV transmission and other drug-related harms among both IDUs and the general community.

1.2 Harm minimisation: Supply, demand and harm reduction

Harm minimisation comprises three categories of interventions to address drug use: supply reduction, demand reduction and harm reduction. Each category of harm minimisation targets a different aspect of drug use, from production and distribution of drugs, to preventing drug use and treating dependent users, to reducing the negative outcomes associated with drug use (see table 1.1).

Table 1.1: The harm minimisation approach to drug use

	HARM MINIMISATION		
	Supply reduction	Demand reduction	Harm reduction
Goal	To reduce the availability of drugs	To prevent initiation to drug use and treat dependent drug users	To prevent or reduce the harms associated with drug use
Typical strategies	<ul style="list-style-type: none">- Crop eradication- Maintaining border controls- Legal sanctions against the sale and distribution of drugs.	<ul style="list-style-type: none">- Drug education in schools- Drug dependency treatment	<ul style="list-style-type: none">- HIV education for drug users- Outreach services- Needle and syringe programs

Supply reduction has traditionally been the avenue through which governments have attempted to control drug use (Morin & Collins, 2000; Wodak, Ali, & Farrell, 2004). However, supply reduction is expensive and there is little to no evidence to suggest it results in reduced drug use (Morin & Collins, 2000). Demand reduction strategies such as drug treatment have been shown to be effective in reducing drug use and related HIV transmission and are a cost-effective adjunct to supply and harm reduction strategies (World Health Organization, 2005a).

1.3 Demand reduction in institutional settings

Drug users are over-represented in prisons and other criminal justice settings throughout the world (Dolan, Kite, Black, Aceijas, & Stimson, 2007; UNAIDS, 1997). For example, a 2003 survey of prisoners in Indonesia found that just over half (54%) were drug users (UNODC Regional Centre for East Asia and the Pacific, 2005), compared to an annual prevalence of drug use among students of 3.9% (UNODC Regional Centre for East Asia and the Pacific, 2006). With large numbers of drug users, closed institutions such as prisons and compulsory drug treatment centres provide an opportunity for delivering demand reduction strategies.

A wide variety of demand reduction strategies are found in prisons throughout the world (Larney, Mathers, & Dolan, 2007). Drug and HIV education is provided to prisoners in most developed and many developing nations. Education usually focuses on topics such as the effects of drugs, how drug dependence develops and HIV transmission and prevention. Some programs employ principles of peer education, in which a member of the group being targeted by the education program (a peer) delivers the educational material. The World Health Organization has produced a comprehensive HIV education manual specifically for use in closed settings (World Health Organization Western Pacific Regional Office, 2007).

More intensive than HIV and drug education are treatment programs such as therapeutic communities and methadone maintenance treatment. Therapeutic communities (TCs) are common in prisons in Australia, the United States and the United Kingdom. Evaluations of prison-based TCs often find positive effects on subsequent drug use and offending. A five-year follow-up of inmates who participated in the Amity program, a prison-based TC in California, found that participants were less likely than non-participants to be reincarcerated (Prendergast, Hall, Wexler, Melnick, & Cao, 2004). Another study found that TC participants were significantly more likely than non-participants to be abstinent from drug use at five-year follow-up (Inciardi, Martin, & Butzin, 2004).

Methadone maintenance treatment (MMT) is also available in prisons in a number of countries, including Australia, Canada, Spain and Germany. In a randomised controlled trial of the prison methadone program in New South Wales, Australia, treated inmates had lower levels of drug use and syringe sharing than non-treated inmates (Dolan et al., 2003). A four-year follow-up of this study found that, compared to non-treated inmates, inmates who remained on MMT for a minimum of eight months were less likely to be reincarcerated, less likely to contract hepatitis C and less likely to die (Dolan et al., 2005).

The above research demonstrates that implementing demand reduction strategies in institutional settings can benefit both detainees and the communities they return to on release. Despite the large numbers of drug users currently in prisons and compulsory drug treatment settings in various countries throughout South and South-East Asia, little

is known about what treatments and other demand reduction strategies are in use in these countries. This study aims to collate data to produce a coherent picture of the availability of demand reduction strategies in prisons and compulsory treatment settings in China, Indonesia and Vietnam.

2. CHINA



Drug use situation

There are 1.14 million registered illicit drug users in China (Chu & Levy, 2005). However, this represents only a proportion of the drug using population. Surveys of areas with high levels of drug use have found that around one percent of the population report using illicit drugs in the past year (Hao et al., 2004; Hao et al., 2002) and it is estimated that there are as many as 3.5 million injecting drug users (IDUs) in China (Aceijas, Stimson, Hickman, & Rhodes, 2004). Heroin is the most frequently used illicit drug, but drug use patterns vary between regions. Among drug users interviewed in Yunnan province in 2003, 89% reported heroin to be their current primary drug, with another seven percent reporting combined heroin and benzodiazepine use and only four percent using “other” drugs. The majority (95%) of users in Guangxi also nominated heroin as their drug of choice, with four percent using buprenorphine and one percent “other” drugs (Kumar, 2004). In line with other East and South-East Asian nations, the use of amphetamine type stimulants (ATS) such as methamphetamine and MDMA is increasing (Fang, Wang, Shi, Liu, & Lu, 2006; Kulsudjarit, 2004). Cannabis use, usually reported to be uncommon in China, also appears to be increasing (National Surveillance Center on Drug Abuse, 2005).

Also increasing is the injection (as opposed to smoking) of drugs, which poses the risk of HIV and other blood borne virus transmission (Hao et al., 2004; Tang, Zhao, Zhao, & Cubells, 2006). HIV prevalence among IDUs varies widely across the country, from less than five per cent in provinces with low levels of drug use, to greater than 50% in Yunnan, Xinjiang and Sichuan provinces (Ministry of Health China, 2006). In 1998, HIV prevalence of 82% was recorded among IDUs in Yining, Xinjiang (Qian, Schumacher, Chen, & Ruan, 2006) and in 2005 in Gejiu, Yunnan, 62% of surveyed IDUs were infected (L. Zhang, 2005). Approximately 45-55% of new HIV infections in China are associated with injecting drug use (Ministry of Health China, 2006; UNODC Regional Centre for East Asia and the Pacific, 2005). Heroin is the drug most commonly injected, but a small proportion of registered drug treatment cases also report injecting ATS (UNODC Regional Centre for East Asia and the Pacific, 2005). HIV risk behaviour is

common, with half of IDUs reporting sharing needles and syringes and 10% engaging in high-risk sexual behaviour (Ministry of Health China, 2006)

2.2 Demand reduction in the community

Much community-based demand reduction in China focuses on educating the public about drugs and drug-related harms (Cunyi, 2005; National Narcotics Control Commission, 2005). In particular, school children are exposed to strong anti-drug messages (National Narcotics Control Commission, 2005). The establishment of ‘drug-free communities’ is an extension of these education programs. Under this initiative, entire villages and communities pledge to work together to eliminate drug use in their area. Education and other drug control activities are provided by schools and community organisations with the intention of protecting individuals against the desire to use drugs (Cunyi, 2005), while current drug users undergo detoxification and rehabilitation (National Narcotics Control Commission, 2005). Officially, drug-free communities have been established in ten provinces (National Narcotics Control Commission, 2005).

The majority of treatment-based demand reduction in China is administered through the compulsory treatment system (Zhengyan, Beroud, Maojin, & Shirong, 1998). Community-based voluntary drug treatment is available, but in practice may differ little from compulsory treatment (discussed below). Voluntary treatment may take place in the same setting as compulsory treatment (McCoy et al., 1997) and while the patient may enter treatment voluntarily, completion of the treatment program is mandatory (Tang, Zhao, Zhao, & Cubells, 2006). Some centres that provide treatment to voluntary patients operate under a modified therapeutic community model that takes into account Chinese norms and attitudes. Such centres manage patients’ withdrawal symptoms and provide a highly structured program of social and moral education, counselling, labour and relapse prevention training (McCoy et al., 1997). Local hospitals often provide in-patient detoxification and rehabilitation, typically for a three-week period (Zhengyan, Beroud, Maojin, & Shirong, 1998). Other voluntary treatment programs utilise traditional Chinese medicines and techniques, such as acupuncture and *qigong* therapy (breathing exercises) (Tang, Zhao, Zhao, & Cubells, 2006).

One treatment option available to voluntary patients that is separate from the compulsory treatment system is methadone maintenance treatment (MMT; known in China as *meishatong weichi liaofa*). MMT was introduced in China in 2004, with eight clinics in five provinces (R. Zhang, 2006). An evaluation of these clinics reported that frequency of patients’ drug injection fell from three times daily to less than once a day (Wu, Li, & the National Methadone Working Group, 2005). The Chinese government strongly supports the expansion of MMT. In 2006 there were 313 clinics in 22 provinces and autonomous regions, and there are plans to open 1000 MMT clinics, with 200,000 treatment places, across the country by 2010 (Ministry of Health China, 2006; R. Zhang, 2006).

2.3 Demand reduction in institutional settings

2.3.1 Data collection

An extensive literature review was undertaken to identify published and unpublished documents relating to drug treatment and demand reduction in China, with an emphasis on closed institutions such as compulsory drug treatment centres. In addition, a fact-

finding mission was conducted during which demand reduction services were visited in Guizhou and Shanghai. Finally, key informants in China were approached via email and asked to complete a comprehensive survey on drug treatment in closed settings. Key informants included researchers and staff of non-government organisations (NGOs) working with drug users. Because of the vast size of the country, these experts were asked to provide information specific to the province they were most familiar with. This produced information specific to Yunnan and Shanghai. National information was provided by a contact within the Bureau of Re-education Administration. Informants provided numerous documents in Chinese that were translated into English by a native Chinese speaker.

Unless otherwise referenced, information in the following sections was gathered during the fact-finding mission or was provided by the key informants described above.

2.3.2 Legal and policy environment

Illicit drug use is considered by the Chinese government to be a major threat to public security and the advancement of Chinese society. Drug control is accorded great importance and there are over 30 separate pieces of relevant legislation. Penalties for crimes such as manufacturing and trafficking illicit drugs are severe, including life imprisonment and the death penalty (Information Office of the People's Republic of China, 2000).

