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REPORT OF THE ASIAN MULTICITY EPIDEMIOLOGY WORK GROUP 1994

Pusat Penyelidikan Dadah dan Ubat-Ubatan
(Centre for Drug Research)
W.H.O. Research and Training Centre
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MALAYSIA

REPORT

OF

THE ASIAN MULTI-CITY EPIDEMIOLOGY WORK GROUP

SOUTH ASIA (11 - 16 APRIL 1994)

EAST ASIA (8 - 12 AUGUST 1994)

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FOONG KIN
TAN BEE LENG

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The city drug abuse indicator trend reports contained in this document are substantively the same as originally submitted by the authors. However, reports have been edited to enhance the presentation. The National Centre for Drug Research (NCDR), USM acknowledges the contributions made by the members of the Asian Multi-City Epidemiology Work Group (AMCEWG) who have invested their own time and resources in preparing the reports presented at the meetings.

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INTRODUCTION

There is ample evidence that very little timely and consistent information on the extent and nature of drug abuse and related problems exist at national, regional and international levels to assist in policy and strategy formulation and in the development of epidemiologically targeted demand reduction interventions. Equally, there is insufficient information which is available on the change in trends to assist development of appropriate responses.

The goal of this programme is to use agreed upon drug abuse indicators in selected cities, to assess and compare the changing pattern of the extent and nature of the problem within the context of cultural and socio-political framework, thus facilitating better interpretation, understanding and utilization of the results.

During 1994, two meetings cum trainings of the Asia Multi-City Epidemiology Work Group were held. The first for the South Asian Group was held on 11 - 16 April 1994. Fourteen participants from five countries i.e. India, Nepal, Kenya, Sri Lanka and Bangladesh participated. The second meeting for the East Asian Group was held on 8 - 12 August 1994. Fifteen participants from nine countries, i.e. Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, South

Korea, Thailand and Vietnam participated. During the meetings, participants reported on the problem of drug abuse in their cities/countries. The drug abuse indicator instrument for standardised reporting developed earlier was reviewed. In addition several training sessions were conducted on drug abuse epidemiology, information and network development. Concepts on ethnography and its potential application in drug-related studies were also reviewed.

This publication is based on the reports provided by the participants at these meetings.

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SECTION ONE

SOUTH ASIAN COUNTRY REPORT

DRUG ABUSE IN COLOMBO, SRI LANKA

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ABSTRACT

As there is no compulsory reporting system in respect of drug abuse in the country at present, the number of abusers of different substances is not possible to be determined. An event reporting system called Drug Abuse Monitoring System (DAMS) was established recently by the National Dangerous Drugs Control Board with UN assistance. It is the only official source of epidemiological information on drug abuse in Sri Lanka. The pattern of drug abuse recorded in 1993 is very much similar to the pattern observed during the past decade. There is an increase of incidents reported and increased types of drugs used. The most common drugs were cannabis and heroin during the year 1993. There is evidence to indicate that psychotropic substances are also abused for different purposes. So far no acquired immunodeficiency Syndrome (AIDS) among intravenous drug users (IDUs) was reported in Sri Lanka.

Sri Lanka

Sri Lanka has been ruled over a period of almost 24 centuries by a continuous monarchical chain, the capital city has moved from place to place. Foreign dominations began in Sri Lanka in 1505, with the advent of the Portuguese who ruled the parts of the country until 1657, when the Dutch took over. Their period of domination was 137 years, when they yielded to the British, who for 150 years ruled the entire country. In 1948, Sri Lanka got her independence.

Sri Lanka is a relatively small (62,337 sq. km.) tropical island close to the Southern end of India. The Central hill country rises a little south of the centre of the island and is surrounded by a low-lying coastal plain.

The mid-year population estimate for 1993 was 17.4 million, with a marginal male preponderance. The population pyramid has a distinct preponderance of the 15 - 34 age group. The population is multi-ethnic and multi-religious. The population is mostly (75 percent) rural.

The Sri Lankan family was traditionally of the extended type. But urbanization, population pressures, life-style trends, employment of women, rising costs of living, difficulties in housing, etc. all have been contributing to a rapid shift towards the nuclear type.

Traditionally an agricultural country, Sri Lanka has now begun to expand into other areas of production and export. Tourism is another economic area into which the country is moving rapidly. Recent years have seen many people seeking long-term employment abroad. Many of them go for low-income forms of employment. Due to this reason, many families have temporarily become single parent unit.

The health status of the country is good compared to that of other countries in the southern hemisphere. Schooling is compulsory in Sri Lanka. The country has a literacy rate of 91% for males and 83% for females.

Greater Colombo

The Colombo metropolitan (greater Colombo) comprises of three districts and has an area population of 1.6 million residents of whom 77.6% are Sinhalese, 11.2% Tamil (both Sri Lankan and Indian). The rest (11.2%) include Moors, Burghers etc. Of the total population 82.2% are found in the Colombo District. The majority of the multi-ethnic and multi-religion population is Sinhalese and Buddhists.

The city of Colombo was the former capital of Sri Lanka and is still its main economic, administrative and cultural centre. As such is exerts a considerable influence on the development of the whole country. The economic activities and specific functions spread out a great deal beyond its administrative boundaries. Very strong economic, demographic and social links bind Colombo to surrounding areas and are evident within the range of 30 - 50 km of Colombo. These considerably affect the settlement network, demographic characteristics, composition of employment and other relevant features. Development of Colombo and its suburbs is usually carried out within this broader territorial framework.

To meet the drug abuse information requirement of the country a central system of drug data collection called Drug Abuse Monitoring System (DAMS) was established recently with UN assistance. The general objective of the system is to establish a sound data base for effective programme planning and monitoring. At present the system receives data regularly from government and non-government treatment facilities.

In addition it analyze information gathered from other sources such as Police Narcotic Bureau and Department of Prisons.

The main source of data presented in this paper is the Drug Abuse Monitoring System, which is the only official source of epidemiological information on drug abuse in Sri Lanka. The DAMS is an event reporting system. Thus, it suffers from all the limitations of event reporting. In addition, as it is not compulsory all events specially treatment events, are not reported to the system. Lack of training, expertise, equipment and software are other factors that limit the quality of information.

DRUG ABUSE TRENDS

Greater Colombo

Greater Colombo area is the most affected area of the country. More than 30% of drug addicts and pushers live in Colombo. There are some pockets of the city where all households are affected. Thus, the former capital city is becoming the centre of drug abuse. Most prevalent drugs in the area are cannabis and heroin. No data is available on drug related deaths, hospital admissions (excluding special treatment centres for heroin dependents) and drug related crimes. The trends of drug abuse recorded in 1993 is very much similar to the pattern observed during the past incidents reported and increased types of drugs used.

Heroin

Heroin continues to be the problem drug of abuse in the city. It was unknown till 1981 when the use was first discovered. There is no evidence to indicate that heroin base (monoacetyle morphine) is being smuggled into the city or to the country. South West Asian heroin (Heroin No. 3 or "brown sugar") is the type of heroin available in Colombo. It is smuggled in from the 'Golden Crescent' region (Pakistan, Afghanistan, Iran).

Table 1: Significant Quantities of heroin seized and number of persons arrested in 1991 and 1992

Year	Quantity Seized (Gm)		Number of Arrests	
	Colombo	Other areas	Colombo	Other area
1991	21351.717	0.0	31	0
1992	22605.319	9420.0	42	3

Source: Drug Abuse Monitoring System

As shown in the table 1 the number of arrests has been similar to the previous year. The highest number of heroin offenders were in the age group of 20 - 35 years similar to previous year. The most popular method of drug administration, still, is 'Chasing the Dragon' locally known as the 'Chinese Method'. However, there is a slight increase in intravenous drug use records. Women's increasing involvement in heroin abuse in the city was noticed in 1993 compared to 1991.

Table 2: Average of street level prices for heroin in 1991 and 1992.

Year	Retail price (Rs)		Wholesale price (Rs)	
	For locals	For foreigners	For locals	For foreigners
1991	1,008,333.30	1,491,666.60	783,333.33	1,237,500.00
1992	1,183,333.30	1,575,000.00	1,050,000.00	1,141,666.60

Source: Drug Abuse Monitoring System

Majority (64%) of reported heroin dependents who received treatment were from Greater Colombo, in 1992. The trend in 1991 was the same.

Heroin user profile

Heroin users are generally from urban areas. They are predominantly young males, between the age of 20 - 39 years (mean 26 years). The most vulnerable age for heroin use is seen as 15 - 24 years. Peer pressure appears to be the main influencing factor for initiating drug use. Drug users predominantly single. Most of them belong to the poorest social strata in the country. Most users are self employed. Some of the users are also petty drug peddlers.

A large percentage (33 per cent) are self-proclaimed anti-social elements (petty thieves, prostitutes, etc.) The majority of heroin users have been using the drug for over 5 years, 33 per cent are petty thieves or self proclaimed sex workers. Inhalation (chasing the dragon) is the preferred mode of intake. Most users smoke tobacco daily, and drink alcohol occasionally. Also noted is the use of various psychotropic drugs as a substitute for, or in addition to heroin. Family relationships are seen to be unsatisfactory in the heroin-user population. Crime is a common association.

Cannabis

Cannabis, commonly called ganja in Sri Lanka, has been used since ancient times as a herbal medicine in the traditional pharmacology. There was however, abuse of cannabis at the same. Cannabis is illegally grown in the jungles of eastern and southern regions of Sri Lanka. The production is far in excess of domestic consumer demands and is illicitly exported to Europe and Australia mainly through Colombo ports.

Table: Quantity of cannabis seized and number of persons arrested in 1991 and 1992

Year	Quantity seized (kg)		Number of arrests	
	Colombo	Other areas	Colombo	Other areas
1991	199.954	5,205.056	6	52
1992	893.56	48,138.396	12	61

Source: Drug Abuse Monitoring System

The declining importance attached to this problem by the society including Law Enforcement agencies was a discernible trend over the last decade. Thus, the records presented in the table 3 on arrests and seizures are itself not of any significance in determining the extent of the problem of ganja abuse. Street prices of cannabis during last decade have been maintained at a stable level with little variation.

Table 4: Average street level and wholesale prices of cannabis in 1991 and 1992.

Year	Street level price		Wholesale price	
	For locals	For foreigners	For locals	For foreigners
1991	445.83	675.00	366.66	550.00
1992	1000.00	1700.00	800.00	1500.00

Source: Drug Abuse Monitoring System

There are no records available on treatment aspects of cannabis dependents

Opium

Opium continues to be available and abused in Sri Lanka though the numbers are smaller. The number of suspects arrested in 1991 compared to the arrests in 1992 shows an increase of opium abusers (table 5).

Table 5: Quantity of Opium seized and number of persons arrested in 1991 and 1992.

Year	Quantity seized		Number of arrests	
	Colombo	Other areas	Colombo	Other areas
1991	38	69.95	01	02
1992	926	5331.00	01	02

Source: Drug Abuse Monitoring System

With the dawn of the 1980s the popularity of opium abuse has taken a downward trend. However, with the increase in the arrests shown in 1992, the situation is to be watched and monitored. At present the abuser obtains his requirements either from the stocks of opium which are imported licitly from India for medicinal purposes or from the stocks which are illicitly brought into the country.

Table 6: Average of street level prices for Opium in 1991 and 1992

Year	Street level price		Wholesale price	
	For locals	For foreigners	For locals	For foreigners
1991	8,500.00	11,833.33	8,000.00	9,875.00
1992	20,000.00	23,000.00	15,000.00	20,000.00

Source: Drug Abuse Monitoring System

The opium eating habit remained mainly with middle and old aged persons.

Other categories of drug substances.

Drugs of other categories are no significant problem at the moment in the city or in the country.

Psychotropic Substances

Dependence on psychotropic substances is of very recent origin and is not present in any significant degree. However, recent surveys have shown a demonstrable incidence of the use of psychotropic substances. Dependence on one or more of these substances stems either from medical use, or as a consequence of adjuvant use with heroin. Some of these are (willingly or unwillingly) incorporated in seemingly innocuous medicinal preparations. Although these substances are prescription-controlled, some of these substances are available in the illicit market. In 1992 three persons were arrested in relation to psychotropic tablets of Methadone, 30 tablets of Amphetamine and 20 tablets of Diazepam.

Direct Admissions of Convicted Prisoners According to Highest Number of Offences (1989 - 1991)

Offence	1989	%	1990	%	1991	%
Narcotic Drug offences	3091	38.6	6654	47.1	7,642	40.2
Excise offences	1275	15.9	2248	15.9	5,723	30.1
Theft	853	10.6	1080	7.6	1,140	6.0
Appearing in public drunk	244	3.0	331	2.3	164	0.7
Looting	176	2.2	309	2.2	259	1.4
Viewing of blue films	136	1.7	-	-	75	0.4
Simple hurt	178	2.2	244	1.8	165	0.9
Cheating	117	1.5	163	1.2	125	0.6
Acceptance or retention of stolen property	116	1.4	161	1.1	295	1.6
Maintenance	103	1.3	166	1.2	204	1.1
Other offences	1725	21.5	2772	19.6	3227	17.0
Total	8014	100.0	14128	100.0	19019	100.0

PATTERNS AND TRENDS OF DRUG ABUSE IN DHAKA, BANGLADESH

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ABSTRACT

This report is based on analysis of data collected from 686 treatment seekers attending for the first time at the out patient clinic of the Central Drug Addiction Treatment Hospital (CTC), only public establishment of such kind in a city of 6,537,308 population, over a period of 12 months (October, 92 to September 1993). In addition, there were 162 cases who came for relapse of their abuse problem. Out of those fresh and relapsed cases 474 were admitted into the hospital. Among the new patients, majority were abusing heroin (53.06%) followed by those abusing codeine, polydrugs, pethidine and cannabis in that order. Most of the patients were between 21 and 30 years of age and half of the patient population were unmarried. Petty business was the main profession although more than 35% did not have any job. Most of the patients were coming from highly populated families and average family income of majority of the patients (59.18%) were between Tk. 1001.00 to 5000.00 per month. Nearly two-third of the patients had 6 - 12 years of school life. More than 70% where making their substances of abuse available from street sale and almost similar numbers were using smoking as their route of drug administration.

Over the period of this one year, 2,672 persons were arrested for drug-related offences. Most of the seizures done by the Department of Narcotics Control (DNC) were for alcohol followed by those for cannabis. Among hospital patients, 17.50% met with traffic accidents when under the influence of drugs and about 5% had health related problem. More than 20% clients had family/job or school disruptions.

Introduction

In Bangladesh, the problem of drug abuse has been showing an uninterrupted upward trend over the past two decades. It has already affected multiple facets of national life and endangered social and economic well being of the people. To understand the nature and extent of the problem, it is necessary to take into account and analyse different sources of data on the incidence, prevalence, morbidity, mortality and other consequences associated with the problem. No nationwide broad based survey has yet been carried out in Bangladesh, not even in the capital city. Only source of data available is a student population survey done by Department of Psychiatry, Institute of Post-Graduate Medicine and Research with financial assistance from Government of Bangladesh and World Health Organisation. The most common attempt at understanding the epidemiology of drug abuse include survey of population at risk in an effort to secure total prevalence and projections or studies of identified abusers to understand those for whom drug use has already become a problem. The growing realization of the fact that the scourge of drug abuse post a positive threat to the very fabric of our society and our traditions and values encouraged the participation in this Multi-city Epidemiological Study.

The application of epidemiology to the study of drug abuse is relatively recent. Despite the long history of drug use in the society, the use of epidemiological approach to study this complete public health problem began, in earnest, less than two decades ago.

Although most of the scientific community recognized both the validity and the benefit inherent in using the tools of epidemiology in understanding and addressing the problem of drug abuse, the introduction of technique is not without criticism. However, over the years, drug abuse has moved from the position of being challenged as an appropriate object of epidemiological study to the object of advanced epidemiological investigation having areas of evident immediate similarities with subjects of conventional interest. Drug abusers pattern of behaviours which can be measured and factors can be computed are incidence, prevalence, attack rates, risk factors, aetiologies and consequences. And there lies the rationale of this participation.

Area description (Exhibit - A)

Dhaka, the capital of Bangladesh, encompasses an area of 116 square miles. It is one of the most densely populated cities in Southeast Asia and Metropolitan Dhaka has a population of

6.54 million. The male and female ratio stands at 1.27 : 1. 46.3% population is below 15 years of age and more than 30% between 15 and 30 years. More than half of the population are unmarried and 45.80% are unpaid family workers. Most of the employed population are self employed. Nearly half of the households have 6 - 9 members in the family and 43.2% population above five years of age do not have any formal education. Per capita GDP of the city population is Tk. 7617.00 The city is well connected with the rest of the country by air, marine, rail and road transport. There is regular container service to the city from two sea ports and communication is easy from districts having common border with neighbouring countries and long unguarded beach. Dhaka has air routes to most of the major cities of the world. The city is a destination for massive internal migration.

Data sources

The data related to treatment indicators are solely collected from the Central Treatment Hospital, the only public establishment of such kind, from both out-patient clinic and in-patient facilities. A semi-structured questionnaire, meant for routine information collection, was mainly used. Both the clients and their accompanying relatives were interviewed.

Information from other data sources like private treatment centres, other public facilities, emergency rooms could not be made available because of various reasons. Those sources usually do not have any organized data collection system and they usually do not entertain each and every case walking into their clinic. However, efforts are being taken to form a continuous liaison and stable network between different facilities dealing with the drug abuse problem.

Efforts to make data from jail sources available is kept suspended for time being for administrative reasons. The channel would be reestablished very soon.

Data related to arrest and seizures are obtained from Department of Narcotics Control and those for traffic accident from Central Treatment Hospital. Health and social indicators are collected from treatment seekers.

All the information provided in this report are based on input gathered during October, 1992 to September, 1993.

DRUG ABUSE TRENDS (EXHIBIT B, C, D, AND E)

1. Overall drug use

The outpatient department attendance and law enforcement indicators indicate that the drug abuse problem in the city shows an upward trend. It is evident that opiates as a type are most frequently abused category of drugs. It is followed by the use of cannabis and polydrugs in that order. Although alcohol had the highest number of seizures, it has not yet posed any real threat. More than 60% treatment seekers were between 21 and 30 years of age. The age of initiation, however, lies between 15 and 20 years. Half of the patients were unmarried and more than 35% were jobless. Other users were mostly petty business people, public and private service holders, day labourers and long distance motor vehicle drivers. About 12 % of clients were students, many of whom, however, left school long ago. It should be mentioned here that many of the patients, reported as jobless, lost their jobs due to abuse related problems.

Available data shows that although most of the patients (90%) came from crowded families, nearly 60% patients had 7 - 12 years of schooling. Though it would be difficult to comment on the relationship of affluence and drug habit, it was seen that 59.18% patients came from families having monthly income of Tk. 1001.00 - 5,000.00. Next in order were those having family income of Tk. 5001.00 - 10,000.00. 71.10% drug users collected their drugs from street sale, rest did it from diversion of prescription drugs. Most of the abusers had drugs by smoking (64.35%). Other routes of abuse were oral and parenteral.

In the capital city, 2,672 persons were arrested for drug related offences over the defined period. Most of the seizures were done for alcohol followed by those for cannabis. Quantity mentioned are those reported by DNC. These amounts do not include additional bulk recovered by Police, Border Security Forces and Sea Port Customs. Reports about drug related road traffic accidents are those which could be made available from treatment seekers. Actual picture could be completely different. There is no provision for immediate routine breath or biological fluid analysis for motor vehicle drivers even after road traffic accidents. About one sixth patients reported of such accidents. Similarly, this report could produce only very conservative figures on drug related health and social indicators. There was only one death and 4.96% patients reported of associated psychological illness. 6.71% lost their jobs, 3.64% had family disruptions and 11.37% were school dropouts.

2. Heroin

Heroin is still the most widely abused drug among the treatment seekers. 53.06% of total out patient attendants were heroin abusers. Personal characteristics like age, age at onset, marital status, occupation, members in household, family income and literacy were almost similar to those described in section 3.1. It is found mostly in the form of brown sugar and is smuggled in from different country sources. The consumers collect it from illicit dents and street sale. It is taken only by smoking. No injectable is available.

Heroin is most frequently incriminated for drug related crime. There was 320 seizures and 21.55 kg of heroin was recovered during the defined period. There were some foreign nationals among the arrested persons. From available data, it was seen that 73.33% of drug related road traffic accidents were due to heroin and other opiates. Similarly, almost all the jobless, family disruption and scholastic failures were due to opiate abuse.

3. Other opiates

Other opiates used by the study population include codeine (15.60%) , and pethidine (07.73%). Codeine is taken orally in the form of branded cough syrup and smuggled in from across the border. Recent data (not included in the present report) shows an upward trend of codeine abuse because probably of easy availability, lower cost and easier to administer. There are patients who are switching over to codeine use from heroin use. This is only available in black market. Number of arrests, seizures (235) and recovery of the drug (2,881.10 litres) is showing a remarkable alarming increase.

Among injectables, a new addition to pethidine is tidigesic (bupronorphine), again smuggled in from across the border and only available in the black market. With the availability of the drug, chances of abusing injectables and sharing needles increased manifold.

4. Cannabis

Frequency of cannabis abuse (4.96%) among hospital population was next to opiates and polydrug abuse. There was no significant difference from opiate abuse in most of the parameters. Only route of cannabis administration is smoking (100%) and the drug is available only in black market. Production and marketing has been prohibited since 1989. But limited illicit cultivation of cannabis is still going on in remote rural areas. There were 928 seizures and 1517.10 kg of cannabis

was recovered during the study period in Dhaka City more than 60% psychological illness associated with drug abuse were reported by cannabis users.

5. **Polydrugs**

These include cannabis, sedative-hypnotics, alcohol and at times opiates together. More than 10% patients were polydrug abusers. In most of the cases, history of polydrug abuse were revealed during the course of interview. Characteristically they were not different from other abusers.

6. **Sedative-Hypnotics**

These were used mostly by younger population (15 - 20 years age group) and for a shorter duration. Only route of administration was oral route and drugs were made available by diversion of prescription drugs. There were only three seizures with recovery of 119 pills. This type of abuse was never incriminated with any offence of arrest. 17.5% reported road accidents were associated with abuse of these psychotropics.

7. **Alcohol**

Only 2.92% of study population came for the treatment of alcohol abuse. Alcohol available in the licit and illicit market are mostly country liquors. The patients treated during the study period were mostly using country liquors and foreign branded alcohol produced in local distilleries. They mostly came from lower socio-economic background.

Highest number of seizures (1,082) done by DNC were for alcoholic beverages, 52,378.15 litres of alcohol were recovered during the year and about 90% of those were country liquors. Little less that 10% of reported drug-related accidents were due to alcohol and driving. No alcohol related health problem and only a few cases of family disharmony were reported due to alcohol abuse. Religious and social stigma attached to alcohol abuse may be an important factor for lower reporting of alcoholism for treatment.

8. **Solvents/Inhalants**

Although there were seizures and recovery of these substances, no case of abuse has been reported in treatment centre during the year.

9. **Cocaine**

Cocaine abuse has not been reported by the study population. There was only one seizure over the year where only 220 gms of cocaine was recovered.

SPECIAL STUDIES

As mentioned earlier, the only broad based survey on drug abuse available in the country is that on student population of metropolitan Dhaka. This was a class room study and information were collected by a semi-structured self-reporting questionnaire. Main drugs of abuse by the student population were found to be:

Alcohol

Tranquillizers and hypnotics

Marijuana

Amphetamines and Opiates in that order:

Summary of factors

Factors spelled out from the above study to indicate trend of abuse were as follows:

<u>Factors related to environment</u>

- increased availability and production of drugs in legal and black markets;
- increased consumption of specific drug and its derivatives;
- rise in the outpatient attendance of treatment seekers for their addiction;
- increased rate of drug related crime and arrest

<u>Factors related to abuse</u>

a. <u>Vulnerable population</u>

- male, unmarried, above 20 years of age studying in 13th academic year or above;

- members of affluent family with highly educated mothers;
- students staying in hostel, mess or similar residential accommodations.

b. Personal attributes

- lower value of academic recognition;
- lower religiosity;
- higher value attached to political recognition;
- greater perceived influence for drug use from friends and family;
- lower compatibility with family and friends;
- greater friend and family model for abuse behaviour;
- lesser perceived parental protection, affection and control;
- higher extra income and personal expenditure;
- greater proto delinquent behaviour;
- greater peer approval for abuse behaviour.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS (IDUS)

Number of injecting drug abusers is increasing alarmingly with the availability of smuggled injectable Tidigesic (Bupronorphine). There is possibility of parallel increase of trend of needle sharing. So far 21 cases of sero-positive HIV infection have been detected in Bangladesh of whom nine reportedly died. The relationship between diagnosed cases of HIV infection and history of drug abuse could not be established for various reasons. Screening for HIV infection is not routinely done in this hospital. Demonstration of anti-HIV antibodies in the serum is quite expensive in this country. Screening in different categories of population could not detect any sero-positive case. All the cases, diagnosed so far, were having employment abroad sometimes in their life.

Operational issues

At the end some operational issues impeding the smooth functioning of the project should be mentioned.

Individual

The Central Drug Addiction Treatment Hospital is under administrative control of Department of Narcotics Control which is again a directorate under Ministry of Home Affairs, Government of Bangladesh. Most of the health staff (doctors and nurses) are deputed to this hospital by the Ministry of Health and Family Welfare, over which the Department has little control. The positions (including that of chief consultant) in transferable. Frequent changes of principal investigators always impede the proper functioning of any ongoing project. Besides, there is difference of research interest between individuals.

Organisational

Following limitations have been identified during the course of conducting the study:

i) Lack of proper liaison between different treatment facilities including that in jail.

ii) Lack of uniformity in information gathering system.

iii) Difficulties to get information related to law enforcement indicators according to format outlined in project protocol.

iv) Health indicator data could not be made available due to lack of central register facility, absence of liaison and financial constraints. Referral service is also not well organized.

v) Emergency room data are specially lacking in the report due to nonavailability of data from relevant sources. The hospital (CTC) does not provide any emergency service.

vi) Lack of logistic support (both manpower and equipment) interfere with data collection compilation, analysis and reporting).

vii) Limited transportation facility

viii) Lack of adequate fund to meet contingency expenses.

EXHIBIT A

General Population demographic Indicators 1992 - 1993
(According to 1991 Census)

A1	Total Population		6,577,308	
			N	%
A2	Sex	Male	3,651,653	55.85
		Female	2,885,655	44.14
A3	Age	Under 15 yrs	3,032,003	46.38
		15-24 years	1,126,378	17.23
		25-34 years	860,963	13.17
		34+ years	1,517,964	23.22

A4 Ethnic Group

Mixed
Ethnic A
Ethnic B
Ethnic C
Others (Specify)

A5 Marital Status:

	N	%
Single, never married	3,648,471	55.81
Married	2,592,042	39.65
Widowed	272,606	04.17
Divorced/separated	24,189	00.37

A6 Occupational Categories

	N	%
Self-employed	1,935,043	29.60
Employed	620,044	09.50
Day labourers	987,133	15.10
Unpaid family workers	2,994,088	45.80

A7 Number of People in Household:

	N	%
1 (alone)	111,134	01.70
2 - 5	2,091,938	32.00
6 - 9	3,085,609	47.20
10 +	1,248,627	19.10

A8 Number of Years of Education

	N	%
(above 5 years of age): illiterate	2,344,582	43.20
1 - 5	1,351,391	24.90
6 - 12	1,497,927	27.60
13+	233,373	04.30

A9 Annual Per Capita Income:

Per capita GDP	Tk. 7617.00
Per capita GNP	Tk. 7887.00
Per capita NNP	Tk. 7317.00

EXHIBIT B
Drug Treatment Indicators

B1 Total No. of New Cases in Drug Treatment 686
Relapsed cases 162

B2 Number of admission
New admission 474
Readmission 393
81

B3 Number of patients by Primary Drug of Abuse:

Type of Drugs	N	%
Heroin	364	53.06
Pethidine	53	7.73
Codeine	107	15.60
Cannabis	34	4.96
Sedatives	33	4.81
Alcohol	20	2.92
Polydrugs	75	10.92

B4 Agewise Distribution of Treatment Seekers:

Age in years	N	%
15 - 20	80	11.66
21 - 30	437	63.70
31 - 40	141	20.55
41 +	28	4.09

B5 Marital Status of Treatment Seekers:

Status	N	%
Unmarried	343	50.00
Married	322	46.94
Divorced	9	1.31
Separated	9	1.31
Widower	3	0.44

B6 Occupationwise Distribution of the Treatment Seekers:

Occupation	N	%
Jobless	245	35.72
Business	166	24.20
Service	54	7.87
Labourer	58	8.45
M.V. Drivers	50	7.29
Students	79	11.52
Agriculture	11	1.60
Others	23	3.35

B7 Route of Administration of Drugs:

Route	N	%
Smoking	305	64.35
Oral	132	27.85
Parentral	37	7.80

B8 Drug Sources:

Sources	N	%
Street sale	337	71.10
Legal prescription	0	0
Diversion of prescription Drugs	137	28.90

B9 Number of People in Patient Household:

Range	N	%
Alone	8	1.69
2 - 5	175	36.92
6 - 10	270	56.96
11+	21	4.43

B10 Number of Years of Education:

No. of Years	N	%
0	81	17.00
1 - 6	67	14.14
7 - 12	271	57.17
13+	55	11.60

B11 Monthly Family Income

Amount (Tk.)	N	%
Below 1,000.00	18	2.62
1,001 - 5,000.00	406	59.18
5,001 - 10,000.00	154	22.54
10,000.00+	108	15.75

EXHIBIT - C
Law Enforcement Indicators

C1 Number of Persons Arrested for Drug Related Offences: 2,672

C2 Number and Quantity of Drug Seized by Drug Type

Drug Type	No. of seizures	Quantity
Opiate: Heroin	320	21.55 kg.
Codeine	235	2886.10litre
Injectables	--	--
Cannabis	928	1,517.50kg
Cocaine	1	220 gm
Hallucinogens	--	--
Amphetamines	66	--
Sedatives	3	119 pills
Solvents/Inhalants	92	3003.55 litre
Country Liquor		
Foreign Liquor	1082	52378.18litre

C3 Drug Production Crime

C4 Traffic Accidents

Related to alcohol	11	(1.60%)
Narcotics	88	(12.83%)
Other psychotropics	21	(3.06%)

EXHIBIT D
Health Indicators

		N	%
1.	HIV positive cases	--	--
2.	Psychological cases	34	(4.96%)
3.	Deaths	1	(0.15%)

EXHIBIT E
Social Indicators

		N	%
1.	Jobless	46	6.71%
2.	Family disruption	25	3.64%
3.	School disruption	78	11.3%

PATTERNS AND TRENDS OF DRUG ABUSE IN NEPAL

Nagendra Prasad Shrestha
Director

Community Recovery Centre
CRC
Kathmandu, Nepal

INTRODUCTION

Area Description

Nepal is a tiny land-locked Himalayan kingdom bordered by Tibet-China in North and India in East, South and West. The total area of the country is 1,47,181 sq. km of which two-third is occupied by mountains and hills. Total length from East to West is 850 km. and its width is not uniform. The North-south mean width is 193 km. The total population of the country is 1,84, 91,974 of which males are 92,20,974 and females are 92, 70,123. The urban population was 6.1% in 1981 and has increased to 9.2% in 1991, similarly, the urban areas increased from number 23 to 36 in the same period.

There are numerous ethnic groups, languages and religions in Nepal. The literacy rate was 23.3% in 1981 and has increased to 35% in 1991.

Nepal is still predominantly an agriculture country with villages. The contribution of agriculture to F.D.P. is 56% in 1990 to 1991 occupying 75% in export and absorbing 90% of the labour force.

Nature has adorned Nepal with the highest majestic Himalayan peaks, mountains, hills, valleys, perinual rivers, lakes, waterfalls and plains. It has been a land of spiritual devo tion throughout the ages by saints, sages and persons seeking higher life for peace and truth. Nepal has the honor to become the mother land for SITA the soul of Ramayan, LORD GAUTAM BUDDHA the propounder of peace and non-violence as well as for honest, disciplined and talented warriors known as Gorkhas coming from Nepalese villages. Due to her difficult geographical terrain and confined political outlook of the past regime, Nepal remained almost a forbidden land till the 1950's.

But with the inception of democracy the kingdom was opened to the outside world for tourism. Nepal has a huge potential natural resources, like rivers, stones, forest, wild animals, herbs and varieties of nice climates of which forest and wild animals have been destroyed to the level of serious crisis. It is commonly believed that during the late 1960's with the influx of Hippie tourist the social epidemic of drug abuse also entered in Nepal. Since then, it affected and pushed our adolescents and youths towards this social menace.

Factors sponsoring/contributing to the probabilities of drug abuse in Nepal:

* Serious problem of heroin trafficking from India to Nepal facilitated by open Indo-Nepal border;
* The nature of illegal sales in India's licensed opium farming systems for medical purposes have not been strictly checked;
* Growing massive inordinate free flow of Indian labourers in Nepal's urban areas;
* Nepal is also vulnerable due to its geographical situation from illicit drug producing areas of the Golden Triangle and Golden Crescent;
* Growing international airlines linking Nepal with illicit drug producing areas and routes facilitating for illicit trafficking as a transit point;
* The common and popular traditional use of alcohol and to some extent marijuana is not regarded as socio-cultural taboos by Nepalese society;
* Massive poverty and its disadvantages still exist in the large majority of the people, growing population, unemployment and with massive unskilled labourers;
* Rapid urbanization, modern temptation and curiosity;
* distortion of socio-cultural values, socio-cultural pressures and psycho-socio problems;
* peer-pressure groups;
* low literacy rates and low level of education;
* family problems and environments;

* lack of good education systems and healthy alternatives for creative impulses to adolescents and youths;
* frustrations, unsatisfaction and tensions;
* easy accesses and availabilities of "gate-way" drugs like cigarettes, tobacco, beer and alcohol as well as psychotropic drugs;
* unhealthy video films and T.V. programmes inciting curiosity of sex, violence and crimes;

Data sources and time periods

Data for this report has been drawn from the following sources:

i Community Recovery Centre (CRC) Kathmandu, Nepal --- National Demonstrative Programme for Rehabilitation: Evaluation data of 100 clients from October 1991 to July 1992 to July 1993 and 81 clients from August 1993 to March 1994 (Exhibit I, II, III).

ii Data from sample survey of 100 abusers from five pockets of Pokhara with the financial support of HMG of Nepal conducted by Nepal Association for Drug Abuse Prevention (NEADAP) in 1993 (Exhibit IV).

iii DAPAN's Detoxification Treatment data since 1990 to 1991 and 1991 to 1992 (Exhibit V).

iv Data from Freedom Centre on treatment and rehabilitation Lalitpur, Nepal, since 1990 to 1993 (Exhibit VI).

v Data from Urban Drug Abusers in Nepal; a sample survey on 101 abusers conducted by DAPAN with the financial support of HMG of Nepal in ward No. 19 and 29 of Kathmandu Municipality in 1992 (Exhibit VII).

vi Data from Temple of Health, Pashupati, Kathmandu, Detox-Treatment (Exhibit VIII).

vii Data from random sample survey conducted by Drug Abuse Prevention Association Nepal (DAPAN) on 6218 students of high school and Intermediate campus level relating drug use and other issues of Kathmandu (including Patan), Pokhara and Biratnagar in 1990 (Exhibit IX).

viii Data of drug offences in Nepal from 1988 to 1994 Feb. from HMG of Nepal (Exhibit X, XI). (Including foreigners involved since 1986 - 1993).

ix Data from National AIDS Prevention and Control Programme Teku, Kathmandu Nepal.

x Data from Life Giving and Life Saving Society (LALS). Dilibazar, Kathmandu.

DRUG ABUSE TRENDS

Nepal has been exposed considerably in cases of multiple drug abuse particularly of modern pattern of drugs like heroin. Codeine based Cough Syrups (Phensedyl, Phencodin), other psychotropic painkillers (tidigesic, sosegon) and tranquilizers as well as of traditional pattern of drugs like alcohol and marijuana.

This problem has been seen mainly in urban youths spreading out right from the heart of Kathmandu the capital of Nepal to other principal towns of the country like Lalitpur, Bhaktapur, Pokhara, Dharan, Biratnagar, Bhadrapur, Dhulabari, Birgunj, Hetauda, Bairahawa, Butwal, Nepalgunj and to many other urban areas as well as upcoming towns of the country.

Epidemiological survey as such on drug abuse has not been yet conducted in Nepal. The exact or nearest possible figure of drug addicts is not yet known nor does there exist any reliable data base on the extent of various illicit drug abuse and the size of population abusing it. Since 4/5 years, the often quoted disputable unconfirmed estimated figure roughly is around from 10/15 thousands to 25/30 thousands of addicts in the country of which 2% to 3% are estimated to be females and nearly half of the total is said to be in Kathmandu valley only. However, it is very difficult to validate and rely on. If one tends to view modern patterns of drug abuse like heroin and other psychotropic drugs prevailing in Nepal's urban areas, then the above-mentioned figures of 10/15 thousands may be nearly right only for that very much prevalent traditional as well as socio-cultural commonly abused drugs like alcohol and to some extent marijuana, the growing numbers of drug abusing urban areas, upcoming towns, educational institutions and also the places of tourist interest then the figure might grow much higher than what has been roughly suggested till now.

The available data of sample surveys are very scanty and has not been conducted in successive periods for comparison of trends. The trend whatever likely it may suggest by these

few surveys seems to be only tip of the iceberg for drug abuse scenario in the overall context of the country.

The predominantly abused modern illicit drug is heroin in Kathmandu the capital of Nepal as well as in its other cities Lalitpur (Patan) and Pokhara (Exhibit I, VI, V, VI, VII, VIII). The second category of widely abused modern drug is codeine based cough syrups popularly known as pensedyl (Indian imported) and Phencodin (Nepalese product) especially in the Eastern part and to some extent in other parts of Nepal (Exhibit X). The third category of abused modern drugs are psychotropic substances like; Tidigesic and sosegon pain killers, sleeping compounds like Nitrozepam and various type of tranquilizers. These drugs are also used widely as substitutes during unavailability of choice drug.

The traditionally abused drugs are alcohol and marijuana. Except marijuana alcohol is not an illicit drug. Alcohol is not only a primary commonly used drug in Nepal but also abused frequently as substitutes by addicts. Marijuana grows like a wild grass in Nepal since ancient times. It was used as medicines. Farmers of hills used to make ropes, clothes and hats from marijuana plants and certain Hindu religious sects smoke freely. However, law has prohibited its cultivation since few years back. Nevertheless, marijuana is abused very frequently than hashish in Nepal.

The new nonsense known abuses during the crisis of unavailability of drugs are lizard's tail, shoe-polish, iodex and handiplast in Nepal.