Drug dependent individuals were previously characterised in Chinese policy as criminals and “social loafers”; more recently, there has been a shift towards conceptualising drug users as victims requiring assistance. Accordingly, compulsory treatment is central to China’s approach to drug dependency treatment (Information Office of the People's Republic of China, 2000). The *Regulations on Prohibition Against Narcotics*, introduced in 1990, provide for three levels of penalties to be applied to drug users. First-time offenders are fined and attend a ten-day detoxification program managed by the Ministry of Health. Those who are caught using drugs following voluntary detoxification are detained in compulsory detoxification and rehabilitation centres (CDRC) for six to twelve months. CDRC are overseen by the Ministry of Public Security. Those who relapse following this treatment are sent to re-education through labour centres (RELC), which are run by the Ministry of Justice, for three years (Qian, Schumacher, Chen, & Ruan, 2006).

Under the *Procedures for Compulsory Drug Addiction Rehabilitation*, officers of public security departments of local governments may detain people they suspect or know are drug users in order to place them in compulsory treatment. Family members, employers, or senior community figures can also request Public Security officials detain drug users for compulsory treatment (Zhengyan, Beroud, Maojin, & Shirong, 1998).

2.3.3 Compulsory detoxification and rehabilitation centres

The compulsory drug treatment system in China treats approximately five times as many individuals as the voluntary system (Zhengyan, Beroud, Maojin, & Shirong, 1998). The bulk of these are detained in compulsory detoxification and rehabilitation centres (CDRC), which are administered by provincial-level Public Security Bureaus and reporting to the Ministry of Public Security. Nationally, there are 583 CDRC, with a total of 116,054 beds. When compulsory treatment in a CDRC is ordered, a letter stating this

is provided to the drug user. The drug user's family, workplace and local police station are also notified (National Narcotics Control Commission, 2005). The drug user may appeal the compulsory treatment order (National Narcotics Control Commission, 2005), however, no information on the frequency with which these appeals are mounted or are successful could be located.

Those detained in CDRC are referred to as "residents". Detention is usually for six months, during which time residents receive medical and psychological treatment, legal and moral education and education on the effects of drugs. Residents are also required to participate in exercise and undertake physical labour. If, at the conclusion of the rehabilitation period, there is reason to believe that the resident is not fully rehabilitated, their period of compulsory treatment can be extended to up to twelve months in total. The costs associated with receiving compulsory treatment are borne by the resident and/or their family (National Narcotics Control Commission, 2005).

Two key experts stated that drug use within CDRC is minimal, but that small amounts of heroin and ATS are occasionally found. This suggests that drug use and possibly, drug injecting, is occurring within closed settings.

Relapse following release from compulsory detoxification centres is common. Data from the National Surveillance Center on Drug Abuse indicate that 62% of heroin users who complete detoxification relapse within three days of release. A further 20% relapse within thirty days (National Surveillance Center on Drug Abuse, 2005).

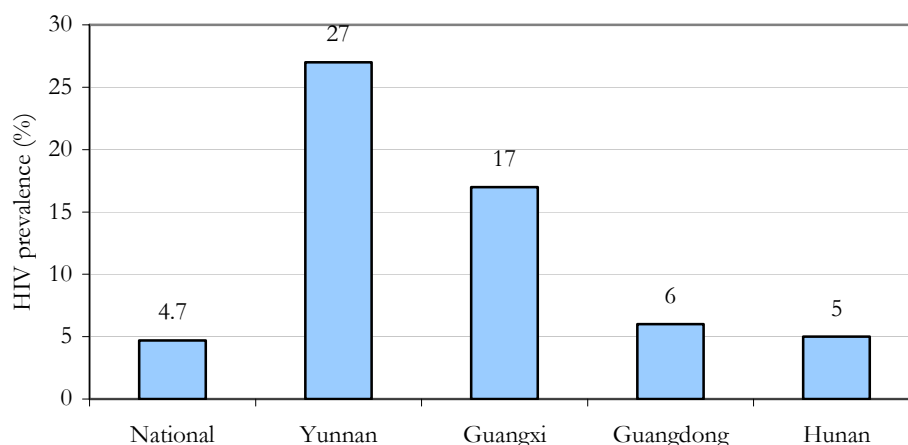
2.3.4 Re-education through labour centres

Those who are found to have relapsed to drug use after leaving CDRC are detained in re-education through labour centres (RELC) for up to three years. These centres are managed by the Bureau of Re-education Through Labour Administration, under the Ministry of Justice. Detainees in RELC are required to undertake manual labour in addition to attending education and training programs. Programs include drug education, citizenship and moral education and vocational skills training (Tang, Zhao, Zhao, & Cubells, 2006; C. Zhao et al., 2004). There are 151 labour centres with 130,000 inmates throughout China and 300,000 drug dependent individuals pass through this system annually (Tang, Zhao, Zhao, & Cubells, 2006).

Key experts reported that there is some variability as to the number of times a person may be detained in a compulsory detoxification centre before they are placed in a re-education through labour centre. Generally speaking, an individual who relapses after a single treatment episode in the CDRC is placed in an RELC. However, in some areas, two or three attempts at treatment in CDRC are permitted before the drug user is ordered to the RELC. This in part is related to the ability of the drug user or their family to pay for treatment in the more expensive detoxification centres.

Nationally, HIV prevalence in RELC is 5%, although it varies widely between provinces (see figure 2.1) (Bureau of Re-education Administration, 2006). HIV transmission is believed to occur within CDRC and RELC, although data to support this claim are unavailable (UNODC Regional Centre for East Asia and the Pacific, 2004).

Figure 2.1: HIV prevalence in re-education through labour camps, nationally and in selected provinces



Source: Bureau of Re-education Administration. (2006). Re-education centers and HIV (presentation on file with authors).

2.3.5 Demand reduction in CDRC and RELC in Guizhou, Yunnan and Shanghai

Compulsory detoxification and rehabilitation centres and re-education through labour centres are administered through separate government bodies. However, in practice they are very similar. Demand reduction strategies available in the centres include medicated detoxification services, drug and HIV education programs and in Shanghai, a pilot relapse prevention program.

2.3.5.1 Detoxification

On arrival in compulsory treatment settings, the resident is medically assessed and a treatment plan determined. Drug withdrawal symptoms are monitored for the first 7-10 days of detainment. Medications available to assist the detoxification process include methadone (provided in tapering doses) and symptom relief preparations including traditional Chinese medicine. At present, there are no standardised protocols for the provision of detoxification services. Rather, medical staff of the treatment centres rely on their experience and clinical judgement.

2.3.5.2 Methadone and other pharmacotherapies

Methadone is provided for withdrawal purposes only. No methadone maintenance programs were operational in any of the compulsory treatment centres about which information was available. However, in line with China's current up-scaling of methadone maintenance treatment, there are plans for its implementation in closed settings.

2.3.5.3 Resident programs and counselling services

Following detoxification, all residents participate in a range of education programs. These programs are typically administered by security staff of the institutions who have received training in the program content. Basic HIV education was offered in all three regions

surveyed. All residents must also attend didactic education classes on laws around drug use, morality and citizenship. The effectiveness of these programs has not been evaluated.

The availability of counselling is limited and is usually provided by trained security staff rather than professional counsellors. In Guizhou, no one-on-one counselling was available to residents, but group therapy sessions were offered. In practice, these sessions do not conform to models of counselling as a collaborative process; rather, they are didactic presentations by staff to residents. In Yunnan, some centres provide one-on-one counselling with security staff. External social workers often visit compulsory treatment centres in Shanghai to provide counselling and other assistance around drug use.

An experimental treatment is available in one compulsory detoxification centre in Guiyang, Guizhou province. It employs principles of conditioning via aversion therapy. Residents watch video footage of people smoking and injecting heroin while receiving electrical stimulation through electrodes attached to their temples. The treatment is reportedly unpopular with residents. A trial to assess treatment effectiveness is underway.

A pilot relapse prevention program is available to a small number of inmates in Shanghai Rehabilitation Labour Camp. The program consists of the standard labour camp programs with additional relapse prevention training. The training is delivered in two phases. In phase one, inmates attend up to three two-hour group sessions weekly in the two-three months prior to their release from the camp. Topics addressed in these groups include identifying and coping with high-risk situations and managing lapses. Phase two of the program takes place in the community, with psychologists maintaining weekly contact with the inmate and their family to provide support and counselling for three months. A randomised controlled trial of this program compared the standard program plus relapse prevention training to the standard labour camp program. The group receiving relapse prevention training showed significantly greater improvement on Addiction Severity Index scores than the control group and at three-month follow-up, significantly more control group participants had relapsed to drug use compared to relapse prevention participants (83% vs. 63%) (M. Zhao et al., 2005).

Physical activity is encouraged as part of the treatment program. Residents engage in daily exercise and labour, often while repeating anti-drug slogans. Creative activities such as performing are also undertaken, with a focus on education through dance and song. Residents who take part in performances attend local schools and community events to educate others about illicit drugs and HIV.

2.3.5.4 Drug-free units

Officially, there is no drug use in compulsory treatment settings; thus, there is no need to establish separate drug-free units. However, as noted above, two key experts stated that drug use does occur, albeit on a limited scale, in closed settings.

2.3.5.5 Future directions

Epidemiological studies are planned for compulsory treatment centres in Shanghai.

2.3.5 Other information

An herbal remedy known as 626 is provided to residents of Changpo, the largest detoxification centre in Kunming. This remedy was developed by a pharmaceutical company located on the grounds of Changpo. It is provided in reducing doses over 12 days and is used to alleviate withdrawal symptoms. It is claimed that 626 is “effective” in 98% of cases (McCoy et al., 1997). However, it is uncertain what is meant by “effective” and no independent evaluations of 626 could be located.