The cases of death which were drug-related were traced among dropouts in CRC records as 1 person in each successive year from 1992 to 1994. DAPAN's Urban Drug Abusers in Nepal, 1992 survey conducted in ward No. 19 and 29 of Kathmandu Municipality on 101 abusers reported that the mortality trends of drug abusers since 1988 to 1992 were 142 cases of which 6 of them were females. The average deaths per year were 14 in Kathmandu alone with the exception ofd 27 deaths in 1991. This data was collected along with names and addresses from the abuser's oral history and there is no way to confirm verify them from hospital record.

The ER and drug-related death cases ME data are not available from hospitals of Nepal. There is no DUF system of urinalysis data in Nepal.

There are 5 HIV positive (AIDS) cases among drug abuser as reported by National AIDS prevention and Control Programme, Teku, Kathmandu Nepal.

Life Giving and Life Saving Society (LALS), Dillibazar, Kathmandu has also revealed 4 cases of HIV positives among IDUs.

The dominating remarkable pattern of drug abusers in the cities of Nepal are predominantly IV heroin abusers between 16 to 35 years age-group of unmarried males with low-level of education, unemployed and concentrated in urban areas (Exhibit I, II, III, IV, V, VI, VII, VIII) Majority of them are old chronic hard-core cases with high relapsed rates. The trend of IDUs heroin abusers in the main cities is increasing. So is the trend of codeine based cough syrup abusers followed by various types of other psychotropic drugs which are abused and used as substitutes.

DAPAN's survey of 1990 on student and drugs in Nepal conducted in main cities is also source of information about the drug abuse trend in a majority of public schools and campus students. Since then, the number of abusers in each educational level has increased along with drug abusing trend (Exhibit IX).

The data of Drug Offences of Nepal since 1988 to 1994 February (i.e of 6 years and 2 months) as well as foreigners involved since 1986 to 1993 indicate the trend of illicit trafficking in Nepal (Exhibit X, XI). This data does not include data of arrested addicts which are not available at the moment. Although this data may include some addicts involved in illicit trafficking and with possession of drug to support their drug habit.

The total number of arrested persons are 3,046 out of which 2663 are nationals and 383 are foreigners. Out of this total 120 are females of which 106 are Nepalese and 14 are foreigners.

The data of Drug Offences from 1988 February 1994 shows the trend of arrested persons decreased in 1989, 1990 and increased in 1991, 1992, 1993 and February 1994. Heroin increased by 75% in 1989, decreased by 71.43% in 1990, increased by 300% in 1991 and increased by 162.5% in 1992 and again decreased by 14.29% in 1993.

Phensedyl seized increased by 309.5% in 1991, nil in 1992 and increased by 3,151.16% in 1993. Opium is not a problem and the seized total quantity was 1.8 kg. only. Traditional drugs such as cannabis and hashish show a trend of decrease in 1989, 1990 and 1991 and increase in 1992 and in 1993 with a sharp increase.

The data relating to the price of drugs prevailing in Nepal is not available.

1. **Heroin**

Heroin appears to be the number-one choice of drug for large majority of addicts in the main cities of Nepal. So is the case of heroin injecting drug users.

The evaluation outcome of heroin abusers in CRC were 74%, 79% and 90.12% in successive periods from October 1991 to March 1994 of whom all the admitted clients were males. The percentage of heroin injecting users were 50%, 61.3% and 64.2%, respectively in the above period. The increase trend of heroin abuse was from 7.08% to 13.73% and the increase trend of heroin injecting was from 22.6% to 4.73% (Exhibit 1).

NEADAP's survey on 100 male drug abusers of Pokhara in 1993 also revealed 74% of heroin abusers (Exhibit IV).

DAPAN's detoxification treatment in Lalitpur admitted 149 cases in 1990 to 1991. Out of which 141 were males and 8 females. In 1991 to 1992 the total cases were 136 of which 129 males and 7 females. The heroin injectors were 42% and 55% respectively in the above period. Thus, showing very insignificant decrease of 1% heroin abuser, while showing 30.95% increase in heroin IDUs (Exhibit V).

Freedom Centre's treatment and rehabilitation admission cases in Lalitpur since 1990 to 1993 were 76,86,58 and 61 male cases of heroin abusers showing 13.16% increase, 32.56% decrease and 5.17% again increase in these years (Exhibit VI).

In Temple of Health, Pashupati, Kathmandu the total detoxification treatment cases in 1992 were 3 males out of which 2 used heroin and 1 was on alcohol with marijuana. In 1993 the total cases were 14 out of which 12 were males and 2 females. Among 14 persons 9 were heroin and 5 were alcohol with marijuana abusers (Exhibit VIII).

DAPAN's survey on Urban Drug Abusers in Nepal, numbering 101 cases in ward No. 19 and 29 of Kathmandu Municipality were 100% male heroin abusers and 75% heroin IDUs (Exhibit VII).

2. **Phensedyl**

The number two abused drug after heroin is the codeine based cough syrup popularly known as Phensedyl and is imported from India. There is also its equivalent Nepalese product known as Phencodin. The widespread abuse of this psychotropic drug

began from the Eastern part of Nepal like Dharan, Biratnagar, Birgunj, Bhadrapur, Dhulabari to Pokhara, Kathmandu and in other parts of Nepal. HMG of Nepal seized 21 bottles of Phensedyl in 1990, 86 bottles in 1991 and 2,796 bottles in 1993 (Exhibit X). The abuse of Phensedyl in the above-mentioned urban areas has been very often widely reported by popular Weekly News media in Nepal. The only available above data of HMG is simply an indicator of Phensedyl abuse and not the size of abusers population. Hence, in reality phensedyl abuse is increasing more widely and a growing concern.

3. Other Psychotropic Drugs

In addition to Phensedyl the various types of other abused psychotropic drugs are Nitrozepam and its equivalents sleeping compounds, pain killers like Tidigesic and Sosegon which are widely abused by IDUs as heroin substitutes and various types of other tranquillisers abused by general addicts. The data are not properly kept to support this trend but the practical experiences of detoxification clinics, centres and case intake assessment of rehabilitation centres firmly confirm these trends.

4. Alcohol

Alcohol is undoubtedly the highest abused drug in Nepal. Socio-cultural tradition of large majority of Nepalese society freely use this drug in many social occasion and festivals. The licensed distilleries of Nepal produce a wide variety of Nepalese alcohol with its rampant distribution system in such a way that any bypasser can buy in any corner or place of the streets and lanes of any urban areas of the country. The local restaurants are the most common places to use this drug.

Alcohol is not an illicit drug in Nepal and the numbers of alcoholics are increasing. Most of the addicts not only begin their drug career with alcohol but also use it as substitutes and some use it with marijuana.

5. Marijuana

This ancient traditional drug has been frequently used in Nepal much less than alcohol. Most of the addicts begin their drug career also with marijuana. Marijuana is also abused along with alcohol. Marijuana grows like wild grass and is easily available even in lanes, bylanes and in home or office compounds. The hashish derived from the resin of marijuana is stronger and is abused much less than marijuana.

The hard-core heroine addicts often abuse hashish also.

6. Other

The non-sense abuses of lizard's tail, shoe-polish, iodex and handiplast are the new substances abused by addict when there are crises of unavailability of drugs or money.

ACQUIRED IMMUNODEFICIENCY SYNDROME(AIDS) AMONG DRUG USERS AND INJECTING DRUG USERS (IDUs)

AIDS cases have been tracked among drug abusers by National AIDS Prevention and Control Programme, Teku, Kathmandu, HIV positive was tracked on 2 males in 1990 and also on 2 males and 1 female in 1991. These 5 cases of drug abusers were tracked as transmitted by heterosexual relation.

Life Giving and Life Saving Society (LALS), Dillibazar, Kathmandu in its recently held Seminar-cum workshop from March 23 - 27 in 1994 at Blue Star Hotel has also revealed 4 cases of HIV positive in males among injecting drug abusers since 1992 to 1993.

The risks of transmission of AIDS through IDUs seems to be very high indeed in Nepal. Because the higher percentages of heroin IDUs prevalent among the old hard-core chronic addicts are clear indicators of this trend in Nepal (Exhibit I, V, VII).

OPERATIONAL ISSUES

Nepal is still lacking a central system of collecting of data on drug abuse. Nepal is divided into 75 districts politically for administration purposes. The Chief District Officer of all districts are assigned by law as Chief Narcotic Drug Control Officers in those districts.

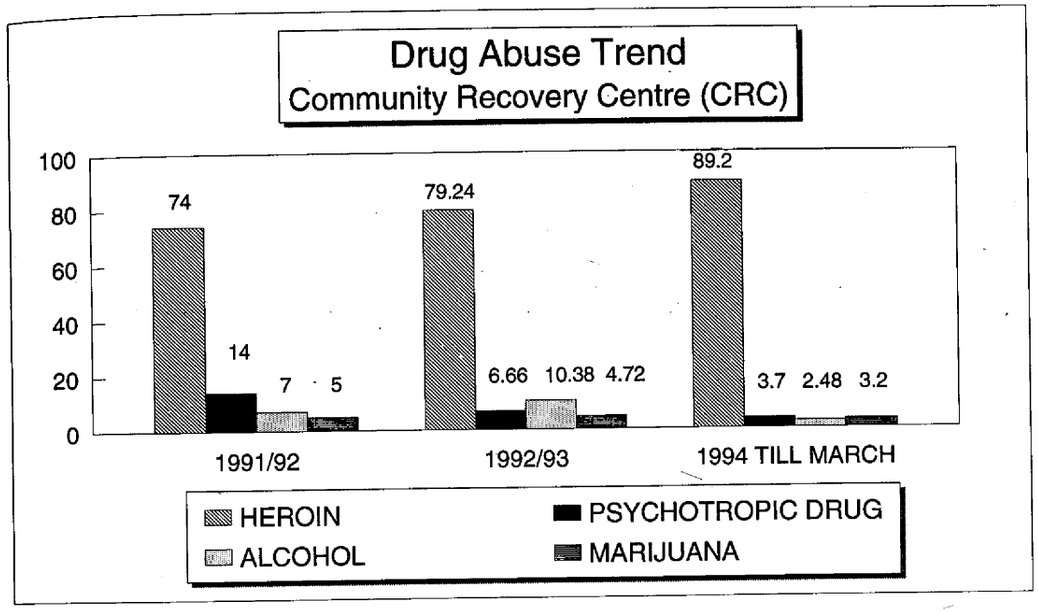
The centre has its Chief Narcotic Drug Control Officer looking all these districts from Ministry of Home.

If proper co-ordination and net-working arrangement are made in keeping data by these authorities along with public hospitals, private clinics, treatment and rehabilitation centres, NGOs and other related agencies as well as organisation, then, a lot of data collecting problems can be resolved with out much cost. Of course, standard formats which are simple and easy to fill-up data register have to be developed giving due regard to the nature of institutions.

Perhaps, next step could be to complete, as much as possible, conducting survey of the main popularly known drug abuse urban areas of the country for overall data purposes. HMG of Nepal and/or donor agencies' financial support should be channeled successively for this purpose. Recently, implementation of the 5 years Master Plan sponsored by UNDCP and HMG of Nepal could also facilitate in resolving this problem to some extent.

However, financial sources are necessary to develop a reliable data base at least to collect from the popular drug abuse urban areas and centres of the country.

To make efficient data reporting by GOs, NGOs treatment and rehabilitation centres, hospitals, private clinics and nursing homes a standard format is needed for making entries of data in the registers which should be classified and freely available from the support of HMG of Nepal or/and international agencies.



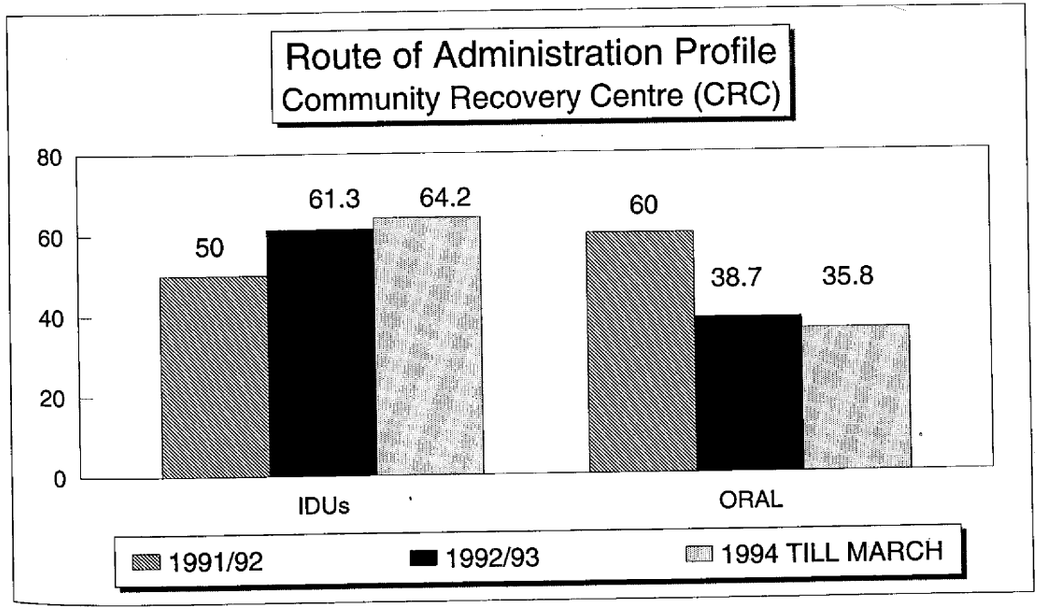
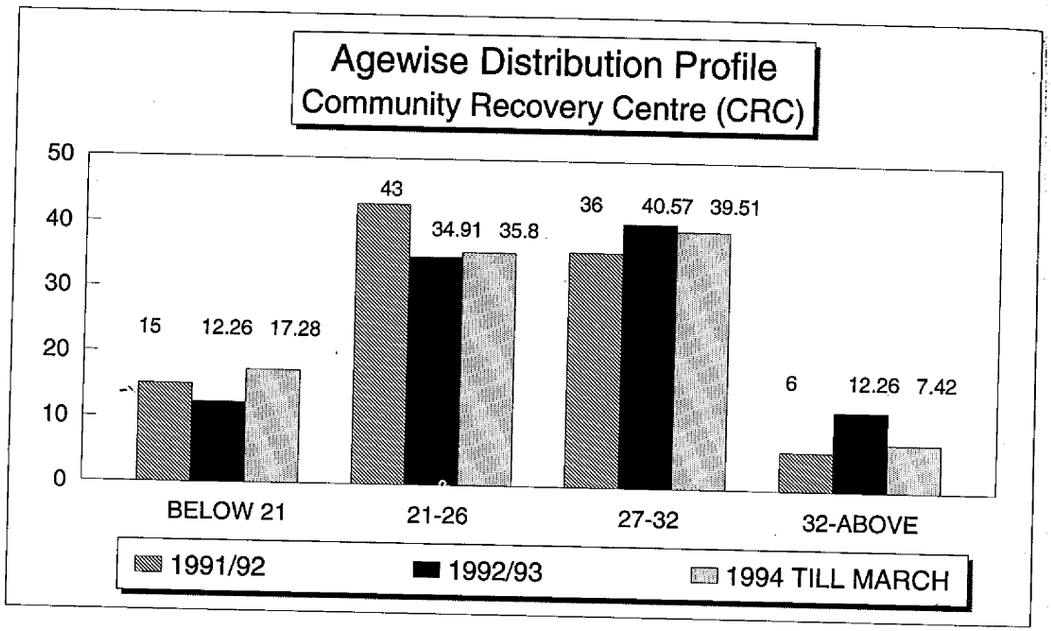


EXHIBIT - II



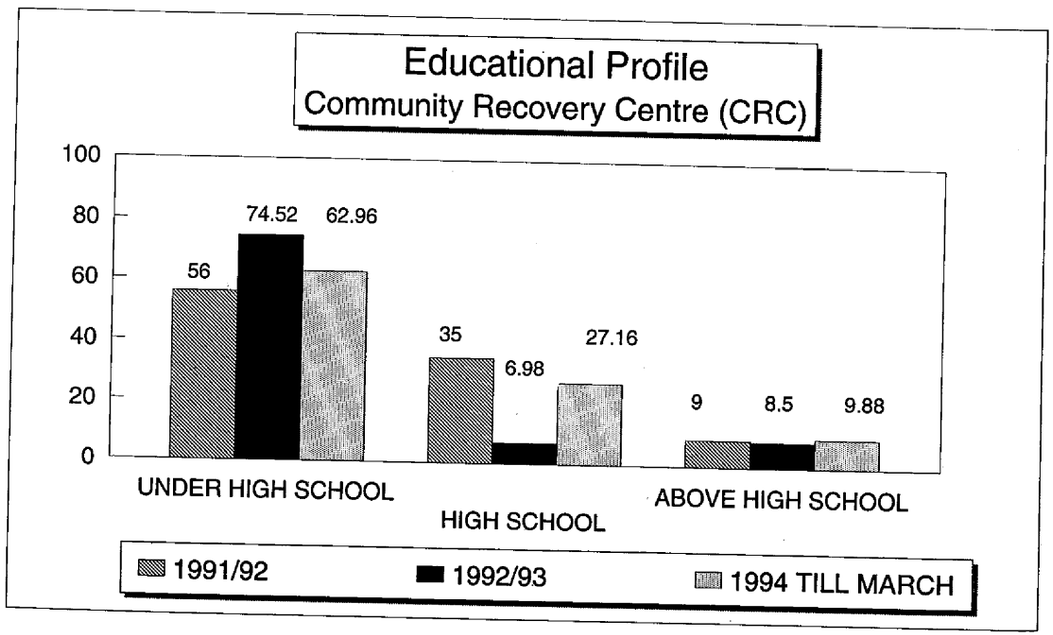
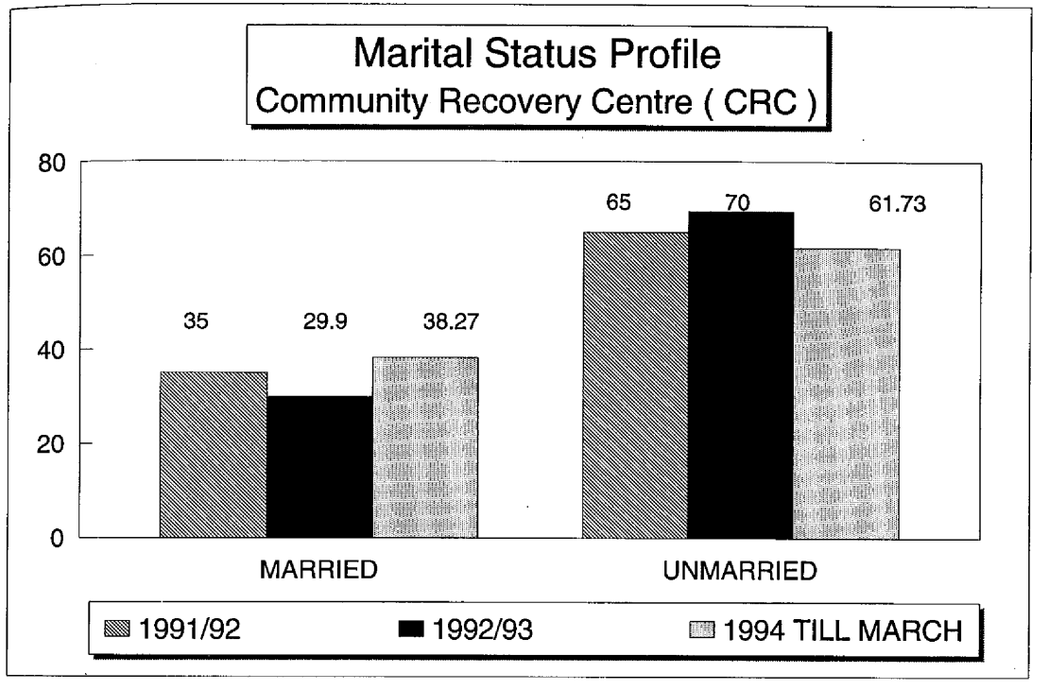


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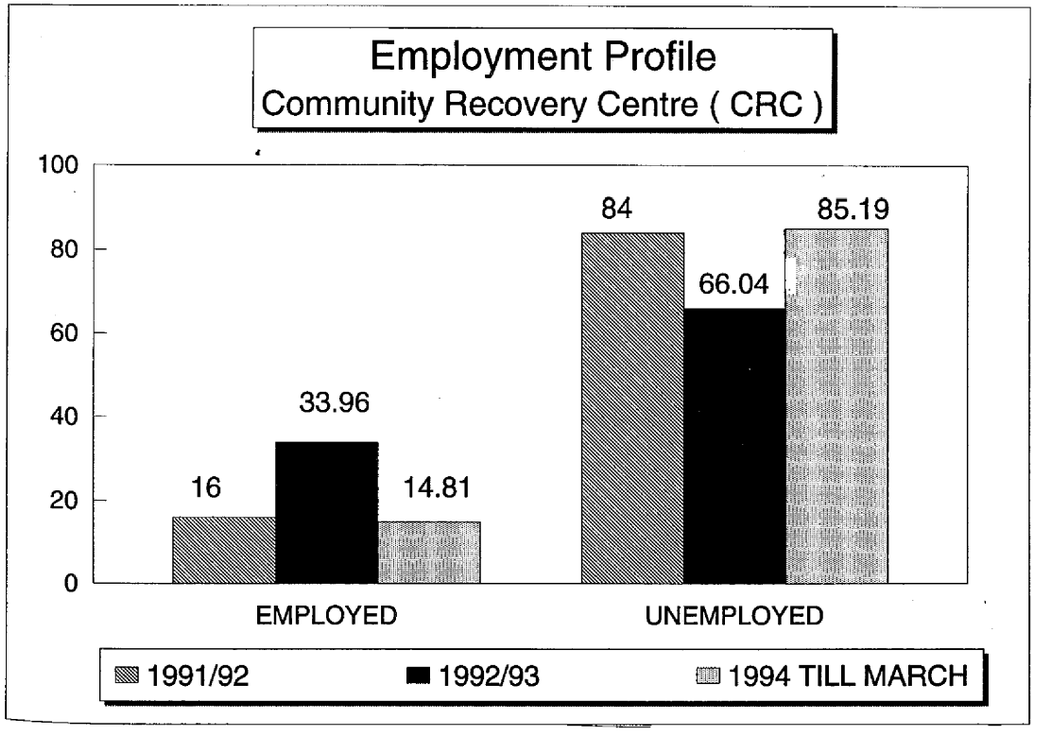


EXHIBIT - IV

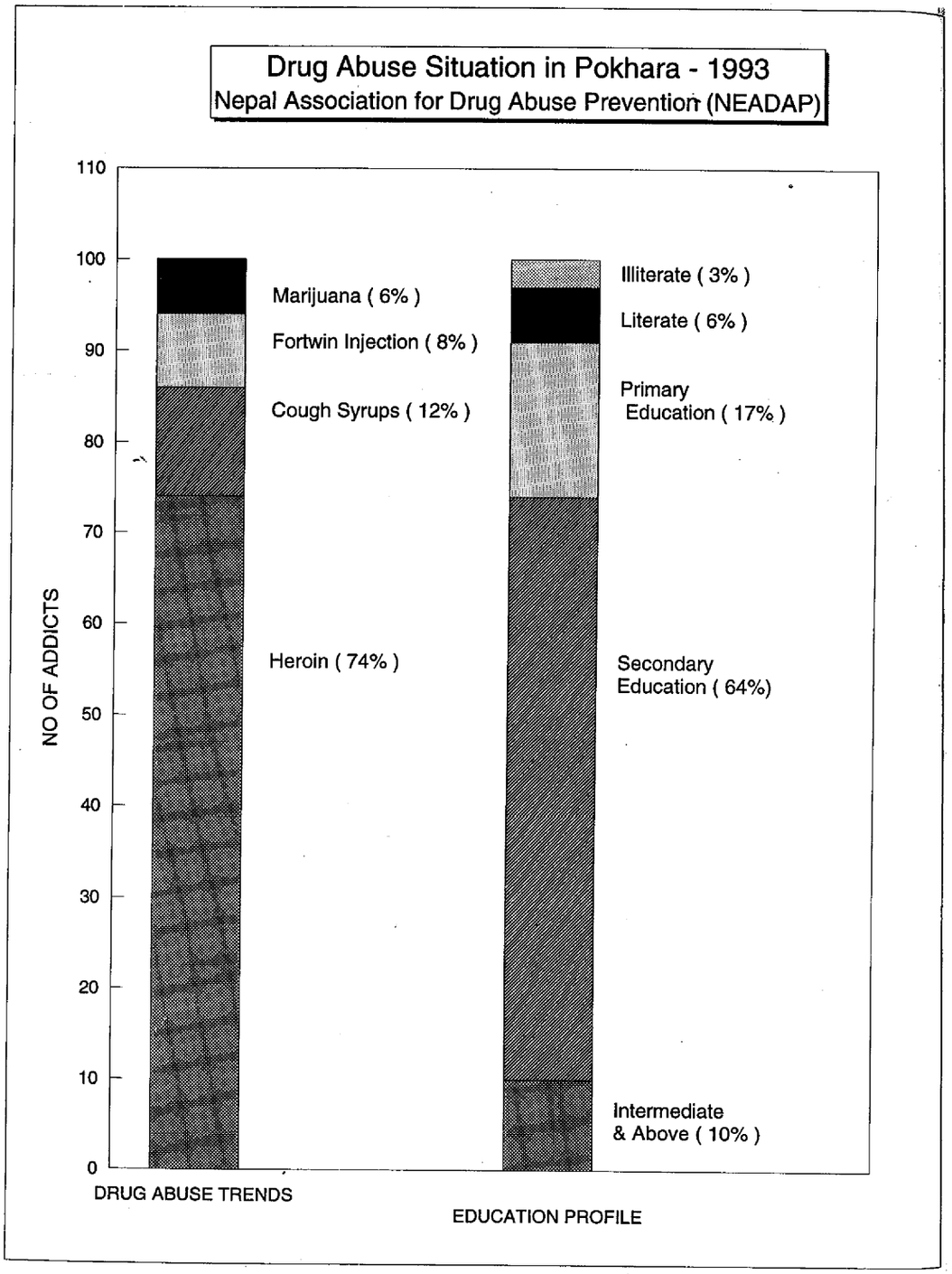


EXHIBIT V

Drug Abuse Prevention Association Nepal (DAPAN)
Nava Jeevan Ashram (Detoxed Treatment)

Year	No. of Clients	Male	Female	Heroin Case	Marijuana Alcohol	IDUs
1990/91	149	141	8	98%	2%	42%
1991/92	136	129	7	97%	3%	55%

NB. In 1991/92 i) 70% addicts were between 15-25 age group
(ii) Old cases 47.8% (more than 7 years), New cases 22.8% (1-3 years)
(iii) 14% uneducated, 44.9% below High School, 11.1% High School to Intermediate, 5.8% under graduate.

EXHIBIT VI

FREEDOM CENTRE, LALITPUR, NEPAL

Year	No. of Clients
1990	76
1991	86
1992	58
1993	61

NB. All clients were male heroin abusers.

EXHIBIT - VI

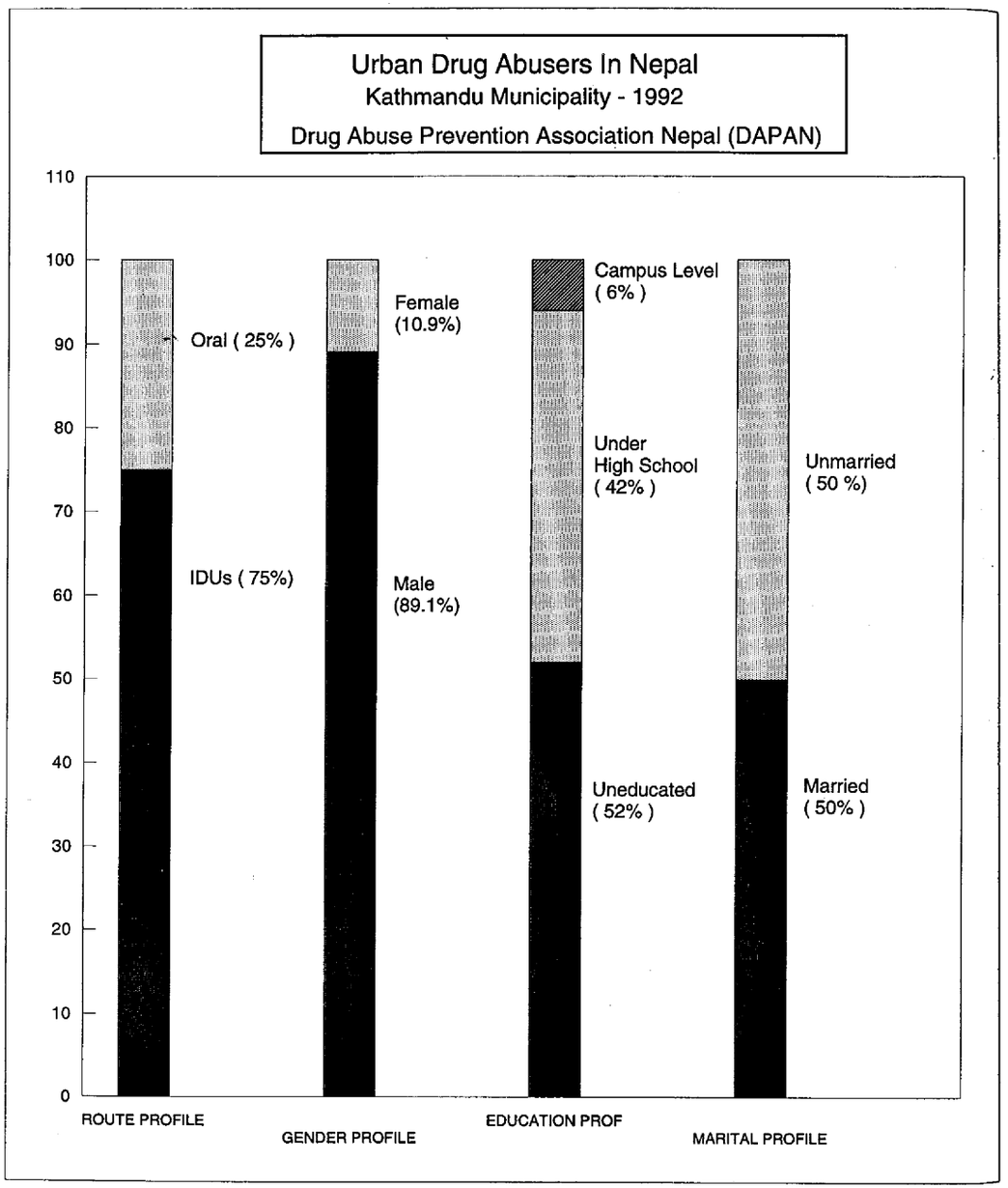


EXHIBIT VIII

Year	No. of addicts	Male	Female	Heroin	Alcohol/ Marijuana
1992	3	3	-	2	1
1993	14	12	2	9	5

EXHIBIT IX

Drug Use by Sex and Type of Drug
(Lifetime, Last 12 Months and Last 30 days)
(Drug Abuse Prevention Association Nepal)

Drug Used	Lifetime			Last 12 months			Last 30 days		
	Male	Female	Both	Male	Female	Both	Male	Female	Both
Cigarettes	23.1	6.7	17.2	12.3	10.0	10.8	9.3	7.6	8.2
Tobacco	17.2	3.4	12.2	14.7	7.5	8.1	8.5	6.9	7.5
Alcohol	26.9	12.7	21.8	19.0	14.7	16.3	15.5	11.7	12.7
Tranquil-isers	3.7	2.6	3.3	1.0	0.8	0.9	0.6	0.6	0.6
Cough syrup	5.3	3.1	4.5	2.4	2.2	2.3	1.5	1.3	1.4
Amphe-tamines	2.7	2.2	2.5	0.4	0.4	0.4	0.2	0.2	0.2
Cannabis	8.5	1.8	6.1	3.0	2.6	2.8	1.5	1.4	1.4
Heroin	2.7	2.2	2.5	0.4	0.4	0.4	0.3	0.3	0.3
Opium	2.6	2.3	2.5	0.3	0.3	0.3	0.3	0.3	0.3

(N = 6218)

NB. DAPAN's sample survey on 6218 students of public high school and intermediate campus level of Kathmandu, Patan Pokhara and Biratnagar in 1990.

EXHIBIT X

DRUG OFFENCES IN NEPAL 1988 - 1994 FEBRUARY

Year	No. of persons arrested	Nepalese M	Nepalese F	Foreigner M	Foreigner F	Cannabis Kg.	Cannabis Gm	Hashish Kg.	Hashish Gm	Heroin Kg.	Heroin Gm	Opium Kg.	Opium Gm	Others
1988	502	388	-	114	-	5689	81	206	44	4	18	-	2	
1989	375	351	10	12	2	1165	376	212	244	7	626	-	793	350 GM Bhang
1990	312	296	16	-	-	736	80	396	234	2	306	-	90	21 bottle phensedyl
1991	520	451	20	45	4	545	494	709	767	8	424	-	171	103 gm bhang 8650 Ml Phensedyl
1992	529	395	34	95	5	2076	324	958	105	21	395	-	737	2 kg. Bhang
1993	687	570	22	92	3	2448	194	517	897	18	147	-	4.9	Phense-dyl 2796 Bottles, Tedigesic 191 ampules
1994														
Jan.	60	56	-	4	-	197	470	224	950	-	975	-	-	
Feb.	61	50	4	7	-	264	300	122	530	2	64	-	-	

NB. 1409.6 hector illicit cultivation of marijuana in 1991 and 369 such cultivation in 1992 have been destroyed in different districts of Nepal.

NB. Source:- Chief Narcotic Drug Control Office, HMG, Ministry of Home.

EXHIBIT XI

FOREIGNERS INVOLVED IN ILLICIT DRUG TRAFFICKING

Year	Indian	German	Japanese	American	British	Swiss	Nigerian	French	Others
1986	41	5	1	1	2	3	-	1	5
1987	90	4	-	1	-	1	4	2	6
1988	92	5	7	-	2	-	-	-	8
1989	40	-	1	3	1	-	-	-	6
1990	27	NA	NA	NA	NA	NA	NA	NA	NA
1991 till April	17	NA	NA	NA	NA	NA	NA	NA	NA
1992	90	1	1	-	-	-	1	-	7
1993	90	-	-	1	1	1	-	-	2
Total	487	15	10	6	6	5	5	3	34

NB. Source: Chief Narcotic Drug Control Office, HMG, Ministry of Home.

NA. Not Available.

THE SUBSTANCE ABUSE SCENARIO IN THE REPUBLIC OF KENYA

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THE REPUBLIC OF KENYA

GEOGRAPHY

The Republic of Kenya lies astride the equator and is bordered by Tanzania, Uganda the Sudan, Ethiopia and Somalia, with the Indian Ocean on the East. The total land area is 583,000 square kilometres. The largest waters are Lake Victoria and the lakes of the Rift Valley, e.g. Lakes Turkana, Baringo, Naivasha, Magadi and Nakuru. The largest river is the Tana, which runs from the eastern plains to the Indian Ocean. The Tana is the only river that has importance as a transport route.

Kenya can be divided into four geographical areas:

i the generally flat southeast coastal plains, which are dry and hot and sparsely populated;

ii the northeast coastal and inland plains with less than 50 mm annual rainfall, consists of thorn bush which of little agricultural or forest value;

iii the northwest scrubland, including Lake Turkan is in many ways similar to the north east;

iv the plateau in the southwest, bisected by the Rift valley; it includes Mount Kenya, Mount Elgon and the Aberdare Mountain range. This plateau is the fertile part of the country. In parts, the annual rainfall is more than 750 mm. The climate is temperate and the main features in the landscape are grasslands and forests.

The altitude varies from sea level to 5,200 metres (the summit of Mount Kenya).

THE SUBSTANCE ABUSE PROBLEM

Drug abuse and trafficking has slowly grown into a major problem in Kenya with the result that this country has now become an important drug centre for traffickers from Asia and the West. Abuse of bhang, heroin and mandrax is now widespread. According to a United Nations report last year, dangerous drugs such as mandrax (methaqualone) are being manufactured in Nairobi from where they are smuggled to countries as far south as South Africa. This piece of information came as a shock to many Kenyans, who all along viewed the drug problem as a malady that only affected far away lands such as United States, Europe and South East Asia. Efforts by law enforcement agencies to arrest the situation have so far concentrated at the Jomo Kenyatta Airport, where many foreigners on transit to West African and European cities have been caught with large quantities of heroin and other hard drugs manufactured in Asia for the lucrative European market. The government has also established a specialized anti-narcotics unit within the police force which has been receiving valuable training and technical assistance from donor foreign governments.

The law has been amended to allow the courts to hand down stiffer sentences, which now include longer prison terms and confiscation of property of individuals known to have benefited from the illegal drug trade. It would appear, however, that the government can achieve more if emphasis was put on educating the youth against use of narcotics. The United States, which has a great deal of experience in dealing with the drug problem, initially concentrated its efforts on apprehending and prosecuting those involved in the supply of drugs but soon discovered that with the huge sums of money at stake in the narcotics business, the drug kings and their associates quickly found new routes for their merchandise, and were able to circumvent the law by bribing law enforcement officers.

In Kenya, not much effort has been put in educating youths on the dangers of drug abuse, a situation that cannot be allowed to continue if the fight against drug abuse is to make appreciable impact. The fight against drugs cannot be left entirely to the police force, no matter how well trained or equipped. Indeed, even though the anti-narcotics squad will continue to require support and co-operation, especially from countries such as the United States of America and Britain, the country will need to introduce educational programmes in schools and other institutions, on drug abuse. Community involvement will also be crucial in efforts to curb the drug problem, for unless parents and other concerned members in the community are brought in, not much will be

achieved. To fight the growing drug menace effectively, the police will need resources and training, but equally important, they will need the support of the public.

SITUATIONAL ANALYSIS (NATURE AND MAGNITUDE OF THE PROBLEM)

Until recently, Kenyans have all along deluded themselves about the real dangers of alcohol and drug abuse practically treating the same as if it has never been a problem. The entertainment and media industries have too often glamorized and promoted the use of such mood altering substances like alcohol and tobacco without the slightest mention of harmful aspects of the drugs contained thereof.

Just like in the case of alcohol and tobacco, Kenyans have for a long time been complacent about the use and abuse of drugs amongst our young people with the occasional cases that are identified being referred to the courts where those convicted only get away with small fines and light custodial sentences.

Addressing the Kenyan High Commissioners and Ambassadors on 7th August, 1990 during their conference at Mombasa Beach Hotel, the Commandant of the Kenya Police Anti-Narcotics unit Mr. P. M. Kimanthi revealed that in the early 1980s, Kenya was identified as an ideal staging point for illegal drugs originating from South West and South East Asia. "On reaching Nairobi" Mr. Kimanthi stated, "the drugs mainly heroin and Mandrax (Methaqualone) would be repacked and transhipped to Europe, North America and South Africa".