Limited evaluations of the compulsory treatment system have been carried out in other areas of China. One study in the cities of Xian and Shenzhen claimed that twelve months of compulsory treatment in labour centres resulted in 80% of detainees being rehabilitated (Wang, 1999), however, it is uncertain how rehabilitation was defined or how this figure was arrived at. A more rigorous evaluation of labour centres found that, of 120 opiate dependents detained for three years, more than half (56%) relapsed to drug use within one year (Li & Mao, 1999). The estimated abstinence rate three years after release from compulsory treatment is 15% (Tang, Zhao, Zhao, & Cubells, 2006).

The first therapeutic community (TC) in a labour camp in China, located in Hunan, was evaluated in comparison to standard re-education through labour. The modified TC program consisted of psychotherapy, relapse prevention training, vocational and social skills training, family meetings, self-help groups, recreation and labour. Six-month follow-up of TC inmates and inmates in the standard labour camp program showed that both groups had significantly lower scores on the Addiction Severity Index (ASI; lower scores indicate improvement) compared to baseline. TC inmates had significantly lower ASI scores than labour camp inmates, suggesting the modified TC was more effective than the standard labour camp program in addressing inmates’ drug dependence (M. Zhao et al., 2002).

Limited harm reduction programs, implemented by NGOs, are in place in some compulsory treatment centres. The AusAID-funded Asia Regional HIV/AIDS Project provides training and education on overdose prevention, safer injecting practices and condom use. Overdose education focuses on the mechanisms by which heroin overdose occurs, what to do and what to avoid in the event of an overdose and how to prevent overdose. This education program is suitable for both staff and residents of compulsory treatment settings. Safer injecting education is provided to residents of compulsory treatment programs through a guided discussion group. The prevention of injecting-related harms such as vein damage and infections, the transmission of blood borne viruses and overdose are discussed in detail. The focus of this group is on providing practical skills and strategies for reducing injecting-related harms.

2.4 Discussion

The Chinese government is clearly committed to reducing demand for illicit drugs. The focus of their efforts has been community education programs and compulsory treatment for drug dependent persons. In addition, community-based methadone maintenance treatment (MMT) has been made available in recent years as a tool to help reduce both illicit drug use and HIV transmission among the drug using population and their sexual partners.

On the basis of the information presented above, it appears that current practices in compulsory treatment settings are of limited effectiveness in reducing the demand for

drugs in the long-term. Key experts from within compulsory treatment centres signalled their awareness of this fact, and also their willingness to adopt evidence-based approaches to drug treatment. It was suggested by several KE that staff of compulsory treatment centres require training to improve their understanding of drug dependence and treatment options such as counselling. Such training could also extend to include training in specific drug treatment interventions such as motivational interviewing or relapse prevention.

The results of two studies in particular may provide guidance in improving treatment effectiveness in Chinese compulsory treatment centres. The relapse prevention program in a re-education through labour centre in Shanghai has resulted in increased abstinence levels among released residents, while the Hunan therapeutic community also resulted in improved resident outcomes (M. Zhao et al., 2002; M. Zhao et al., 2005). Expansion of these programs, which have been designed specifically for Chinese populations, is to be encouraged.

A further consideration of particular relevance to the Chinese context concerns MMT. If methadone maintenance patients are placed in compulsory treatment, they will experience withdrawal from methadone. Options for compulsory treatment centres with methadone-maintained residents will be to treat methadone withdrawal, or alternatively, continue to provide methadone throughout the period of compulsory treatment. The latter option will assist in co-ordinating treatment for individuals moving between compulsory treatment and the community.

3. INDONESIA



3.1 Drug use situation

Estimates of the number of drug users in Indonesia vary widely. Government estimates state that there are between 1.3 and 2 million drug users in Indonesia, with up to 40,000 of them injectors (Directorate General Correction, 2005). Others estimate that there are between 148,000-167,000 (Pisani, 2006), or as many as one million, injecting drug users in Indonesia (Aceijas, Stimson, Hickman, & Rhodes, 2004).

Cannabis is the most frequently used illicit drug, followed by amphetamine-type stimulants (ATS). ATS are usually consumed by smoking or swallowing. Heroin is the most frequently injected drug in Indonesia and the drug for which most people seek treatment. Additionally, while cocaine is rare, there have been marked increases in use, including injection, in recent years (UNODC Regional Centre for East Asia and the Pacific, 2005).

HIV has spread rapidly through Indonesian IDUs. In 1997, HIV prevalence among IDUs treated at the RSKO Hospital, Jakarta, was zero. By 2001, it had risen to 48% (Riono & Jazant, 2004). In 2002, it was estimated that 20-33% of IDUs across the country were infected (Ministry of Health Indonesia, 2003), and it has been estimated that up to 80% of new infections are due to injecting drug use (IHRD, 2006). There is potential for this concentrated epidemic to expand into the general community through unsafe sexual practices. In a survey of IDUs in Jakarta, Surabaya and Bandung, almost half reported multiple sex partners but less than 10% reported consistent condom use. A high proportion (40%) of IDUs had visited a sex worker in the previous 12 months, of whom 88% stated that they rarely or never used condoms (Pisani, Dadun, Sucahya, Kamil, & Jazant, 2003). With such high prevalence of HIV and risk behaviours, transmission to non-injecting sexual partners is inevitable and the risk of a generalised epidemic is high.

3.2 Demand reduction in the community

A wide range of demand reduction strategies has been implemented in the community in Indonesia in an effort to stem the HIV epidemic. Education seminars and workshops aimed at preventing drug use among young people are common. These are conducted by the National Narcotics Board (BNN) and various NGOs (Centre for Harm Reduction, 2005a, , 2005b). Voluntary drug treatments and services are available including detoxification, counselling, residential rehabilitation and in some areas, methadone maintenance (Passa, 2005; UNODC Regional Centre for East Asia and the Pacific, 2005). Private drug treatment and rehabilitation centres exist in addition to numerous NGO-operated treatment and rehabilitation programs (AIDS Project Management Group, 2005). The Drug Dependency Hospital (RSKO) is the largest drug treatment centre in Jakarta, in the main providing short-term detoxification services. The hospital also runs a pilot methadone maintenance treatment program. In addition to providing MMT, Sanglah Hospital in Denpasar offers HIV education, cognitive behaviour group therapy sessions and voluntary counselling and testing (Passa, 2005). Other locations in which MMT is available include Fatmawati Hospital, Jakarta and Dr. Soetomo Hospital, Surabaya (Centre for Harm Reduction, 2005b). These programs are generally small-scale and often dependent on donor funding. Preliminary findings from small MMT programs in Jakarta and Denpasar show that after six months in treatment, IDUs reduce their drug use, criminal behaviours and HIV risk behaviours (World Health Organization, 2005b).

3.3 Demand reduction in institutional settings

3.3.1 Data collection

An extensive literature review was undertaken to identify published and unpublished literature relating to drug treatment and demand reduction in Indonesia, with an emphasis on prison-based programs. In addition, a fact-finding mission was undertaken to Cipinang, Kerobokan and Banceuy prisons and prison authorities and employees, prison health workers and prisoners were interviewed. A translator was present during the interviews. The same translator prepared English-language transcriptions of the interviews. Local key experts provided information where gaps remained in the data collected. A number of documents were supplied in Bahasa; these were translated by a native speaker.

3.3.2 Legal and policy environment

Indonesia is known for issuing severe penalties, including death sentences, to those convicted of drug-related crimes. The *Law of the Republic of Indonesia No. 22, 1997, on Narcotics* sets out penalties for the manufacture, distribution and consumption of illicit drugs. Many offences do not distinguish between the sale and purchase of drugs, meaning drug users can face the same harsh penalties as drug dealers. The narcotics law also mandates that drug dependent individuals must report to government authorities for treatment, and can be imprisoned for up to six months for failing to do so. It is unclear if this aspect of the legislation is enforced.

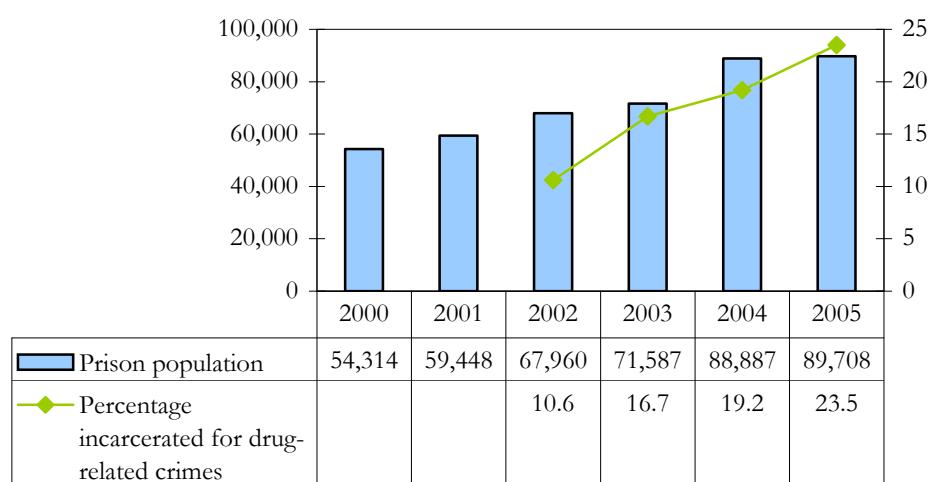
The Indonesian government has produced a national strategy for the linked issues of drug use and HIV transmission in closed settings. The *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention* outlines the approach of the Directorate General Correction to these dual epidemics. The Strategy adopts a harm minimisation approach to drug use in prison, advocating measures to

reduce the supply of drugs, the demand for drugs, and the harms associated with drug use. Demand reduction strategies recommended in the strategy include education about drug dependence and methadone maintenance treatment (Directorate General Correction, 2005; Winarso et al., 2006).

3.3.3 Narcotic prisons

The Directorate General Corrections, under the Ministry of Law and Human Rights, is the government office responsible for Indonesian prisons. There are 402 prisons across the country. The prison population has grown rapidly in recent years, increasing from 54,314 in 2001 to 88,887 in 2004, exceeding the capacity of 68,141. Simultaneously, the proportion of inmates incarcerated for drug related crimes has rapidly increased, from 10% in 2002 to 23% in 2005 (see figure 3.1). Official estimates state that approximately 20% of all prisoners are drug users (Directorate General Correction, 2005), however, research suggests that 50% is a more reliable estimate (UNODC Regional Centre for East Asia and the Pacific, 2005).

Figure 3.1: Indonesian prison population, 2000-2005; and percentage of prison population incarcerated for drug related crimes, 2002-2005.



Source: Directorate General Correction. (2005). *National Strategy: Prevention and Control HIV/AIDS and Drug Abuse Indonesian Correction and Detention 2005-2009*. Jakarta: Directorate General Corrections; Winarso, I., Irawati, I., Eka, B., Nevendorff, L., Handoyo, P., Salim, H., et al. (2006). Indonesian National Strategy for HIV/AIDS control in prisons: A public health approach for prisoners. *International Journal of Prisoner Health*, 2, 243-249. Data on proportion of prisoners incarcerated for drug-related offences in 2000-2001 was unavailable.

Thirteen correctional institutions are designated narcotic prisons, accommodating those convicted of drug use or dealing. The goal of narcotic prisons is to provide treatment and rehabilitation to inmates. However, due to overcrowding, some inmates convicted of drug-related offences are housed in general prisons (Directorate General Correction, 2005). Involvement in drug treatment is voluntary for all prisoners.

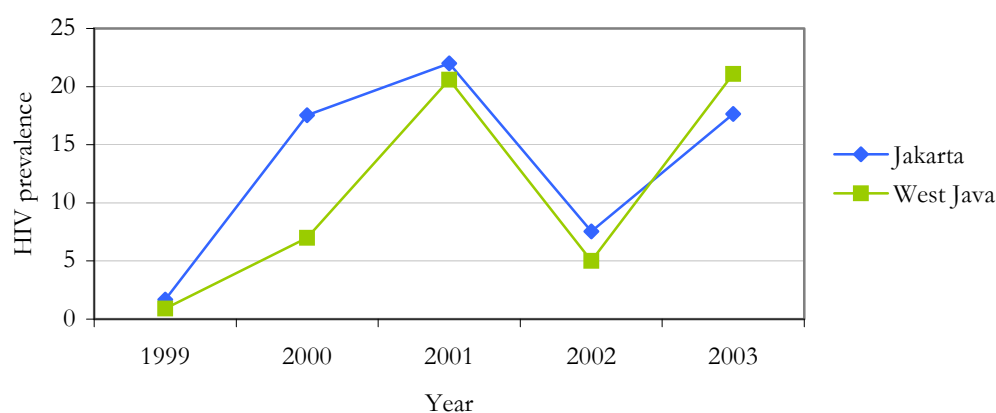
The Indonesian government has acknowledged that drug use occurs in prisons. No data are available on the extent of drug use in prison, however, interviewees admitted that

visitors to prisons are sometimes found to have drugs on them, including heroin, amphetamine-type stimulants and cannabis. Other interviewees stated that all types of drugs are available in prisons. The Indonesian print media regularly publishes details of drug trafficking in prisons, including the involvement of prison guards in drug dealing. The cases most commonly involved amphetamine-type stimulants such as *shabu-shabu* (methamphetamine) and ecstasy (Centre for Harm Reduction, 2005a, , 2005b) An unpublished report (Dolan, 2005) cites prisoners, prison guards and prison health staff who agreed that drug use, including injecting, is widespread in Indonesian prisons.

HIV is a major concern for Indonesian prisons. In 2002, HIV prevalence across all prisons was estimated at 8-12% (Ministry of Health Indonesia, 2003). Studies in specific sites show prevalence to be as high as 19-21% in some institutions (Directorate General Correction, 2005; National AIDS Commission Indonesia, 2006). Key experts disclosed that of 180 inmates tested in one narcotic prison, 120, or 67%, were HIV positive. However, it is unknown whether the sample was representative or selected according to previous risk behaviours. Data from the National Narcotics Agency (BNN) show that half of incarcerated drug users are HIV-infected (Sabarini, 2006). Prisoner deaths due to AIDS-related illnesses have been reported in the Indonesian media, including 80 deaths in one prison in Jakarta in 2004 and 30 deaths in Cipinang Prison between January and March 2005 (Centre for Harm Reduction, 2005a, , 2005b).

HIV prevalence data from Indonesian prisons are strongly suggestive of intra-prison HIV transmission. The data in figure 3.2 show HIV prevalence in prison in Jakarta and West Java, 1999-2003, as determined by anonymous surveillance surveys. Recorded prevalence increases between 1999-2001, before a sharp decrease in 2002. This does not represent a real drop in prevalence in the prisons, but reflects a change in data collection methods. In 2002, only newly-received inmates were included in the surveillance sample. In 2003, the sampling strategy again included all inmates, and prevalence returned to the levels seen in 2001 (Directorate General Correction, 2005). These data show that only 5%-10% of inmates are HIV-positive on entry to these prisons, but that approximately 20% of the total population are infected. While not conclusive, this suggests that HIV is being transmitted in prison, through unsafe drug injecting, unprotected sexual activity and other risk behaviours (MAP, 2004).

Figure 3.2: HIV prevalence in prison in Jakarta and West Java, 1999-2003.



Source: National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention: 2005-2009. Jakarta, Directorate General Correction, 2005.

3.3.4 Demand reduction in Cipinang narcotic prison, Jakarta; Kerobokan prison, Bali; and Banceuy narcotic prison, Bandung

Cipinang and Banceuy prisons are both narcotic prisons. Kerobokan prison holds both drug- and non-drug related offenders. Just over half (51%) of inmates at Kerobokan have been imprisoned for drug-related offences (Irawati, Mesquita, Winarso, Hartawan, & Asih, 2006).

3.3.4.1 Detoxification

No formal detoxification services are provided as inmates have typically completed withdrawal prior to their arrival at prison. Those who experience withdrawal symptoms in prison are offered paracetamol only. There is insufficient funding for other medications. At Kerobokan, psychosocial support during detoxification is provided by NGOs.

3.3.4.2 Methadone and other pharmacotherapies

Kerobokan prison operates what is currently the only prison-based methadone maintenance program in Indonesia. The program is a satellite of the community methadone maintenance program run by Sanglah Hospital. The program began in August 2005. In July 2006, there were 31 patients receiving methadone daily (Irawati, Mesquita, Winarso, Hartawan, & Asih, 2006). Four new patient places are made available each month.

Inclusion criteria for participation in the program include a history of opiate dependence as defined by the DSM-IV, being male, being aged over 20 and serving a term of at least 12 months. Inmates with liver or kidney disease are excluded. Inmates who wish to begin methadone treatment present to a clinic within the prison. The inmate is first referred to a counsellor, who provides a detailed explanation of the program. Following this, the inmate is clinically assessed and the dose is determined. The inmate must then present daily for dosing, which is supervised by nurses and social workers. Regular counselling is provided as an adjunct to treatment.

While on the program, allowance is made for inmates who vomit within forty-five minutes of dosing, with replacement doses provided. Those who miss three consecutive doses are re-assessed on their next presentation. Inmates who miss five consecutive doses are considered to have dropped out of the program. Inmates may be discharged from the program if they are involved in violence or aggression towards clinic staff or other patients. After 18-24 months, the prison doctor and/or psychiatrist and the inmate will discuss ceasing MMT. Inmates who decide to cease treatment will be placed on a reducing schedule.

3.3.4.3 Inmate programs and counselling services

Drug and HIV education programs are available to inmates. Education sessions are usually scheduled to run several times a week, however, funding shortfalls can reduce the number of sessions offered. A number of inmates have been trained as peer educators to improve the provision and coverage of HIV and drug education.

A World Health Organization HIV education program, *HIV 101*, has been implemented in Kerobokan prison. This program provides information about HIV transmission and

prevention and harm reduction. An evaluation found that participants' HIV knowledge significantly increased after undertaking this program. Inmates who had completed the program showed improved behaviour and violent incidents had decreased. Those who had completed the program also shared the information they had learnt with their families and other prisoners and relations between HIV negative and HIV positive prisoners had improved (Angela, Booker, & Morgan, 2005).

A psychologist is available for consultation with inmates at Cipinang prison. Key experts stated that the psychologist sees an average of 180 inmates a week. Counselling related to substance use was available, as was pre- and post-HIV test counselling. Counselling was also available at Kerobokan and Banceuy.

A cognitive-behaviour therapy (CBT) program has been developed specifically for use with drug using inmates in Kerobokan prison. Topics covered in this program include coping with cravings and increasing motivation to cease drug use and remain abstinent. Practical skills such as functional analysis and problem solving are taught. An evaluation of this program was carried out through interviews with prison directors and guards and program facilitators. The director of Kerobokan prison reported that the CBT program had led to inmates behaving more positively towards each other and more co-operatively with prison staff. Prison staff reported that inmates who had completed the program no longer broke prison rules. The evaluation concluded that the CBT program had a positive impact on both prisoners and the prison environment (Angela, Booker, & Morgan, 2005).

Therapeutic communities were operating in all prisons surveyed. In Kerobokan, many of the inmates in the therapeutic community are also in methadone maintenance treatment. To date, the therapeutic communities have not been evaluated.

The "Criminon" program has been implemented at Cipinang narcotic prison. This is an education program, developed by the Church of Scientology, that aims to reduce recidivism by providing drug education and rehabilitation, education in ethics and morality and skills training in areas such as anger management and communication. The program has not been evaluated.

Regular Narcotics Anonymous meetings are held in Kerobokan and Banceuy prisons. All interested inmates may attend. "Gang Anonymous" meetings are also held to assist inmates to remain outside gang activity in prison and the community.

Therapeutic discussion groups are held in Kerobokan prison. One discussion group focuses on providing support for drug dependent inmates; the other on providing support for HIV positive inmates.

Vocational training is provided to inmates in all prisons surveyed. Inmates are trained in handicrafts and similar activities. These are sold to provide income to the prisoners.