Almost at the same time the Child Welfare Society of Kenya reported in the Society's publication that drug abuse among children in Kenya is increasing at an alarming rate. According to the said publication, "one out of every 10 pupils is believed to be using drugs while five out of 10 non-school going children are addicts". The society's publication lists the eight commonest drugs amongst the Kenyan children as tobacco, miraa (Khat), alcohol, cannabis (bhang), cocaine, stimulants, inhalants and tranquillisers. The publication further discloses that 27.6 percent of the children use alcohol, 20.7 percent of the children take miraa (khat), almost the same percentage take tobacco, while 11.2 per cent use tranquilisers, 10.7 per cent take stimulants like speed, uppers and pep-pills while those who use bhang, cocaine and inhalants like glue, petrol and aerosols constitute 3.6, percent respectively.

When the foregoing situation is viewed together with the fact that the youth of this country constitutes about 70 per cent

of the population, the problem of alcohol and drug abuse in this country will no doubt have serious direct implications on the overall national economy and state security in the not too distant future.

THE KENYA - PRIDE PROGRAMME

The Kenya - Parents Resources Institute on Drug Education (KENYA - P.R.I.D.E.) is a non-Governmental, non-Secretarian, non-political and non-profit making nationwide parents organisation aimed at preventing, controlling and if possible total elimination of Alcohol and Drug Abuse amongst the young people of Kenya.

PROGRAMME OBJECTIVES

The Kenya-PRIDE Programme will endeavor to motivate and facilitate the Kenyan parents to rise up to this challenge of alcohol and drug abuse so that they can play their legitimate role in supplementing the Government efforts in the war against this scourge. Essentially the programme will address itself to the issues of inter alia:-

1) Establishment of Data Base

Save for the printed budgets and profits of the alcohol brewing and distribution firms, the occasional printed budget of tobacco manufacturing firms, the police and court statistics on arrest and prosecution of alcohol and drug related offences, there is virtually no organized empirical information (data) in Kenya today which would give the true picture of the nature and extent of this drug scourge amongst our youths. Yet it is absolutely vital to have the basic facts about this problem of alcohol and drug abuse amongst our youths before any meaningful programme to combat the problem can be launched.

The significance of the establishment of the data base as an initial measure need not be emphasized. There is a doubt that for any programme to succeed, information is a very vital tool or resource particularly for programme planning, decision-making, policy formulation, collaboration and co-operation, networking, communication, monitoring and evaluation. Conversely, ignorance or lack of the relevant information leads to mismanagement of resources, generates apathy, organizational conflict, misunderstanding, frustrations and duplication of effort. Lack of the right information also

inhibits institutional capacity building and programme sustainability.

To ensure that KENYA - PRIDE Programme is founded on, managed and sustained along clearly defined objectives, it is imperative that information be collected, analyzed and efficiently stored on inter-alia:-

a) Known facts about the commonest substances (alcohol) and the various legal and illicit drugs), their likely effects on the health and socio-economic status of the individual person, their effects on the national economy and state security.

b) The confirmed characteristics of the use of these substances by the Kenyan youth in and out of school/college environment, their sources and availability.

c) Information on as to why our youths get involved in the use of these harmful substances.

d) What and where are the existing national, community and international programmes, facilities and resources aimed at the prevention, control and eradication of this menace.

e) What measures need to be taken on and by the parents within their families, the youths in and out of school environments, the teachers and other educational administrators, the law enforcement agencies and the community at large to give a clear, firm and consistent response that alcohol and drugs are harmful and unlawful and that their use will not be tolerated at either the family level, school/college level, estate community neighbourhoods or at the place of work.

f) The most appropriate (in terms of content and relevance) strategy options which are practical, affordable, efficient and cost-effective in combating this menace in all the facets of the Kenyan Society.

g) The most appropriate monitoring and evaluation procedures to be employed at predetermined programme periods to gauge the programmes successes or shortcomings.

It is only when sufficient data on the above factors has been assembled that the KENYA-PRIDE Programme can be planned and executed with measureable levels of optimism.

2. **Programme Planning and Policy Formulation**

On the basis of observable data as described above, the KENYA-PRIDE Programme will organize a programme planning and policy formulation workshop to inter alia:-

a) Review the existing data on all the factors mentioned in paragraph III(i) above.

b) Define the programmes operational terms and concepts.

c) Carry out a critical appraisal of identified approaches which have been implemented to combat this problem in the past in this country and elsewhere. This will lead to adoption of the most practical, affordable, efficient and cost-effective approach or approaches to be implemented by KENYA-PRIDE in this country.

d) formulate sound administrative, personnel and financial/accounting procedures.

e) determine the evaluation criteria for satisfactory performance as well as efficient supervision, monitoring and evaluation procedures to ascertain achievement of desired levels of performance.

f) formulate the management development policies or training approaches to ensure viable institution capacity building and programme sustainability.

3. **Programme Implementation and Execution**

In accordance with the programme plan and policies arising from (2) above, the KENYA-PRIDE will launch a coordinated nationwide programme aimed at giving a clear and firm "NO USE,", "ZERO-TOLERANCE" message from all the segments of our population. In launching this programme, the KENYA-PRIDE emphasis will not necessarily be on those who have used these substances at one time or another but rather mainly on those who have never used them at all. Early preventive intervention will be the primary goal used these substances from "Experimenting". As for those youths and adults who will be identified as having already began using these substances the goal will be to get them to STOP. In executing this programme, KENYA-PRIDE intends to use two main methods namely:-

a) **The Educational/Information and Moral Persuasion Approach**.

It is now common ground that information and moral persuasion do greatly help to shape an individual youth's preferences,

values and attitudes towards a given phenomenon. Traditionally, the conventional approach in the case of alcohol and drug abuse has been "DEMAND REDUCTION" strategy whereby the parents, teachers and the clergy have presented devout moral values with a hope of inhibiting demand for these substances. In recent times however, there has emerged evidence that when such strategy is employed leaving certain aspects of the alcohol and drugs phenomenon, unexplained, this may fuel the young men's curiosity about these substances and thus achieve negative results when they "experiment" with these substances.

If however, this education/information strategy is methodically employed on the basis of known facts by the parents at the family level the teachers and school administrators at the school/college level, and the neighbourhood communities and churches in and out-of-school environments, there is no doubt that this strategy works as a preventive "demand reduction measure".

b) **The Confrontational Approach**

This is a more effective approach whereby the individual is made to fear the consequences and penalties that the parents, neighbourhood community and school/college authorities or the society in general will impose for identified cases of alcohol and drug abuse. This approach especially works when appropriate (in terms of content and relevance) messages is given to the effect that the personal costs will definitely outweigh whatever temporary benefits these harmful substances can provide. By content, the message must be clear and consistent that at every facet of our society (home, school/college, community neighbourhood or at the place of work) alcohol and drug abuse is certainly unacceptable.

4. Early preventative intervention - model approach

As stated above, the KENYA-PRIDE programme will lay emphasis on early prevention as opposed to therapeutic or curative approaches to deal with the problem of alcohol and drug abuse amongst the young people of Kenya. It is the considered view of KENYA-PRIDE that when both methods (Educational/Information and Moral persuasion and the Confrontational approaches) are systematically used at both the family level, school/college level, and the neighbourhood community level there is a greater expectation of reducing demand of alcohol and drugs by the young people in this country. To achieve the desired results the entire community must be involved. The parents, the schools, the student's themselves, the law enforcement authorities, religious groups, social service agencies and the media must all give one clear and consistent

message that alcohol and drug use is wrongful and dangerous and that it will not be tolerated. This message must be reinforced through strong, consistent law enforcement and disciplinary measures. The KENYA-PRIDE programme envisages to adopt the following measures:-

(i) Through seminars at their respective Parents Teachers Association which now exist in all the schools and colleges or through carefully prepared parents guides and training manuals, the parents will be assisted so as to be able to :-

- Teach to their children the standards of right and wrong and demonstrate these standards through personal examples.

- Help their children to resist peer pressures to use alcohol and drugs by closely supervising their activities, knowing who their friends are, and talking with their children about the children's interests and problems.

- Be knowledgeable about drugs and signs of drug use and when symptoms are observed to respond firmly and promptly.

- Co-operate and collaborate with other parents, teachers and school administrators and the law enforcement agencies by contributing their own time, intellectual and financial resources towards the administration of anti-alcohol and anti-drug policy.

(ii) FOR THE SCHOOLS AND COLLEGES

The KENYA-PRIDE programme will act as a facilitator for the schools and colleges to be enabled to:-

- Determine the extent and character or alcohol and other drug use in the institutions environment and how to monitor that use regularly and also to be able to evaluate the effectiveness of the drug preventive efforts in the respective schools and colleges.

- Set and administer anti-drug policy where clear and specific rules regarding alcohol and other drug use are established with an attendant prescription of a strong corrective action. The rules which should apply equally to students and school/college personnel should clearly specify what constitutes a drug offence, the procedures to be followed in dealing with violations and the consequences for violating the drug rules.

- Enforce the anti-alcohol and anti-drug policy fairly and consistently.

- Teach about drug prevention by implementing a comprehensive curriculum for the relevant classes that drug use is wrong, harmful and unlawful and rewarding and strengthening resistance to drugs. To implement such a comprehensive anti-drug curriculum effectively, teachers need to be trained to become experts in drug prevention, training materials and teaching aids must be developed and the programme must involve students at all levels.

- Enlisting the community support by strengthening the contacts, information exchange and community support with the necessary resources to implement the school/college anti-drug policy.

(iii) FOR THE STUDENTS THEMSELVES

Through carefully developed curriculum, trained teachers, learning materials and aids, the students will be enabled to:-

- Learn about the harmful effects of alcohol and other drugs use, the reasons why drugs are harmful and the ways to resist pressures to try drugs.

- Learn about the symptoms of drug use and what to do when they identify cases of drug use.

- Knowing the laws on drug use and the penalties attendant thereto.

- Use their understanding of the harmful effects of alcohol and other drugs in assisting their fellow students to avoid getting involved and the authorities to effectively administer the school/colleges' anti-drug policies.

(iv) FOR THE CHURCHES AND COMMUNITIES

The KENYA-PRIDE programme is intended to facilitate the churches (through their congregation and sponsored institutions and activities) and the estate neighbourhood communities to support this effort by:-

- Providing expertise and financial resources of the church or community groups and agencies.

- The law enforcement agencies and the courts to volunteer assistance to lecture to schools and colleges and also help school administrators in implementing anti-drug policies effectively.

- The parents either through their various Parents Teachers Association or other parents groups to contribute expertise and financial resources towards activities organized to help the young people lead drug-free and healthier life styles.

- Social service and health agencies providing volunteers to speak to schools about the effects of drugs. The health agencies can also assist the schools to evaluate students who may be potential drug users, provide referrals to students already using drugs as well as conducting drug counselling and support groups for the youths in school and out-of-school environment.

- The business community will be encouraged to offer support by helping with expertise and financial resources to prepare anti-sponsoring curriculum materials as well as sponsoring drug-free activities for the young people.

- The co-operative and collaborative effort of the business community, Government and parents groups to build and develop an institutional facility or centre equipped with the state-of-the-art equipment, materials and skilled personnel to offer counselling and treatment (detoxification etc) services to identified cases of addiction.

(v) INSTITUTIONAL DEVELOPMENT AND SUSTENANCE

In order to attain the requisite capacity or institutional capability to carry out this gigantic task and be able to sustain the effort, the Kenya Parents Resources Institute on Drug Education will inevitably have to rely on voluntarism as a basic resource and efficient and sound management practices.

1. Voluntarism As a Parent and Community Resources:

One of the remarkable phenomenon of the Kenyan society right from the date of Independence is the concept of collective voluntarism or the Harambee spirit as a national culture in promoting development project. The Harambee concept is essentially an expression of the recognition of the collective will and strength of the people acting in concert to take their destiny in their own hands and supplementing the Government's development effort in all spheres of national development. This collective voluntary action is based on the peoples' realisation that because of limited Government resources, the Government cannot do everything for them hence their pulling together of whichever resources are at their disposal to supplement the Government effort in meeting their own needs.

The KENYA-PRIDE programme envisages to make maximum use of this volunteer effort whereby the Parents themselves, through their membership in their respective church, community and Parents Teachers Associations will be motivated to contribute both their expertise and financial resources so as to make these parents' effort a success. Purely on the basis of their numerical strength through their membership of the respective school/college Parents Teachers Associations, the parents need only to make a token contribution say five to ten shillings per annum and the total amount will be sufficient to provide operating budget for this programme.

However, to motivate the parents and enlist their support in this effort, two factors are necessary as prerequisites to their acceptance and participation in the programme.

a) The first and crucial factor is the official (inter-ministerial) recognition and acceptance of the KENYA-PRIDE programme as a legitimate and viable national effort to combat the problem of the alcohol and drug abuse amongst the youth in this country. Judging from the current pronouncements, by the country's political leadership it is not being too very optimistic to expect positive official (Government) support and encouragement.

b) The second crucial factor is the evidence of observable steps being taken which are indicative of a viable programme. Such evidence can only be presented by way of the organized data collected through the initial research investigations, preparation of the working document spelling out the programme objectives, operational policies. It is such working document which is intended to be produced at the initial programme planning workshop mentioned in paragraph III (2) above.

There must also be evidence of operating secretariat equipped with qualified personnel and equipment to operate as the nucleus of the nationwide effort. It is in pursuit of this second factor that seed money, equipment funds and money to provide the initial operating budget will be sought as facilitation finance from donor organizations and agencies both local and international.

2. Management Development and Orientation:

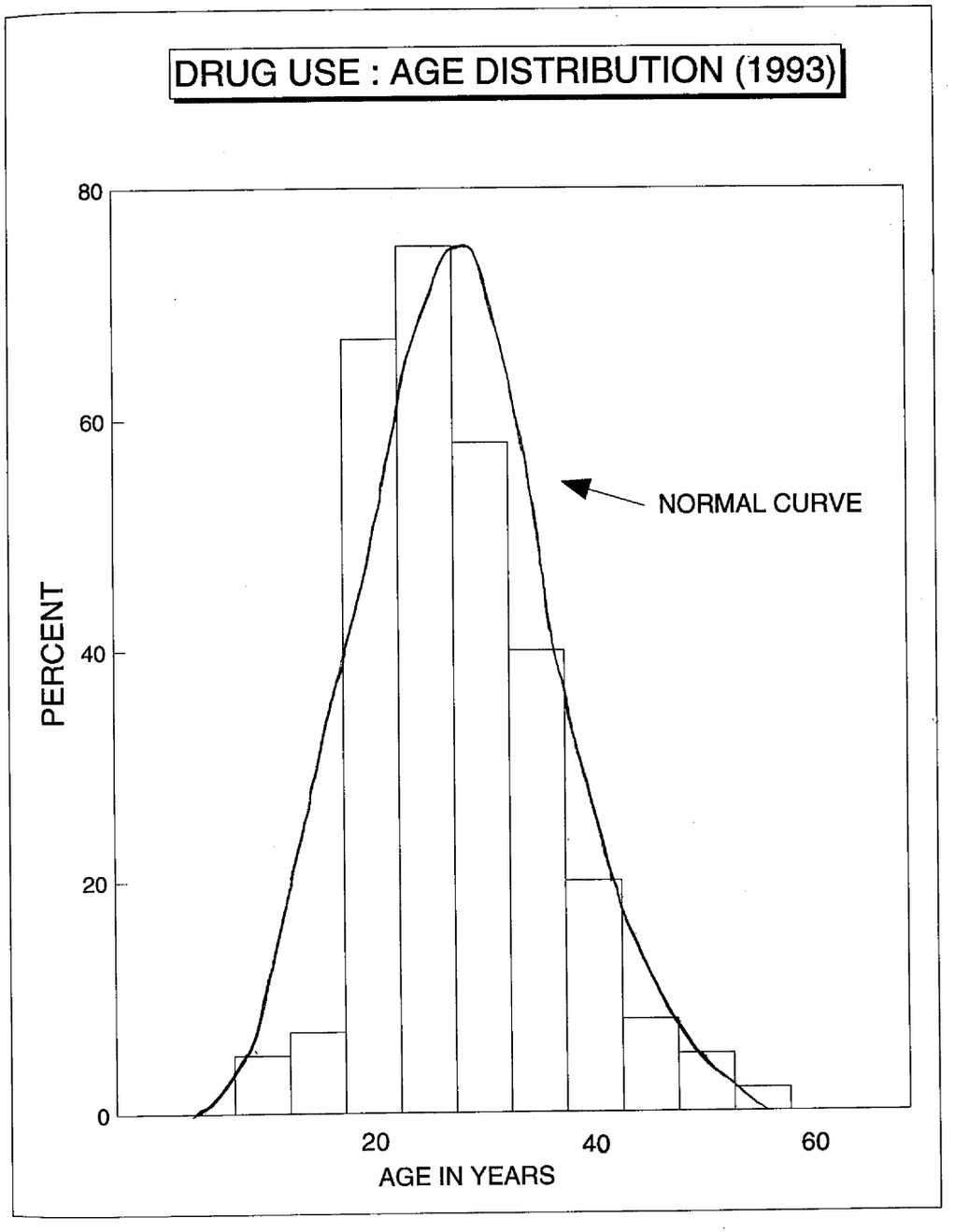
As a Non-Governmental Organization, KENYA-PRIDE will deliberately right from the start adopt personnel recruitment, training and deployment procedures that will reflect the peculiar requirements of voluntary social service agencies as distinct from Government departments (which are funded from the exchequer) or the commercial firms which are funded and sustained through investment capital and profits accruing. This deliberate personnel development policy is vital if the KENYA-PRIDE organization is to play its role effectively and efficiently manage whatever resources that may be donated to it either in intellectual, material or cash contributions. The management must be equipped with the appropriate skills and orientation to ensure their ability is not only carrying out the programmer's policies and objectives but also to enable them to effectively motivate the participant groups in this effort (the parents, the youth, the teachers and school/college administrators, the law enforcement agencies, the country's political leadership and the donor agencies) so as to ensure their maximum cooperation and continued support.

3. Programme Evaluation and Periodical Progress Reports

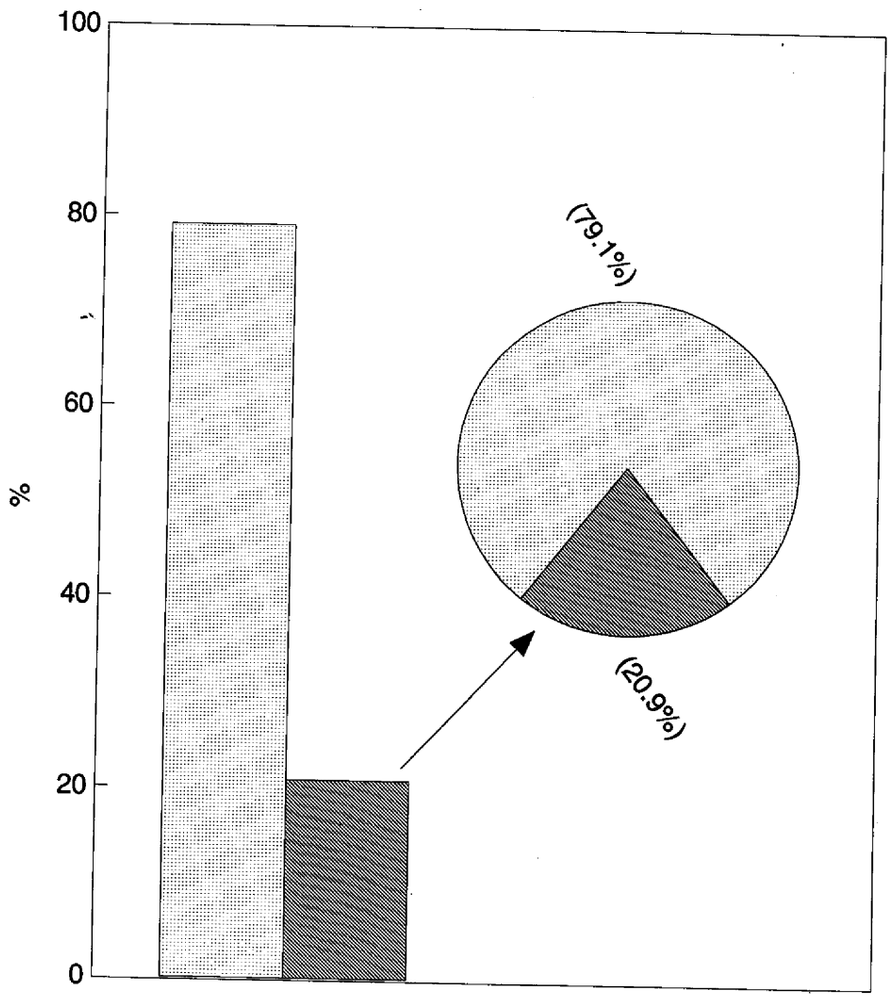
In order to build and sustain credibility of the Parents' Institute on drug education as an effective tool for achieving a drug - free youth environment, it is imperative that sound evaluatory criteria and procedures be established and administered regularly. It is the results of such evaluations as are periodically reported which will justify or otherwise the participants groups and agencies continued participation and support. In this connection, it is envisaged that whereas the general evaluation criteria and procedures may be formulated at the initial programme planning workshop, specific projects will be determined on a case-by-case base and in collaboration with the funding agencies. The results of such evaluations will in turn form the basis of preparing the periodical progress reports.

Table 1: Drug Seizure Statistics from 1988 - 1992

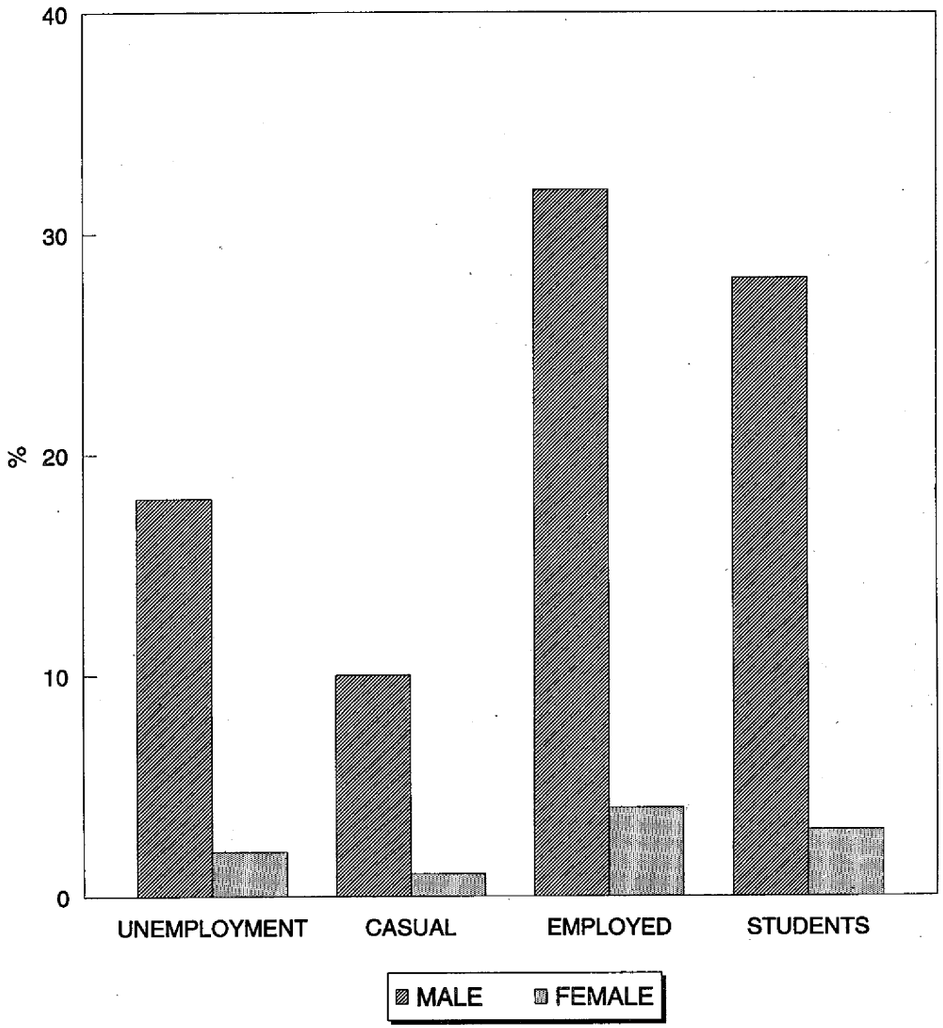
Year/Drug	Quantity	No. of cases
1988		
Bhang	553,299 kg	103
Cocaine	0.200 kg	5
Heroin	24,924 kg	40
Methaqualone	40 tablets	1
1989		
Bhang	7,466,700 kg	1000
Cocaine	-	-
Heroin	30.705 kg	31
Methaqualone	100.050 tablets	5
1990		
Bhang	10,319.700 kg	2655
Cocaine	0.200 kg	3
Heroin	56.420 kg	68
Methaqualone	1,517,598 tablets	4
1991		
Bhang	7,359,598 kg	3057
Cocaine	-	-
Heroin	9,744 kg	43
Methaqualone	1,462,000 tablets	5
1992		
Bhang	370,944 kg	4138
Cocaine	0.040 kg	2
Heroin	12.656 kg	30
Methaqualone	648,700 tablets	5

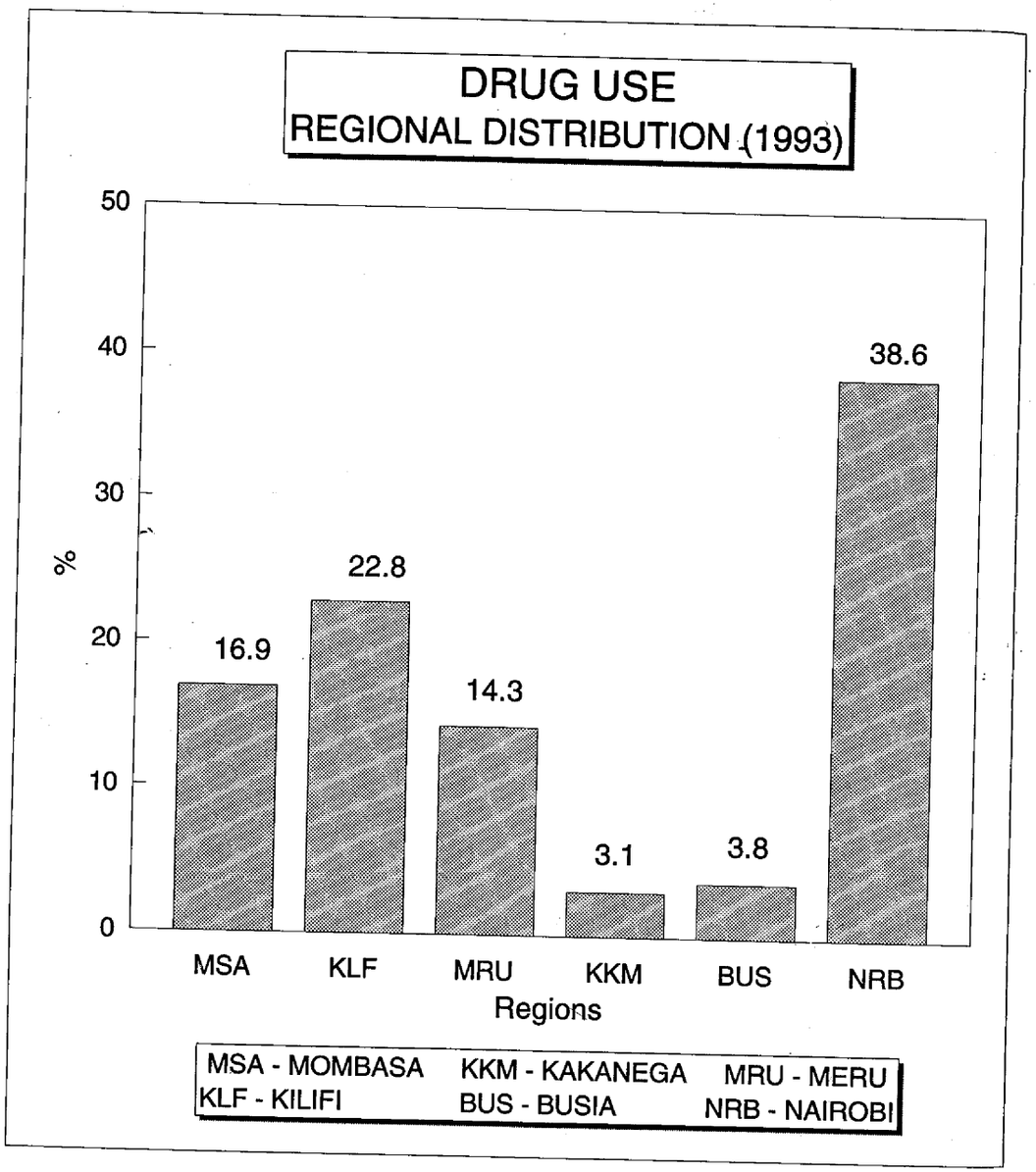


DRUG USE
LITERATE VS ILLITERATE (1993)



DRUG USE
GENDER & OCCUPATION





PATTERNS AND TRENDS OF DRUG ABUSE IN BOMBAY

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INTRODUCTION

Geographically India is situated between two main drug producing areas of the world i.e. the 'Golden triangle' and its 'Golden crescent'. This in turn making India into one of the major transit routes for drug trafficking to different parts of the world.

Bombay being a major International metropolis, sea port, financial capital of the country, multi-ethnic population, and a sizeable transit flux, the spill over is but obvious. This contributing to Bombay, as the 'Drug Capital' of the country. This is further exaggerated by the process of urbanization - disintegrating social and family ties, lowering of the influence of culture and heritage, and the lowering of moral responsibility and accountability.

The problem of substance abuse, therefore is multifaceted. It is not restricted to certain socio-economic strata, cultures, though certain population/professions do show a slight preference.

Amongst the population, the traffickers, the driver (taxi/autorikshaw/truck) and college students (experimentation, usually begin use of cannabis then gradually mature to other drugs).

The Bombay Drug De-addiction Centre of Excellence is a joint programme of Bombay Municipal Corporation, Govt. of M. Maharashtra, Govt., of India and United Nations Drug Control Programme. The Centre was sanctioned in January 1990 and its activities began in February, 1991.

K.E.M. Hospital and Seth G.S. Medical College has been involved in the Alcohol and Drug Abuse Control and Prevention Programme for the last 14 years. The centre provides clinical services and also training of undergraduate and postgraduate medical students as well as students of nursing, social work, clinical psychology and occupational therapy. It also provides facilities for undertaking research projects. Daily out patient service, 30 beds and 24 hours emergency services are provided through this programme.

In March, 1992, the analytical laboratory was set up with donations of highly sophisticated instruments given by United Nations Drug Control Programme and the centre was recognized as a Nodal Centre by the UNDCP. Till now about 17,500 persons with alcohol related problems and about 8000 persons with drug-related problems have been registered at the Centre.

The centre has been conducting training programmes for Medical Officers, trained social workers, trained nurses and community leaders. On behalf of Govt. of India and Ministry of Health and Family Welfare, we have completed training programmes of 3 weeks duration for 3 batches of General Duty Medical Officers, and a 6 hr sensitization training programme for 104 dispensary doctors of the Public Health Department of Bombay Municipal Corporation of Greater Bombay.

In collaboration with the Dept. of Preventive and Social Medicine, we have started outreach programmes at the two urban health centres located at Malavania and Niagaum.

Preventive education programme in the community for the high risk groups. These programme of health education will be conducted for the community located at Malvani and Naigaum. Also such programmes will be conducted for the pre-adolescent and adolescent boys and girls in the schools. Both these programmes will be conducted in collaboration with the Preventive and Social Medicine Dept.

Individual and group psychotherapy as well as counseling for family members done. Pharmaco therapy behaviour therapy is also done. Therapeutic community meetings are held twice weekly for indoor patient in the afternoons. Group psychotherapy sessions are held twice a week for out-patients. Recreational therapy sessions, psychoeducational programmes are held twice a week for a patients and family members. Also group counselling is held every week for family members.

Teaching programmes for undergraduate medical students, nursing students. Occupational therapy students - attend the centre for learning the problems of alcohol and drug addict patients. medical interns, postgraduate students in psychiatry and postgraduate students in social work are placed in the centre on a rotational basis.

Research : Clinical research into the factors contribute to the alcohol and drug addiction has been started. Special proformas are filled up. Another project is to be undertaken is the study of natural history of drug taking behaviour for a period of 5 years. This project will be started when the computer and other equipments are made available to the centre.

Net working : The staff members attend seminars and meetings organised by different organisations working in the field in the city of Bombay. Quarterly reports of the activities are sent to the Directorate of Health Services, Govt. of Maharashtra and Ministry of Health and Family Welfare, Govt. of India. Meetings convened by the state and central Government as well as Bombay Municipal Corporation are attended by the staff members, to co-ordinate the activities of the Centre. The staff members also take part in health education programmes which are conducted through electronic and press media.

The following data has been collected and compiled from the patients attending treatment facilities for deaddiction at the K.E.M. Hospital Drug De-addiction Centre of Excellence.

I. New Cases Registered at the Centre

Primary Drug of Abuse

	1991	1992	1993
Alcohol*	NA	1449	1352
Opioid-type**	211	460	544
Cannabis-type	5	22	38
Polysubstance type	NA	NA	NA
Prescription drugs	NA	39	56

* When alcohol is the primary drug of abuse it is usually abuse alone/singly.

** Must abusers of opioid at some given time abuse multiple drugs.

II. No. of patients seeking in drug deaddiction centre*

	1992	1993
1. Alcohol	2626	2877
2. Opioid-type	527	723

* Old case and new cases

Alcohol : Socio Economic Status

1. Rs 1500 Lower 577 | Rs 1500 - 3500 Middle 502 | Rs 3500 Upper 92

2. Type of Alcohol

	N
Country	910
I.M.P.L./Whiskey/Rum	85
Both	158

3. Alcohol : Diagnosis

Primary	1070
Secondary	64

4. Alcohol : Present age

Age in years	No. of Patients
16 - 20	5
21 - 25	67
26 - 30	213
31 - 35	328
36 - 40	233
41 - 50	254
50	93

5. Duration of Alcoholism

	N
2 years	65
2 - 4 years	63
4 - 6 years	128
6 - 7 years	113
8 - 10 years	179
10 - 12 years	94
12 - 15 years	167
18 - 20 years	207
20 years	165

6. Alcohol : Areawise Distribution

Area	N
Bombay South up to Parel	807
Bombay Western line	212

	Bombay Central line	316
	Bombay Harbour line	105
	Out of Bombay in Maharashtra	14
	Out of Maharashtra	7

7.	Alcohol : No. of Follow Ups	N
	0 - 5	562
	5	27

BROWN SUGAR/OPIATE

MODE OF TAKING

		N
1.	Smoking	164
2.	Chasing	268
3.	Injection	13
4.	Others	18

B.5./OPIATES: ANALYSIS DISTRIBUTION

AREA	N
South Bombay upto Parel	121
Western suburbs	92
Central Bombay	140
Harbour Line	33
Maharashtra	9
Out of Maharashtra	1

B.5./OPIATES : DIAGNOSIS

Primary	384
Secondary	14

B.5./OPIATES : SOCIO-ECONOMIC STATUS

Rs 1300 : 168	1500 - 3500 : 164	3500 :54
Lower	Middle	Upper

OPIOID ADDICTION: AGEWISE DISTRIBUTION

Age in years	
10 - 15	3
16 - 20	27
21 - 25	114
26 - 30	121
31 - 35	83
36 - 40	39
40	20

B.S./OPIATES: DURATION

Duration of consuming	
6 months	19
6 mths - 1 year	21
1 - 1 1/2 year	16
1 1/2 - 2 years	24
2 - 2 1/2 years	9
2 1/2 - 3 years	28
3 - 4 years	27
4 - 5 years	36
5 - 6 years	37
6 - 8 years	77
8 - 10 years	61
10 years	33

B.S./OPIATES : FOLLOW UPS

No of follow-ups	
0 - 5	106
5 - 10	6

DRUG TRAFFICKING AND CONTROL IN INDIA

Shri Shailinder Sharma
Om Prakash

Nacotic control Bureau
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The effects of trafficking in narcotic drugs started being felt in India only in the beginning of the 80s. Traditionally opium and ganja was used by local population and the abuse of these drugs was being dictated by age old customs and religious rituals. This did not pose a grave problem. The problem was aggravated in the 80s.

The strategic and geographical location of India between the world's two major producers of illicit opium (Golden Crescent and Golden Triangle) made India a major transit country between these countries and destinations in Europe, Africa and America.

These activities led to a spill over effect and resulted in increase in incidences of addiction and abuse particularly in metropolitan cities and North Eastern border areas of India.

The Government of India in order to exercise strict control over narcotics drugs and psychotropic substances in India in the manner as envisaged in the United Nations Conventions, consolidated the erstwhile principal acts, namely the Opium Act, 1857, the Opium Act 1978 and the Dangerous Drugs Act 1930 and the enacted the Narcotic Drugs and Psychotropic Substances Act 1985. The NDPS Act provides for stringent provisions for control and regulation of Narcotic Drugs and Psychotropic Substances besides providing for the forfeiture of property derived from, or used in, illicit traffic in Narcotic drugs and Psychotropic substances. The penal provisions under the act are very deterrent and adequate to meet the challenge of well organised gangs and smugglers.

The Government of India has adopted a multidisciplinary approach to tackle the problem of drug trafficking and drug abuse. The NDPS Act empowers a number of Central and State Government Enforcement Agencies to enforce the provisions of the Act. In order to maintain an effective coordination among the agencies, the Government of India created the Narcotics Control Bureau in the Ministry of Finance, Department of Revenue in the year 1986. Apart from playing the role of coordinator among the various agencies, the officers of the Narcotics Control Bureau are also empowered to exercise the Enforcement provisions under the Act.

We have adopted a multi-disciplinary approach and the enforcement powers have been delegated to a number of central and state enforcement agencies. The Narcotics Control Bureau is the apex coordinating agency but also functions as an enforcement agency through its field units located mainly at the drug exit point viz. Bombay, Delhi, Calcutta, Madras, Varanasi and Jodhpur.

The zonal units cultivate intelligence and work in close cooperation with the Customs for interdiction of transit drug through air, sea and land barriers and with police for interdiction in the interiors. In size, the NCB is much smaller in comparison to Central Excise and Customs, Border Security Force, the Directorate of Revenue Intelligence, the Central Bureau of Narcotics and the State Police and Excise. The state police has concurrent powers of enforcement, and several states, particularly Maharashtra and Tamilnadu and North Eastern States have taken initiative to strengthen Anti-Narcotics work by setting up dedicated cell for narcotics.

The major responsibility for controlling street level peddling and trafficking including its interfaces with transit traffic falls upon the state enforcement agencies, particularly the police. The major responsibility for controlling the transit traffic along the land borders falls on the BSF and Customs Anti-Smuggling formations. At the sea ports, the Customs play a dominant role whereas along the coast and on the high seas the responsibility is discharged jointly by the Customs and the Coast Guard.