3.3.4.4 Drug-free units

Cipinang has several drug-free units. Prisoners enter voluntarily. They must pledge to remain abstinent from drugs, sexual activity and not engage in violence. These prisoners are housed separately from others.

Key experts noted that drug-free units were in operation in Kerobokan, but pointed out that drugs were known to enter these units. One interviewee suggested that establishing a drug-free unit close to the medical clinic where MMT is provided could be useful.

3.3.4.5 Other demand reduction strategies/information

Several government departments that previously provided services to inmates have recently ceased this assistance. For example, the Department of Education has previously taught reading and writing to inmates of Kerobokan prison but these classes have stopped. The Department responsible for employment ceased visiting inmates in 2005.

3.3.4.6 Future directions

The expansion of methadone maintenance treatment to others prisons, including Cipinang and Banceuy, is planned.

As noted above, several prisons have implemented the “Criminon” program. At least 21 correctional officers have completed training in conducting the Criminon program and the expansion of this program is planned (Directorate General Correction, 2003).

Lack of funding restricts research and program implementation, however, key experts stated that they want to monitor hepatitis C infection among the inmate population and conduct an evaluation of the prison methadone maintenance program.

3.3.5 Other information

Several prisons, including Wirogunan in Yogyakarta, are reported to have implemented religious-based rehabilitation programs, which include attending religious services and late night prayers.

Working committees on HIV in prison are being formed on a regional basis. The first of these was established in Bali. The committee will oversee HIV education and prevention programs at Kerobokan and Bangli prisons (Juniartha, 2004). Other working committees around the country are developing networks with NGOs to provide HIV-related services to inmates (Prabawanti & Puteranto, 2005).

At a national level, linkages are being established between the Ministry of Justice and Human Rights, the Ministry of Health and the Ministry of Home Affairs. This will facilitate the provision of drug treatment.

Complementing the variety of demand reduction strategies available, harm reduction programs have been introduced into many narcotic prisons. The Indonesian HIV/AIDS Prevention and Care Project, funded by the Australian and Indonesian governments, provides bleach and condoms in nine prisons (see also figure 3.3). Prisoners can access these anonymously. This project also provides HIV education for prisoners and staff, referrals for voluntary counselling and testing, and referrals to HIV/AIDS treatment and care (Winarso et al., 2006).



Fig 3.3: Cupboard containing condoms and bleach, and instructions for using bleach to clean syringes in Kerobokan prison, Bali. Photos: Kate Dolan.

3.4 Discussion

Indonesia stands out for its commitment to providing education and evidence-based treatment to drug users in prison. This is demonstrated in the development of the *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention*, the only one of its kind in the region. This strategy is valuable in that it acknowledges a number of facts of prison life that are often denied. Firstly, it accepts that drug injection and consensual and non-consensual sexual activity occurs in prisons. It also acknowledges that these behaviours can lead to HIV transmission between prisoners. Finally, it accepts that prison authorities have a responsibility to implement measures to reduce drug use and HIV transmission, including methadone maintenance treatment and condom and bleach provision.

Another strength of this strategy is its breadth of coverage. While the focus is generally on HIV prevention and care rather than injecting drug use in itself, the strategy promotes the use of supply, demand and harm reduction approaches to drug use. In relation to demand reduction specifically, the promotion of methadone maintenance treatment in institutional settings is a positive step that will assist in reducing drug use and related HIV transmission. However, provision of demand reduction strategies is limited by lack of resources and funding. For example, one group of interviewees commented that the frequency with which drug and HIV education classes can be provided depends on funding being available.

While the breadth of programs on offer is good, the quality of service provision is unknown. For example, KE stated that the psychologist at Cipinang sees 180 inmates a week; it would be extremely difficult to provide quality assessment and treatment with such a high case load. The Criminon program is promoted as evidence-based by its

developers, the Church of Scientology, but no independent or peer-reviewed evaluations could be identified to confirm this.

The quality of service provision could be improved through program evaluations. Evaluations of existing programs are limited. Again, this is in part due to a lack of funds. However, program evaluations are valuable for ensuring resources are used effectively and efficiently and it is recommended that the Directorate General Correction investigate opportunities to seek international funding and assistance to conduct such evaluations.

4 VIET NAM



4.1 Drug use situation

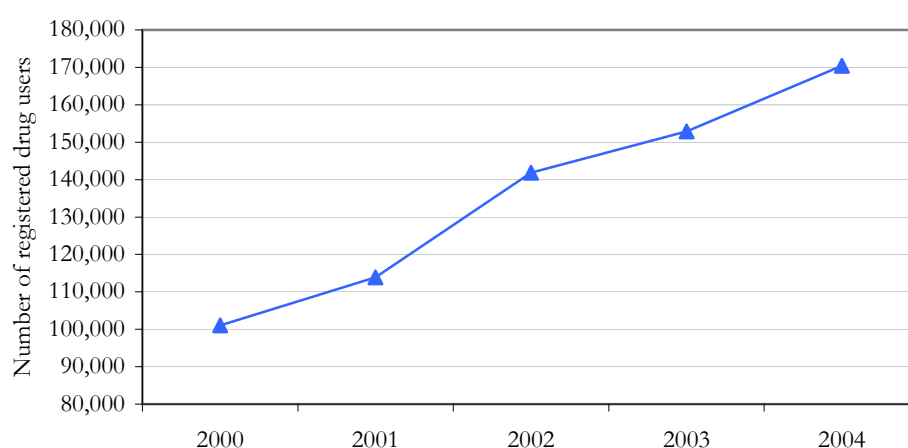
Prior to the 1990s, drug use in Vietnam was largely restricted to opium and cannabis smoking. Throughout the 1990s, the availability of heroin increased and the age of drug users in contact with government agencies decreased. A steady increase in the number of registered drug users was recorded from 2000 to 2004 (see figure 4.1). In 2000, heroin was the main drug used by 80% of drug users in contact with authorities (UNODC Regional Centre for East Asia and the Pacific, 2006).

In 2004, the Ministry of Health reported that there were 170,400 registered drug dependent individuals in Viet Nam (UNODC Country Office Viet Nam, 2005).¹ Of these, 88%, or approximately 150,000, were injecting drug users (UNODC Regional

¹ The names of registered “drug addicts” are removed from the register only if the person is drug-free for a period of three years, is imprisoned or dies (USAID/MOLISA, 2006).

Centre for East Asia and the Pacific, 2006). Some sources note that these figures are likely an underestimation of the true extent of drug use (Devaney, Reid, & Baldwin, 2006). However, a recent study by the United Nations Reference Group on HIV/AIDS and Injecting Drug Use produced a high-level estimate of 156,000 injecting drug users (Aceijas, Stimson, Hickman, & Rhodes, 2004), similar to the official figure released by the Ministry of Health. Heroin, usually injected, remains the most widely used drug, although consumption of methamphetamine pills is increasing (UNODC Regional Centre for East Asia and the Pacific, 2006).

Figure 4.1: Registered drugs users in Viet Nam, 2000-2004



Source: UNODC Country Office Viet Nam. (2005). *Country Profile: Viet Nam*. Hanoi: UNODC.

As in other countries in the region, HIV has spread rapidly throughout Viet Nam. In May 2006, a cumulative total of 108,000 cases of HIV infection had been reported (Vietnam Administration of HIV/AIDS Control, 2006) and in 2005, estimated adult prevalence was 0.5% (UNAIDS, 2006). Injecting drug use has been a primary mode of HIV transmission, with injecting drug use accounting for just over half (51%) of all HIV infections in 2003 (Hien, Long, & Huan, 2004). Prevalence of HIV among injecting drug users varies throughout the country. Nationally, HIV prevalence among IDUs in 2005 was estimated at 34% (Ministry of Health, 2005). However, in Ho Chi Minh City in 2004, over half (53%) of IDUs were HIV-infected (Hien, Long, & Huan, 2004) and it is reported that HIV prevalence levels over 40% “are not uncommon” within IDU communities (Ministry of Health, 2005).

4.2 Demand reduction in the community

The national government has characterised illicit drug use as a “social evil” that must be eliminated through education and treatment of current drug users. Prevention of initiation of drug use is the focus of drug education campaigns, to the exclusion of messages aimed at reducing drug-related harms. Under the *Law on Narcotic Drugs Prevention and Suppression* (Narcotics Law), enacted in 2001, individuals, educational institutions and government-sponsored organisations are all responsible for preventing drug use, primarily through the provision of education about drug laws (National Assembly of the Socialist Republic of Vietnam, 2000).

While the majority of drug treatment is provided compulsorily in closed settings, there are some community-based treatment options. However, the focus of treatment is usually detoxification, with little follow-up or ongoing support. Options for those volunteering for treatment include home-based detoxification or admittance to a private residential drug rehabilitation centre for detoxification, moral education and information about HIV prevention (National Assembly of the Socialist Republic of Vietnam, 2000; Trang, 2001). Individuals may also voluntarily enter compulsory treatment facilities. However, access to private treatment and voluntary treatment in closed settings is limited, as the patient is required to meet all costs.

Numerous non-government organisations and international agencies are active in Viet Nam. The majority focus on harm reduction activities such as outreach, peer education, safer sex education and small-scale needle and syringe programs. Others provide a mix of harm and demand reduction projects. From 2004-2007, UNODC has conducted a project aimed at preventing initiation to drug use, particularly among young people. This project has included the provision of training to professional and volunteer drug prevention advocates and the development of anti-drug resources such as posters, leaflets and newsletters (UNODC Viet Nam, 2004). A second UNODC project is concerned with drug use prevention and treatment among ethnic minorities in highland provinces. This project has developed culturally appropriate drug education materials, provided training on HIV and harm reduction to local law enforcement officers, established a network of peer educators and established needle and syringe programs in two provinces. Additionally, a culturally appropriate, voluntary drug treatment program was developed. The program is of three months duration and consists of medically supervised detoxification, vocational training, HIV education and basic life skills. Long-term follow-up programs include local peer support and relapse prevention groups and micro-credit programs to enable financial independence (UNODC Viet Nam, 2005).

At present, methadone maintenance treatment (MMT) is available only through a small number of pilot projects. However, support for the wider implementation of MMT is growing. The National Mental Health Institute of Vietnam has recommended the establishment of methadone maintenance treatment centres (Ministry of Health Viet Nam, 2005) and a nationwide community survey of 4,000 people demonstrated that there is strong public support for this strategy, with three-quarters of respondents agreeing that long-term substitution treatment should be available to drug users (Centre for Public Opinion Surveys, 2005). The *Law on HIV/AIDS Prevention and Control* (AIDS Law), which came into effect on January 1, 2007, specifically refers to the introduction of harm reduction and demand reduction interventions for drug users, including opioid substitution treatments (National Assembly of the Socialist Republic of Vietnam, 2006).

4.3 Demand reduction in institutional settings

4.3.1 Data collection

An extensive literature review was undertaken to identify published and unpublished literature relating to drug treatment and demand reduction in Viet Nam, with an emphasis on programs in compulsory drug treatment centres.

A fact-finding mission was undertaken to a compulsory drug treatment institution in Ba Vi, near Hanoi. Interviews with health and security staff of this institution were conducted. A translator was present during these interviews. Additionally, several

residents of this centre spoke with the translator and interviewers, but only in the presence of centre officials.

Interviews were also conducted with key experts from the Department of Social Evils Prevention, Ministry of Labour, Invalids and Social Affairs. Local key experts, predominantly staff of NGOs working in compulsory drug treatment settings, provided information where gaps remained in the data collected. A number of documents were supplied in Vietnamese; these were translated by a native speaker.

Unless otherwise referenced, information below was obtained during interviews with staff and trainees of the No. 1 and No. 4 06 Centres, Ba Vi, and other key experts.

4.3.1 Legal and policy environment

The *Narcotic Drugs Prevention and Control Master Plan up to 2010* (Drug Master Plan; National Assembly of the Socialist Republic of Vietnam, 2005) outlines the Vietnamese government's approach to drug use as a "social evil" (*te nan xa boi*). The social evils campaign began in 1995, and was designed to mobilise bureaucratic institutions and community organisations against activities such as drug use and commercial sex (Marr & Rosen, 1998).

The *Law on Narcotic Drugs Prevention and Suppression* (the Narcotics law; National Assembly of the Socialist Republic of Vietnam, 2000) outlaws the use, possession and distribution of illicit substances (as determined by the national government). Under this law, it is also an offence for a drug dependent person to fail to register for detoxification, or to "resist or obstruct" detoxification. Those who do not voluntarily present to the authorities for detoxification may be detained in social education and labour centres for compulsory detoxification.

The recently passed *Law on HIV/AIDS Prevention and Control* (AIDS Law; National Assembly of the Socialist Republic of Vietnam, 2006) has implications for illicit drug users. This law states that harm reduction measures to prevent HIV transmission in high-risk groups should be implemented, although does not define what these measures may be. The *National Strategy on HIV/AIDS Prevention and Control in Viet Nam* (National Assembly of the Socialist Republic of Vietnam, 2004) includes scaling up of harm reduction strategies as a priority. Activities included under harm reduction in this document include needle and syringe programs and condom distribution. Neither of these documents reference demand reduction as an HIV prevention strategy.

4.3.2 05-06 centres

Viet Nam's social education and labour centres (SELC) were established as part of the social evils campaign to provide rehabilitation and re-education to drug dependent individuals. The Department of Social Evils Prevention (DSEP), under the Ministry of Labour, Invalids and Social Affairs (MOLISA) is responsible for the administration of the majority of SELC, with others run by the Vietnamese Youth Union.

SELC are commonly referred to as 05 and 06 centres. 05 centres are primarily for female sex workers, but also house female drug users, who may or may not also be sex workers. 06 centres hold male drug users. There are 83 05-06 centres throughout the country. As noted above, some drug users voluntarily seek treatment in 05-06 centres; however, the

majority of detainees are treated compulsorily following arrest. Detention in 05-06 centres is usually for two years, but in Ho Chi Minh City can be for five years. Those detained in 05-06 centres are referred to as trainees. Nationwide, there are 50,000-55,000 trainees in 05-06 centres, all of whom are required to contribute to the cost of their treatment.

05-06 centres are often overcrowded, although rural centres tend to be less so compared to those in urban areas (Human Rights Watch, 2006). There are also reports of drug use, mainly heroin, in 05-06 centres, but these are officially denied (UNDP, 1998). During the site visit, visitors and trainees were observed interacting and it was noted that visitors are allowed full contact with trainees and can provide them with medications and food. This could be a route by which illicit drugs enter the centres. HIV is a major concern; several key experts independently stated that approximately 65% of trainees in 05-06 centres in Ho Chi Minh City are HIV-infected, and that HIV prevalence is between 40-60% in 05-06 centres across the country. The combination of heroin injection and high HIV prevalence makes HIV transmission within 05-06 centres a possibility.

4.3.3 Demand reduction in 05-06 centres

All centres provide detoxification services and education in morality and citizenship. However, it was noted by a number of sources that activities in centres vary widely depending on factors such as geographical location, centre management and staffing.

4.3.3.1 Detoxification

All trainees undergo detoxification. Medical supervision is provided where possible, however, most trainees undergo detoxification without medical assistance. Benzodiazepines may be available in some cases. A period of 10-20 days is allowed for detoxification, after which trainees submit to a urine test. If this test is clear, trainees pass to the next stage. Testing positive for illicit drugs result in the trainee spending more time in detoxification.

Trainees at the Ba Vi 06 centre suggested that making acupuncture available to trainees may assist in reducing the discomfort of detoxification.

4.3.3.2 Methadone and other pharmacotherapies

At the time of writing, no 05-06 centres provided methadone or other opioid agonist pharmacotherapies. In some centres, trials of naltrexone as a relapse prevention agent were underway. Naltrexone is administered for one month prior to release from the 05-06 centre and treatment is continued following the trainee's return to the community. A study of 384 trainees found that after six months, 70% had relapsed to drug use (Communist Party of Vietnam, 2006).

4.3.3.3 Trainee programs and counselling services

It is in program availability that 05-06 centres vary most widely. The majority of centres provide basic school-level education and classes in morality and citizenship. Most centres also require participation in labour activities. These may range from farming to mechanics to producing goods such as handicrafts and toys for sale.

Programs beyond these typically depend on international donor funding, meaning they are usually time-limited and implemented in only a few centres. As in the community, most programs have focused on HIV prevention and other harm reduction activities. However, some agencies have implemented demand reduction programs.

The Living Values Education Program (LVEP) has been implemented in 05-06 centres in Hanoi and Ho Chi Minh City. This program encourages positive attitudes and values such as respect for self and others, tolerance and honesty. LVEP has also developed a program specifically for people recovering from drug dependence, focusing on rebuilding relationships with family, dealing with emotional issues that arise following cessation of drug use and developing skills in relapse prevention. Employees of 05-06 centres were trained in providing the Living Values program with the aim that there would be ongoing classes.

A model relapse prevention program involving 12-15 trainees and their families has been developed at the 05-06 centre in Lang Son. This program was developed by Catholic Relief Services (CRS) in collaboration with a local NGO, the Centre for Community Health and Development (COHED), and Lang Son Provincial Health Services. Pre- and post-release counselling is also offered and a micro-credit/job placement program is being developed.

Some 05/06 staff have been trained in the therapeutic community model of drug treatment. However, at the time of writing no therapeutic communities were in operation in 05/06 centres

4.3.3.4 Drug-free units

Officially, there is no drug use in 05-06 centres, and thus no need to operate specific drug-free units. However, a “drug-free space” has been established in a centre in Lang Son to provide counselling and other activities. As above, this project was supported by CRS, COHED and Lang Son Provincial Health Services.

4.3.3.5 Other demand reduction strategies/information

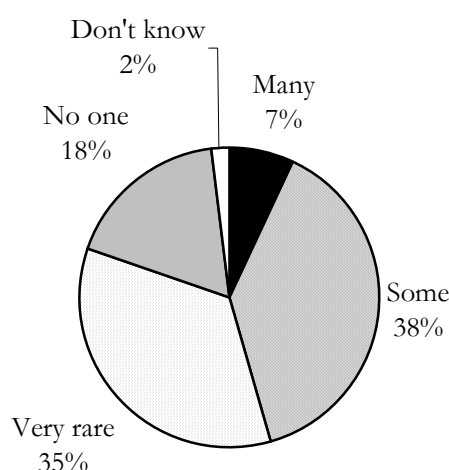
In collaboration with the USAID-funded Health Policy Initiative, the DSEP has conducted research into the costs associated with 05-06 centres in comparison to community-based opioid substitution treatment (e.g. methadone maintenance) and needle and syringe programs. It is estimated that, between 2006 and 2015, on average VND213 billion (US\$13.3 million) will be required annually to maintain the current approach of incarceration. In 2006, the annual cost per trainee in an 05-06 centre was VND3.6 million (US\$400) in rural areas and VND8.9 million (US\$554) in urban areas. In comparison, the annual cost per patient of opioid substitution treatment was estimated in the range VND4.7 million-VND9.4 million (US\$292-\$587). Harm reduction, in the form of needle and syringe programs was the least expensive strategy at only US\$20 per injecting drug user per year (see table 4.1) (USAID & Department of Social Evils Prevention, 2006).

Table 4.1: Comparison of annual costs associated with interventions for IDU

	VND	US\$
Annual cost per trainee in 05-06 centres		
Rural areas	3,594,600	400
Urban areas	8,898,632	554
Annual cost per IDU		
Opioid substitution treatment	4,664,992 - 9,377,912	292 - 587
Needle and syringe programs	243,315 - 337,413	15 - 21

There is evidence that despite official support of 05-06 centres, the general public is uncertain of their effectiveness. A national survey conducted in 2005 asked respondents to estimate the number of drug users successfully treated in 05-06 centres in their area. Only seven per cent of 4,000 respondents thought that the centres had successfully treated “many” drug users, while 18% believed that no one had been treated successfully and a third thought it was “very rare” (see figure 4.2) (Centre for Public Opinion Surveys, 2005).