The Central Bureau of Narcotics headed by the Narcotics Commissioner of India supervises the control system over elicit cultivation of opium poppy and production of opium.

The Bureau also coordinates through its resources for organising training of officers staff of the Police, State Excise and other law enforcement agencies.

Special efforts have been made to impress upon the State Government to establish Special Courts for trial of offences under the NDPS Act. As on date there are 30 Special Courts functioning, namely, in Maharashtra 8, Goa 1, Manipur 4, Meghalaya 5, Tripura 1, West Bengal 4, Tamil Nadu 6 and Rajasthan 1. The courts in West Bengal, Tamil Nadu and Rajasthan were created during the year 1993. This Bureau has been actively persuading the other State Government for the creation of the statutory Special Courts for expeditious trial of offences under the NDPS Act. The efforts made by

the Bureau have led to sanction for creation of ten Special Courts in Delhi which is under active consideration of State Government and seven additional courts in the State of Maharashtra.

As an incentive for extra risk taken by the enforcement officers engaged in the war against drug trafficking, the Government of India have formulated a scheme of rewards to be entirely funded by the Government of India through the Narcotics Control Bureau. During the year 1993, rewards amounting to Rs 68.83 lacs was sanctioned for disbursement to the officers of various enforcement agencies and to their informers.

Drug Trafficking Scenario in India

The main drugs trafficked from across north-west frontier are heroin and hashish originating in Pakistan and heroin from across the north-eastern border originating in Myanmar.

The traffickers of Pakistan and Afghanistan have been using India for transit of drugs to Western Countries, through its well developed international sea and airports, for over a decade. The porous land borders in Rajasthan sector have been particularly exploited for trafficking of heroin and hashish, but sea route to Gujrat and Maharashtra coast is also very vulnerable, due to factors such a proximity of Pakistan Coast, and close nexus in the trafficking networks of the two countries. In 1992, 850 kilograms of heroin of SWA origin were seized, which accounts for nearly 73% of the all India seizure and a number of them in bulk quantities. Some recent bulk seizures of heroin of Pak origin (October 1993 - 60 kgs entered through Jaisalmer, detected in Delhi) indicate that there is no change in the basic pattern of traffic and Pak traffickers will continue using India as transit country.

The pattern of trafficking through the Indo-Myanmar border, has also not undergone any basic change. Despite being the world's largest source of opium and heroin, and having a common border of 1800 Kms with India shared by seven North Eastern States, heroin is smuggled into India through a few vulnerable entry points and routes in the states of Manipur and Mizoram. Presently, the modus operandi of trafficking through Indo-Myanmar border consists of all manner of concealment in person or personal baggage of pedestrians. Free movement of the people of the adjoining areas in both countries, facilitates trafficking in small quantities from across the border town on Myanmar side. This fact is corroborated by data of seizure for several years.

Methaqualone

The next significant drug of concern to India is methaqualone, a psychotropic substance. Its production in India was banned in 1984 but it continues to be produced clandestinely in and around Bombay and some cities of Gujrat and Madhya Pradesh. There is a big demand in South Africa, and the profit margin of smuggling is enormous. A tablet of Mandrax(methaqualone) which may not cost even 50 paise for manufacture in India, fetches an equivalent of more than Rs. 50/- in South Africa. The traffickers network extends from India to South Africa and some East African countries and also the middle-east. The enforcement agencies have stepped up their efforts and very encouraging results have been achieved. During 1992, about 7.4 tonnes of methaqualone was seized whereas about 14 tonnes was seized, including world's biggest seizure of 4.8 tonnes of tablets. These seizures are pointer to an escalation in trafficking and growing strength of trafficking network in India as well as in the countries of transit and final destination. To curb it effectively there is need for greater cooperation among the law enforcement agencies of affected countries, and strengthening of the intelligence network. We have taken initiative in both directions.

Acetic Anhydride

Acetic Anhydride, which is not a drug but a precursor chemical, without which heroin can not be manufactured, is a feature of India-Pak Drug trafficking. India is a major producer of Acetic Anhydride, and its smuggling to Pakistan is extremely lucrative because of very high price difference. A litre of Acetic Anhydride costs about Rs. 80 in Bombay and Rs. 5000/- across the border in Rajasthan Sector. It is largely produced in and around Bombay and some cities of Gujrat and smuggled to Pakistan through Rajasthan Sector of the border. Small quantities are also reported to have been smuggled through the land border check post at Wagah Amritser.

One of the strategies adopted by various countries to combat illicit traffic in drugs is exercising control over precursors, essential chemicals and solvents which are used in the manufacture of drugs so that such substances are not diverted for illicit manufacture of drugs. The 1988 U.N. Convention against illicit Traffic in Narcotics Drugs and Psychotropic Substances to which India acceded as a party recognises the importance of this strategy and requires the member countries to establish a control programme over these precursors,

essential chemicals and solvents which are essential for the manufacture of certain commonly abused drugs.

The Government of India have taken serious note of this fact and apart from stepping up the enforcement efforts particularly in Indo-Pak border have also taken following legislative and administrative measures to control the diversion of Acetic Anhydride for illicit manufacture of drugs:-

(i) The NDPS Act 1985 was amended in the year 1989 conferring powers on the Central Government to declare such substances as "Controlled Substances" and by order regulate or prohibit the production, manufacture etc of such substances.

(ii) Consequent on receiving reports that Acetic Anhydride, a substance included in the Table appended to 1988 UN Convention, which is essential chemical for the manufacture of heroin and methaqualone, is diverted for illicit manufacture of such drugs within the country and is smuggled out of the country for the ultimate use in such illegal activities, Government has declared the Acetic Anhydride as a `Controlled Substance' under Section 2 (viia) of the NDPS Act, 1985. A detailed order namely, the Narcotic Drugs and Psychotropic Substances (Regulation of Controlled Substances) order, 1993 has also been notified under Section 9A of the Act. This order has come into force with effect from 15 April 1993.

The basic thrust of the order is the full records regarding manufacture, distribution, sale, import, export and consumption of Acetic Anhydride are kept for a minimum period of two years. Periodic returns of the activities are to be sent to the designated authority. While on movement, any consignment of the substance is to be accompanied by a consignment note.

(iii) The movement of Acetic Anhydride has also been regulated under Customs by notifying it as a `Specified Item'.

(iv) The movement of Acetic Anhydride has been restricted within 50 kms of India-Pakistan border and 100 kms of Indo-Myanmar border under the Customs Act of India.

(v) Under the current Import-Export policy of India, Acetic Anhydride can be exported only after obtaining a no-objection certificate from the Department of Chemicals and Petrol Chemicals. That Department consults the Narcotics Control Bureau before giving no objection certificate. While recommending, the Narcotics Control

Bureau keeps in view the possibility of diversion of Acetic Anhydride for manufacture of illicit drugs.

Indo-Nepal Border

On the Indo-Nepal border, the traditional vulnerable routes continue to be used for trafficking of hashish into India, part of which is smuggled to Western countries through various air and sea exit points. The traffickers of the sub-continent are attempting to exploit this sector for smuggling heroin of Southeast Asian origin taking advantage of the open land border and unrestricted movement of the people of either country through numerous entry and exit routes. The arrest of some Nigerian nationals along with heroin shows that the well known Nigerian trafficking network, which has been actively involved in the trafficking of heroin of Pak origin, mainly through metropolitan cities, has extended its tentacles along Indo-Nepal border. The enforcement agencies have been alerted of this development. The seizures along with border have also registered a significant increase over the past year.

The national drug enforcement statistics are annexed.

NATIONAL DRUG ENFORCEMENT STATISTICS AS ON 31 JANUARY 1994
QUANTITIES ROUNDED TO NEAREST KGS.

1. QUANTITY OF VARIOUS DRUGS SEIZED WITH NO. OF CASES.

	1990	1991	1992	1993	1994*
Opium	2114 506	2145 566	1918 1286	2908 1529	11 5
Morphine	6 27	6 21	35 158	36+110 amps 105	- -
Heroin	2183 764	622 1158	1153 2779	1074 2991	64 9
Ganja	39090 1782	52633 3140	64341 5839	94864 4926	112 3
Hashish	6388 753	4413 335	6621 2516	7979 2486	113 7
Cocaine	1 2	0.008 1	0.420 4	2 4	- -
Methaqualone	2141 60	4415 78	7475 167	1472 225	6768 4
Amphetamine					
Phenobarbital			118020 2		
L.S.D.			50 sq.paper	164 sq.paper 1	
Acetic Anhydride				19758 22	630Ltrs
2. Persons Arrested					
a. No. of persons arrested including foreigners	4302	5300	12850	12529	42

	1990	1991	1992	1993	1994*
b. No. of foreigners arrested	234	93	116	144	4
3. Action taken against persons involved in drug trafficking					
a. No. of persons prosecuted	4299	5546	7172	8809	-
b. No. of persons convicted	551	855	761	1428	-
c. No. of persons acquitted	1160	1940	1762	1349	-
4. Action taken under cofeposa/pindps (NDPS) Act, 1988.					
a. No. of detention orders issued under PITNDPS Act, 1988 with no. of detained in Bracket	211 (190)	109 (80)	97 (80)	116 (92)	16 (5)
5. Destruction of narcotic drug yielding plants					
a. Poppy plant area (in acres) with potential yield in bracket (in kgs)	59 (1616)	46 (671)	19 (135)	67 (754)	-
b. Cannabis plant area (in acres) with potential yield in bracket (in kgs)	1907 (1896034)	1013 (1497274)	1219 (1230209)	2587 (3270661)	329 (381250)

	1990	1991	1992	1993	1994*
6. Destruction of Manufacturing Facilities					
a. Facilities detected and quantity of finished drugs (in kgs) in bracket.					
Heroin	3(0.090)	2(1.060)	5(1.010)	4(1)	-
Hashish	-	-	-	-	-
Methaqualone	1(525.000)	-	3(3851.000)	2(1710)	-
Morphine	-	-	1(0.760)	-	
b. No. of persons arrested	2	7	7	3	-
c. Incri-minating materials seized in kgs					
Opium	-	3.150+5ltrs Opium solution	37.950	2.750 Opm. solution	-
Ganja	-	-	Acetic Anhydride Sodium carbonate Amonium chloride Methanol Diethyl ether Acetic chloride	Acetyl chloride Acetyl chloride Sodium carbonate Ammonia chloride	
Precursor Chemicals & equipments	Lab Equipments	-	-	-	-
Other drugs					

SECTION TWO

EAST ASIAN COUNTRY REPORT

BANGKOK CITY DRUG ABUSE TRENDS (THAILAND)

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Drug Addicts Information Sub-Division
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INTRODUCTION

Thailand is situated in the heart of the Southeast Asian mainland, covering an area of 513,115 square kilometers. Thailand consists of 76 provinces with a population of 56,303,273. The main ethnic group is Thai. Buddhism, the national religion, is the professed faith of 95 percent of the population.

Bangkok metropolis is the capital and centre point of the country. The 1992 census figures show Bangkok's population to be 5,562,141. The city includes 36 incorporated districts.

Because Bangkok is the centre point of the country, poor people living in other provinces have increasingly been moving into Bangkok to seek employment resulting in housing crisis and slum areas. A survey in 1990 indicated that there were 977,190 people living in 981 slum communities.

Drug problem is a worldwide social problem that has confronted all nation, both developed and developing countries. Different nations encounter different aspects of drug abuse problem. Thailand happens to be one of the very few countries in the world that faces a complete cycle of the problem, i.e. the problems of drug production, illicit trafficking routes as well as the spread of drugs use.

Data Sources

The sources of data for this report are derived from;

- The Voluntary Treatment System. The system records the details of drug addicts who voluntarily come out for treatment.
- The Narcotics Case Register. The system records the details of all arrested drug offenders from the arrest through court judgment.
- The AIDS Voluntary Reporting System. It provides information on the number of persons affected with AIDS and/or other symptomatic HIV infection.

CURRENT DRUG ABUSE SITUATION IN THAILAND

a. Illicit drug productions

- **Illicit opium poppy cultivation**

The opium poppy cultivation in Thailand is actually cultivated by the hilltribe people in the northern part of the country for their own consumption. Only a few decades ago opium was grown for commercial purpose leading to the wide extension of opium poppy cultivation in the so-called Golden Triangle areas. However, after over 10 years of successful implementation of crops replacement and highland development programme, opium poppy cultivation area is reduced to the level that its production is sufficient for the consumption of the hilltribes only. According to the 1991/1992 survey, there were about 7,541.6 acres. During the eradication programme, 4,265.6 acres were destroyed, so there were only about 15.8 tons of opium production left (Exhibit 1).

- **Illicit heroin production**

The Thai authorities have launched intensified suppression on the heroin refineries, most of which were along the Myanmar border. These refineries were of temporary nature, easily dismantled and move away. In 1991, 4 heroin refineries along the borderline were neutralized but after 1992 none was identified.

- **Illicit marihuana cultivation**

Marihuana can be grown anywhere at all seasons if water resources are sufficient. The marihuana cultivation become illegal and the Thai Government has been carrying out marihuana eradication measures since 1978. The result of this matter changes the situation of marihuana epidemic. The marihuana cultivation area has spread to various

provinces throughout the country (Exhibit 2).

- **Amphetamine**

At present, methamphetamine hydrochloride in "ice" form and pure amphetamine consumption have not been found in Thailand. The tablets which are call "stimulant" or "amphetamine" in Thailand are, infact, methamphetamine hydrochloride mixed with caffeine, powder and colour. The content of methamphetamine hydrochloride in each tablet is about 10-20%.

The production of methamphetamine hydrochloride and amphetamine tables has been continually in Thailand. In 1993, 9 stimulant refineries were smashed and 8,385 cases of arrest with the seizure of 855 kgs. of tablets. In 1994, an important syndicate of methamphetamine hydrochloride producers was arrested with 1,440 kgs. of Ephedrine. The spread of amphetamine is getting more serious in Thailand because of the economic and social situation. It has been widely used in the following groups, i.e. drivers, workers in the factory, workers in agricultural sector and students. Its spreading tends to expand to the other groups.

- **Volatile Substances**

The problem of volatile substance abuse has been emerging in the drug scene because of low price, ample availability, and difficulties in legal control. Most of users are unemployed youngsters aged between 15 - 19 years. The youths as young as 10 years old were also found inhaling volatile substance.

b. Extent of drug abuse

As a result of narcotics law enforcement activities in 1993, the number of arrests was higher than the previous year both in terms of cases and offender. The number of drug offences in 1993 was 111,030, an in crease of 18,585 or 20.0% from 1992.

Regarding the arrest of drug offences classified by types of drug and the areas where the arrests were made during 1992 - 1993, most drug offences were committed

in the provincial area (65.0% and 68.0%). In 1993, the statistics of arrest increased to 76,047 cases from 60,401 cases in 1992. In Bangkok Metropolis there was an increase to 34,983 in 1993 from 32,044 cases in 1992. When comparing the arrest of drug offences in 1993, between the Bangkok Metropolis and the provincial areas classified by types of drugs, it was found that most drug offences in Bangkok Metropolis were marihuana followed by heroin, volatile substances and amphetamine (77.66%, 18.26%, 8.94% and 0.91%) respectively. In provincial areas, most drug offences were marihuana followed by heroin, volatile substances and amphetamine respectively (33.36%, 25.33%, 25.05% and 11.26%) (Exhibit 3).

For treatment data the number of drug dependents admitted for treatment were 38,864 and 47,668 in 1992 and 1993 respectively. Most of them were at the age of 21 - 25 year. It was found that majority of them used heroin No. 4 followed by opium, volatile substances and marihuana. Furthermore, most of drug dependents had their residence in Bangkok and heroin No. 4 is the main drug of abuse (Exhibit 4-5).

c. Trend of drug abuse

The continual socio-economic change, the rushing city life and the high competition in industry and services, will undoubtedly be contributive factors to the prevailing of drugs abuse problem. This has no exception to Thailand. Heroin will still be the most popular drugs especially in urban area such as in Bangkok Metropolitan, in the central and southern regions. Opium will be widely used in the north and north-eastern regions. Marihuana will still be consumed but in a more limited extent. It is anticipated that amphetamine will be increasingly used among workers and volatile substances among the youths. However, it is foreseen that there might be a spreading of new types of drugs with potent effect.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS (IDUS)

During 1984-1994, the cumulative number of reported AIDS cases is 5,990. Over 60 percent of cases was reported in 1993 alone (Exhibit 6).

Regarding the reported AIDS cases by route of transmission, sexual intercourse accounts for 75% of AIDS cases while infection among injection drug users accounts for 8% of AIDS cases. The proporting of vertical transmission of HIV from infected mothers to their babies is about 8% (Exhibit 7). Reports also indicate that more than 80% of the cases are in the age range of 15 - 49 years. Male to female ratios are 6.6 to 1.

Problems on collection of drug abuse-related data for reporting and monitoring

The ONCB could not supply all the figures as requested by the Colombo Plan Multi-city Epidemiology Study. Examples of statistics which are not available are:

- Social and health indicators. These are not available at all.
- Treatment. No figures are available for the number of addicts who have been using cocaine, hallucinogens, sedatives and cigarettes.
- Source of drugs. The details on the sources that supply drugs to abusers are not available.

Suggestion for data collection methods

(1) It would take quite a long time in order to adjust the ONCB statistics system to meet all requirements of the Colombo Plan Multi-City Epidemiology Study.

(2) Most of our statistics figures collected throughout the country are based on regional profiles. As such, specific figures of each province, for example, Bangkok, are not available.

(3) The statistics forms of the Colombo Plan Multi-City Epidemiology Study is similar to that of IDASS International Drug Abuse Assessment System designed by UNESCO, whilst IDASS contains more details. At present, the ONCB also has to fill out IDASS form annually.

Exhibit 1

Opium Eradication 1988 - 1993

Harvest season	Cultivation area rais (acres)	Eradication areas rais (acres)
1988/1989	30,100 (12,040)	11,459.5 (4,583.6)
1989/1990	26,109 (10,443.6)	14,970 (5,988)
1990/1991	23,295 (9,318)	21,076 (8,430.4)
1991/1992	18,854 (7,541.6)	13,422 (5,368.8)
1992/1993	16,906 (6,762.4)	10,664 (4,265.6)

Exhibit 2

Comparison of marihuana eradication

Year	Eradication area of marihuana (rais)	Amount of Fresh marihuana (kg)	Amount of Dried marihuana (kg)
1989	1,154.75	575,578.00	154.40
1990	797.21	331,765.50	399.50
1991	392.53	212.049.50	3000.50
1992	185.56	192,538.00	0.00
1993	421.18	301,058.00	26.00

Exhibit 3

The number of drug offences exhibit classified by types of drugs and regions where the offences occurred

Type of Drug	Year	Bangkok Metropolis	Other Provinces	Total
Heroin	1992	5,816	17,541	23,357
	1993	6,388	19,266	25,654
Marihuana	1992	23,613	23,175	46,788
	1993	25,068	25,371	50,439
Opium	1992	16	3,612	3,628
	1993	13	3,446	3,459
Amphetamine	1992	152	5,980	6,132
	1993	320	8,560	8,880
Volatile Substances	1992	2,385	9,602	11,987
	1993	3,129	19,080	22,209
Kratom Plant	1992	59	436	495
	1993	58	309	368
Others	1992	3	55	58
	1993	7	15	22
Total	1992	32,044	60401	92,445
	1993	34,983	76047	111,030

Exhibit 4

The number of drug dependents admitted for treatment in Thailand and Bangkok during year 1991-1993

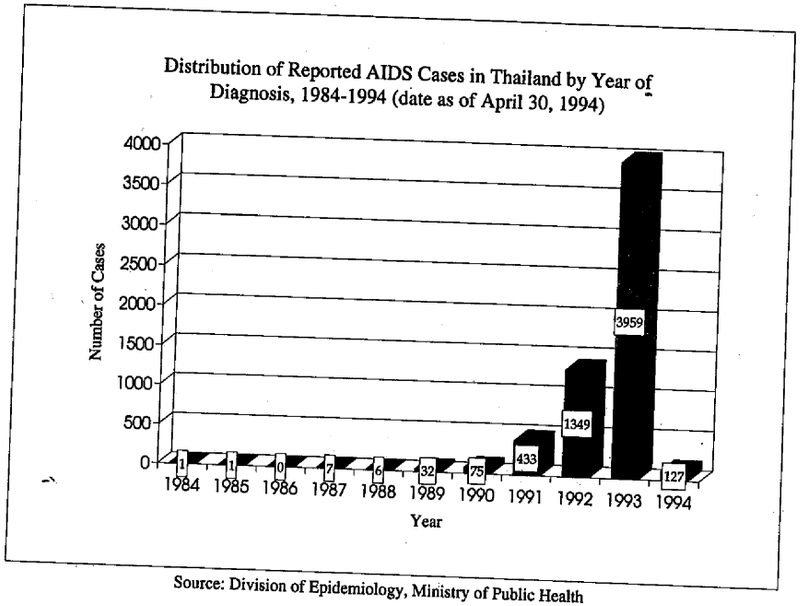
Year	Number of drug dependents admitted for treatment	
	Thailand	Bangkok
1991	32,880	10,667
1992	38,864	12,503
1993	47,668	15,402

Exhibit 5

The number of drug dependents classified by Heroin 4 in used during year 1991-1993

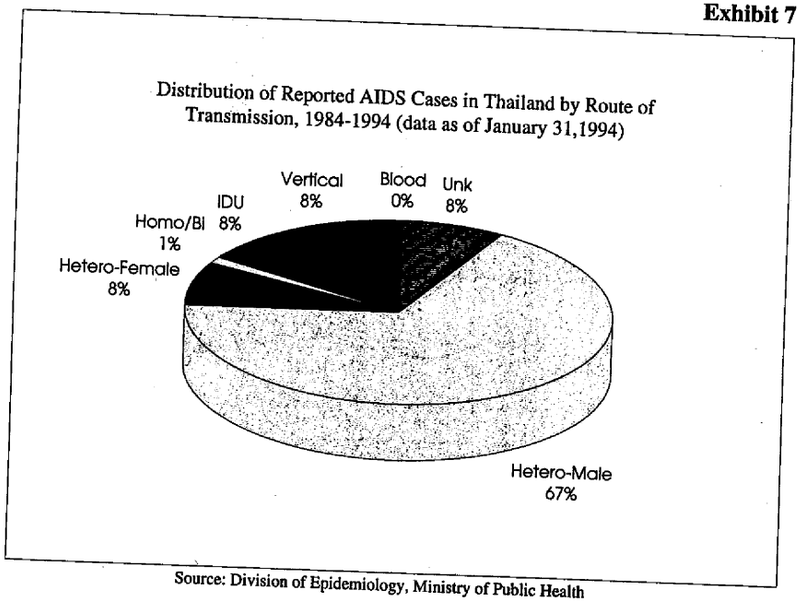
Year	Number of drug dependents admitted for treatment for Heroin 4	
	Thailand	Bangkok
1991	26,626	9,929
1992	32,191	11,722
1993	40,007	14,617

Exhibit 6



Source: Division of Epidemiology, Ministry of Public Health

Exhibit 7



Source: Division of Epidemiology, Ministry of Public Health

PATTERNS AND TRENDS OF DRUG ABUSE IN KUALA LUMPUR

Anti Narcotic Task Force, National Security Council, Prime Minister's Department of Malaysia

Abstract:

The Federal Territory of Kuala Lumpur has one of the largest population of addicts in Malaysia. Recent trends show that the number of new and relapsed addicts are on the increase. Patterns of drug use however have remained the same with heroin and cannabis being the major drugs of abuse by the mainly male addict population. The typical addict is between 20-34 years of age and employed as general labourers or sales workers. Seizures of most drugs have increased over the years while arrests have remained the same.

INTRODUCTION

1. Area Description

1.1 Malaysia consists of fourteen states and has an estimated land area of 329,757 square kilometres. Its population of 18,180,853 (from the 1991 statistics) was made up of the main ethnic groups which were Malay, Chinese and Indian.

1.2 The capital of Kuala Lumpur has an area of 243 square kilometres with an estimated population of 1,257,662 (in 1991) or approximately 6.9 percent of the total population of Malaysia. In the same year, the population density of Kuala Lumpur was 5,175.6 per square kilometre with an annual growth rate of 2.2 percent. There was a floating population of immigrants and workers estimated at 10,000 to 15,000 persons at any one time.

1.3 In 1991, the age group distribution were 416,038 persons (33.1 percent) in the 0-4 year age bracket, 800,552 persons (63.6 percent) in the 15-64 year age bracket and 41,072 persons (3.3 percent) in the 65+ year age bracket. There were 106 males for every 100 females in the population in 1991.

2. Data Sources and Time Periods

2.1 Data was derived from the National Drug Abuse Information System at the Anti Narcotics Task Force, National Security Council, Prime Minister's Department Malaysia. The system collates all data submitted by anti drug and health care agencies throughout the country. These include hospitals, police, prisons, treatment and rehabilitation centres and others.

2.2 This report covered the time period January to December 1993 and compared to the equivalent reporting period of January to December 1992.

2.3 The major drug of abuse was heroin and cannabis. There was minimal reporting on other types of drugs abused. Therefore, data was not categorised by the type of drug abused but rather by new and relapsed cases (cases detected more than once by the system).

2.4 Problem in data collection include the following:-

(a) individual departmental priorities occasionally delayed regular submission of data by agencies.

(b) transfers of data collection staff have affected continuity of data submission.

(c) incomplete reporting have led to loss of valuable information.

DRUG ABUSE TRENDS IN KUALA LUMPUR

1. Number of Addicts Identified

A total of 4348 addicts was identified in 1993 compared to 3453 addicts in 1992, an increase of 25.92 percent (**Figure 1**). From the total number identified in 1993, 1566 persons (36.02 percent) were new cases (never before detected by the NADI system) and 2782 persons (63.98 percent) were relapse cases (detected more than once by the NADI system). The total addict population detected in Kuala Lumpur in 1993 was made up of 4223 males (97.13 percent) and 125 females (2.87 percent).

2. Type of Drug Used

The majority of new addicts (90.09 percent in 1992 and 79.63 percent in 1993) abused mainly heroin (**Figure 2**). The second major type of drug abused was cannabis, abused by 8.06 percent of new addicts in 1992 and by 18.2 percent of new addicts in 1993. Other substances abused include other types of opiates and psychotropic substances. No new cases of solvent abuse was detected in 1992 or 1993.

The main route of administration used by new heroin abusers was by the `chasing the dragon' method. The rest either injected or smoked the drug. All new morphine abusers injected the drugs. Cannabis was smoked while psychotropic substances were taken orally.

3. Age When Detected

The majority of new addicts (77.68 percent in 1992 and 73.89 percent in 1993) were in the 20-34 year old age bracket when they were detected (refer **Figure 3**). The second largest group was from the 34+ year old (13.79 percent in 1992 and 13.98 percent in 1993) followed by the 15-19 year old (8.55 percent in 1992 and 12.2 percent in 1993). Only one new addict aged less than 15 years old was detected in 1992.

4. Level of Education

From the new addict population in 1993, 505 addicts (68.24 percent) had between 7-12 years of formal education while 200 (27.03 percent) had between 1-6 years of formal education (**Figure 4**). This population profile did not appear to differ very much from that detected in 1992.

5. Occupational Status

In 1993, general labour workers (19.02 percent) and sales workers (19.02 percent) made up the largest number of new addicts detected, followed by workers in the service industry (15.05 percent) and the unemployed (14.47 percent) (**Figure 5**). Compared to 1992, general labour workers formed 13.04 percent of the new addict population. Sales workers were the largest group (19.09 percent) in 1992. Workers in the service industry were the second largest group (18.71 percent) followed by the unemployed at 13.23 percent.

6. Source of Supply

It was reported by 61.94 percent of the new addict population in 1993 that the main source of drug supply was friends or fellow addicts while 37.92 percent reported obtaining supply from the streets. This did not seem to differ much from reports in 1992.

7. Drug Seizures

Seizures of heroin, morphine and cannabis rose in 1993 while that of prepared opium and psychotropic pills fell (**Table 1**).

8. Arrests of Drug Offenders

The number of drug offenders arrested for illicit drug activities in Kuala Lumpur in 1992 and 1993 are shown as **Table 2**.

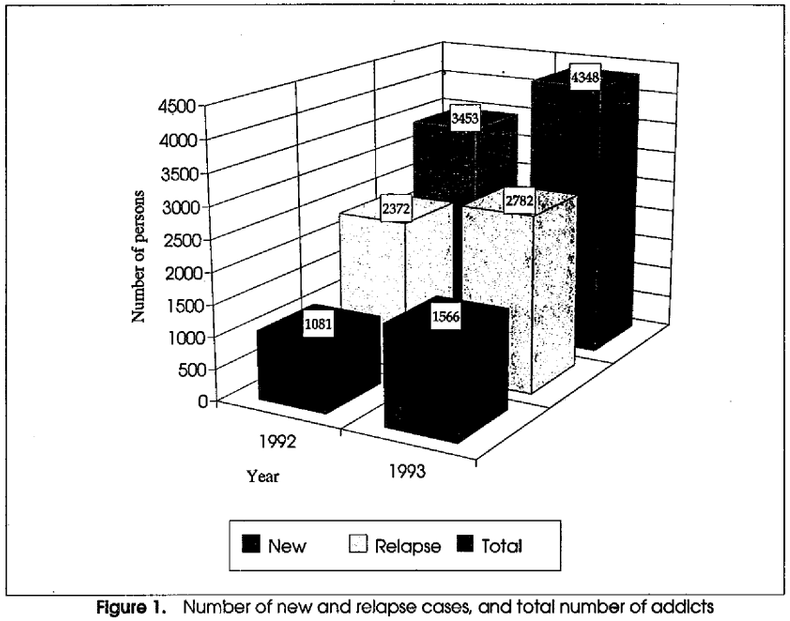


Figure 1. Number of new and relapse cases, and total number of addicts in Kuala Lumpur, 1992-1993

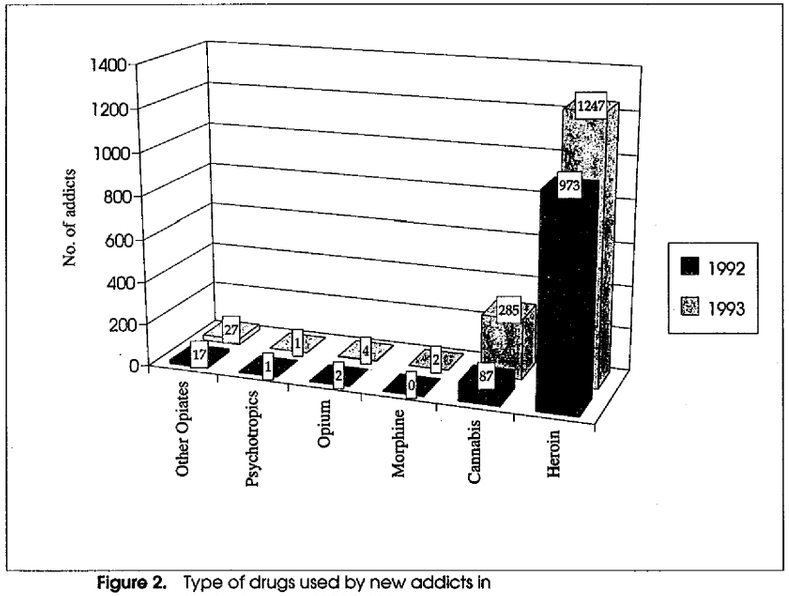


Figure 2. Type of drugs used by new addicts in Kuala Lumpur, 1992-1993

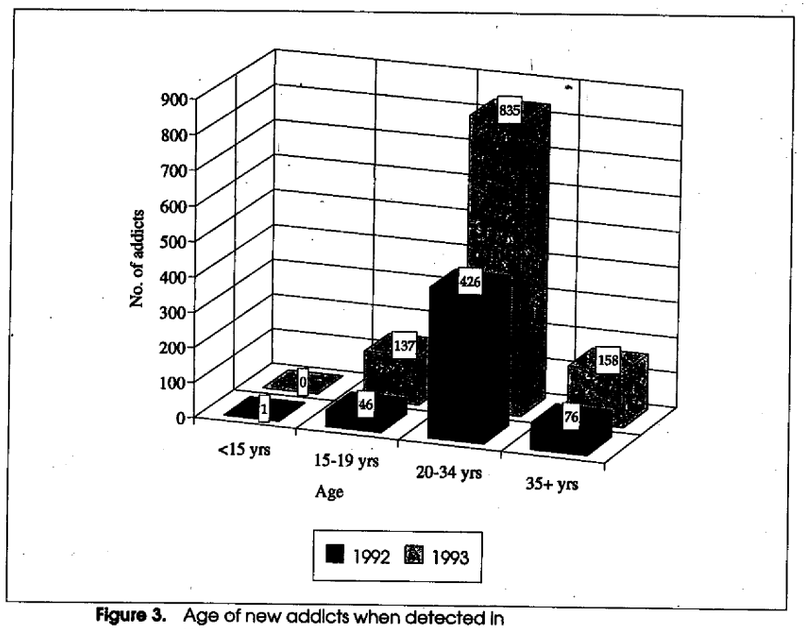


Figure 3. Age of new addicts when detected in Kuala Lumpur, 1992-1993.

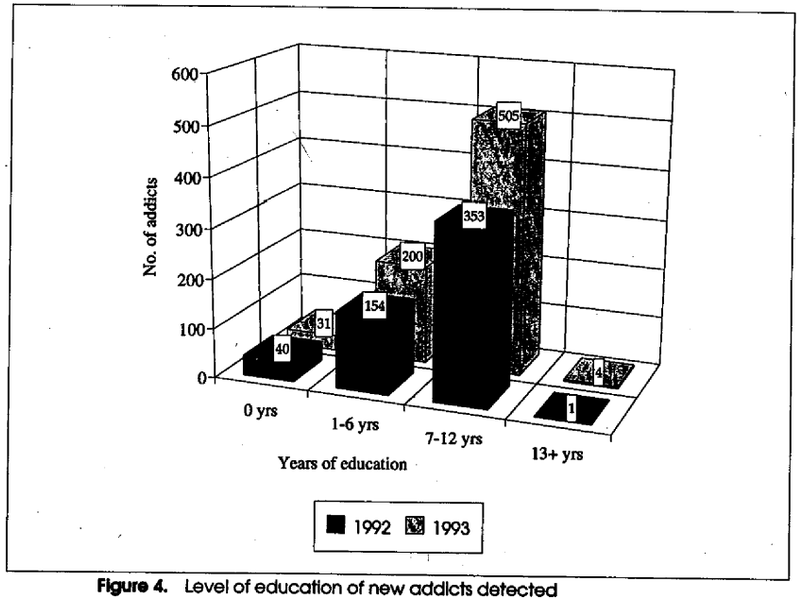


Figure 4. Level of education of new addicts detected in Kuala Lumpur, 1992-1993.

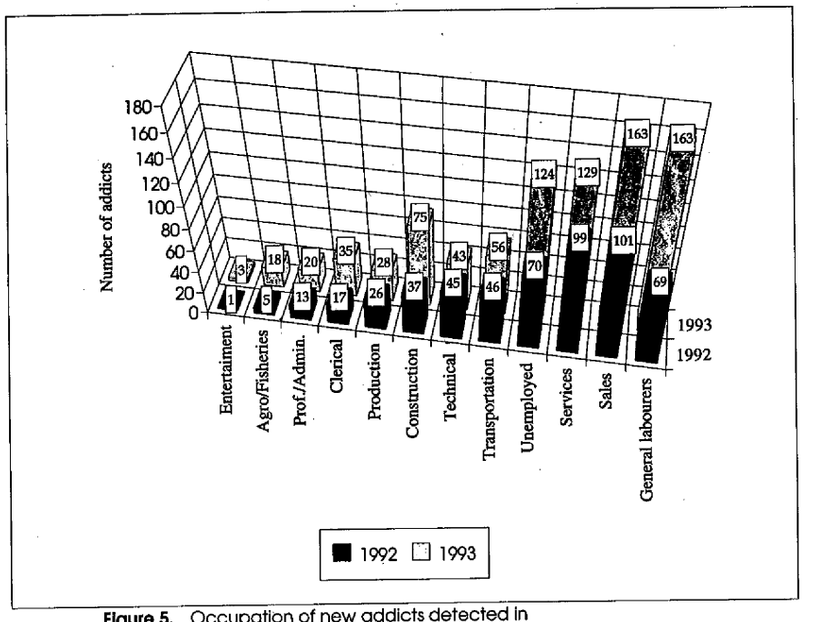


Figure 5. Occupation of new addicts detected in in Kuala Lumpur, 1992-1993.

Table 1

Seizures of drugs in Kuala Lumpur
1992 - 1993

Type of Drug	Amount seized (gms)	
	1992	1993
Prepared opium	181.57	6.00
Morphine	0.00	0.03
Heroin	29,150.01	29,573.95
Cannabis	42,587.10	56,280.98
Psychotropic (pills)	186,072 pills	15,699 pills

Table 2

Number of drug arrests in Kuala Lumpur
1992 - 1993

Section under the Dangerous Drugs Act 1952	Number of arrests	
	1992	1993
Section 39B (a)	210	226
Section 39A (b)	544	426
Other sections (c)	509	489

Explanatory notes:

(a) Traffickers - possession of 15 gms and more of heroin/morphine

(b) Pushers - possession of less than 15 gms of heroin/morphine

(c) Includes the offence of self-administration of illicit drugs

SPECIAL STUDIES

THE PREVALENCE OF HIV INFECTION AND HIGH RISK BEHAVIOURS AMONG INTRAVENOUS DRUG USERS (IVDUs) IN HOSPITAL KUALA LUMPUR

A study was conducted to estimate the prevalence of HIV infection and high risk behaviours among IVDUs at the Drug Detection Unit, Psychiatry Department, Hospital Kuala Lumpur and those admitted to various wards in the hospital. The study was limited to the specified setting and findings were based on self-reports by the subjects.

The study found that subjects were sexually active with 44% having multiple sexual partners. Subjects did not practice safe sex although they were equipped with the knowledge. Seventy three percent of the subjects shared needles but did not sterilise needles or other injecting equipment.

The study found that the prevalence of HIV infection was 30.7%. While the figure was lower than estimates in other countries, it may still be an underestimate as some subjects were still in the `window period' i.e. some subjects were still engaged in risk behaviors three months prior to interviews. Subjects in the study were those who have no previous contact with treatment and rehabilitation facilities. The prevalence of HIV infection was high when compared to a seroprevalence survey conducted in the drug rehabilitation centres and medical facilities where the incidence rate of HIV infection was found to be 6.9% in 1991.

Findings indicate that more intensive intervention strategies are needed to prevent further spread of HIV among IVDUs and from IVDUs to the general population through their sexual activities. The extent of heterosexual spread of HIV remain to be explored.