Figure 4.2 Public opinion of the proportion of drug users successfully treated in 05-06 centres



4.3.4 Other information

Several NGOs are active in providing HIV prevention and harm reduction education to both staff and trainees of 05-06 centres. The Asia Regional HIV/AIDS Project (ARHP) has conducted a large capacity building program in Soc Son 06 centre, Hanoi. Staff responsible for providing education to trainees were trained in HIV prevention and reducing drug-related harm. Basic skills in effective educational methods and counselling techniques were also taught. An evaluation of this project found that attitudes of staff members towards people living with HIV/AIDS improved, knowledge of HIV transmission and drug dependency increased and communication skills improved (Thi Le, 2006).

The project also trained 60 peer educators (PE) to provide HIV and harm reduction education. The program evaluation found that, as with staff trained through the program, PE showed improved attitudes towards PLWHA and increased knowledge of HIV transmission and drug dependency. PE also felt pride in their role as someone who could be asked for help or information (Thi Le, 2006).

4.4 Discussion

The Vietnamese approach to demand reduction has focused on community education campaigns and compulsory treatment for drug dependent individuals. In Viet Nam, illicit drug use is a highly stigmatised behaviour. This stigma is reinforced by the government's conceptualisation of drug use as a "social evil". The social evils campaign was initiated in order to eliminate drug use; however, it has been ineffective in achieving this goal and more than likely has been counter-productive. By stigmatising drug use, dependent drug users are less likely to access treatment and support services. Rather, they continue to use drugs covertly and remain at risk of contracting or transmitting HIV. A shift in policy that reduces the stigma associated with drug use may assist in improving access to treatment and other services for drug users.

The most widely available demand reduction programs in 05-06 centres are moral education and labour. These are of limited effectiveness, as evidenced by the high relapse rate among trainees. However, some centres have attracted donor funding which has enabled the implementation of a wider range of programs, such as the Living Values Education Program. There is still a need to introduce programs specifically targeted to the treatment of drug dependence. Examples of such programs include therapeutic communities and methadone maintenance treatment. At present, methadone and other opioid agonists are not widely available in Viet Nam and their legal status is uncertain. The legislative framework around opioid agonists may need to be clarified before maintenance treatment can be introduced into 05-06 centres.

Medical treatment for opioid dependence has focused on naltrexone, an opioid antagonist. A trial is underway of the effectiveness of naltrexone in preventing relapse among 05-06 centre trainees who have returned to the community. This is a treatment option that has been found to be effective for only a small proportion of opioid dependent people (Kirchmayer, Davoli, & Verster, 2003), but is associated with high levels of mortality compared to other treatments for opioid dependence (Gibson & Degenhardt, 2005; Ritter, 2002). Naltrexone treatment may also exacerbate symptoms of depression (Ritter, 2002). Extreme caution should be exercised throughout this trial in order to ensure the safety and wellbeing of participating trainees.

5. SUMMARY

5.1 Drug use and injecting-related HIV transmission

Illicit drug use is a major concern for China, Indonesia and Viet Nam. Heroin is the most commonly injected drug in all three countries, but the use of amphetamine-type stimulants such as methamphetamine and ecstasy is increasing throughout the region.

Injecting drug use is one of the main drivers of the HIV epidemic in each of these countries (see figure 5.1), and estimates of HIV prevalence among IDUs range from 34% in Viet Nam to as high as 60-80% in parts of China (see figure 5.2).

Figure 5.1: Percent of new HIV infections due to injecting drug use, by country

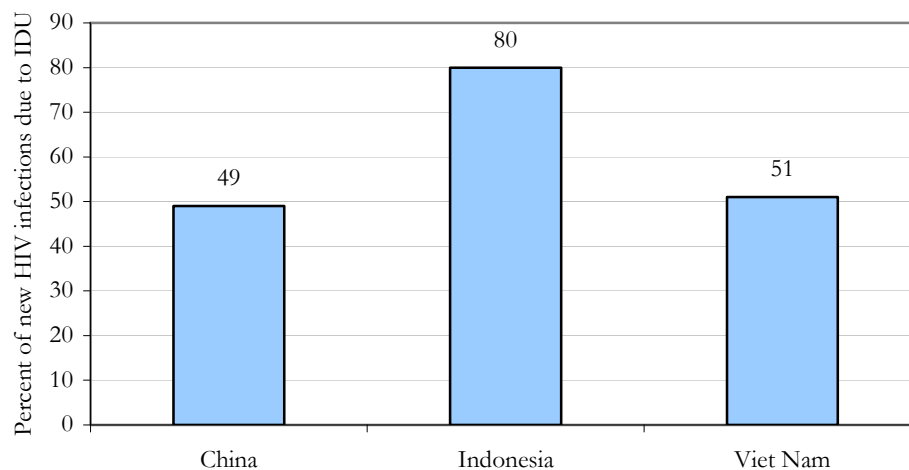
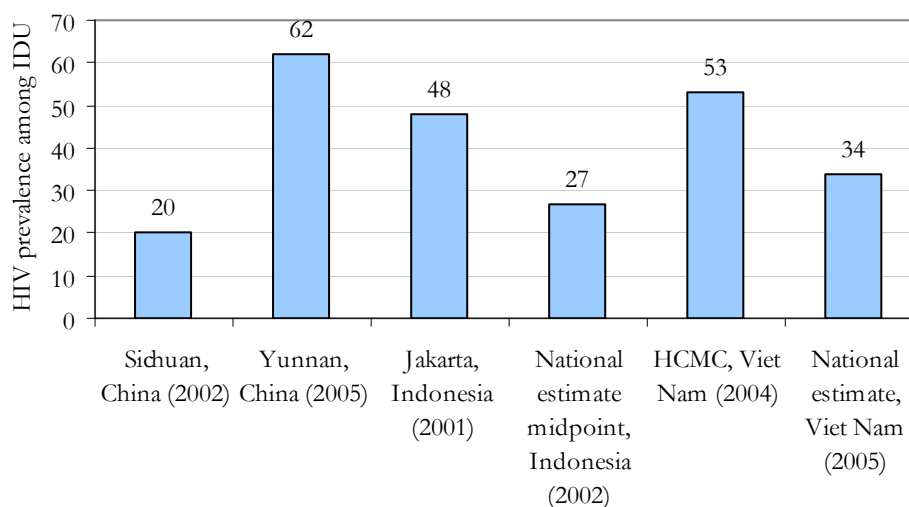


Figure 5.2: HIV prevalence among injecting drug users in selected locations



5.2 Demand reduction in the community

All three countries reviewed have instituted community-based demand reduction programs. Drug education is provided through school programs, community activities and mass media campaigns. Education programs focus on drug-related harm and promote complete abstinence from drug use.

The availability of community-based treatment for dependent drug users varies between and within countries. In China, local hospitals provide short-term detoxification and there are a small number of therapeutic communities in operation. Methadone maintenance treatment, begun in 2004, has strong government support and is rapidly being made available across the country. Indonesia also provides methadone maintenance treatment, although on a limited scale, and has numerous detoxification and rehabilitation centres run by non-government organisations and private operators. In Viet Nam, there are few community-based treatment options and at the time of writing, methadone maintenance treatment is available only through small pilot projects.

5.3 Demand reduction in institutional settings

5.3.1 Types of institutions housing drug users

All three countries have systems in place for detaining drug users in isolation from other offenders, and China and Viet Nam both institutionalise drug users in compulsory treatment centres. In China, drug users may be detained for six to 12 months in compulsory detoxification and rehabilitation centres and up to three years in re-education through labour centres. In Viet Nam, detention in 05/06 centres is for two years, increasing to five years in Ho Chi Minh City. Indonesian drug users are sentenced to narcotic prisons. Sentence length varies according to the crime or crimes an individual has committed. Participation in drug treatment is voluntary for these detainees.

The focus on compulsory detention and treatment for drug dependent individuals in China and Viet Nam has been at the expense of quality, community-based treatment options. However, it should be acknowledged that efforts are being made in both countries to increase the availability of voluntary, community-based treatments. These efforts should continue, as accessible treatment services will assist in reducing drug use at a cost much less than that associated with compulsory detention.

Table A1.1 (see appendix 1) provides a comparison of the types of institutions housing drug users in China, Indonesia and Viet Nam.

5.3.2 Availability of demand reduction strategies in institutional settings

5.3.2.1 Detoxification

Both Chinese and Vietnamese institutions offer detoxification services to detainees. In China, medical staff monitor the withdrawal symptoms of newly received residents for 7-10 days. In some centres, tapering doses of methadone are provided to alleviate withdrawal symptoms. Symptom relief medications, including traditional Chinese medicine, may also be available.

Similar provisions for detoxification are made in Viet Nam's 05/06 centres. Trainees spend 10-20 days in a detoxification wing of the centre. Medical supervision is provided when possible, as are benzodiazepines to alleviate withdrawal symptoms.

Narcotic prisons in Indonesia do not offer specialised detoxification services, as most prisoners have already completed drug withdrawal before their reception to prison. Prisoners who report withdrawal symptoms are offered paracetamol for pain relief.

No country's institutions reported following clinical protocols in managing detainees' withdrawal symptoms. Rather, clinical experience is relied on. While experienced clinicians are a valuable resource, the provision of detoxification services in institutions could be improved by implementing standardised guidelines for treatment provision.

Table A1.2 (see appendix 1) compares detoxification services provided in each country reviewed.

5.3.2.2 Methadone and other pharmacotherapies

Indonesia is the only country reviewed that provides methadone maintenance treatment (MMT) in prison. It is currently available in one prison only but there are plans to expand the program to other prisons. The option of MMT in compulsory treatment settings is reportedly being considered in China. Naltrexone is available as a relapse prevention agent to trainees released from 05/06 centres in Viet Nam.

Indonesia has taken the lead among Asian countries in demonstrating the feasibility of MMT in institutional settings. The program will assist in reducing drug use in prison, and therefore the transmission of blood borne viral infections. Efforts to expand this program should be encouraged. With a rapidly expanding community-based MMT program, China is well placed to follow Indonesia's example and make MMT available in compulsory treatment settings.