AUTOIMMUNE DEFICIENCY SYNDROME AMONG INJECTING DRUG USERS

A total of 4,597 cases of HIV was reported in 1993 where 3,162 cases (68.9 percent) were detected as drug addicts by the National Drug Information System (NADI System).

In 1992, 31 new AIDS cases were identified of whom 19 were intravenous drug users. A total of 2,377 persons were identified as HIV carriers with 1964 (82.6 percent) intravenous drug users.

Since 1985 until December 1992, a total of 69 AIDS cases with 42 death were identified. Out of this total, 28 cases (40.5 percent) and 13 deaths (30.9 percent) were intravenous drug users. During the same period, 4902 HIV carriers were identified where intravenous drug users comprised 81.9 percent or 4015 persons.

THE REPUBLIC OF KOREA COUNTRY AND CITY REPORT
DRUG USE AND ABUSE TRENDS

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1. COUNTRY DESCRIPTION

1.1 Geography

The Republic of Korea is located in the South of Korea Peninsula, which extends southward from the eastern end of the Asian continent, and lies south of Russia, east of China, north-west of Japan.

The Korea Peninsula is roughly 1,000 km long and 216 km wide at its narrowest point, and is separated by demilitarized zone at roughly the 38th parallel: Republic of Korea in the south and the Communist D.P.R.K. in the north since the end of World War II.

The land area of the Republic of Korea is about 99,200 sq. km. Administratively, the Republic of Korea consist of nine provinces (do): one special city, Seoul; and the five metropolitan cities of Pusan, Taegu, Inchon, Kwangju and Taejon. There are 68 cities (shi) and 136 countries (gun) in the nine provinces.

1.2 Population and Socio-Economic Factors

Population of the Republic of Korea in 1993 was about 43.7 million. Population growth rate has been declining from 1.57% in 1980 to 0.93% in 1990 due to a successful family planning programme. The proportion for metropolitan cities (above mentioned 6 major cities) of total population is 47.5%.

The people of Korea Peninsula is highly homogeneous. Ethically, Korean belong to the Mongolian race, but for centuries the people have maintained their own unique language, culture and customs.

Freedom of religions is fully guaranteed in the Republic of Korea. Korea's traditional religions are Schamanism, Buddhism and Confucianism. These played important roles in the country's early cultural development and greatly influenced the People's thought and behavior. Christianity was introduced in the late 18th Century, but has spread rapidly to claim the largest following. There are also various major religions which combine elements of the traditional religions. At present, about 19% of Koreans are Buddhist, and 15%, 4% and 1% are Protestant, Catholic, and Confucian, respectively.

The city of Seoul is the capital of the Republic of Korea, containing about 10.8 million of the Nation's 43.7 million people and is the financial, political, commercial, educational and cultural centre of Korea.

2. DRUG USE AND ABUSE TRENDS

2.1 Historical background of drug abuse

The history of drug abuse in Korea started after the opium war in 1884, when Korea was unable to restrict inflow of opium from China. But in those days prior to World War II, poppy cultivation was encouraged and to sell opium as monopoly goods.

Under the confused social conditions following World War II and Korean War, opium was in great demand among civilians. Opium abuse became prevalent through the country, and this has resulted in appearance of 50,000 drug addicts in the south in 1954.

To cope with this situation, the government enacted Narcotics Control Law in 1957 and strengthened drug enforcement activities.

But this being insufficient, in 1961 the Government designated narcotic abuse, as one of the five social evils and devoted its efforts to block the source of narcotics.

A new situation was precipitated by strengthening of punishment for narcotic control in Korea, bringing in almost eradication of narcotic offence with induction of drastic changes in the local drug abuse patterns. With the sharp decline of opium abuse, the problem of methamphetamine and cannabis abuse gained an area of social concern.

Faced with such a situation, Habit Forming Drug Control Law was enacted in 1970 to prevent abuse and illicit trafficking of psychotropic substances.

In the 1980s the result of joint efforts of the Korean and Japanese law enforcement agencies, smuggling out of methamphetamine was controlled.

However, the civilian living in the southern area of Korea began to abuse methamphetamine which had been manufactured locally, and it became widely spread to the whole nation, in parallel with economic development.

To cope with this situation the Government established Narcotic Division in Supreme Prosecutors Office to supervise and control illicit drug crime in 1989. As a result, most of clandestine manufacturer of methamphetamine were arrested and put in prison.

The most common type of drug abuse among youngsters remains inhalation of organic solvents, butane and glue sniffing.

2.2 Drug Use and Abuse Trends

A. Heroin

Heroin abuse had been almost non-existent in Korea until recently, except that Korea being used as a transit route for heroin from the Golden Triangle. The situation, however, had drastically changed.

Last year a number of heroin abuse cases have been detected, and about 30 offenders were arrested for heroin abuse.

The largest seizure of heroin ever took place in September 1993; 22.4 kgs of heroin destined for the United States was discovered in a bonded Seoul Customs. The joint operation with Hong Kong Customs and US DEA resulted in the arrest of 3 persons, by conducting control delivery.

Year	Quantity seized
1991	3,190 grams
1992	22,003 grams
1993	25,905 grams

B. Cocaine

In Korea, due to the climate and soil conditions, cultivation of the cocabush is not favorable, therefore the problems regarding cultivation of cocabush is negligible and there have been very few cocaine abuser. The first seizure of cocaine was made in 1990. After that in 1991, drug law enforcement agencies seized 140 grams of cocaine which was smuggled from the United States.

Year	Quantity seized
1991	140 grams
1992	13,306 grams
1993	23,170 grams

C. Opium Poppy

Before 1945, opium poppy was cultivated under the government license as a monopoly goods. Opium addicts had increased constantly by the unchecked outflow of stocks. As a result cultivation has been prohibited by newly enacted Narcotic Control Law since 1957, and opium abuser has decreased significantly.

At present, even though cultivation of opium poppies has been banned in Korea, illegal cultivation of poppies restrictedly take place in secluded and mountainous places for first aid medicine and veterinary purposes. Until 1991, there had not been any problem concerning opium except illicit cultivation.

However, since the establishment of diplomatic relations with China in 1992, some ethnic Koreans who live in China have smuggled opium into Korea.

Year	Quantity seized
1991	6,369 plants
1992	11,730 plants
1993	33,714 plants

D. **Cannabis**

Cannabis cultivation has a long history in the country for raw material of textile. However, the amount of cultivated cannabis is decreasing due to the sanction on it. At present, those who live in the countryside legally cultivate hemp under the permission and strict control from the prefecture.

Cannabis smokers had increased until enactment of the Cannabis Control Law in 1976, and was mostly limited to foreigners, entertainers, and college students.

As a result of strengthening suppression activities by the law enforcement agencies, smokers, significantly decreased from the late of 1970's to the late of 1980's.

However, since 1989. cannabis smokers have rapidly increased and become wide spread, not restricted to social stratum but all including housewives, fishermen, office workers, drivers and labourers (Exhibit 1).

This trend is assumed to be increasing. It is assumed that increase of cannabis smokers results from the shortage and high price of methamphetamine. Therefore, cannabis is the second most widely abused drug following methamphetamine (Exhibit 2).

In 1993 the number of cannabis offenders reached a 143% increase compared with the previous year (Exhibit 2).

E. **Methamphetamine**

Methamphetamine, so-called 'ice' remains the most commonly abused drug in Korea (Exhibit 3). In 1989 and 1990, most of the clandestine manufacturers of methamphetamine were apprehended as a result of active drug control measures of the law enforcement agencies.

Subsequently, the number of methamphetamine offenders sharply decreased because of the limited supply and high price of drug.

The high price of methamphetamine entailed increase of smuggling of cheaper drug into Korea (Exhibit 6). Since 1991, about 4.6 kgs of methamphetamine smuggled from abroad have been seized in 29 cases.

In order to tackle the re-emerging problem of methamphetamine abuse more effectively, the Government has strengthened law enforcement activities. As a result, in the year 1993, seizure of methamphetamine and ephedrine, the precusor of methamphetamine, recorded 29.6 kgs and 358 kgs, respectively (Exhibit 5).

These records represented substantial increase compared with the previous year, which had recorded 3.1 kgs and 267 kgs, respectively.

F. **Other Drugs**

In Korea, therapeutic drugs such as dextromethorphan, zippeprol, nalbupine, etc. are recently prevalent as alternative drugs because these medicines are easily available without control by drug law enforcement agencies.

For the last 3 - 4 years, it has been reported that these medicines abuse have increased but there is no available statistical data related to these abuses. It is assumed to be rapidly spreading to juvenile groups, because these medicines can be available at moderate prices through legal distribution routes which are not controlled.

G. **Inhalants**.

Sniffing of organic solvents and gases have increased among youths. Abuse of these substances include problems as follows:

- Sniffers of these substances have created many social problems under the hallucination condition.
- The abuse of these inhalants implies a gateway of drug abuser.

In consideration of these points, some of these substances were included late in the controlled drug list. However, they are widely used in the industrial fields, thus the entire suppression of the substances is regarded as a more difficult problem to solve.

3. ACQUIRED IMMUNODEFICIENCY SYNDROM (AIDS) AMONG INJECTING DRUG USERS (IDUs)

Since the first identification of HIV seropositive in December 1985, 255 persons have been reported infected with HIV by 1993. Among them, 12 persons developed AIDS as reported to WHO in 1993. There was no report of cases that were both IDUs and heterosexual, and IDUs and homosexual/bisexual.

4. DATA SOURCE

- o Supreme Public Prosecutors Office
  - data related to drug offences and offenders

- o 22 National or Public mental hospitals
  - data related to drug addicts treatment

5. NATURE AND PATTERNS OF DRUG USE AND ABUSE

A few nature and patterns of drug use in Korea were selected from the statistical data of drug-related offences in 1993, which were provided by the Supreme Public Prosecutors Office.

- Drug offenders were classified into three parts by type of drugs, such as narcotic, cannabis, psychotropic (mainly methamphetamine). The proportion for narcotic, cannabis and methamphetamine abuse offenders of the total drug offenders was 1.4%, 14.4% and 18.4% respectively (Exhibit 6).

- These figures increased by 930%, 153%, and 260% compared with the 1992 figures (Exhibit 7).

- According to breakdown by the frequency of use, user of once a month in narcotic and cannabis was the most plentiful and user of once a day in methamphetamine was the most plentiful (Exhibit 8).

- According to breakdown by period of drug use, the proportion for user, used within a month of the total drug user was the highest at 45.4% and user, used within three months accounted for 20.6% (Exhibit 9).

- The second offence (abuse) rate of methaphetamine in the three drug types were the highest at 17.2% (Exhibit 10).

Twenty-two national or public mental hospitals have been designated as drug addiction treatment centres and treatment activities have been carried out under the Presidential Decree on Protection for Drug Addicts Treatment since 1990.

Actual result of drug addict treatment are presented in the tabulated forms as follows:

Table 1: Actual result of drug addicts treatment

(Unit: persons)

Year	1991	1992	1993
No. of treatment persons (A)	81	88	131
No. of drug abuse Offenders (B)	1335	1123	2312
Treatment percentage (A/B) (%)	6.07	7.84	5.67

Table 2: Breakdown by types of drug

(Unit: persons)

Year	1991	1992	1993
Narcotic	1	-	1
Cannabis	-	-	6
Psychotropic (mainly methamphetamine)	80	88	124

Table 3: Breakdown by period of treatment

(Unit: persons)

Year	1991	1992	1993
Within 3 days	6	12	15
Within 4-7 days	31	34	47
Within 8-15 days	24	17	36
Within 16-30 days	12	18	23
Over a month	8	7	10
Mean period of treatment (days)	12.4	11.9	14.6

Table 4: Breakdown by age

(Unit: persons)

Year	1991	1992	1993
Less than 19 years	1	-	3
20 - 29 years	26	22	50
30 - 39 years	30	36	56
40 - 49 years	20	19	17
50 - 59 years	3	10	4
Over 60 years	1	1	1

Table 5: Breakdown by regional groups

(Unit: persons)

Year		1991	1992	1993
Seoul (Capital)		7	11	17
Metro-polises	Pusan	39	30	38
	Taegu	33	44	69
	Inchon	-	-	6
	Kwangju	-	-	-
	Taejon	-	1	-
Others		2	2	1
Total		81	88	131

As stated above, the proportion for treatment of abuse offenders was 5.67% in 1993. Regarding regional status, 99.2% was from 6 major metropolises.

It is assumed that the patterns and trends of drug abuse were as follows with treatment statistics.

1. Owing to the compulsory hospital treatment system by drug law enforcement agencies and shortage of social conditions for voluntary treatment, very few addicts were treated and voluntary treated patients were rare.

2. 5.67% drug abuse offenders were treated persons and the mean treatment periods were 11 to 15 days. From these statistics, it may be construed that in Korea the problems of drug addicts have not become serious yet.

6. OPERATIONAL ISSUES

6.1 Difficulties in data collection

We face many difficulties in the collection of drug abuse data for routine reporting and monitoring as follows:

- lack of interests, motivation, and financial assistance on drug epidemiology study at national level.

- lack of cooperation among related agencies.

- lack of unified nationwide data assessment and monitoring system

- no special agency which is fully responsible for the data collection duties and functions.

6.2 **Suggestion for drug epidemiology study**

As a result of these difficulties,it seems that in Korea, the subject of drug epidemiology study, should be conducted on a national basis rather than at city level because of as follows:

1. Accurate statistics of drug abuse in Korea could not be obtained yet, but the Drug Criminal Indicator (DCI; No. of drug offenders per 0.1 million population) is 9 in Seoul and 15 in Korea. If we compare Seoul with cities in other countries, we know that DCI of cities are higher than DCI of its country, contrary to the status of Korea. (Exhibit 1).

2. As stated above, Koreans belong to the Mongolian race, are homogeneous people and have maintained their own unique language, culture and customs. According to the breakdown by proportion for treated patients of total drug abusers in 6 major cities, all of the cities except Taegu are lower than the national (5.6%) as average shown in the table below and the city, is higher than national average has not been fixed and has been changing every year.

City	Seoul	Punsan	Taegun	Inchon	Kwangju	Taejon
No. of patients	17	38	69	6	-	-
No. of drug offenders	938	689	326	748	1814	827
Treatment percentage	1.8	5.5	21.2	0.8	-	-

7. Exhibits

Exhibit 1. Status of Cannabis offenders by strata

(Persons)

Occupation	'91	'92	'93
Unemployed	346	394	525
Prostitutes	94	92	121
Agriculture	82	53	151
Industry	64	43	58
Fishery	1	-	3
Commerce	120	81	120
Entertainers	39	41	40
Housewives	1	1	2
Students	53	25	52
Labourers	72	59	95
Office workers	36	38	69
Drivers	57	53	82
Medical vocations	-	3	4
Sailors	2	6	5
Others	171	165	181
Total	1138	1054	1509

Exhibit 2: Classification of the offence type

(Persons)

	Narcotic		Psycho tropics		Cannabis		Total	
	'92	'93	'92	'93	'92	'93	'92	'93
Manufacture	-	-	18	21	-	-	18	21
Smuggling	20	24	11	27	2	1	33	52
Trafficking	20	21	256	400	21	16	297	437
Cultivation	804	3158	-	-	64	174	868	3332
Abuse	10	93	479	1245	634	974	1123	2312
Possession	31	20	50	45	233	297	314	362
Other	64	55	151	92	100	47	315	194
Total	949	3371	965	1900	1054	1509	2968	6773

Exhibit 3: Numbers of Methamphetamine Abuser

Year Unit	'86	'87	'88	'89	'90	'91	'92	'93
Person	862	1,459	3,320	1,418	1,158	602	479	1245
Per-cent	100	169	385	231	181	134	112	220

Exhibit 4: Price of Methamphetamine by Year

(Unit: US$)

Year Unit	'88	'89	'90	'91	'92	'93
Per kg	4,375	5,625	18750	37500	50000	625000
Per g.	125	250	1250	1250	1875	2500
One dose	12.5	37.5	125	125	187.5	825

Exhibit 5: Quantity seizure of Methamphetamine by Year

'89	'90	'91	'92	'93
131.62	31.93	3.75	3.11	29.6

Exhibit 6: Number and rate of abusers by type of drugs

	Narcotic	Cannabis	Methamphetamine
No. of abuser	93	974	1,245
Abuser rate of total drugs offenders (%)	1.37	14.38	18.4

No. of total drug offfenders are 6,773 persons

Exhibit 7: Number of drug use by type of drugs

(Persons)

	'89	'90	'91	'92	'93	
Narcotic	7	58	10	10	930%	93
Cannabis	501	735	723	634	153%	974
Methampheta mine	1418	1158	602	479	260%	1245
Total	1926	1969	1335	1123		2312

Exhibit 8: Breakdown by the frequency of use

(Unit: percent)

	Narcotic	Cannabis	Methamphe tamine	Total
Over twice a day	2.7	0.6	3.3	2.3
Once a day	21.9	8.2	25.4	19.1
Twice a week	19.2	10.5	5.9	28.2
Once a week	4.1	8.7	7.0	7.4
Twice a month	12.3	17.1	13.1	14.5
Once a month	20.5	32.5	15.3	21.7
Once per three months	4.1	12.8	5.4	8.0
Others	15.2	9.6	24.0	18.8
Total	100	100	100	100

Exhibit 9: Status by period of drug

(Unit: percent)

	Narcotic	Cannabis	Methamphe tamine	Total
Within a month	36.7	36.1	51.6	45.4
Within 3 months	40.4	24.0	17.1	20.6
Within 6 months	10.0	19.8	11.6	14.5
Within a year	3.3	11.2	11.8	11.2
Within 2 years	1.7	3.7	3.4	3.4
Within 3 years	0.0	1.2	1.3	1.2
Over three years	8.3	4.0	3.2	3.7

Exhibit 10: A second offence rate of drug abuser

	Drug abuse offenders(A)	The second offenders(B)	The second abuse rate (B/A)
Narcotic	93	8	8.6 (%)
Cannabis	974	137	14.1 (%)
Methamphe tamine	1,245	214	17.2 (%)
Total	2,312	359	15.5 (%)

Exhibit 11: DCI of Cities

(persons)

City	Drug Offenders	Drug Criminal Indicator(DCI)		Year
Washington D.C.	7,753	1,292	U.S.A. 422	1992 1993
New York	43,716	599		
Los Angeles	28,626	753		
Paris	3,323	151	France 35	1991
Rome	4,041	109	Italy 58	1993
Tokyo	2,665	24	Japan 14	1992
Seoul	938	9	Korea 15	1993

PROBLEM OF DRUG ABUSE IN YANGON CITY

(1993)

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Myanmar

INTRODUCTION

Union of Myanmar is situated in Southeast Asia. It is a neighbour to Thailand, Laos and China to the east and India and Bangladesh to the west. Union of Myanmar is divided into 14 states and Divisions. The population of the country is about 43 million. Buddhism is the predominant religion and there are 135 ethnic groups in the whole country.

In Myanmar there are 6 major drug treatment centers, 2 treatment and rehabilitation centres, 22 treatment sub-centres, totalling 30 treatment units for the drug addicts. Also, every township hospital undertakes the treatment of drug addicts. Plans for upgrading drug treatment centres at Mong Yang, Tachilek and Kawthaung are underway.

Up to December 1993, the registered addicts are as follows,

(Accumulative figure)

Heroin	14,508	26.8%
Opium	34,371	63.5%
Marijuana	416	0.8%
Tranquilizer	220	0.4%
Other drugs	4,638	8.6%

Drug addiction is one of the major public health problems in our country. Opium and Heroin are the two most consumed drugs. In Yangon City, the capital of Myanmar, the most common drug consumed among drug addicts is heroin (61.4%).

This paper presents the drug abuse problem in Yangon city during 1993.

BACKGROUND HISTORY OF DRUG USE IN MYANMAR

There is no evidence to indicate exactly where and when opium was first grown in Myanmar. The earliest history recorded

the sale of opium to the people in Bago by an Italian trader, Frederick Cesar who visited Myanmar in 1581. There are many factors affecting drug use in our country. The mountainous area in northern Thailand, eastern Myanmar and north western Laos is known as "The Golden Triangle" where heroin is refined illegally. Up to the end of 1970, there were no serious drug problem except opium addicts in rural areas, especially in the hilly and frontier regions.

Previously, opium use was part of the cultural habit in rural areas. Villagers use opium as drug for treatment of some physical illnesses and against anxiety and emotional disorders. It is also used for recreational purposes. We have no accurate figures about opium addiction during that time.

In the late 1960's and early 1970's there was an explosive increase in manufacture and refinement of opium to heroin and opium cultivation. This might be to meet the increasing demand of US troops in Vietnam. The increase availability of heroin led to an increase in the indigenous people taking drugs.

LAW ENFORCEMENT ACTIVITIES

(a) Enactment of the Narcotic Drugs and Psychotropic Substances Law.

On January 27, 1993 the State Law and Order Restoration Council enacted the Narcotic Drugs and Psychotropic substances law No. 1/93.

The new law which replaced the 1974 Legislation encompasses action against all breaches beginning with possession, abuse, failure to register as addicts and other related offences.

(b) Some Legal Aspects:

Drug User means a person who uses a narcotic drug or psychotropic substances without permission in accordance with the law;

Narcotic Drug means any of the following:-

(i) poppy plant, coca plant, cannabis plant or any kind of plant which the Ministry of Health has, by notification declared to be a narcotic drug, substances and drugs derived or extracted from any such plant;

(ii) drugs which the Ministry of Health has, by notification declared to be a narcotic drug, and substances containing any type of such drug;

Section -15

A drug user who fails to register at the place prescribed by the Ministry of Health or at a Medical Centre recognized by the Government for this purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment shall be punished with imprisonment for a term which may extend from a minimum of 3 years to a maximum of 5 years.

Section -16

Possession, transportation, transmission and transfer of a narcotic drug or psychotropic substance;

(c) Destruction of seized Narcotic Drugs (Supply reduction Activities)

Up to the eighth exhibition, narcotic drugs destroyed were: 8220.354 kilos of opium, 1310.642 kilos of heroin, 68.237 kilos of opium oil, 116.151 gallons of liquid opium, 3572.552 kilos of marijuana, 54.4 kilos and 19,818.655 litres of phensedyl, 63.435 kilos of morphine base and 176.47 liters of cough mixture.

CURRENT SITUATION OF DRUG PROBLEM IN YANGON CITY

Yangon city is composed of 31 Townships and the population is nearly three millions. According to hospital record, there were 343 persons registered to Yangon Drug Dependency Treatment Centre in 1993. Most drug users are male.

Experimentation and peer group pressure were the most important determinants of becoming an addict.

The average drug addict administers 2 - 3 times a day. The amount of heroin being used by daily users before admission range from 250 mg to 1500 mg.

The major problem of drug addiction is the proness to frequent relapse. Death due to overdose frequently occurred in IVDU. HIV infection rate in IVDU is found to be the highest as they usually share injection equipments. IVDU are also more prone to get Hepatitis (Type B).

"Behavioral changes" is the major determining factor leading

to health and social economic problems in the country.

Table 1: Type of drug use during 1992 and 1993 in Yangon

Year	Type of Drug								Total
	Opium		Heroin		Marijuana		Others		
	N	%	N	%	N	%	N	%	
1992	48	11.2	364	85.1	15	3.5	1	0.2	428
1993	30	8.7	307	89.5	5	1.5	1	0.3	343

Table 1 depicts the type of drug use during 1992 and 1993. The most commonly consumed drug in Yangon city is Heroin (89.5%) in 1993.

Table 2: Age and Sex distribution of drug dependence during 1992 and 1993.

Age group in years	1992		1993		Total	
	Male	Female	Male	Female	Male	Female
15-19	34	2	44	-	78	2
20-24	142	2	140	1	282	3
25-29	164	1	93	-	257	1
30-39	66	1	59	-	125	1
40-49	14	-	6	-	20	-
50-59	2	-	-	-	2	-
60 & above	-	-	-	-	-	-
Total	422	6	342	1	764	7

Table 2 depicits the distribution by gender and age group. Among new registrants in 1993 12.8% were aged 15 - 19, 41.1% aged 20 - 24, 27.1% aged 25 - 29, 17.2% aged 30 - 39, and 1.8% aged 40 - 49 respectively.

Table 3: Route of Administration (1992 and 1993)

Year	Injection		Smoking & sniffing		Oral		Total
	N	%	N	%	N	%	
1992	298	69.6	81	19.0	49	11.4	428
1993	192	56.0	120	35.0	31	9.0	343

Table 3 shows the most common routes of administration are injection, smoking & sniffing, and oral use. It shows changes in the pattern of route of administration. There is an increase in number of smoking & sniffing addicts.

PATTERN OF DRUG USE

The injecting drug use among heroin users has been observed to be decreased from 1992 to 1993. Figure (1) shows this decrease in Yangon Drug Dependency Treatment Centre where rates decreased from 81.9% to 62.5%.

Table 4: Reasons for not injecting heroin among Non IDU patients attended at follow-up treatment sessions.

Sr. No.	Reasons for not injecting heroin	No.	%
1	Awareness of HIV/AIDS	32	80
2	Fear of overdose	11	27.5
3	To avoid arrest	11	27.5
4	To protect infection	5	125
5	IDU is more serious addiction than Non-IDU	4	10
6	Injection phobia	3	7.5
7	Self treatment	1	2.5
8	Fear of rigor after injection	1	2.5

n = 40

Table 4 provides the reasons for not injecting heroin among Non IDU attended at follow-up treatment sessions. When asking them for reasons of not injecting heroin by convenient sampling method, low risk behaviours are found in their reports, which reflects, the impact of education, information system, and counselling of HIV/AIDS.

Table 5: Background Characteristics of IDU admitted to Rehabilitation Centre (Wettigan) in 1993.

Item	Description
Age	3.5% < 19 years of age, 70.2% 20 - 29 years of age, 26.3% 30 - 39 years of age.
Duration of use	21.1% < 2 years of duration, 59.6% 2 - 5 years of duration, 19.3% 6 years and above.
Previous # of admission	31.6% 1st and 2nd times, 56.1% 3rd to 5th times, 12.3% 6 times and above.
History of arrest	12.3%
Employment	14.0% Part time employment, 86.0% unemployed.

Table 5 provides background characteristics of IDU admitted to rehabilitation centre in 1993.

All together 1247 IDU have admitted to the rehabilitation centre from 1982 - 1993.

Significant features of IDU admitted to Rehabilitation Centre (Wettigan)

(1) Chronic user
(2) High relapse rate
(3) No motivation
(4) Mostly IDU
(5) Unmanagable
(6) High defaulter rate
(7) Deterioration of social adjustment and employment

Table 6: Suspected Drug Users Sent by Police in 1993

Sr. No.	Year 1993 (Quarterly)	# of cases sent by police	Non user	Drug Users	
				Registered for treat-ment	Not Regis-tered
1	1st quarter (Jan, Feb, March)	483	365	40	78
2	2nd quarter (April, May, June)	568	439	42	87
3	3rd quarter (July, Aug, Sept)	544	408	49	87
4	4th quarter (Oct, Nov, Dec)	478	375	12	91
	Total	2073	1587	143	343

Table 6 provides suspected drug users sent by police in 1993.

Among drug users, 143 out of 2073 were registered and relapsed cases, the remaining 343 were non-registered users. There were 343 newly registered cases in 1993 and there were 343 drug addicts brought by police in the same year. This shows whenever there is a new registered case there is a possibility of another addict to be brought by police. It reflects certain number of drug users are still in community and so we should consider our treatment programme be extended the unreach.

Table 7: New Cases of Drug Addiction in 1993 by States and Divisions

No.	Drug Type	Yangon Division	Shan State	Kachin State	Mandalay Division	Mon State	Total
1.	Opium	30	106	23	1	1	161
2.	Heroin	307	221	257	141	1	927
3.	Marijuana	5	1	4			10
4.	Tranquilizer						
5.	Other drugs	2			2		4
6.	Total	344	328	284	144	2	1102
7.	% Out of Total	31.2%	29.8%	25.8%	13.1%	0.2%	100%

Yangon Division reports the highest number of cases (31.2%), whereas reporting is lowest for Mon State at (0.2%)

There is nil cases reported Bago Division, Magway Division, Ayayarwady Division, Segaing Division, Rakhine State, Chin State and Kayin State.

No reports were received for Tanintharyi Division and Kayah State. Follow up is recommended on this issue; especially for Tanintharyl where population movement across the Thai-Myanmar border predisposes this area as high risk for drug addiction in addition to HIV infection.

In 1993, the most commonly consumed drug is Heroin (84.12%).

Table 8: Cumulative No. of Registered Cases at 31/12/93 by State & Division

No.	States & Div.	Opium		Heroin		Marijuana		Tranqui-lizer		Other Drugs		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1.	Yangon Div.	790	22.0	5003	61.4	344	4.2	180	2.2	833	10.2	8150	15.0
2.	Sagaing Div.	7656	82.5	618	6.7	2	0.0			1006	10.8	9282	17.1
3.	Manda-lay Div.	741	28.0	1363	51.5	3	0.1	1	0.0	541	20.4	2649	4.9
4.	Magway Div.	196	98.0	4	2.0							200	0.4
5.	Bago Div.	109	56.2	22	11.3	4	2.1	21	10.8	38	19.6	194	0.4
6.	Tanin tharyl Div.	16	44.4	14	38.9	1	2.8			5	13.9	36	0.1
7.	Ayeyar wady Div.	82	66.7	9	7.3	9	7.3	3	2.4	20	16.3	123	0.2
8.	Mon State	59	42.1	78	55.7	2	1.4			1	0.7	140	0.3
9.	Rakhine State	58	98.3							1	1.7	59	0.1
10.	Chin State	400	99.8							1	0.2	401	0.7
11.	Kachin State	8298	57.3	4384	30.3	32	0.2	13	0.1	1759	12.1	14486	26.7
12.	Shan State	14733	81.1	2973	16.4	17	0.1	2	0.0	435	2.4	18160	33.5
13.	Kayah State	233	84.7	40	14.5	2	0.7					275	0.5
Total		34371	63.5	14508	26.8	416	0.8	220	0.4	4640	8.6	54155	100.0

The maximum number of registered cases is reported from Shan State (33.5%) and Kachin State (26.7%)

The most commonly consumed drug is opium (63.5%). Tranquilizers are least commonly consumed drug (0.4%).

HIV/AIDS SITUATION IN DRUG USER

HIV positive rate is somewhat high in drug users compared to other risk groups. In Yangon, among the users admitted to the treatment centre, approximately 60 - 70% use intravenous as the main route of administration. Out of all injectors, the percentage of HIV positive case ranges from 66% to 84%.

Conclusion.

Although the present report on current drug situation in Yangon City Myanmar, does not represent the whole country situation, it may give certain amount of information on drug abuse. Drug addiction is a social disease, chronic and relapsing in nature.

References

1. 1993 Annual Report of National AIDS Prevention and Control Programme in Myanmar, published by Disease Control Programme Department of Health, Myanmar.

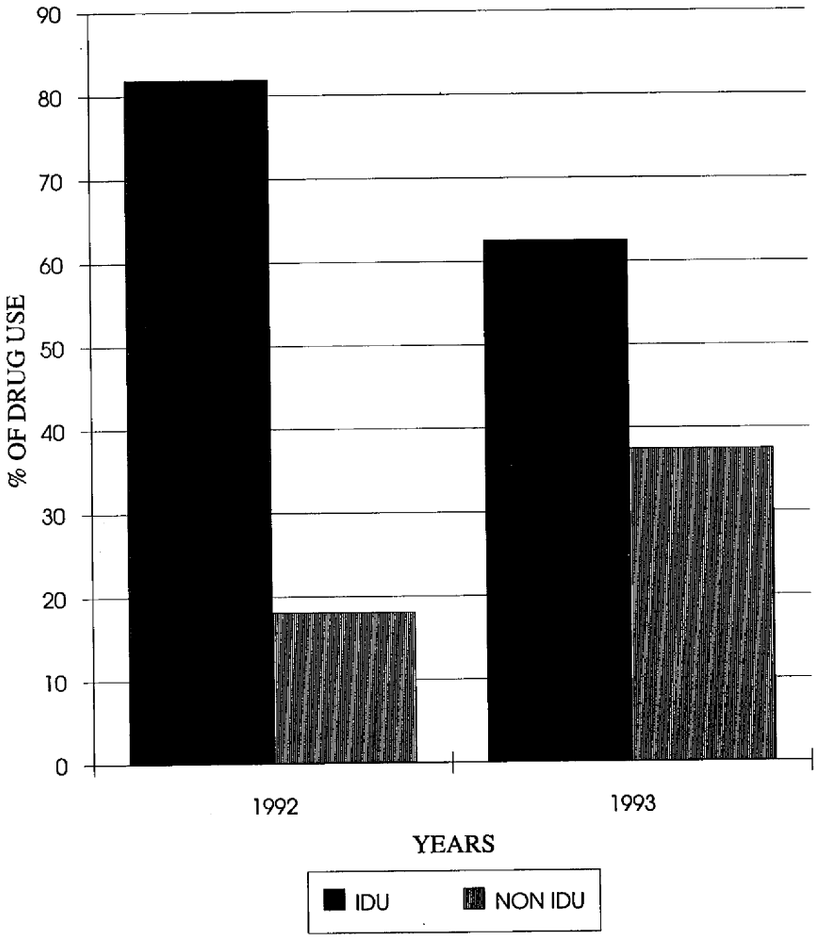
2. 1993 drug abuse report published by Department of Planning & Statistics, Ministry of Health.

3. 1983 population census published by Immigration and Manpower Department, January 1986.

4. Narcotic drugs and Psychotropic Substances Law published by Ministry of Home Affairs.

5. Hospital records.

FIGURE 1 : Pattern of drug use among heroin addicts in 1992-1993



REPORT ON NARCOTIC DRUG ABUSE IN VIETNAM

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With its growing tendency in recent years, drug addiction has become a social evil, a deep worry for the addicts' families, and a great concern for communities and for society as a whole. The Government has taken strong and resolute measures to prevent and fight against drug abuse and illicit trafficking of narcotics.

The following is an overview on drug addiction, viewpoint and solutions for this situation in Vietnam.

1. SITUATION ON DRUG ADDICTION

1.1 In mountainous areas

The results of a short survey on drug addiction implemented in some districts, namely Mocchau (Sonla), Haquang (Caobang), Dongvan (Hagiang), Tuongduong (Nghean) and Maichau (Hoabin together with the result of the sociological investigations at four districts of the Northern mountainous province of Laichau conducted in 1991, 1992 and 1993 showed that in opium poppy planting areas there are 40 percent household planting it having addicts (chewing or swallowing) and consuming nearly 58 percent of the total amount of opium volume produced; 14.7 percent of the investigated addicts (1264 addicts) are female. Their age bracket commonly ranges from 31 to 60 accounting for 61.62 percent; over 60: 24.58 percent and under 30: 14 percent.

Drug addiction by way of injection is growing in townships and cities. The number of the under 5 year-long drug addicts makes up 70 percent of the total drug addicts.

Out of the 71 investigated addicts in Yenbai town, 31.4 percent are under 25 years old, 10 percent illiterate, nearly 40 percent unemployed.

1.2 In industrial areas, cities and townships

The sociological investigations in Hanoi City (1989, 1990 and 1992), Ho Chi Minh City (1990 and 1991) showed that most of the drug addicts are youths (accounting for 75-80 percent), among which 4 percent are under 18 years old. Noteworthy here is that drug abuser by injection (making up 78-80 percent), 36 percent are people with occasional jobs: 93.5 percent are addicts with a period of abusing from 1 to 6 years.

1.3 In rural areas

Out of the 140 drug addicts investigated in Namha and Thaibinh (northern provinces) at the end of 1993, the number of under 45 year old persons addicted for 2 to 6 years accounts for 85 percent, about 40 percent are unskilled workers; 20 percent are carpenters and mechanics. Seventy percent of the total opium addicts (smoking) used to earn their living in the mountainous areas.

2. CONSEQUENCES OF DRUG ADDICTION

2.1 Declining moral and negative effects

Declining moral and negative effects can be seen on the daily life activities, social order and security due to the following causes:

+ A considerable group of young people who have access to opium, neglect their responsibilities towards their families and society because of their duping, deceiving and using tricks.

+ Among drug addicts in cities and townships, 70 percent are involved in theft, prostitution, illegal businesses (40 percent of which are criminal offenders).

+ Negative influence on daily life and social structures, inharmonious cases of divorced spouses, 24 percent of their families and relatives refuse responsibilities for the addicts.

2.2 Causing severe consequences for health and race

85 percent of addicts are ill and diseased, out of which 39 percent are subject to skin and venereal diseases, 42 percent suffer from serious diseases such as tuberculosis, liver cancer, symptoms of mental disease etc, especially 5 percent become unable to work.

The evil of prostitution-drug addiction is the main cause leading to HIV/AIDS infection. If in Ho Chi Minh City, December 1990 we detected only one person infected by HIV; in November 1993 a total of 1,003 persons were tested HIV positive in Vietnam. The figure included 926 Vietnamese and 77 foreigners. Among 926 Vietnamese HIV carriers, 801 were drug users and 47 were prostitutes.

According to the recent report of the National AIDS Committee, up to June 1994, persons infected have amounted to 1486 in 30 provinces. Out of which, 107 cases become HIV/AIDS patients and 33 persons out of 107 died (they were drug addicts by injection).

The illicit narcotic drug trafficking is becoming serious as it is not only a problem in Vietnam but also in international scope. Take some typical cases:

For example in April 1994 the seaside guard force of southern coastal province of Minhhai seized 1,904 kg cannabis illicitly transported in Vietnam territorial waters and the police of northern highland province of Sonla seized 227 kg opium illicitly transported by land from one foreign country to Vietnam etc.

2.3 Causing severe economic consequences

+ 100 percent families having drug addicts gradually fall into poverty. The result of an investigation showed that out of the 200 addicts in Hanoi City, 12 percent are managers of production units in bankruptcy, 14 percent are workers fired from or laid off their jobs at factories.

In only two years (1993 and 1994) the Government provides considerable funding to support localities in the whole country in the exercise on control and fighting against the drug addicts, illicit narcotic drug trafficking; and investigations on drug addiction. In addition to which, tens of billion VND to assist in prevention of HIV/AIDS infection have been allotted.

CAUSES OF DRUG ADDICTION

3.1 Sociologically, this bias comes from:

+ Those people who want to have a luxurious, lavish and hedonistic lifestyle with high delight

and hedonistic lifestyle with high delight demands, therefore they consider drugs as pleasure and inspirative sources.

+ Difficult life, underemployment and low level of education, shortage of information on harmfulness of drug abuse.

+ At present, family education has still many shortcomings; there are conflicts between various generations not to be solved rationally and expeditiously/on time.

+ In the high mountainous areas where inhabitants usually treat their numerous diseases by using opium because of shortage of medicine, the residents are ethnic minority with a low level of economic, cultural and social knowledge. They consider the use of opium as necessary demands for their social activities and traditional festivals.

3.2 In economic aspects

Due to big money earned from drug trafficking and increasing consumption of addicts, the drug traffickers and organizers of the illegal use of narcotics have done whatever they can do to carry out illicit drug businesses.

3.3 In State administration

Vietnam is shifting to market economy. However, the legal system and domestic laws have not yet meet requirements of the new time. So far, there have been no specific legal system and domestic laws dealing with drug matters, but a draft law on narcotics has been prepared to be submitted to National Assembly for approval next year with a view to the prevention and fight against the problems resulting from illicit use of and trafficking of narcotics.
At present, we apply provisions prescribed in code of Public Health, Penal code of Vietnam for prevention and fight against the problems related to the misuse of and illicit trade in narcotic drugs and psychotropic substances as follows:

*Article 29 of Code of Public Health mentioned the compulsory treatment:

1. Medical institutions shall take practicable

measures of compulsory treatment for persons suffered from serious mental diseases, cancer, leprosy in contagious period, contagious diseases through genital organs, narcotic drug addiction disease, AIDS/HIV disease and some other contagious diseases that may lead to harmfulness for society.

2. Compulsory treatment at medical institutions must be observed in conformity with the present laws.

*Article 203 of Penal Code, Organizing the use of narcotics:

1. Any person organizing the use of narcotics in any form shall be subject to a term of imprisonment of six months to five years.

2. If the offence entails serious consequences or constitutes a serious case of recidivism, the offender shall be subject to a term of imprisonment of between three and ten years.

*Article 61 of the Constitution of the Socialist Republic of Vietnam stipulated that, among others:

It is strictly forbidden to produce, transport, deal in, store and use unlawfully opium and other narcotics. The State shall enact regulations on compulsory treatment of drug addiction and treatment of dangerous social diseases.

Recently, in order to further strengthen the State guidance of prevention and fight against and control of narcotics, the Government has set up the Department for Social Evils Prevention under Ministry of Labor, Invalids and Social Affairs.

4. VIEWPOINT AND SOLUTION

4.1 Viewpoint

We always maintain that, in order to effectively deal with drug abuses and other matters related to narcotic drugs, there is no other alternative than prevention by the following ways:

Warning the whole society of dangers of the spread of HIV among drug abusers and of the spread of violence, increased criminality and economic dislocation;

promoting activities of information, propaganda and education to enable all people to be aware of great harmful effects of drug abuse, addiction and illicit trafficking, so that every citizen is conscious of their behavior and actions. That is the very responsibility of authorities at all levels in co-operation with other social organizations through a specialized professional agency.

Combining solutions - economic, legal and social on the basis of education, respect of human virtue and personality, but punishing severely people who engage intentionally in the illicit storage, trafficking and organizing drug use.

Prevention of drug addiction should start from grass-roots communes/villages and communities.

Actively seeking for financial resources for such activities from State budget through social protection programmes such as drug control, new economic zone development, human settlement, reduction of poverty, employment generating, vocational training, social fund raising, relief fund and humanitarian assistance from various foreign organizations.

4.2 Main solutions

Establishing a system of professional agencies specialized in prevention and fight against social evils including drug addiction from central level (Department for Social Evils Prevention) to provincial, district/precinct and village/commune levels.

Strengthening activities of information, educational promotion to increase knowledge of all people on special importance for the prevention and fight against drug addiction in particular and social evils in general.

Dealing with on time negative phenomena that may lead to social evils by paying special attention to stricter administration of various population areas.

Taking effective practicable measures:

Giving priority to drug giving-up, treatment and rehabilitation for addicts.

Organizing vocational training and job generating for addicts at the very areas where addicts live

through social services, employment promotion centers and production units.

Creating financial sources for production purposes in support of the aftercare addicts.

Strengthening co-operation between organizations concerned with the aftercare addicts' families to stabilize gradually their life and integrate them to communities.

Helping the drug addicts being treated in social treatment and rehabilitation institutions to be aware of harmful effects from drug abuse and especially of a potential danger of race caused by AIDS/HIV infection, and the sense of responsibility in their behavior and actions.

Developing and gradually improving a legal system for the prevention and fight against social bias and social evils caused by drug abuse.

5. NATIONAL ACTION PROGRAMME

5.1 Long-term Programme

Developing a service system for social works activities aimed at restricting demands of narcotic drug consumption and creating a network of social institutions with adequate and sufficient facilities for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social re-integration of the persons involved.

5.2. Immediate Action Programme

Investigating and classifying drug addicts, establishing step by step a drug matters' databases in service of state administration and prevention and fight against the illicit drug use and trafficking.

Organizing Pilot Treatment-Rehabilitation Programme for drug addicts in mountainous, plain areas and some special important provinces.

Organizing Training courses, special seminars for persons whose social works (Information, treatment, after-care, rehabilitation, and integration into society for addicts) requires good understanding of the

problems of drug abuse and its prevention.
Strengthening co-operations relations aimed at exchanging information and experience in the administration of social work from foreign countries especially from countries in Asian and the Pacific Regions and seeking support and assistance from International organizations foreign countries and non-governmental organizations for the prevention and fight against drug abuse and illicit drug trafficking and consequences thereof.

Vietnam remains a developing country going through major changes. We still lack experience of prevention and control of the abuse and illicit trafficking of narcotics. While the relevant authorities are making efforts to overcome such difficulties to contribute to building social order and security, we would highly appreciate any assistance and help from International organizations, foreign countries and non-governmental organizations in this field.

We do hope that Vietnam with foreign assistance and by its efforts will effectively prevent and fight against drug abuse and illicit drug trafficking.

DRUG ABUSE IN SINGAPORE

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Heroin abuse remains the main drug problem in Singapore since 1974. Most addicts are unmarried and fall in the age range of 20-39. Drug abuse has been successfully under control over the last decade. In 1993, the number of addicts arrested and sent to Drug Rehabilitation Centres was only slightly higher than in 1990. The number of drug traffickers arested in 1993 was lower than the previous years. The predominant method of consumption is `Chasing the Dragon'. Intravenous drug use is rare and thus not many contracted HIV through this mode. From 1993 to first quarter 1994, only 2.5% of HIV cases was infected through intravenous drug use. There is a significant fall in the number of persons abusing inhalants since the introduction of Intoxication Substance Act in 1987.

INTRODUCTION

Drug abuse in Singapore started in the early 1970s with MX pills and cannabis. However, by 1974, heroin became the main drug of abuse. In December 1975 death penalty was introduced to counter the epidemic of heroin abuse.

Three enforcement agencies are entrusted with the responsibility of taking counter-measures against drug trafficking and abuse in Singapore. They are:

a. Central Narcotics Bureau
b. The Police
c. Customs and Excise Department

In September 1977, the Narcotics Detector Dog Unit was established. At all entry points, Narco dogs are used to sniff out drugs hidden in mails, parcels, baggages and cargoes. Instant urine test machines were installed at major entry point to screen suspected drug addicts.

Most of the addicts admitted to DRCs were singles and in the age group of 20 to 39. They usually attended schools up to primary level or below.

DRUG ABUSE TRENDS

1. Heroin

A. General

Heroin abuse is still the main drug problem in Singapore. The primary method of consumption is `Chasing the Dragon'. Intravenous drug use is uncommon. The withdrawal symptoms and degree of addiction of present local addicts are comparatively milder than those in the 1980s.

B. Number of Drug Addicts Arrested

Five thousand eight hundred and fifty-seven local drug dependent persons were arrested in 1993. Of this, 4,697 were in the 20 to 39 age group. 11.6% or 679 were below 20 years old. 5,711 or 97.5% of the arrested drug dependent persons abused heroin. For the 1st quarter of 1994, 1,474 local drug dependent persons were arrested. Majority, i.e. 80.3% or 1,184 were in the 20 to 39 age group. One thousand four hundred and twenty or 96.3% abused heroin.

Singapore has been quite successful in controlling drug abuse. The number of addicts arrested and sent to the DRCs has increased slightly from 4,505 in 1990 to 4,740 addicts in 1993.

C. Seizure/Price

On the supply side, the number of drug traffickers arrested has dropped from 166 in 1992 to 111 in 1993. The proportion of large scale traffickers arrested was 45.9% in 1993 compared to 46.4% in the previous year. The proportion of small scale traffickers arrested was approximately the same (12.6% in 1993 and 12.0 in 1992). For the 1st quarter of 1994, 54 drug traffickers were arrested.

In 1993, a total of 71 kg of heroin, 57 kg of cannabis and 7 kg of opium were seized. For the 1st quarter of 1994, a total of 10 kg of heroin, 1 kg. of cannabis and 1 kg of opium were seized. The street price of South-east Asia heroin no. 3, the choice drug of abuse, is at $15 to $18 per 0.1 g.

In 1993, 46 drug traffickers whose charges carry death penalty were prosecuted in court compared to 36 in the 1st quarter of 1994. Since the introduction of manda-

tory death penalty for drug trafficking, a total of 136 persons have been sentenced to death. Of this, 61 were executed and 64 are awaiting the outcome of their appeals.

D. Treatment Data

Drug addicts may be sent to the DRCs for treatment and rehabilitation under the Misuse of Drug Act. Four thousand seven hundred and forty drug dependent persons were admitted to DRCs for treatment and rehabilitation in 1993. Of this, 1359 or 28.9% were newcomers. After the treatment programmes, they usually undergo a 2-year statutory supervision. The administration and operation of drug rehabilitation centres and Day Release Camps are under the purview of the Prisons Department. There are two main rehabilitation programmes. They are:

a. Exit Counselling Programme (ECP) for experimenters

b. Residential Day Release Scheme (RDRS) for repeated abusers.

After detoxification, experimenters undergo a 2-week ECP which was implemented on 18 April 1998. These experimenters are usually young persons who have not committed any criminal/drug offence.

The ECP comprises intensive counselling, anti-drug education and physical training. After completing the programme, the recovering addicts have to report to various Reporting Centres for urine test and counselling. As an incentive, if they show good progress at this stage, they will be eligible for early release from statutory supervision.

The RDRS comprises three phases. In the first phase, the addicts are sent to DRC for treatment and rehabilitation. Physical training and counselling are provided to rebuild their health and equip them with basic coping skills.

The second phase aims at re-integrating the addicts to society through work programme. During this period, the addicts go to work in the community and return to the DRS camp after work.

In the third phase, the addicts are permitted to return home after work. However, to keep them from mixing with their negative peers and help them to re-

establish rapport with their family, a curfew condition is imposed. Electronic Monitoring which was introduced in December 1991 is utilised to effectively enforce this curfew condition. As on 31 December 1991, 1876 persons were placed on Electronic Monitoring under RDRS.

One thousand two hundred and four addicts were put under a two-year statutory supervision at the end of March 1994. During the same period, there is a total of 4,776 supervisees undergoing supervision. 79.1% of the cohort of drug supervisees placed under supervision in 1992 relapsed to drugs.

2. **Inhalant Abuse**

Intoxication Substance Act was introduced in November 1987. The data shows that there is a significant drop in the abuse of inhalants since the introduction of the Act. The monthly average of persons detected for inhalant abuse dropped from 93 in 1987 to 36 in the 1st quarter of 1994. Most of the abusers were put on compulsory supervision for one year. In 1993, 89 persons were sent to Inhalant Centre for treatment and rehabiliation. For the 1st quarter of 1994, 28 persons were sent to Inhalant Centre for inhalant abuse.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INTRAVENOUS DRUG USERS

Singapore's first case of human immunodeficiency virus (HIV) was detected in May 1985. From 1985 to mid-1990, 50 cases were detected. None was infected through intravenous use. As at 1 April 1992, a total of 118 cases of HIV infection were detected. Of these, 5 or 4.2% were infected due to intravenous drug use (see Table 1A). From 1993 to 1st quarter of 1993, 80 people were infected with HIV. Only 2% or 2.5% were infected through intravenous drug use (See Table 1B).

N.B.: Source of data on drugs - Central Narcotics Bureau

Table 1A: Mode of Transmission of HIV infection (as at April 1992)

Mode of Transmission	Period 1* No.	%	Period 2# No.	%	Combined @ No.	%
Heterosexual	10	20	34	50	44	37.3
Homosexual	6	52	22	32.3	48	40.7
Bisexual	12	24	2	2.9	14	12
Blood transfusion	1	2	-	-	1	0.8
IV drug use	-	-	5	7.4	5	4.2
Organ transplant	-	-	3	4.4	3	2.5
Perinatal	-	-	1	1.5	1	0.8
Unknown	1	2	1	1.5	2	1.7
Total	50	100	68	100	118	100

* 60 months prior to mid-1990

\# 22 months after mid- 1990

@ periods 1 and 2 combined

Note: Table 1A is extracted from "HIV infection in Singapore : the second wave," in Epidemiological News Bulletin, May 1992, Vol. XVIII, 25-26.

Table 1B: Mode of Transmission of HIV infection (from Jan 1993 - 1st quarter 1994)

Mode of Transmission	No
Heterosexual	58
Homosexual	10
Bisexual	10
IV drug use	2
Total	80

PATTERNS AND TRENDS OF DRUG ABUSE IN MANILA

Mr. Diony Varela
Dangerous Drugs Board
Philippines

INTRODUCTION

1. Area Description

Manila is the capital of the Philippines. It has a total land area of 38.8 square kilometer or roughly 3,830 hectares and is divided into 16 geographical districts. It does not fall within the geographical or political jurisdiction of any other local political unit although for certain administrative purposes, it is considered a component of Metro Manila which is governed by the Metro Manila Commission. The population is estimated to be about 2.9 million. Population density is around 7,500 per square kilometer.

Manila is the center of trade, commerce and industry and has the most number of schools in the country. In addition to the resident students of the city, thousands from the provinces flock to Manila every year to pursue college education. This has contributed to the enlargement of the city's youth population.

Consequently, authorities have felt a greater need to implement effective drug abuse prevention and control programmes. A reliable monitoring and assessment of the trends and patterns of drug abuse such as the one we are doing will surely contribute to the successful implementation of these programmes.

2. Data Sources and Time Period

The data were based on the statistical reports submitted by various treatment and rehabilitation facilities, hospitals and law enforcement agencies in the City of Manila proper.

The reports cover the period January to December 1993. Drug treatment data come from two hundred thirty-eight (238) male and twenty-five (25) female patients. This represent a ratio of about 9 males for every one female.

DRUG ABUSE TRENDS

Filipino drug abusers continue to use drugs in combination. No report of heroin and opiate abuse was reported for the entire period.

Marijuana, which is cultivated in many parts of the Philippines was abused by forty-one percent (41.06%) of the patients. Metamphetamine Hydrochloride, a stimulant, locally known as Shabu was the most popular among Manila drug abusers. Seventy-six percent (76.43%) admitted using Shabu.

Sedative drugs were abused by only three clients representing more than one percent (1.14%) while inhalant was abused by three percent (3.04%) of the clients.

Majority (61.98%) of the clients belong to the 20-34 age bracket while twenty-two percent (22.05%) were 15-19 years of age. Less than two percent (1.52%) were under 15 years of age. Around fifteen percent (14.45%) were already over 35 years old. The mean age was 25.

We have observed that for the past several years, drug abusers in our country tend to be getting older. This is due to the popularity of Shabu which caused it to be more expensive than most drugs being abused. Expectedly those who are already working are the ones who can well afford the drug and naturally, they are older compared to students and out-of-school youths who now comprise a smaller portion of our drug abusers.

With regard to marital status, unmarried clients constituted more than half (55.13%) while thirty percent (30.41%) were married. Those separated from their spouses amount to more than seven percent (7.22%) and those who have live-in relationship, less than seven percent (6.46%). While the singles still comprise the largest group, the increasing number of married drug abusers is a serious cause of concern as most of them are parents who should be the role models and source of authority in their families.

Sources of drugs indicated are the following: Street sale, seventy-two to eighty-one percent (72.81%); legal prescription, two to six percent (2-6%); diversion of prescription drugs, three to twelve percent (3 to 12%).

Clients who had 6-12 years of education comprised the biggest group of seventy-six percent (76.05%) followed by those who had more than twelve (12) years (15.59%). Three percent (3.42) had less than six (6) years in school.

For law enforcement indicators, the sources are Dangerous Drugs Board, Narcotics Command, Manila Police and the National Bureau of Investigation.

Arrest for use/consumption	12.20%
Arrest for possession	18.09%
Arrest for sales	32.72%
Arrest for trafficking	20.73%
Arrest for conspiracy	16.26%

Drug seized were cannabis, amphetamine, inhalants and some cocaine.

Table 1

Distribution of Respondents According to their Awareness of Different Drugs '1'

Drug Type	Frequency	%
Marijuana	715	96.75
Shabu	699	94.59
Rugby	652	88.23
Beer	651	88.09
Gin	640	86.60
Whiskey	623	84.30
Acetone	548	74.15
Solvent	547	74.02
Gasoline	534	72.26
Cough Syrup	527	71.31
Thinner	515	69.69
Valium	318	43.03
X-pinoy	279	37.75
Ionamine	193	26.12
Mandrax	181	24.49
LSD	110	14.88
Cocaine	79	10.69
Heroin	22	2.98
Opium	17	2.30

Table 2

Distribution of Respondents According to Primary Source of Information on Drugs and Substance Abuse

Primary Source	Frequency	%
Media	483	65.36
Peer	98	13.26
Books	38	5.14
Teachers	38	5.14
Parents	27	3.65
Neighbor	18	2.44
Classmates	16	2.17
Sibling	7	0.95
N/R	14	1.89
Total	739	100.00

Table 3

Distribution of Respondents According to Action Taken When a Family Member is Using Drugs

Action Taken	Frequency	%
Encourage him to be rehabilitated	239	32.34
Tell him to stop using drugs	198	26.79
Inform my parents	189	25.58
Ask help of Brgy. officials	65	8.80
Ignore	13	1.76
Punish him	11	1.49
Ask help of my relatives	7	0.95
N/R	17	2.30
Total	739	100.00

Table 4

Distribution of Respondents According to Whom Subject Would Ask Help on Drug Problems

Person to Ask Help	Frequency	%
Parents	342	46.28
Doctor	141	19.08
Friend	110	14.88
Police Officers	76	10.28
Teacher/Counselor	23	3.11
Sibling	18	2.44
N/R	29	3.92
Total	739	100.00

Table 5

Distribution of Respondents According to Their Attitude Toward People Who Use Drugs Occasionally

Response	Frequency	%
Disagree	293	39.65
Strongly Disagree	277	37.48
Uncertain	90	12.18
Agree	37	5.01
Strongly Agree	23	3.11
N/R	19	2.57
Total	739	100.00

Table 6

Distribution of Respondents According to the Prevalence of Smoking, Drinking and Drug Taking Status

Status	Frequency	%
Smoking	490	66.31
Drinking	414	56.02
Drug Taking	132	17.86

Table 7

Prevalence of Smoking According to Age First Smoke

Age	Frequency	%
< 10 years	12	2.45
10 - 14	77	15.71
15 - 19	284	57.96
20 - 24	65	13.27
25 - 29	12	2.45
30 - 34	2	0.41
N/S	38	7.76
Total	490	100.00

Mean Age = 16.93/17 years old (Age of first smoke)

Table 8

Prevalence of Drinking According to Age First Drink

Age	Frequency	%
< 10 years	14	3.38
10 - 14	63	15.22
15 - 19	238	57.49
20 - 24	60	14.49
25 - 29	12	2.90
30 - 34	7	1.69
35 - 39	5	1.21
N/S	15	3.62
Total	414	100.00

Mean Age = 17.43/17 years old (Age first drink)

Table 9

Prevalence of Drug Use According to Age of First Drug Use

Age	Frequency	%
< 10 years	3	2.27
10 - 14	13	9.85
15 - 19	77	58.33
20 - 24	29	21.97
25 - 29	4	3.03
N/S	6	4.55
Total	132	100.00

Mean Age = 17.71 years old (Age of first drug use)

Table 10

Frequency Table According to Drug First Used

Drug Type	Frequency	%
Marijuana	65	49.24
Shabu	28	21.21
Cough Syrup	16	12.12
Rugby	8	6.06
Cocaine	6	4.55
Valium	2	1.52
N/S	7	5.30
Total	132	100.00

Table 11

Distribution of Cases According to their Source of First Drug Use

Source of 1st Drug	Frequency	%
Friend	96	72.73
Pusher	14	10.61
Drugstore	9	6.82
Neighbor	5	3.79
Relative	4	3.02
Classmate	4	3.03
Total	132	100.00

Table 12

Distribution of Cases According to Frequency of Drug Use

Frequency of Drug Use	Frequency	%
Tried once	56	42.42
Only when there is a party	36	27.27
2-3 times a week	11	8.33
Everyday	11	8.33
N/S	18	13.64
Total	132	100.00

Table 13

Distribution of Cases According to their Attempt to Stop Drug Use

Tried Stop Drugs	Frequency	%
Yes, I tried and succeeded	94	71.21
Yes, I tried but failed	15	11.36
Does not want to try	9	6.82
Not tried but wanted to	7	5.30
N/S	7	5.30
Total	132	100.00

Table 14

Distribution of Respondents According to Reason/s for Not Using/Stopping to Use Drugs & Substances

Reasons	Frequency	%
Bad for health	491	66.44
Will adversely affect studies	346	46.82
It will ruin our family ties	313	42.35
I am afraid of my parents	287	38.84
I am afraid to be put behind bars	246	33.29
I don't want my children to also become drug abusers	188	25.44
No money for drugs	137	18.54
My loved one will not allow me	109	14.75
No friend who is abusing drugs	101	13.67
I just tried and felt the effect	66	8.93
No known source	52	7.04

Table 15

Distribution of Cases According to the Number of Respondents Who Have Attended Drug Symposium

Response	Frequency	%
Yes	350	47.36
No	295	39.92
N/R	94	12.72
Total	739	100.00

Table 16

Frequency Table of the Effect of Drug Symposium to the Respondents

Response	Frequency	%
Lost interest in drugs	291	83.14
No effect	45	12.86
Got interested in drugs	2	0.57
N/R	12	3.43
Total	350	100.00

Table 17

Distribution of Respondents According to the Extent of awareness of the Drug Problem in their Community

Opinion	Frequency	%
A problem but not serious	200	27.00
Very serious	147	19.89
I don't know	143	19.35
Serious	106	14.34
Not a problem	56	7.58
N/R	87	11.77
Total	739	100.00

LAOS COUNTRY REPORT

Prasith Sayasith

The Lao People's Democratic Republic is a landlocked country with a land area of 236,800 sq. km, stretching more than 1,700 km from north to south and between 100 and 400 km from east to west. It shares borders with Vietnam (1,957 km), Cambodia (492 km), Thailand (1,730 km), Myanmar (230 km), and China (416 km). About two thirds of the country is mountainous with ranges from 200 to 2,820 metre high. About 47% of the area is covered by forest. An estimated 300,000 hectares of forest are lost annually largely due to shifting cultivation and logging activities. The total cultivated area is 7,094 sq. km of which 1,554 sq. km irrigated cultivation.

The Laos PDR is a "multi-ethnic" state with a population of 4.36 million (1992). It is home to about 47 different ethnic groups, commonly divided into three broad categories:

1. The Lowland Lao (LaoLoum) occupy the lowland plains where they practice irrigated agriculture. They constitute about 65% of the population. This category also includes Tai, Lue and other Tai-speaking groups. Most of the Lowland Lao practice Buddhism.

2. The Upland Lao (Lao Theung, about 22%) of the population, include Monkhmer speaking groups with Khamu as the largest group. They occupy the mountain slopes where they usually practice swidden rice farming.

3. The Highland Lao (Lao Soung), include Hmong, Yao, Ikor, Musser, Kui, Haw, Phounoy and some smaller groups of the Sino-Tibetan language family. They typically live on the mountain tops in northern Laos and constitute about 13% of the population. The Lao Soung grow non-glutinous rice in swiddens as a staple crop. Opium and livestock are major sources of income.

The overall population growth is 2.6% and at current rate population will increase to 5.6 million by the year 2,000.

THE SOCIAL SITUATION

Laos - in particular the northern provinces - is characterised by high infant and child mortality rates (104 per 1000 live births and 156 per 1000 children respectively); child mortality rates can reach up to 500/1000 or more in some remote area of northern Laos. Life expectancy is 50 years, the second lowest in the region. Half of the children under 5 years old are affected by malnutrition, and approximately 90% of the population lack access to basic health, birth spacing and nutritional services. Diarrhoeal, respiratory and intestinal diseases are widespread, and particularly virulent strains of malaria are prevalent. In northern Laos, opium is commonly used as a pain killer, and opium addiction is a real problem among some of the minority groups in this region.

Although estimates of adult literacy vary between 45% to 76%,reasonable estimates are 50% for all adults, with 65% for male and 35% for females. Significant efforts were made to build up primary education after 1975. Although the ratio of schools to students increased markedly, particularly at the primary school level, the quality of education did not keep pace with expansion of the system. Ethnic minority groups are even more disadvantaged, with literacy rates estimated at 30 - 35% for men and 5 - 10% for women. There are hardly any qualified teachers from ethnic minorities.

THE ECONOMIC SITUATION

The Gross Domestic Product, estimated at US$ 225 per capita in 1992, understates living standards in Laos to the extent that the non-monetized segment of the economy is not fully represented in the income data. This is true in particular for the agricultural sector, where subsistence farming is the main occupation and rice the stable food crop.

Agriculture is the principle economic sector in the Lao PDR, with about 85% of the population engaged in rice cultivation as the primary activity, as well as in livestock, fishery and forestry activities. About 70% of the country's rice is grown in the lowlands. The remaining 30% are grown in the uplands, where the majority of the population do not produce enough to cover their own needs and lack rice for about 3 to 5 months every year. Other crops grown for consumption or export include maize, soyabean, sweet potato, cassava taro, coffee, peanut, tobacco, cotton, sugar-cane and others. Livestock include buffalo, cattle, pig, sheep, goat and poultry. Opium is produced in the ten provinces of northern Laos.

The industrial and service sectors of the economy currently account for about 40% of the GDP which was estimated at about US$ 900 million in 1992, with a growth rate of 7.5% in 1992. Manufacturing is the leading component of the industrial sector, and the services sector is led by wholesale and retail trade.

The transport and communication infrastructure is extremely weak: some of the provinces and 50% of the district capitals have no all-year road access. The airports in several provinces consist of dirt strips, and some provinces can only be reached by helicopter. There are 8,000 telephone lines in the whole of the Lao PDR. An additional 8,000 lines are planned to be installed in the near future. Although electricity is exported to Thailand as a major source of income, the only source of electrical power in most of the provinces is small generators, serving one village or a few households.

In 1945, the Lao PDR embarked upon a major programme of economic reform, the New Economic Mechanism (NEM), focusing initially on granting management autonomy to some state enterprises. Since 1986, the objective of the NEM have been refined, and actions have been taken on a broad front, including decontrol of prices and distribution of goods and services, restructuring of the banking system, passage of a foreign investment law, privatisation of a number of state enterprises etc. Despite short-term adjustment costs, the success of the reform programme is considered encouraging. The GDP in real terms (constant 1990 prices) grew by 13.5% in 1989, 6.6% in 1990, 4% in 1991 and 7.0% in 1992. Inflation in 1992 stayed below 10%. However, about two-third of the country - in particular the more remote areas of northern Laos - do not yet benefit from these developments.

HISTORICAL BACKGROUND

The problems related to opium in Laos can only be understood in a historical perspective. As generally known, large-scale opium production and consumption in Southeast Asia are direct consequences of trade patterns between European and southeast Asian powers from the 18th century onwards, and in particular during the so-called "Opium Wars" in the 19th century.

The origin of opium production in Laos is linked to the migration of highland minorities from China to the south, during which the Hmong brought the knowledge of opium cultivation to Laos in the early 19th century.

French colonialism in Indochina led to a consolidation of opium production, processing and sale under the control of the colonial administration, the so-called "Regie d'opium", first (in 1899) in what today is Vietnam and a few years later also in Laos. In Laos, the Hmong and Yao people of Xieng Khouang were given the monopoly of opium poppy cultivation. It is assumed that the Hmong and Yao had grown opium for local consumption and medical purposes for generations, but it was the intervention of European powers in China and Indochina which changed the nature of opium production and consumption causing opium to be produced for commercial purposes and consumed on a large scale. According to the French Administrator of Xieng Khouang, about 60% of the male population of Xieng Khouang were addicted to opium in the early 1950s.

After the withdrawal of the French and the end of the "Regie d'opium in 1954, opium production continued to increase, according to some sources from about 30 tons in 1944 and about 50 tons in 1953 to 100 - 150 tons in the late 1960s. The various factions during the Indochinese wars tolerated, if not condoned, opium production, refining into heroin and drug trafficking to cover war-related expenses or to ensure the loyalty of ethnic minorities.

On 10 August 1971, the Royal Lao Government passed an anti-narcotics law prohibiting opium, morphine and heroine production, consumption and sale in Laos, with the exception of addicts from ethnic minorities who traditionally grew opium and who were allowed to acquire a permit to continue opium cultivation for auto-consumption.

In 1973 and 1974, the USAID sponsored surveys of "poppy growing regions of north and central Laos". During the survey carried out in early 1974, an area of 435,000 sq. km was photographed including parts of Vientiane, Xieng Khouang, Louang Prabang, Sayabouri and Houakhong provinces. Some parts of these provinces were not covered because of "various restrictions". Provinces such as Oudomsay, Phongsali and Houaphan were not under Government control and therefore not included at all. Today, these last provinces are major opium producers, but it is difficult to estimate what opium production was like in these areas under wartime conditions.

ASSESSMENT OF THE DRUG SITUATION

Considering the attention given to drug production and trafficking, in particular in the so-called "Golden Triangle", it is surprising how little factual information or hard data is available. Most accounts are based on single

events (a seizure or arrest, often on rumours) and stories are built around these events to generalize the drug situation. Other reports are inspired by political considerations rather than by a realistic assessment of the situation.

For 18 years, between 1974 - when the USAID undertook an aerial survey of opium producing areas in parts of northern Laos - and 1992, no data was collected on drug production, trafficking or consumption in Laos. In order to obtain a clearer picture of the drug situation in the Lao People's Democractic Republic, the Lao Government and the United Nations International Drug Control Programme (UNDCP) signed the above mentioned project agreement in February, 1992.

Since the drug problem in the Lao PDR today is primarily considered a problem of opium production, trafficking, refining into heroin and consumption, these aspects of the drug problem were given most attention during the following surveys carried out between March 1992 and February 1993:

Surveys at the provincial and district level in order to:

+ compile an inventory of all villages in northern Laos with information on the number of people and households in each village, ethnic groups, opium addicts and whether these villages grow opium or not;

+ collect socio-economic data on each district to be able to determine the importance of opium in the local economies of northern Laos.

Surveys at the village, household and poppy-plot level to:

+ compile - in a sample of villages - information on how many kilogrammes of opium a household produces on average and on what area of land;

+ determine what percentage of households actually produce opium in an opium-growing village;

+ collect socio-economic data to determine the importance of opium within the village economy;

+ compile information on opium addiction by interviewing addicts.

The purpose of the surveys was, therefore, not only to determine how much opium is produced and used in Laos, but also to determine the possible reasons for production and

consumption, including the overall socio-economic context in which drug production, trafficking and use take place. This was considered necessary in order to be able to design solutions to the drug problem.

In the course of these surveys, detailed data from all of the opium-producing provinces of Laos (i.e. the ten provinces in the north) from more than 40 districts, 25 individual villages, 78 poppy fields and 80 addicts were collected during field visits. In addition, general data (household, population figures and ethnic composition) were compiled for more than 5,000 villages.

The field visits were carried out in two stages:

- In March and April 1992, 20 staff from the Ministries of Agriculture, Health, Education and the Interior as well as the Customs Department, divided into 4 teams, collected provincial and district-level data by visiting all provinces in the north.

- In January and February 1993, a smaller team consisting of 3 staff from the Ministry of Agriculture, 2 from the Ministry of Health, 1 from the Secretariat of the Lao National Commission for Drug Control and Supervision, and the UNDCP Field Adviser visited seven provinces to collect information at the village, household and poppy field-level by interviewing key informants of the village, addicts and poppy-farmers and by measuring and assessing 78 poppy fields.

In addition to these primary data, secondary literature about the socio-economic situation in mountainous areas, about the drug situation in south-east Asia, and, in particular, reports prepared in connection with drug control projects in Laos and missions by the staff of the UNDCP Field Office in Vientiane have been taken into consideration.

The results of these surveys are presented in this report. They may not be absolutely perfect, and analysts may find some flaws, but this report provides the most reliable information available at present. Data collection and surveys were completed in February, 1993; this report presents the drug situation in 1992.

OPIUM PRODUCING AREA

The opium poppy is grown in the 10 provinces of northern Laos. Only 11 of the 69 districts in these provinces are reported to be free of opium production: 3 districts in Borikhamsay, 3 in Sayabouri and 5 districts in Vientiane province. There are reports on poppy cultivation in

Vientiane Municipality and the southern provinces. The fact that the opium poppy is grown in 58 districts of 10 provinces indicates the extent of the problem of opium cultivation. Opium reduction activities eventually have to cover all of northern Laos.

OPIUM-PRODUCING VILLAGES AND HOUSEHOLDS

The total population of Northern Laos is about 2 million, with 10 provinces, 69 districts, about 6,900 villages and more than 350,000 households. Based on information from district and provincial officials, it can be assumed that about 2,200 villages (32%) are involved in opium production.

As mentioned above, a village is classified as "opium-producing", even if only one single household grows opium. With the exception of those areas where drug control projects are in operation, most Lao Soung households in an opium-producing village actually produce opium. This is different from Lao Theung and Lao Loum villages, where normally less than half of the households are involved. Results from village interviews suggest the following:

In opium-producing villages	% of households producing opium
Lao Soung	90%
Lao Theung	45%
Lao Soung	90%
Lao Theung	45%
Lao Loum	40%
Mixed	65%

It can thus be estimated that, in the 2,200 opium-producing villages, about 60,000 households (i.e. 17% of all households in northern Laos) actually cultivate the opium poppy.

Number of Opium-Producing Villages and Households in 1992

Province	No. of Opium-producing villages (and as a percentage of all villages)	Opium-producing households
Bokeo	98 (24%)	2,340
Borikhamasay	70 (13%)	1,790
Houaphan	405 (46%)	10,210
Louang Namtha	252 (46%)	6,890
Louang Prabang	233 (18%)	8,850
Oudomsay	369 (35%)	8,200
Phongsali	406 (60%)	10,600
Sayabouri	33 (9%)	1,010
Vientiane	49 (9%)	2,420
Xieng Khouang	315 (55%)	7,790
Total	2,230 (32%)	60,090

Area under Cultivation

The size of individual poppy fields rarely exceeds 1 hectare (100 x 100 m = 10,000 sq. m). Among the fields surveyed only two fields were larger: 1.3 and 1.6 ha respectively, both belonging to Hmong farmers in Vientiane province. The average size of the 78 fields measured was 2,146 sq. m (0.2 ha). Lao Soung fields (0.26 ha) were larger than Lao Theung (0.12 ha) and Lao Loum (0.06 ha) fields. In terms of regions, fields in the north-eastern part of the country (0.25 ha) were larger than in the north-west (0.17 ha).

However, in many cases households have more than one field, and the average area under cultivation is therefore somewhat larger. Twenty of the 78 households interviewed used less than 0.1 ha for poppy cultivation; at the other extreme, seven used more than 1 hectare. Only one household (again a Hmong from Vientiane province) cultivated more than 2 hectares.

Survey results suggest that the average area under cultivation per household is 0.33 ha, with considerable variations however between regions and ethnic groups:

Average Area under Opium Cultivation per Household (in ha)

Region	Total	Lao Loum	Lao Theung	Lao Soung
North-east	0.4	0.1	0.4	0.4
North-west	0.2	0.1	0.1	0.3
Average	0.3	0.1	0.2	0.4

The combination of these values with the list of opium-producing villages and households results in a total area of 19,190 hectares under poppy cultivation in 1992.

Heroin Production

While it is not too difficult to obtain information on opium production, it is almost impossible to get reliable information on heroin production. Assuming a total opium production of 130 tons per annum and an annual national consumption of 80 tons, then - theoretically - 50 tons of raw-opium are available for export and/or refining into heroin. The maximum possible heroin production would thus be about 5 tons. However, there is not much evidence proving that there is large-scale heroin production in Laos. Laboratories were discovered in Oudomsay in 1988 and in Bokeo in 1990, but no other laboratories have been detected since. Heroin seized between 1991 and 1993 had been manufactured abroad and was on transit through Laos.

The detection of previous laboratories and the involvement of Myanmar and Thai nationals in the operation of these laboratories suggest that, if there are refineries in Laos, they are most likely located in the border areas of the north-west. However, difficulty of access and the fact that laboratories are usually small and easy to move, make it hard to verify this hypothesis.

Cannabis

While opium production is limited to the mountainous areas of northern Laos, commercial cannabis production takes place primarily in the lowlands and in southern Laos, in particular in areas near the Mekong river, from where it can easily be

shipped abroad. Cannabis is produced commercially in the sense that production, transport and sale take place on a large scale (hundreds of kilogrammes at a time) and involve an organization of some sort. In cases in Borikhamsay province, for example, seed, devices for compacting cannabis, down-payments for farmers and for bribing local officials had been advanced from traffickers abroad. In one particular case, 5.5 tons of cannabis were seized in 1991.

Psychotropic Substances

Activities of pharmaceutical companies are controlled by the Department of Pharmacy of the Ministry of Health. Little is known about illicit production of psychotropic substances in Laos. Businessmen tried to import psychotropic substances and precursors for the sole purpose of immediate re-export either to circumvent tax and import-regulations of the target countries or to deviate the substances for illicit purposes. In early 1993, the Department of Pharmacy decided to prohibit the import of such substances for immediate re-export.

Production, Import and Export of Legal Drugs

After the change of Government in 1975, most private pharmacies were closed and, like other health services, drugs for medical purposes were provided free of charge. As a result of changes in the economic policy of the Government in the late 1980s, private pharmacies and drug import/export companies (private and state) started to make drugs available. In 1991, licenses were issued to these companies in line with the regulations established by the Ministry of Health. At present, there are over 1,000 pharmacies, 28 registered companies with a licence to import drugs for medical purposes, and 10 pharmaceutical companies in Laos. It is obviously very difficult to assess the activities of these companies and to exercise control as to whether these companies follow the regulations or whether substances are diverted to illicit markets.

For figures on production and cultivation per household ccording to regions and ethnic groups, assuming a total of 60,000 producing household, the total area under cultivation can be estimated at 19,190 hectares with a total production of 125 to 130 tons of raw opium in 1992.

Opium Consumption in Northern Laos

Based on information from district officials, village interviews, and rough estimates, the following projection is possible:

For 1992, the number of opium addicts in the ten provinces of northern Laos (excluding Vientiane Municipality) can be estimated at about 42,000 (2% of the population of these provinces), of whom about 25,000 were Lao Soung, about 13,000 Lao Theung and about 4,000 Lao Loum.