There is clear evidence of increased risk of overdose death associated with the use of naltrexone as a relapse prevention strategy (Gibson & Degenhardt, 2005; Ritter, 2002). Despite this, the Vietnamese authorities remain committed to trialling naltrexone among released trainees. This trial should be evaluated and the results compared to trials of opioid substitution treatments such as methadone.

Table A1.3 (see appendix 1) provides a comparison of the availability of pharmacotherapies in institutional settings in each country reviewed.

5.3.2.3 Inmate programs and counselling services

A wide range of educational and therapeutic programs is available to detainees in each country. HIV and drug education are common to all three countries. In China and Viet Nam, detainees are required to engage in education on morality and citizenship.

Vocational training is available to detainees in all three countries. In Indonesia, inmates produce handicrafts for sale. Detainees in China and Viet Nam are required to undertake unpaid labour such as farming and manufacturing toys.

Few detainees in the institutions surveyed have access to trained counsellors. In Viet Nam and China, professional counsellors are not usually available. However, some security officers of institutions are trained in counselling techniques. In Indonesia, psychologists are employed in some prisons.

Several pilot programs utilising cognitive-behavioural therapeutic techniques were identified. In China, a relapse prevention program involved psychologists training residents in skills such as identifying and coping with high-risk situations. In Indonesia, a group therapy program uses cognitive-behavioural techniques to increase motivation to remain abstinent and teach skills such as problem solving and relapse prevention. Other pilot programs identified included the Living Values Education Program and a pre- and post-release counselling service in 05/06 centres in Viet Nam.

Therapeutic communities are in operation in Indonesian prisons. While not widespread in China, a pilot, modified therapeutic community in a re-education through labour centre has been evaluated and shown to produce positive outcomes for residents. There were no therapeutic communities in 05/06 centres.

Self-help groups such as Narcotics Anonymous and Gang Anonymous run meetings in narcotic prisons. Other group therapy activities include support groups for drug dependent inmates and inmates living with HIV/AIDS.

A lack of qualified counselling or welfare staff impacts on the quality of treatment provided in the institutional settings reviewed. In compulsory drug treatment centres in China and Viet Nam, security officers deliver educational and therapeutic programs; in Indonesia, a lack of staff means counsellors have extremely high workloads. All countries could benefit from employing more counsellors, psychologists or social workers; however, this is made difficult by inadequate funding and a shortage in personnel trained in these skills.

Few of the programs in place in these institutions are supported by evidence. In particular, China and Viet Nam rely on moral education as a tool for treating drug dependence. There is no evidence that this approach addresses either physical or psychological aspects of drug dependence, and the high relapse rate among detainees released from these institutions suggests the approach is ineffective. Increasing the use of evidence-based programs, such as well-designed therapeutic communities or cognitive-behavioural therapy programs, will assist in improving treatment outcomes.

Table A1.4 (see appendix 1) summarises inmate programs and counselling services across each country surveyed.

5.3.2.4 Drug-free units

Drug-free units have been established in at least two narcotic prisons in Indonesia and in one 05/06 centre in Viet Nam.

Drug-free units are not well supported by evidence (Larney, Mathers, & Dolan, 2007). Authorities wishing to pursue drug-free units as a demand reduction strategy should evaluate their effectiveness in reducing drug use in closed settings.

Table A1.5 (see appendix 1) summarises the availability of drug-free units in institutional settings in each country reviewed.

5.4 Conclusions

China, Indonesia and Viet Nam have all recognised the need to approach drug dependence as a public health issue. However, obstacles such as lack of resources and punitive policies have limited the extent to which institutions have been successful in adopting this approach. Indonesia leads China and Viet Nam in its implementation of evidence-based programs such as methadone maintenance treatment and cognitive-behaviour therapy. China and Viet Nam are encouraged to follow this lead.

In closed settings, authorities should make every effort to implement programs shown to be effective in reducing drug use and associated harms. Such programs include:

- Opioid substitution treatment, such as methadone maintenance treatment or buprenorphine maintenance treatment
- Therapeutic community programs, particularly those with a post-release aftercare component
- Skills training programs that provide detainees with skills to assist them in maintaining abstinence in the community, for example, relapse prevention and problem solving
- Drug and HIV education programs that are realistic and provide information to assist drug users to reduce the risk of HIV transmission and other drug-related harms.

All three countries reviewed should also consider the benefits of establishing a comprehensive, community-based drug dependency treatment system. Such a system would include both harm reduction and demand reduction strategies, ranging from outreach services and needle and syringe programs, to methadone maintenance treatment to abstinence-based treatments such as therapeutic communities. Benefits likely to follow from such a system would include improved treatment outcomes for drug dependent individuals, reduced HIV transmission among injecting drug users and reductions in the number of individuals incarcerated or detained for drug use and drug-related crimes. While the costs associated with implementing a comprehensive treatment system may appear prohibitive for nations with limited resources, the long-term benefits will outweigh initial costs.

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APPENDIX 1. COMPARISON TABLES

Table A1.1: Institutional settings housing drug users, by country

	Type of setting	Administering government department	Length of detainment	Participation in drug treatment compulsory
China	Compulsory detoxification and rehabilitation centres	Public Security Bureau, Ministry of Public Security	6-12 months	Yes
	Re-education through labour centres	Bureau of Re-education Administration, Ministry of Justice	Up to 3 years	Yes
Indonesia	Narcotic prisons	Directorate General Corrections, Ministry of Law and Human Rights	Varies according to crime or crimes committed	No
Viet Nam	05/06 centres	Department of Social Evils Prevention, Ministry of Labour, Invalids and Social Affairs	5 years in Ho Chi Minh City; 2 years elsewhere	Yes

Table A1.2: Detoxification services provided to detainees of institutional settings, by country

	Detainees in withdrawal housed in separate unit	Medical supervision of detoxification	Medication available	Length of time allocated to detoxification
China	Yes	Yes	Methadone and symptom-relieving medication may be available	7-10 days
Indonesia	No; prisoners have generally completed withdrawal prior to arrival at prison	No	Paracetamol	N/A
Viet Nam	Yes	When possible	Benzodiazepines may be available	10-20 days

Table A1.3: Availability of pharmacotherapies in institutional settings, by country

	Opioid substitution treatment (e.g. methadone maintenance treatment)	Relapse prevention pharmacotherapy (e.g. naltrexone)
China	Not available at time of writing. Community MMT program may be expanded to include compulsory detoxification and rehabilitation centres	No
Indonesia	Yes, in one prison only at time of writing. Program is due to expand to other prisons	No
Viet Nam	No. No plans to make methadone or other opioid substitution treatment available in 05/06 centres	Yes, provided to trainees pre-release

Table A1.4: Availability of counselling and therapeutic programs in institutional settings, by country

	HIV/drug education	Other education or skills training	Vocational training/labour	Therapeutic communities	Group therapy	Individual counselling
China	Yes	Classes in morality and citizenship One pilot relapse prevention program	Residents must engage in unpaid labour e.g. farming	One pilot modified therapeutic community	No	Yes, with security officers trained in counselling
Indonesia	Yes	Relapse prevention program	Residents trained in producing handicrafts	In several prisons	Self-help groups, support groups	Yes, but staff have very high caseloads
Viet Nam	Yes	Classes in morality and citizenship	Residents must engage in unpaid labour	No, although staff have received training	No	No

Table A1.5: Availability of drug-free units in institutional settings, by country

	Drug-free units
China	No; drug use in compulsory treatment centres is officially denied so there is no need for drug-free units
Indonesia	Yes; in at least two narcotic prisons
Viet Nam	Yes; a “drug-free space” has been established in one 05/06 centre. Officially, drug use in 05/06 centres is denied

APPENDIX 2. SAMPLE QUESTIONNAIRE

An analysis of demand reduction strategies in compulsory drug rehabilitation centres and re-education through labour camps in China

If you would prefer not to answer some questions please leave them blank.

Background

1. How many compulsory drug rehabilitation centres are there in China?
2. How many residents are they built to hold?
3. How many rehabilitation centre residents are there in total?
4. How long do people stay in compulsory drug rehabilitation centres?
5. How many re-education through labour camps are there in China?
6. How many residents are they built to hold?
7. How many labour camp residents are there in total?
8. How long do people stay in labour camps?
9. Preventing drugs from entering rehabilitation centres and labour camps
10. Are people in rehabilitation centres and labour camps allowed to receive visitors?
11. Are drugs found in rehabilitation centres and labour camps? If so, which drugs and how much?

Detoxification

12. Is there an official withdrawal or detoxification service within the rehabilitation centres and labour camps?
13. Are any medications provided to residents in withdrawal? What is given and to how many people per year?
14. Is there any policy or procedures manual for withdrawal or detoxification? If so, may I have a copy?

Education Programs

15. Are residents educated about drugs in rehabilitation centres and labour camps?
16. What is taught in the drug education sessions?
17. Are residents educated about HIV in rehabilitation centres and labour camps?

18. What is taught in the HIV education sessions?

19. Is there a training manual, a set of guidelines or an evaluation of the drug or HIV education programs? If so, may I have a copy?

Methadone and Other Substitution Therapies

20. How many rehabilitation centres or labour camps provide methadone treatment?

21. When did the methadone program start operating?

22. How many residents receive methadone each day?

23. Are there treatment guidelines or a manual for the methadone program? If so, may I have a copy?

Other drug treatments

24. What other drug treatments or programs are available to residents of rehabilitation centres and labour camps?

25. What other activities are available to residents of rehabilitation centres and labour camps?

26. Do people or agencies from outside the rehabilitation centres and labour camps visit residents to provide help with drug use problems? e.g. religious workers or social workers?

HIV infection

27. How many rehabilitation centre and labour camp residents are tested for HIV each year?

28. What percentage of rehabilitation centre and labour camp residents are HIV positive?

Policies

29. Is there a national drug policy? If so, may I have a copy?

30. Is there a national policy regarding the compulsory drug treatment system? If so, may I have a copy?