The highest rates of addiction were found in the north-western part of the country, that is, in Bokeo (3.12%), Louang Namtha (4.46%) and Phongsali (5.24%). The rates in a number of districts in these provinces are higher than 7%. Most of the addicts in these three provinces are Ikor, Yao and Musser (including Kui), and addiction rates average about 10% of the village population. This serious addiction problem in the north-western border areas is a very disturbing fact, given the increasing heroin addiction across the border in China, Thailand and Myanmar. With expanding trade between China, Thailand, Myanmar and Laos in and through this area, and the trafficking of heroin through this region, it can be expected that the north-west will soon be confronted with a heroin addiction problem, probably combined with HIV/AIDS.

In Oudomsay and Louang Prabang, many addicts are Khamu (Lao Theung), while many of the Lao Theung addicts in Houaphan and Xieng Khouang are Lao Phong. It is possible that the Lao Phong are the ethnic group with the highest addiction rate in Laos.

In absolute numbers, most addicts in the north-east (Borikhamsay, Sayabouri, Vientiane, Xieng Khouang, Louang Prabang and Houaphan) are Hmong. According to information available, the district of Viengthong (Houaphan) is the district with the highest rate of opium addiction in Laos (9.4%).

Based on interviews with 80 opium addicts from various provinces and ethnic groups, the average consumption per addict (kg/year) can be estimated as follows:

Per Capita Opium Consumption of Addicts (Kg/Year)

Region/Ethnic Group	Lao Loum	Lao Theung	Lao Soung
North-East	1.3 kg/y	1.5 kg/y	1.8 kg/y
North-West	1.3 kg/y	1.5 kg/y	1.3 kg/y

On the basis of this ifnormation, the total annual consumption of opium for the purpose of addiction in the ten

northern provinces can be estimated at 61 tons of raw opium. There is an unknown number of addicts in Vientiane municipality and the southern provinces. Allowing about 2 tons for addicts in these areas, the total amount of opium used for the purpose of addiction would be about 63 tons per year.

In addition to opium used for addiction and sale, part of the opium produced is kept for medical and social purposes (reception of guests, ceremonies etc.) Opium-producers interviewed reported that they keep about 250-300 grams for these purposes. This would imply that 15 - 18 tons are used annually for medical and social purposes. The total use of opium in Laos can thus be estimated at about 80 tons per annum.

TRAFFICKING

A. **Sources of Information**

While it is possible to collect information on opium and cannabis production and addiction, data on trafficking are obviously much more difficult to obtain. Individual arrests and seizures only provide pieces of the mosaic. The media only report on specific cases, while the trafficking situation as a whole remains unclear. The few reports which are available are based rather on assumption than on fact and should be dismissed as speculation.

B. **Opium**

1. Trafficking at Village, District and Provincial Levels

Opium trafficking starts with farmers producing 2 to 3 kg of opium on average, and - if these farmers do not use it within the household - selling some or all of the opium to others. Interviews in 27 opium-producing villages in seven different provinces and different ethnic groups gave the following picture:

Opium producers use opium for the following purposes:

- They use it themselves, either to satisfy their needs as addicts or for medical or ceremonial purposes.
- They sell it to addicts in small quantities;
- They pay addicts who work for them in opium;
- They use it to barter for food and household goods with fellow villagers or at village and district markets.

- They sell or barter opium in quantities of one pong (ca. 380 grammes) or more to traders who come from outside the village.

- They take their opium to traders in district or provincial capitals.

Opium trafficking at the village and district level can be categorized in the following three ways:

The first type of trafficking involves opium producers and opium addicts: addicts who do not produce opium themselves, obtain it directly from the producers; they either buy opium or exchange handicrafts for it. In north-western Laos, Lao Soung addicts sometimes work for the Lao Lum in exchange for opium. Addicts who live in non-opium producing areas, either travel to opium areas or ask relatives and friends to purchase it for them. In 1992, a number of arrests took place at Wattay Airport in Vientiane when addicts had tried to purchase opium in northern Laos for their own consumption.

The second category involves producers and petty traders; in many areas, opium is still sold openly at the village market, in particular in remote villages. Sometimes opium is even sold openly at district markets. While opium was still found overtly at some provincial markets in 1992, this does not seem to be the case any more in 1993. The transactions at these markets are on a small scale, and the buyers are often addicts themselves. In remote areas, trader bring household utensils, clothes and other goods to barter for opium thus accumulating a few kilogrammes of opium. Petty traders can often be found walking the mountains during the opium season with baskets of sweets, noodles and other assorted goods to exchange for opium.

The third category involves larger transactions between producers and traders who buy several kilogrammes at a time; sometimes these traders are shop-owners in district or provincial capitals who, while running their legal business (restaurants, shops, etc.), at the same time buy up the whole harvest product by a household. In some areas, producers go to the traders to sell their opium, but the general pattern is that traders purchase the opium in the villages and negotiate with each household individually. A trader may then leave the village with 1 or 2 kilogrammes, or even more than 50 kilogrammes. These traders usually pay in cash, that is, in Kip or, in border areas, in Thai Baht. Rarely, do traders offer silver coins or gold. In only one of the areas studied (in the district of Xaysomboun, in Vientiane province) was the exchange of opium for livestock (cattle, buffalo) a major way of trafficking. Similarly, in only one of the villages studies (Hmong village in Pek district, Xieng Khouang) did villagers report that traders paid for the opium in advance. Traders did not give credit in any of the villages. Villagers said that it was not the same traders that came every year. This suggests that the relationships between producers and particular traders are not very strong, in the sense that traders do not place an order for opium in advance nor manipulate producers into a dependency relationship by giving them credit which then turns them into debtors.

For obvious reasons, the villagers provided little information about the identity of traders. All villagers reported that some of the traders came from the respective provincial capitals. In Oudomsay province, some of the traders came from the Thai area. In Xieng Khouang and Houaphan some of the traders are from the provincial capitals, but some are also Chinese and Vietnamese. Farmers in Xaysomboun either sell to traders from Vang Vieng and Vientiane or to Borikhamsay (Paksan). While most of the opium is produced by the Lao Soung, the Lao traders are from both the Lao Soung and Lao Loum ethnic groups.

It is difficult to make assertions on price trends because some farmers refer to fresh raw opium, while others refer to dry raw opium. Opium from the north-east has a better reputation than opium from the north-west. (The former is said to be stronger, probably because of a higher alkaloid content.) However, in the north-east, some Hmong farmers stretch opium with soya powder to make it more bulky. Moreover, prices vary during the year, with peaks in September/October. Most opium is sold between April and June, that is, when the harvest is over and the opium has become more solid.

Despite these restrictions, information from villagers and provincial and district officials suggests an interesting trend in the price of opium since 1988. Between 1988 and 1991, prices went up steadily from 47,000 Kip (1988) to 84,000 Kip (1991) for 1 kg of dry raw opium. From the middle of 1992 onwards however, there has been a significant drop, with prices averaging only 49,000 Kip during the harvest time of early 1993. Although prices are usually lower during harvest time, this drop of more than 40% between June 1992 and February 1993 confirms a trend already indicated by traders as early as October 1992, when prices should have been at their peak. If inflation is taken into consideration, in real terms prices in early 1993 were considerably lower than in 1988.

Prices are highest in the central northern provinces (Ventiane, Borikhamsay and Saya bouri), in particular in the areas near the Thai border and in Borikhamsay. A considerable decrease can be noted in the other areas bordering Vietnam, where some farmers reported prices as low as 13,000 Kip for one kilogramme of fresh raw-opium.

Farmers gave two explanations for the drop of prices for opium:

- "Law enforcement activities of the Lao Government" prevented traders from visiting villages to buy opium. Traders also had difficulties to export the opium purchased from the area concerned and from Laos itself.

- The "opium market situation in Thailand" was also given as a reason, however, without further explanation.

Most farmers knew that it is against the law to sell opium for 'export'. Most of them did not think there was anything wrong with selling opium within the village or district however. In some areas opium producers thought there was nothing wrong with trading opium as long as it was within the province.

Law Enforcement

Seizures of heroin and destruction of heroin laboratories by Lao PDR authorities in recent years are a demonstration of the government's efforts to curb narcotics refining and trafficking in Lao territory. As with other components of this programme, the law enforcement effort is hampered and restricted nationally by a lack of infrastructure, especially roads, and the inaccessibility to the mountainous areas of the north and western parts of the country. In addition to this are the lack of specialist training, equipment and funds.

Despite this, recent years have seen an increase in law enforcement activities, and statements of farmers and traders confirm that law enforcement activities have become a serious risk which farmers and traders have to take into consideration when they take the decision whether or not to grow and trade in opium or cannabis.

To date the Government has been modest in apprehending traffickers and producers. The table below shows the number of seizures and arrests made by police and customs officers in 1993.

Amount Seized	**1993**
Heroin	6.1 kg
Opium	54.30 kg
Marijuana	133 tons
Number of offenders	99 persons

Legislation

In January, 1990 the new Penal Code was published, comprising Article 135 which prohibits trafficking of drugs, the production of heroin or other narcotics as well as the possession of large amount of narcotics, with penalties ranging 6 months to 10 years in prison. In addition to this article, a number of decrees regulate licit activities (i.e. the production, import, export and distribution of medicines). Laos ratified the 1961 Convention on 22 June 1973.

Legislation is rudimentary. There is no provision for lists of classifications of drugs to be controlled. The decrees on licit activities do not include psychotropic substances. There are no provisions for interdicting the production of narcotics such as cannabis or opium. The paragraph on drug trafficking and possession of drugs is very vague. There are no laws regarding the consumption of drugs. There are no laws providing for international cooperation (extradiction, mutual legal assistance, controlled deliveries etc.) There are no laws to control money laundering or organised crime.

Drug Control Administration

Drug Control activities are co-ordinated by the National Commission for Drug Control and Supervision(LCDC). As a result of decree number 25 of April, 10, 1990 the Council of Ministers announced the formation of the LCDC. It is an independent by body within the council of Ministers and consists of representatives from the Ministry of Foreign Affairs (Chairman), Interior, Finance (Customs Department), Health, Education, Justice, Agriculture and Forests, and a representative from the Prime Ministers Office.

The permanent secretariat is located within the Ministry of Foreign Affairs. It is staffed by two professionals with only one secretarial/general service staff, and it has no annual operating budget. The Commission usually meets at least once each month. The major areas of concern to the LCDC are: planning of new activities, monitoring of ongoing operations, and collecting of data on drug production, trafficking and abuse. Moreover, the LCDC should deal with international agencies, search for bilateral assistance and

arrange the Lao representation at sub-regional meetings, seminars and workshops.

While LCDC's major planning function is to serve as a focal point for all new drug-related activities or initiatives, in practice, however, it has not yet developed the capability to fully exploit this intended role.

Legal activities related to drug under international control (import, export, production, distribution of drugs for medical purposes) are controlled by the *Department of Food and Drugs of the Ministry of Health* (and in particular the Division for Narcotics, Psychotropic Substances and Quality Control).

Law enforcement activities are usually undertaken by the Ministry of the Interior, in particular by the Special Investigation Unit (established in August 1992) and the Department of Customs (Ministry of Finance). However, there is not yet a formal provision for coordination between the different law enforcement agencies.

National policy on drug control from now up to the year 2000 The Comprehensive Drug Control Programme (Master Plan).

In March 1994, the Government of the Lao PDR published a Comprehensive Drug Control Programme up to the year 2000. This Programme sets out the priority needs in drug control matters at the strategy, policy and operational levels. The long term objectives of the programme are:

a) Gradual elimination of opium poppy and commercial cannabis production.

b) Drug demand reduction and prevention;

c) Elimination of trafficking, refining and other drug-related crimes;

d) Control of licit and illicit activities;

e) Facilitation of international cooperation.

Success criteria of implementation of Comprehensive Drug Control Programme are:

- Reduction of opium cultivation from 130 tons (1992) to less than 70 tons by the year 2000.

- Successful implementation of rural development projects.

- No further increase in opium addiction between 1996 and 2000.

- A comprehensive drug legislation adopted between 1996 and 2000

- Ratification of the United Nations Conventions of 1971 and 1988.

The Comprehensive Drug Control Programme contained 16 project proposals. The cost for the implementation of the project are estimated at about US$ 35 million. Since the Lao Government will not be in a position to finance drug control activities exclusively from its own resources, successes in drug control hinge therefore on the availability of external financing for the implementation of planned projects.

To achieve these goals, the Lao Government wishes to make an appeal to the international organisations and community to support technically, material and financially its efforts in order to translate this Master Plan into reality, thus contributing to common struggle of the world community against drug abuses and illicit trafficking.

SECTION THREE

REPORT FROM CONSULTANTS

(1) SOUTH ASIAN COUNTRIES

(2) EAST ASIAN COUNTRIES

AN ANALYSIS OF DRUG ABUSE PATTERNS AND TRENDS OF SELECTED SOUTH ASIAN CITIES

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ABSTRACT

This paper presents an analysis of drug abuse patterns and trends of selected cities in the South Asian region. These cities include Colombo, Dhaka, New Delhi, Madras and Varanasi. Drug treatment and law enforcement data were reported by each city using a standardized instrument. A comparison of the patterns of drug abuse between cities revealed great similarities in socio-demographic profile, primary drug of abuse and other characteristics of abuse such as mode of drug administration.

Most drug dependents who were admitted into specialised drug treatment facilities in each city, were males, between 20 and 34 years of age and employed. Heroin was the main drug of abuse in all the cities with the exception of Madras where alcohol and cannabis abuse were prevalent. Smoking of heroin was the most common, whilst injecting drug use was low. Drug-related arrested and seizures varied substantially between the cities. The city of Colombo has the highest average rate (156.36 per hundred thousand) of drug-related arrests per quarter. Opiates and cannabis were the most common drugs that were seized by most cities. The nature and trend of drug abuse of each city was also examined.

METHOD

Using a standardized instrument, members of the Asian Multi-City Epidemiology Work Group collect information on a number of epidemiological indicators. These include drug treatment and law enforcement data, drug-related health indicators and social factors. Data in these core categories are reviewed on a quarterly basis.

SOURCES AND TYPES OF DATA REPORTED

The number of quarterly reports received from participating cities varied. Colombo has provided the most up to date reporting and data are available from January 1992 to December 1993. Information has been reported from January 1992 to June 1993 for the city of Dhaka. The three Indian cities who are new members in the Epidemiology Work Group have submitted the following: Madras (October 1992 - March 1993), New Delhi (July 1992 - March 1993) and Varanasi (October 1992-September 1993).

Furthermore, the availability of information for each drug abuse indicator differs between the cities. All cities could provide data on the characteristics and patterns of drug use of patients who were admitted into specialised drug treatment facilities, Dhaka and varanasi have also compiled information from individuals who were treated for drug dependence in prison settings. Drug-related arrests and drug seizures were reported by cities. Some data on drug-related health and social problems are available.

DEMOGRAPHIC CHARACTERISTICS OF CITIES

A comparison of selected demographic characteristics of the cities is presented in Table 1. New Delhi has the largest population size of over 8 million people. The distribution of males and females are similar between the cities with each having a larger percentage of males (Figure 1). There are some variations in the distribution of age groups (Figure 2). Colombo has a slightly larger percentage (60%) of people where are over 20 years of age compared to the other cities (about 50% each). Except for the city of Dhaka where most of the people are married, the other cities have a larger proportion of unmarried people (Figure 3).

Information on the number of people in household and the level of educational attainment is not available for most of the cities.

CROSS-CITY COMPARISON

Patient's Socio-Demographic Characteristics

Almost (more than 95%) all of the drug dependents admitted into specialised drug treatment facilities in each of the cities were male. Most (more than 70%) of the patients were between 20 and 34 years old with the exception of Madras where a comparatively larger proportion were older. More than half of total admissions (in the three Indian Cities) were married. Information on occupational background indicates that they were either unemployed, engaged in small business or were manual labourers and drivers.

Pattern of Drug Use

Heroin was the main drug of abuse in all the cities with the exception of Madras. In Colombo and Varanasi, more than 90% were treated for heroin addiction. This was also high in Dhaka (73%). In New Delhi the pattern was more diverse. Half were admitted for heroin addiction, while another one-quarter were with an alcohol problem. A wide range of other drugs such as cannabis, benzodiazepines, codeine, etc.) were also abused. Madras has presented a varied picture. Half were heroin abusers primarily, while another 20% were drinkers. Heroin users constituted only 14% of total admissions.

The abuse of codeine and pethedine was observed in most cities (higher in Dhaka). Other types of drugs were less frequently mentioned.

Route of Drug Administration

Comparison of the modes of drug administration is difficult because the available information is not drug specific. In cities where the types of drugs used are not diverse, such as heroin use in Varanasi and Dhaka this indicator is clear. In the case of these two cities smoking was the predominant route of administration. Oral ingestion was commonly reported in Madras and New Delhi. Injecting drug use was low in all cities. However, a substantial increase of injecting drug use was observed in New Delhi. It rose from 5.3% in the third quarter of 1992 to 20.6% in the first quarter of 1993.

Drug Sources

Drugs were mainly obtained from street sales and only a small percentage were diversion of prescriptions.

Drug-Related Offences

It is difficult to compare the rates of arrest for such offences because of varied time periods of study between the cities. Taking the average number of people arrested per quarter as a crude indicator for comparison the following rates of arrest per 100,00 population were computed for each of the city: Colombo (156.36); Dhaka (16.07); Varanasi (19.09); New Delhi (1.79) and Madras (3.98). It was evident that the city of Colombo had the highest rate of drug-related arrests. Among the three Indian cities, Varanasi has a higher rate compared to the other two cities. These variations between the cities may be a reflection of the extent of police activity or law enforcement in each city. The wider policy and legal aspects relating to drug abuse may also be influencing factors.

Drug Seizures

The amounts and types of drugs seized varied substantially between the cities. Comparing the average amounts of opiates and cannabis seized per quarter between the cities, Colombo had the largest quantity: 1,570 kg and 21,136 kg for each of the drug respectively. The large amounts of cannabis confiscated is probably associated with the production of this drug in some parts of Sri Lanka. In Dhaka, only an average of 322.5 kg of cannabis and only 3.9 kg of opiates were seized. In the Indian cities, cannabis was also the major drug seized. Dhaka had a much wider range of drugs that were seized. They include alcohol, solvents, codeine and sedatives.

ANALYSIS OF TREATMENT DATA: CITY HIGHLIGHTS

This section attempts to characterise the population in treatment in terms of demographic and background characteristics and patterns of drug use of each city. Trends will be discussed where possible.

COLOMBO

The total number of admissions into specialised drug treatment over the last eight quarters was 2,456. This has increased from 122 in the first quarter of 1992 to a peak of 486 in the third quarter of 1993. The average number of admissions was 300 per quarter (Figure 4). Almost all individuals were male. The majority were single (57.6%), while 40.9% were married. More than three-quarters (81.4%) of admissions were between 20 and 34 years of age. A small percentage (15%) were over 34 years old.

Those who were less than 20 constituted a minor proportion. There were no variations in distribution of age and marital status over the whole reporting period.

Information on the occupation of the drug dependents treated was collected from July 1992 to December 1993. Overall, the percentage of unemployed predominates in most of the quarters (Table 2). Those who were involved in small businesses or who were self-employed/laborers were also important categories. Professionals, sales/clerical workers and drivers formed a sizeable portion of those who were treated. This pattern was observed over the whole period of study.

Heroin is the major drug of abuse as it was reported by more than 90% of those in treatment (Figure 5). Other opiates

such as opium and codeine were primary drugs of abuse among a small percentage of those treated. Cannabis, alcohol and other types of drugs were rarely mentioned. Regarding the route of drug administration, slightly more than half of admissions stated "other" method of use, with no further clarification. The other major mode is "smoking". Only 1% reported injecting use (Figure 6).

DHAKA

Data from specialised drug treatment facilities were available for January 1992 to June 1993 in Dhaka. About 80% of those admitted for drug treatment were new admissions. A total of 719 persons were treated over the reporting period. The number admitted in each quarter range from 99 to 171, with substantial fluctuations over the various quarters (Figure 7).

About 90% of the drug dependents treated were twenty years or older. A great majority were in their twenties and early thirties. Although the age distribution has not changed significantly over the years, there was an indication of a rising percentage of younger people who sought treatment in the first half of 1993. This has doubled form 8% in the first quarter of 1992 to 17.3% in the second quarter of 1993 (Figure 8). If this trend persist for the rest of 1993 and assuming other factors (such as admission criteria, recruitment, mechanism, etc.0 will not change, this could be an indication that more people are getting involved in drug use at a younger age.

More than half (54.4%) of the total number of patients admitted over the whole period were single while 40% were married. Some fluctuations were observed in distribution of marital status, but they were not suggestive of any change in trend (Table 3).

The unemployed and those involved in small business were the predominant occupation categories. Students comprised a sizeable percentage. These three groups contributed about 75% of total cases. Professionals and transport workers were also recorded, but in lesser proportions comparatively (Table 4). There were no major changes in this pattern.

Table 5 shows the distribution of total admissions by level of educational attainment. About 44% had between one and 6 years of education. Another 40% had more than six years of schooling. There were substantial variations in the distribution of education level between the quarters.

Heroin is also the major drug of abuse in Dhaka (Figure 9). This was consistent over the reporting period. Abused on a much lesser scale were codeine and pethedine. Cannabis, minor tranquilisers, and alcohol were primary drugs of abuse among a small proportion of cases. Smoking was the predominant mode of drug administration, followed by oral ingestion. Injecting drug use was reported by less than 10% of cases (Figure 10). Street sales was the major source of drugs. Diversion of prescription drugs was another source.

VARANASI

Over the period October 1992 to September 1993, 186 male drug dependents were treated in specialised drug treatment facilities. A large proportion (44%) were readmissions. An average of 46 persons were treated per quarter.

Table 6 shows the demographic profile of the drug dependents. A majority were between 20 and 34 years old and married. About one-third of these cases were engaged in small businesses, while 25% were unemployed. Sales workers and cultivators were other more frequently reported occupations. The percentage of students was low. Most (62%) of the cases were from households of 6 to 10 people. Slightly more than half had more than 12 years of education. About 16% had no schooling. There were no significant changes in the profiles of drug dependents who sought treatment over the study period.

Almost all (97%) of the cases were heroin abusers (Table 7). The abuse of other drugs were rarely reported. A very minor proportion had mentioned polydrug use. Seventy eight percent of the cases smoked their drugs. The other modes of drug administration were seldom reported. Almost all drugs were obtained from street sales.

In addition to data from specialised drug treatment facilities, data from prison treatment programmes were also reported. A total of 459 persons were treated in such programmes over the reporting period. Except for 4 cases, all were new admissions. The numbers admitted each quarter ranged from 96 to 165 cases.

There were no significant variations in the profiles of these cases compared to those from specialised drug treatment centres. An observed difference was the larger proportion of persons with "other" jobs. Included in this category were the drug peddlers.

The pattern of drug use among this group of drug dependents

was similar to those form specialised drug facilities.

MADRAS

Reports from the city of Madras were limited and they were complete only for two quarters (October - December 1992 and January - March 1993). Nevertheless the data provide some indication of the characteristics and pattern of drug use among drug abusers admitted for treatment. Two hundred and seventy three drug dependents were treated in specialised drug treatment facilities. Ninety percent were new admissions. All of them were male. Over 55 were between 20 and 34 years old. Forty four percent were more than 34 years old (Table 8). A great majority (73.5%) were married. Most (61%) were employed as coolies, welders or helpers. The rest were distributed among the other occupational categories. About 10% were unemployed. Seventy percent of these cases come from small households (between 2 - 5 people).

Alcohol was the main drug of abuse constituting 50% of reports (Table 9). Cannabis was next (20% of reports). Of much less importance was heroin (14%). Among the other types of drugs, minor tranquilisers were more frequently reported. Since the primary drug of abuse was highly varied, this was reflected in the wide differences in the route of drug administration. Oral ingestion (for alcohol mainly) was the most common route reported. Smoking was the next most frequently reported method of drug use. Injecting drug was mentioned by 9% of respondents.

Polydrug use was a rather common phenomenon with slightly more than one-third (37%) reporting such use.

NEW DELHI

Over the period July 1992 to March 1993, 602 male drug dependents were admitted for drug treatment in specialised drug treatment facilities in New Delhi. About 70% of these were new admissions.

More than 70% of these cases were between 20 and 34 years of age. Twenty percent above 34 years old. Slightly more than half (53%) were married and 42% were single. Almost were employed. A larger proportion(31%) were employed in small businesses. Drivers was the next commonly reported occupation followed by professional and sales workers (Table 10).

Half of these cases were from small households with 2-5 people, while most of the rest were from larger households. The level of educational attainment varied between the

respondents. A larger proportion (40%) had between 6 and 12 years of schooling. Thirty percent had six years or less. A sizeable proportion had more than 12 years of or more.

Heroin was the main drug of abuse for more than half (54%) of the cases. Twenty five percent reported alcohol as the primary drug of abuse. A wide range of other drugs were also reported though their use were less frequent. A sizeable proportion (19%) were polydrug users (Table 11).

The routes of drug administration reported were diverse. Oral method was most frequently mentioned, followed by smoking and inhalation. Injecting drug use revealed to be on the rise from 5% of total admissions in the third quarter of 1992 to 20.6% in the first quarter 0f 1993. There were substantial variations in reported route of use between the various quarters. Street sales was the predominant source of drugs.

ANALYSIS OF LAW ENFORCEMENT DATA: CITY HIGHLIGHTS

Most cities could provide information on the number of drug-related arrests, the number of drug seizures and the quantity of drugs seized. Reports on other indicators such as purity of seized drugs, drug production crimes and drug-related traffic accidents were generally lacking for most cities.

COLOMBO

Information on drug-related arrests were reported for the period January 1992 to May 1993. A total of 15,943 persons were arrested fro drug-related offences, with an average of 2,657 arrestees per quarter (Figure 11). Excluding the last quarter because of incomplete data, data from the other quarters indicate an increasing trend of number of arrestees (from 2,494 in first quarter of 1992 to a peak of 4,060 in the last quarter of 1992 and remaining high at 3,699 in the first quarter of 1993).

Most of these drug-related crimes were for drug consumption (38.8%) or for possession (46.8%). The rests of the offences were associated with drug sales (10.2%), trafficking (0.4) and cultivation (3.8%). A declining percentage of arrestees had been arrested for drug consumption over the period of study, i.e from 62.5% in the first quarter of 1992 to 24% in the last quarter. On the other had percentages of arrests for drug possession has increased from 37.3% in the first quarter of 1992 to 51.7% in the first quarter of 1993 (Figure 12).

The total amount of opiates seized over the whole period (17

months) was 9,422 kg. There were severe fluctuations in amounts seized each quarter. Overall it was an increasing trend. Cannabis seizures were significantly more compared to that of opiates (13 fold) amounting to 126,818.68 kg. The amounts seized per quarter have increased by about 150 fold in first quarter of 1993 when compared to that of the previous year (Table 12).

DHAKA

Data was reported for January 1992 to June 1993. A total of 3,317 drug-related arrests were made over this period. The number of arrests made per quarter has increased from 287 in the first quarter of 1992 to a peak of about 750 in the last two quarters of 1992 (Figure 13).

The types of drug seized are highly varied ranging from narcotics to illicit liquors. More cannabis (1935 kg) were seized compared to that of opiates (23.66kg). The amounts of each drug that was seized fluctuated between the various quarters. An interesting feature were the seizures of solvents that were made in late 1992 and for the first half of 1993. A total of 2,202.6 litres were seized. Some cocaine (1.7 kg) were seized (Table 13).

VARANASI

Seven hundred and eighty three were arrested for drug-related offences from Oct. 1992 to Sept. 1993 in Varanasi. Seventy five percent of these arrests were for sales of drugs. The rest were arrested for drug possession. There were no arrest for drug consumption. The percentage of arrest for sales has declined over the four quarters (from 96% in the last quarter of 1992 to 56% in the third quarter of 1993). The reverse was observed for percentage of arrest or possession (Figure 14).

Only three types of drugs were seized during this reporting period; opiates (2,812 kg), cannabis (55.19 kg) and phenobarbital (63590 tablets).

NEW DELHI

Out of the 450 arrests made from July 1992 to March 1993, 96% were for drug consumption and 4% were for drug possession. There were no changes in the types of drug-related arrests between the various quarters.

Cannabis was the most common drug seized amounting to 636.99 kg (for the three quarters). To a much lesser extent were seizures of opiates (amounting to 276.3 kg).

About 700 kg of sedatives were also confiscated.

MADRAS

Madras reported a total of 158 drug-related arrests (for possession) over the six month period of October 1992 to March 1993. Opiates and cannabis were the only two types of drugs that were seized by law enforcement agencies. They amounted to about 170 and 190 kgs, respectively. A very small amount of methaqualone was also seized.

DATA ON HEALTH AND SOCIAL INDICATOR

The reporting on these indicators was incomplete for most of the cities. None of the cities collected information on the number of drug-related HIV/AIDS cases. Except for Colombo, all the cities could provide date on some indicators. The number of drug-related psychological cases were recorded by Dhaka, Varanasi, Madras and New Delhi. Drug-related emergency room episodes were not compiled by most of the cities. Reports on drug-related deaths were provided by Dhaka and New Delhi.

Information compiled by the cities on the list of social indicators is comparatively better. Except for Colombo, all the other cities could furnish data on some social consequences of illicit drug use.

DHAKA

From January 1992 to June 1993, 150 drug-related accidents were reported in Dhaka, most (73%) being narcotic-related (Table 14). The numbers recorded for each quarter fluctuated over the period of study. Fifty drug-related psychological cases were recorded for the same period. Data on drug-related emergency room cases were only collected for the first three quarters of 1992. They amounted to a total of 333. Only one case of drug-related death was reported for the whole period.

Persons dismissed from their jobs and students dropping out from school were the most common social effects of drug use. A total of 72 and 96 such cases were reported, respectively. A sizeable number of spouse separations were also recorded (Table 15). There were wide fluctuations in the numbers reported for each quarter.

VARANASI

Varanasi has reported three drug-related psychological cases for the period January -September 1993. There were reports on the various social indicators (Table 16).

NEW DELHI

Reports on health and social indicators from New Delhi are indicated in Table 17. A total of 168 drug-related psychological cases were recorded from July 1992 to March 1993. Twelve drug-related deaths were reported over the same period.

MADRAS

Thirty drug-related psychological cases were recorded over the six months (October 1992 to March 1993). Data were also compiled on other social indicators: persons discharged (N = 2), family disruptions (N = 35) and students expelled (N = 12).

Figure 1 : A Comparison of Selected City Demographic Indicators : Gender

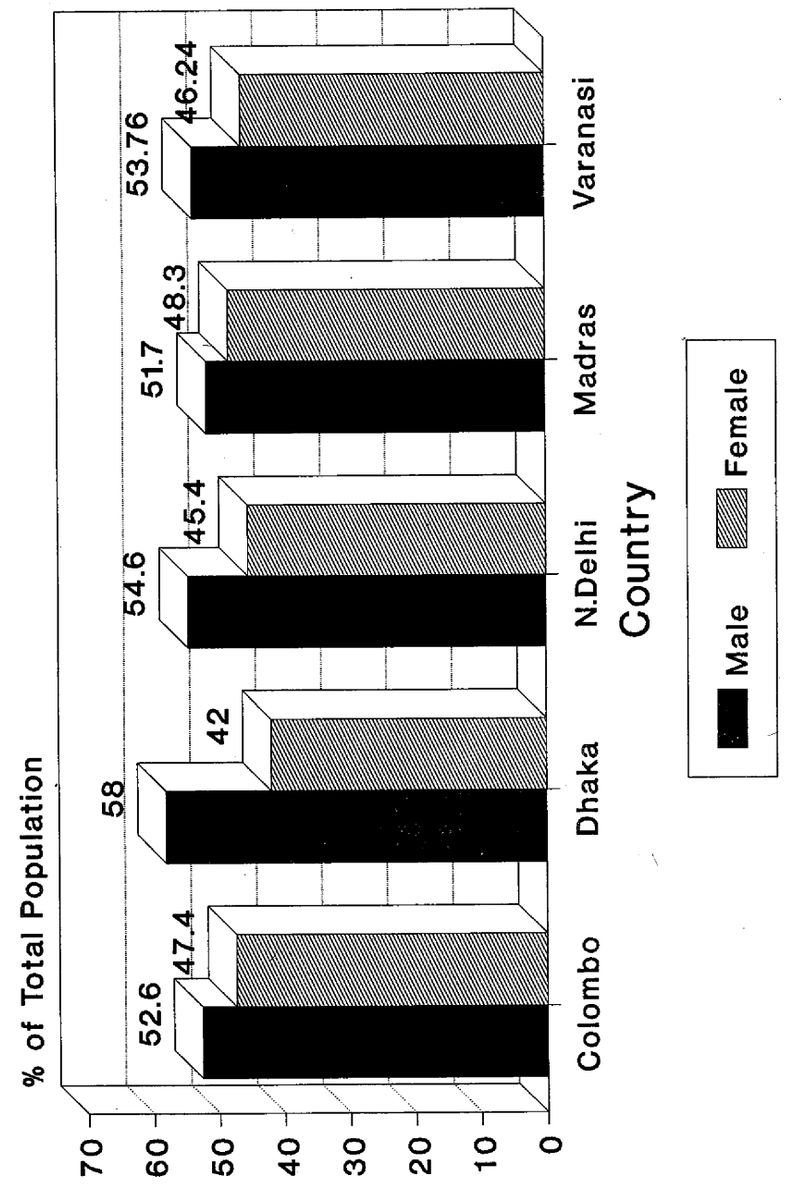


Figure 2 : A Comparision of Selected City Demographic Indicators : Age

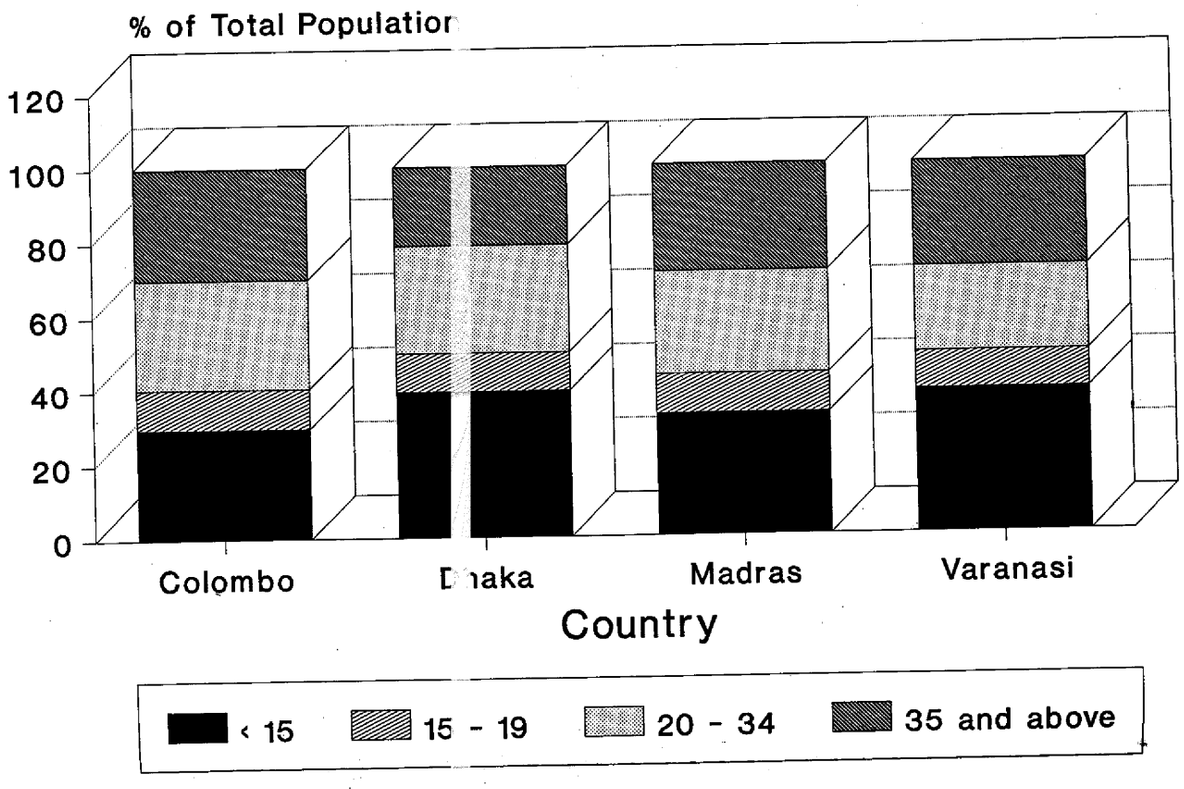


Figure 3 : A Comparison of Selected City Demographic Indicators : Marital Status

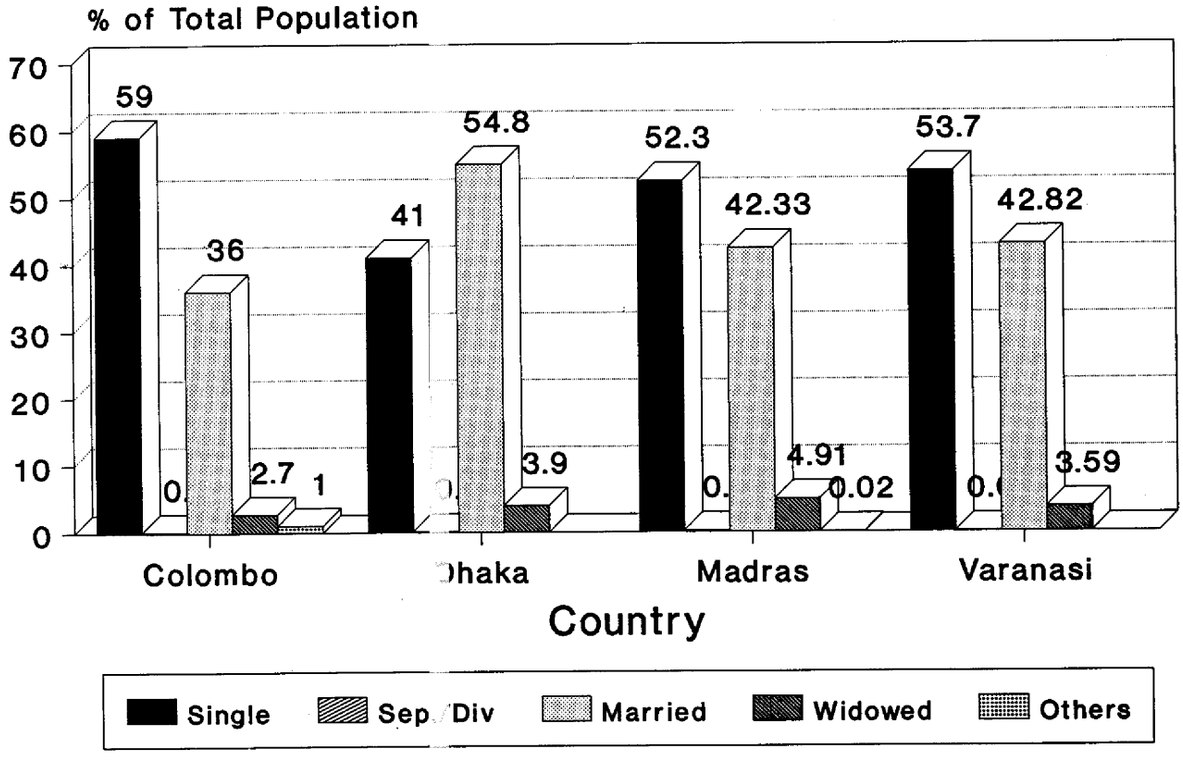


Figure 4: Colombo - Total Admissions into Specialised Treatment
January 1992 - December 1993

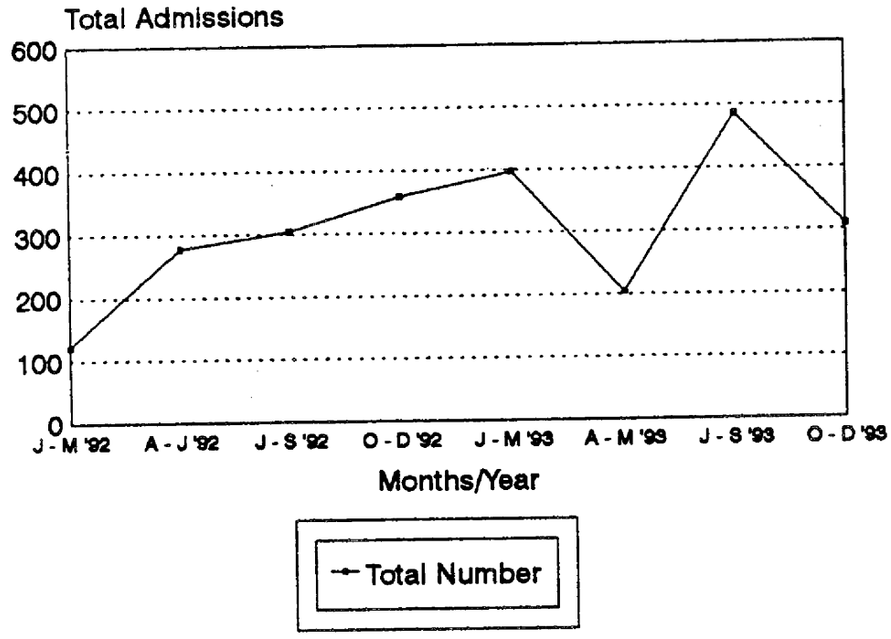


Figure 5: Colombo - Primary Drug of Abuse
January 1992 - December 1993

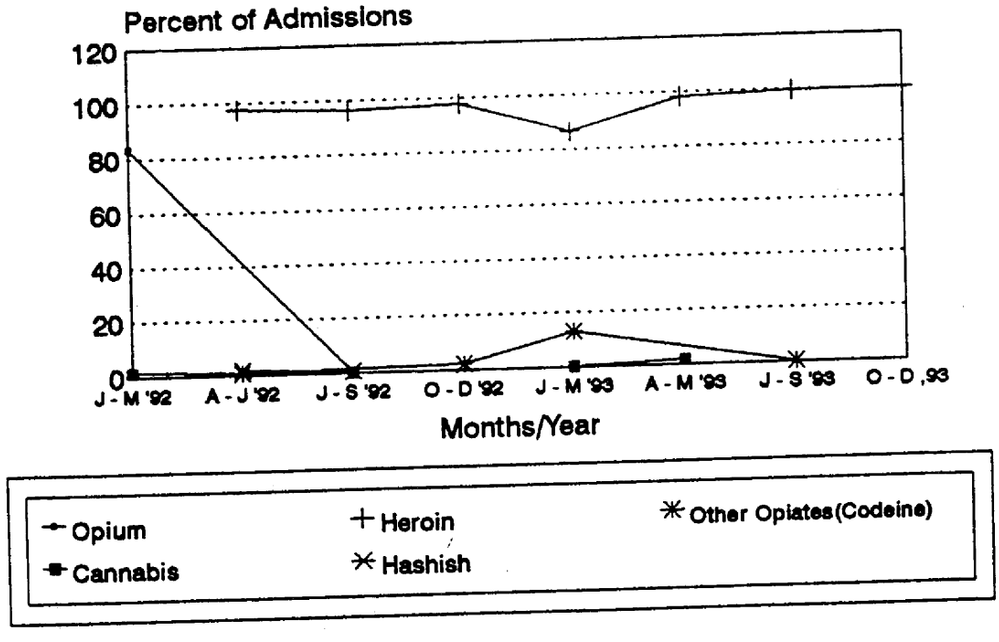


Figure 6: Colombo-Route of Drug Administration Janauary 1992 - December 1993

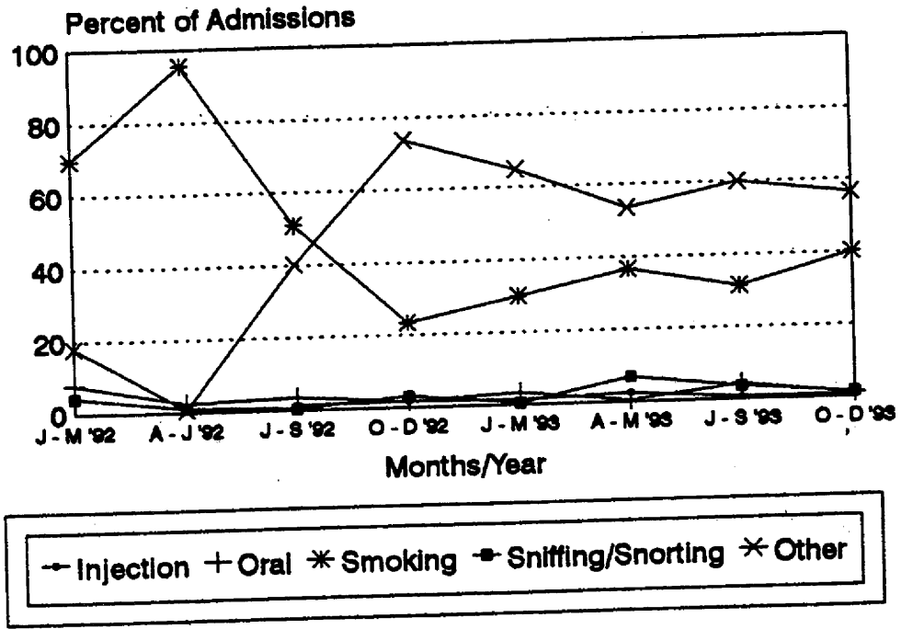


Figure 7: Dhaka - Percentage Distribution of Total Admissions January 1992 - June 1993

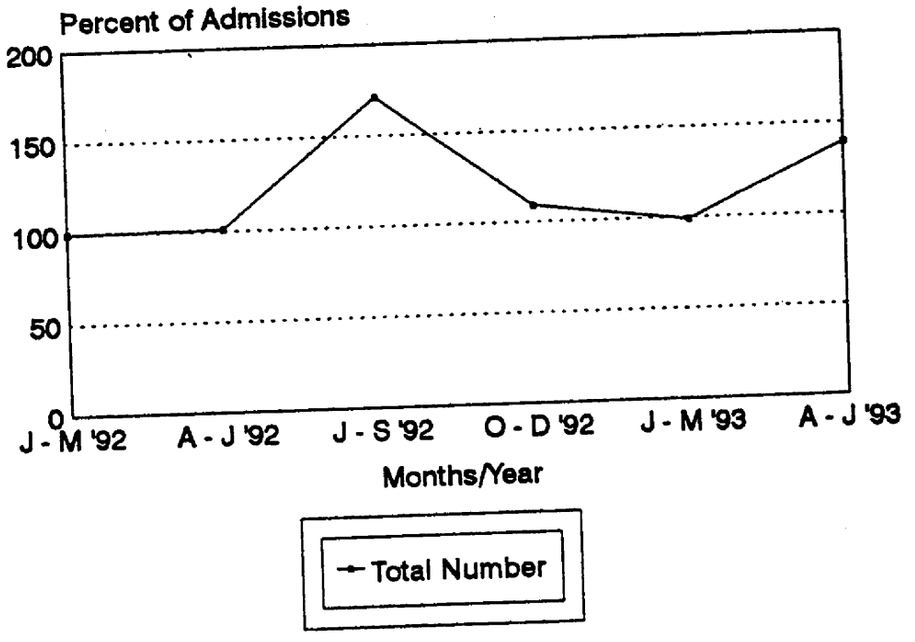


Figure 8 : Dhaka - Age Distribution
January 1992 - June 1993

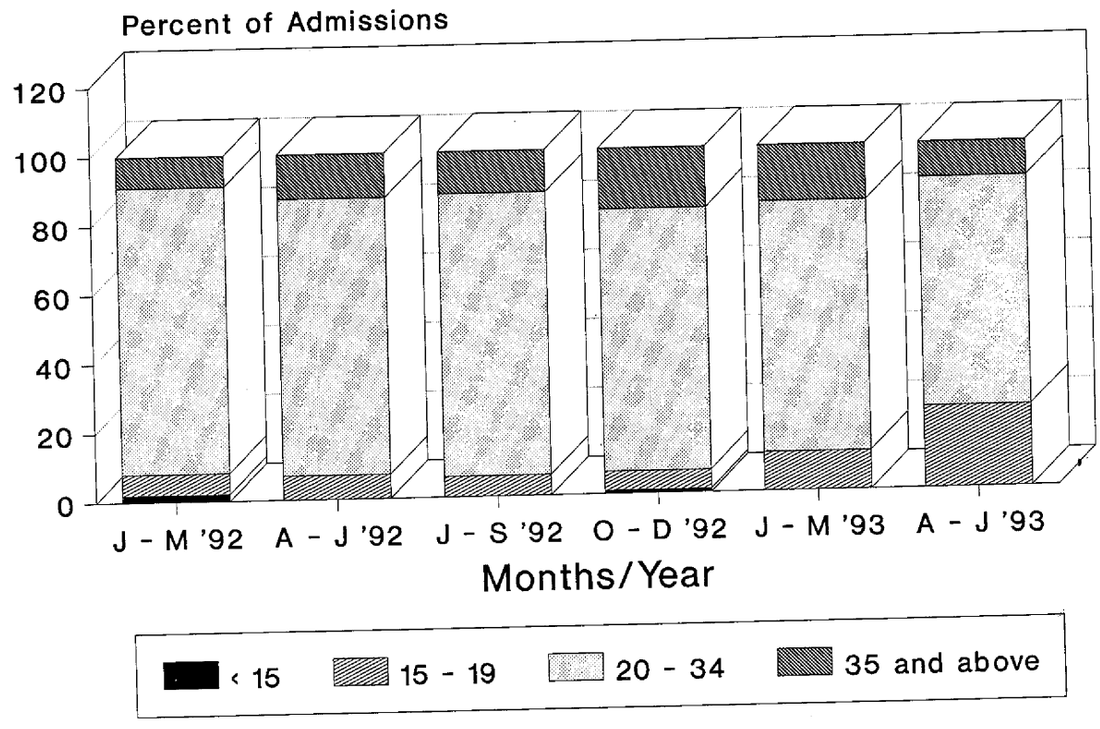


Figure 9: Dhaka - Primary Drug of Abuse
January 1992 - June 1993

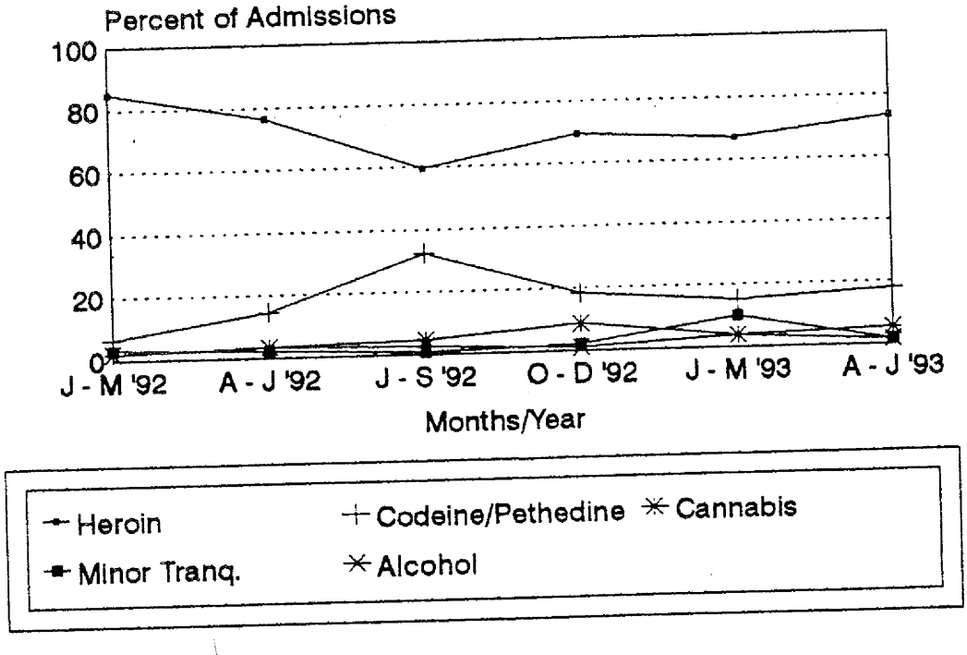


Figure 10: Dhaka: Route of Drug Administration at Treatment Admission
January 1992 - June 1993

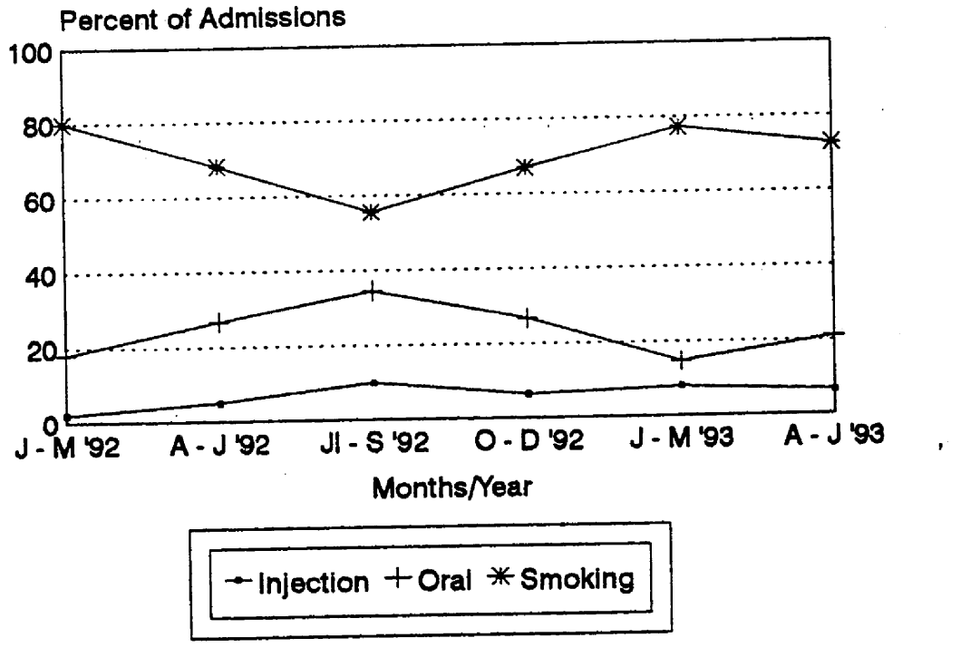


Figure 11: Colombo - Total Number of Drug Related Arrests
January 1992 - March 1993

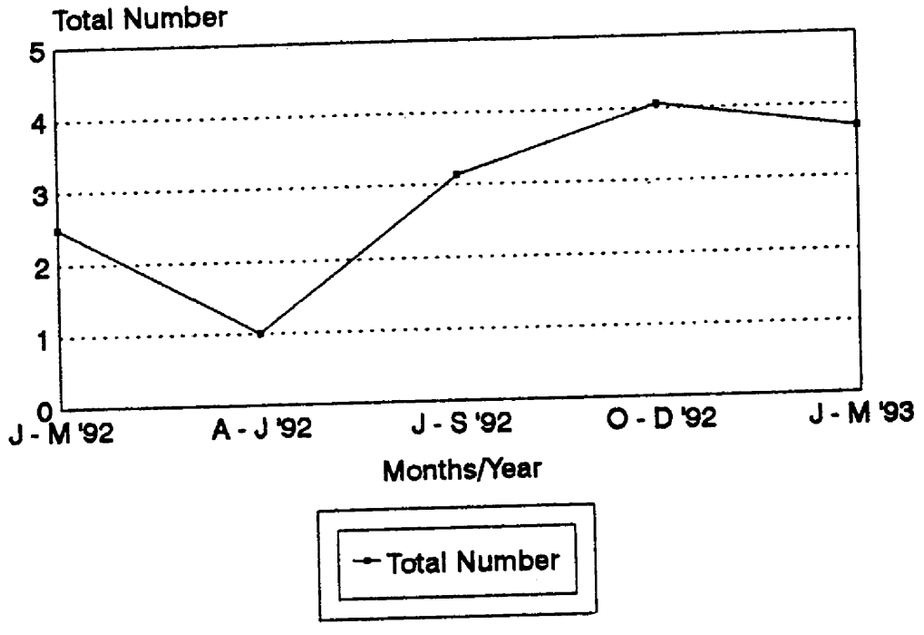


Figure 12:Colombo - % Distribution of Drug-Related Arrests - Jan 92 - May 92

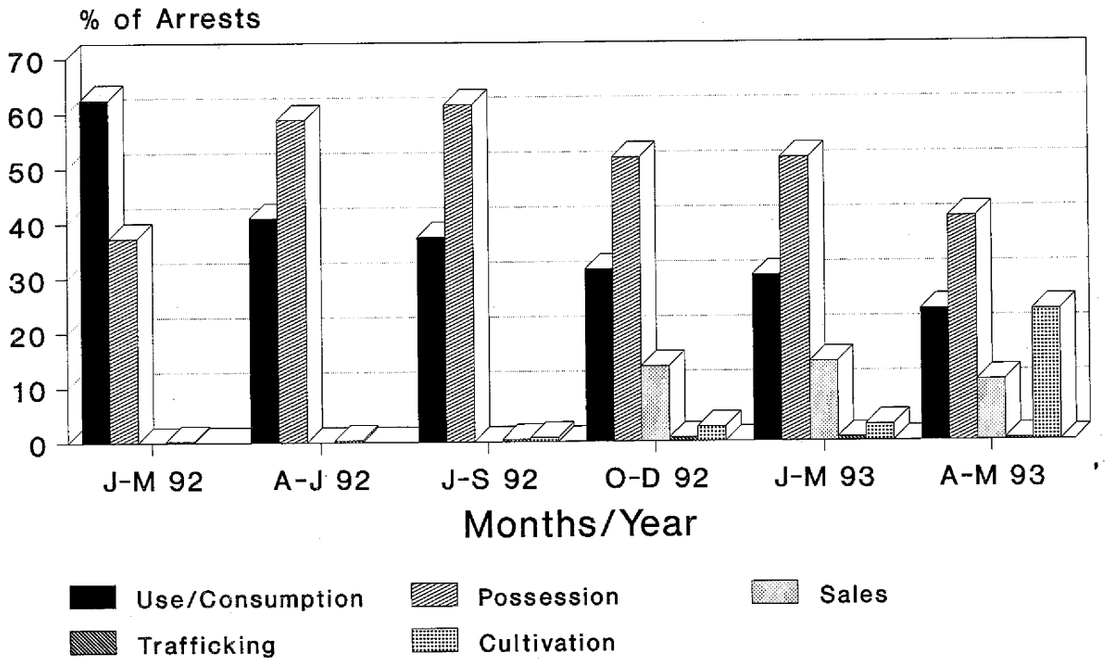


Figure 13: Dhaka - Total Number of Drug Related Arrests January 1992 -June 1993

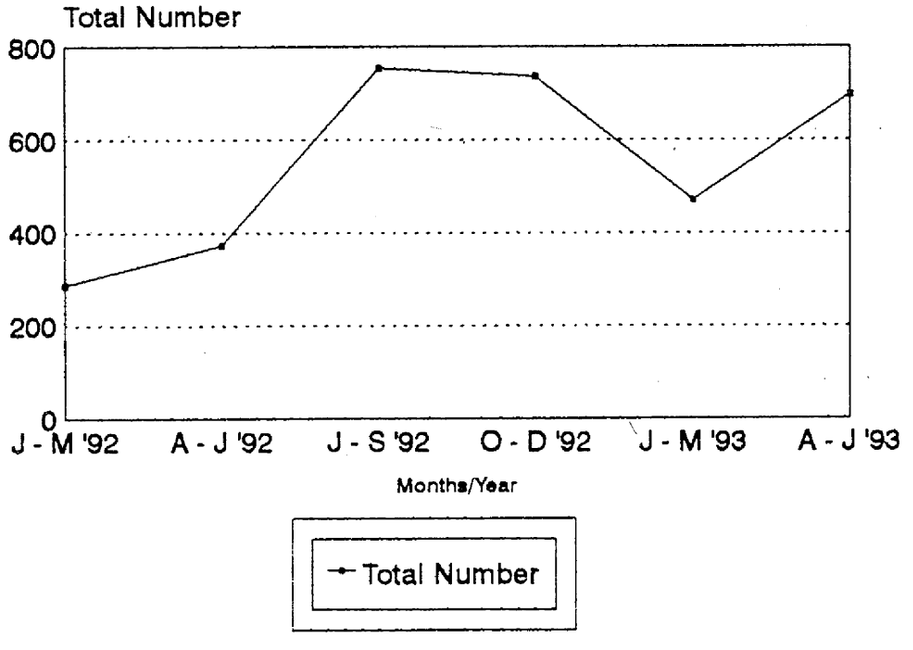


Figure 14:Varanasi - Drug-Related Arrest
Oct 92 - Sept 93

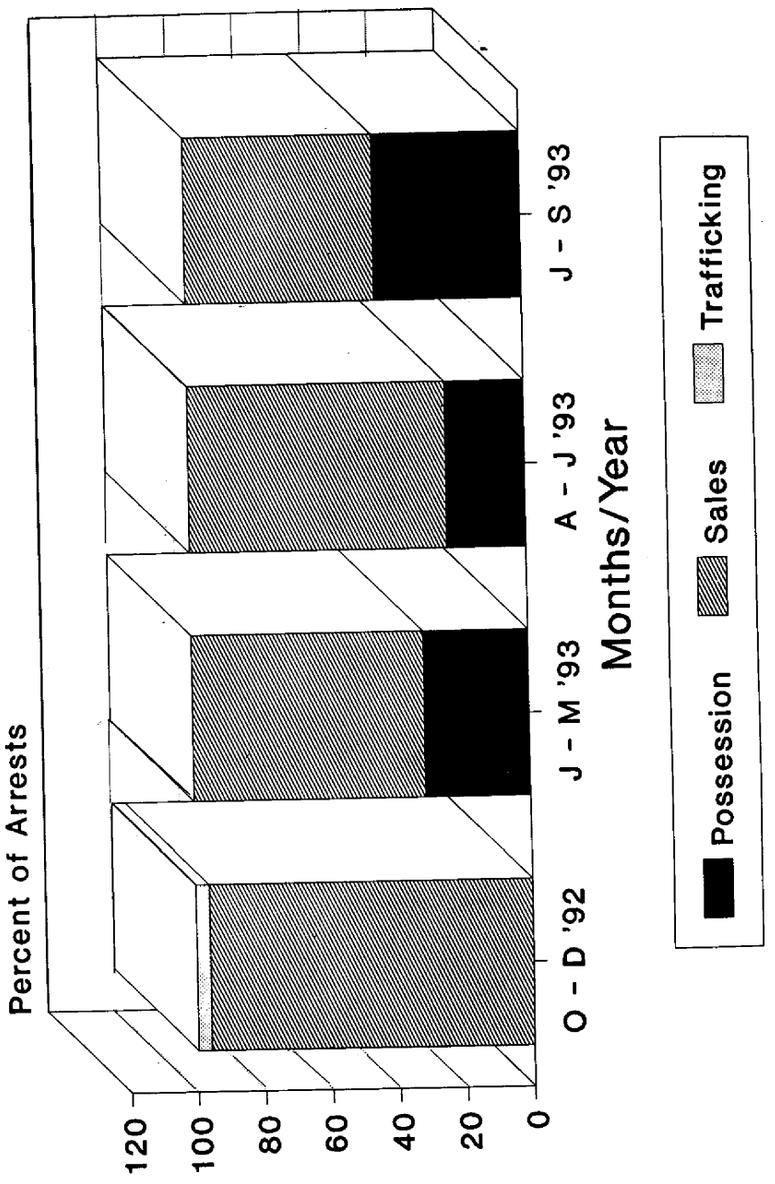


TABLE 1
A COMPARISON OF SELECTED CITY DEMOGRAPHIC INDICATORS

Indicator	Colombo (1981)	Dhaka (1991)	N. Delhi (1991)	Madras (1991)	Varanasi (1991)
Total population	1,699,241	3,440,147	8,375,188	1,986,278	1,026,46
	%	%	%	%	%
Sex					
Male	52.60	58.00	54.60	51.70	53.76
Female	47.40	42.00	45.40	48.30	46.24
Age (in years)					
< 15	29.70	39.30	NA	32.74	38.59
15 - 19	10.80	10.40		10.61	10.07
20 - 34	29.50	29.10		27.76	22.99
35 and above	30.00	21.20		28.89	28.35
Marital Status					
Single	59.00	41.00	NA	52.53	53.70
Separate/ divorced	0.30	0.30		0.21	0.09
Married	36.00	54.80		42.33	42.62
Widowed	2.70	3.90		4.91	3.59
Others	1.90	-		0.02	-

Indicator	Colombo (1981)	Dhaka (1991)	N. Delhi (1991)	Madras (1991)	Varanasi (1991)
<u>No. of people in household</u>					
1 (alone) 2 - 5 3 - 6 7 - 9 10 +	NA	NA	NA	NA	NA
<u>No. of years of education</u>					
None					0.63
1 - 6	NA	NA	NA	NA	13.37
7 - 12					65.01
13+					1.91
Studying in School/Colleges +					19.08

TABLE 2
COLOMBO
PATIENT OCCUPATION AT TREATMENT ADMISSION
PERCENT OF ADMISSION
JULY 1992 - DECEMBER 1993

Occupation	Jul-Sept 1992	Oct-Dec 1992	Jan-Mar 1992	Apr-May 1992	Jul-Sept 1993	Oct-Dec 1993	Total
Professionals	0.9	-	-	1.0	20.4	20.5	8.7
Sales and clerical	2.6	15.9	4.9	4.9	8.3	12.5	8.4
Drivers/ transport	5.1	7.0	7.3	4.4	9.3	5.2	6.8
Cultivators	-	-	1.6	-	-	-	0.2
Unemployed	36.5	29.1	45.7	21.0	42.8	42.3	37.2
Small business	28.3	11.6	20.7	20.0	18.9	18.9	19.5
Students	-	-	-	-	0.2	0.4	0.1
Self-employed/ labourers	26.6	19.4	19.8	48.7	-	-	19.1
Total N	233	258	247	205	40	248	1598

TABLE 3
DHAKA
MARITAL STATUS OF PATIENTS AT TREATMENT ADMISSIONS
PERCENT OF ADMISSIONS
JANUARY 1992 - JUNE 1993

Marital Status	Jan-Mar 1992	Apr-June 1992	Jul-Sep 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-June 1993	Total
Single	42.0	53.5	60.8	45.9	53.5	48.9	54.4
Separated/ Divorced	-	2.0	2.1	2.7	3.0	0.7	1.6
Married	58.0	44.5	38.0	50.5	43.4	29.4	39.6
Widowed	-	-	-	0.9	-	20.9	4.4
Others	-	-	-	-	-	-	-
Total N	100	101	171	109	99	139	719

TABLE 4
DHAKA
PATIENT OCCUPATION AT TREATMENT ADMISSIONS
PERCENT OF ADMISSIONS
JANUARY 1992 - JUNE 1993

Occupation Type	Jan-Mar 1992	Apr-June 1992	Jul-Sept. 1992	Oct-Dec. 1992	Jan-Mar 1993	Apr-June 1993	Total
Professionals	5.0	7.9	9.4	9.1	5.0	7.8	7.6
Sales and clerical worker	1.0	-	-	-	-	-	0.1
Drivers/ transport workers	14.0	8.9	11.7	11.1	6.1	6.5	9.7
Cultivators	2.0	-	-	2.0	-	0.7	0.7
Unemployed	43.0	37.6	39.2	32.3	36.4	31.6	36.7
Small business	23.0	30.7	20.5	19.2	24.2	30.2	24.5
Students	6.0	9.9	16.4	15.2	16.2	9.4	12.4
Others	6.0	5.0	2.8	11.1	12.1	13.7	8.2
Total N	100	101	171	109	99	139	719

TABLE 5
DHAKA
NUMBER OF YEARS OF EDUCATION ADMISSIONS
PERCENT OF ADMISSION
JANUARY 1992 - JUNE 1993

Number of Year of Education (in years)	Jan Mar 1992	Apr-June 1992	Jul-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-June 1993	Total
Zero	28.0	15.8	14.0	19.1	16.2	15.8	17.7
1 - 6	37.0	55.5	22.6	22.6	14.1	59.7	43.8
7 - 12	11.0	11.9	12.9	43.4	54.5	6.5	21.5
13 +	24.0	16.8	14.6	14.2	15.2	18.0	17.0
Total N	100	101	171	106	99	139	716

TABLE 6
VARANASI
DEMOGRAPHIC CHARACTERISTICS OF TREATMENT ADMISSIONS
PERCENT OF ADMISSION
OCTOBER 1992 - SEPTEMBER 1993

Characteristic	Oct-Dec 1992	Jan-Mar 1993	Apr-June 1993	Jul-Sept 1993	Total
	(N=60)	(N=50)	(N=25)	(N=51)	(N=185)
Sex					
Male	100.0	100.0	100.0	100.0	100.0
Female	-	-	-	-	-
Age (in years)					
< 15	-	-	-	-	-
15 - 19	11.7	4.0	-	2.0	5.4
20 - 34	76.6	88.0	84.0	78.4	81.2
35 +	11.7	8.0	16.0	19.6	13.4
Marital Status					
Single	68.3	32.0	16.0	17.6	37.6
Separated	-	-	-	2.0	0.6
Married	31.6	68.0	84.0	80.4	61.8
Occupation					
Sales workers	16.7	10.0	12.0	11.8	13.0
Drivers	6.6	4.0	8.0	5.9	6.0
Cultivators	6.6	16.0	16.0	7.8	10.7
Unemployed	25.0	28.0	12.0	27.4	24.7
Small business	41.7	34.0	32.0	21.6	32.7
Students	1.7	-	4.0	2.0	1.6
Others	1.7	8.0	16.0	23.5	11.3

Characteristic	Oct-Dec 1992	Jan-Mar 1993	Apr-June 1993	Jul-Sept 1993	Total
	(N=60)	(N=50)	(N=25)	(N=51)	(N=185)
No. of people in household					
Alone	-	-	-	-	-
2 - 5	30.0	22.0	24.0	20.0	24.7
6 - 10	63.3	56.0	68.0	62.9	51.8
11 +	6.7	22.0	8.0	17.1	13.5
Education (in years)					
< 6	14.0	14.0	24.0	15.7	15.9
6 - 12	12.0	18.0	16.0	15.7	15.3
> 12	60.0	60.0	36.0	47.1	52.8
No schooling	14.0	8.0	24.0	21.6	15.9
Total	60	50	25	51	176

TABLE 7
VARANASI
CHARACTERISTICS OF DRUG USE OF PATIENTS IN DRUG TREATMENT
PERCENT OF ADMISSION
OCTOBER 1992 - SEPTEMBER 1993

Characteristic	Oct-Dec 1992	Jan-Mar 1993	Apr-June 1993	Jul-Sept 1993	Total
	(N=60)	(N=50)	(N=24)	(N=51)	(N=186)
Primary Drug of Abuse					
Opium	-	-	-	-	-
Heroin	95.0	100.0	96.0	96.0	96.8
Sedative	3.3	-	-	2.0	1.6
Solvent	1.7	-	-	-	0.5
Alcohol	-	-	4.0	-	0.5
% Poly drug users	1.7	4.0	12.0	5.9	4.9
Route of Drug Administration					
Inhalant	10.0	40.0	-	-	5.9
Injection	3.3	-	-	2.0	1.8
Oral	-	10.0	4.0	2.0	4.3
Smoking	86.7	50.0	96.0	96.0	78.0
Drug Sources					
Street sale	91.7	96.0	100.0	98.0	95.7
Medical staff	8.3	4.0	-	2.0	4.3
Total	60	50	25	51	186

TABLE 8
MADRAS
DEMOGRAPHIC CHARACTERISTICS OF PATIENTS ADMITTED INTO SPECIALISED DRUG TREATMENT
PERCENT OF ADMISSION
OCTOBER 1992 - MARCH 1993

Characteristic	Oct - Dec 1992	Jan - Mar 1993	Total
	(N = 141)	(N = 132)	(N = 273)
Sex			
Male	NA	132 (100.0)	132 (100.0)
Female	-	-	-
Age			
< 15	-	-	-
15 - 19	1 (0.7)	-	1 (0.3)
20 - 34	75 (53.1)	77 (58.3)	152 (55.7)
> 35	65 (46.1)	55 (41.7)	120 (44.0)
Marital Status			
Single	38 (27.1)	30 (22.9)	68 (25.0)
Married	100 (71.4)	100 (76.3)	200 (73.5)
Separated/divorced	-	1 (0.8)	1 (0.4)
Widowed	1 (0.7)	-	2 (0.7)
Others	1 (0.7)	-	1 (0.4)
Female	-	-	-
Occupation			
Professionals	7 (4.9)	22 (16.6)	29 (10.6)
Administrators	1 (0.7)	-	1 (0.4)
Sales workers	7 (4.9)	4 (3.0)	11 (4.0)
Drivers	-	11 (8.3)	11 (4.0)
Cultivators	2 (1.4)	2 (1.5)	2 (0.7)
Unemployed	13 (9.2)	13 (9.8)	26 (9.5)
Small business	11 (7.8)	9 (6.8)	20 (7.3)
Student	2 (1.4)	2 (1.5)	4 (1.5)
Others *	98 (69.5)	69 (52.3)	167 (61.2)

* (Coolies, Welders, helpers)

Characteristic	Oct - Dec 1992	Jan - Mar 1993	Total
	(N = 141)	(N = 132)	(N = 273)
No. of people in household			
Alone	2 (1.4)	11 (8.3)	13 (4.8)
2 - 5	91 (65.4)	99 (75.0)	190 (70.1)
6 - 10	43 (30.9)	22 (16.6)	65 (24.0)
> 11	3 (2.1)	-	3 (1.1)
Education			
Zero	9 (6.4)	11 (8.3)	20 (7.3)
1 - 6	43 (30.5)	38 (28.8)	81 (29.7)
7 - 12	75 (53.2)	69 (53.3)	144 (52.7)
13 +	14 (9.9)	14 (10.6)	28 (10.2)

TABLE 9
MADRAS
CHARACTERISTICS OF DRUG USE AMONG DRUG USERS IN TREATMENT FACILITIES
PERCENT OF ADMISSIONS
OCTOBER 1992 - MARCH 1993

Characteristic	Oct - Dec 1992	Jan - Mar 1993	Total
	(N = 141)	(N = 132)	(N = 273)
Primary druge of abuse			
Opium	1 (0.4)	-	1 (0.2)
Morphine	4 (1.6)	-	4 (0.9)
Heroin	31 (12.6)	31 (15.3)	61 (13.6)
Synthetic narcotics	20 (8.1)	6 (2.9)	26 (5.8)
Cannabis	51 (20.7)	38 (18.8)	89 (19.9)
Hallucinogens	1 (0.4)	2 (0.9)	3 (0.7)
Sedatives	6 (2.4)	2 (0.9)	8 (1.8)
Minor tranquiliser	12 (4.9)	14 (6.9)	26 (5.8)
Alcohol	117 (47.5)	109 (53.9)	226 (50.5)
Others	3 (1.2)	-	3 (0.7)
Route of use			
Inhalantion	12 (5.4)	12 (5.0)	24 (5.2)
Injection	29 (13.0)	10 (4.2)	39 (8.5)
Oral	122 (54.9)	117 (49.3)	239 (52.1)
Smoking	49 (22.0)	98 (41.3)	147 (32.0)
Sniffing	1 (0.4)	-	1 (0.2)
Others	9 (4.0)	-	9 (1.9)
% Poly Drug User	54 (38.2)	48 (36.3)	102 (37.4)

TABLE 10
NEW DELHI
DEMOGRAPHIC CHARACTERISTICS OF PATIENTS ADMITTED INTO SPECIALISED DRUG TREATMENT
PERCENT OF ADMISSION
JULY 1992 - MARCH 1993

Characterictics	July-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Total
	(N = 183)	(N = 195)	(N = 224)	(N = 419).
Sex				
Male	N.A.	195 (100.0)	224 (100.0)	419 (100.0)
Female				
Age				
< 15	-	-	2 (1.3)	2 (0.5)
15 - 19	11 (7.8)	5 (3.7)	9 (5.7)	25 (5.8)
20 - 34	101 (71.6)	97 (71.3)	122 (77.7)	320 (73.7)
> 35	29 (20.6)	34 (25.0)	24 (15.3)	87 (20.0)
Marital Status				
Single	56 (48.3)	59 (43.7)	59 (37.6)	174 (42.5)
Separated	4 (3.4)	2 (1.5)	13 (8.3)	19 (4.6)
Married	56 (48.3)	74 (54.8)	85 (54.1)	215 (52.7)
Widowed	-	-	-	-
Other	-	1	-	1 (0.2)
Occupation				
Professionalis	9 (6.3)	32 (23.5)	10 (6.4)	51 (11.8)
Administrators	1 (0.7)	-	-	1 (0.2)
Sales workers	22 (15.4)	1 (0.7)	8 (5.1)	31 (7.1)
Drivers	21 (14.7)	29 (21.4)	29 (18.5)	79 (18.1)
Cultivators	1 (0.7)	-	-	1 (0.2)
Unemployed	10 (7.0)	28 (20.6)	14 (8.9)	52 (11.9)
Small business	43 (30.0)	31 (22.8)	60 (38.2)	134 (30.7)
Students	-	-	1 (0.6)	1 (0.2)
Others	36 (25.2)	15 (11.0)	35 (22.3)	86 (19.7)

Characterictics	July-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Total
	(N = 183)	(N = 195)	(N = 224)	(N = 419)
No. of people in household				
Alone	8 (5.7)	8 (5.9)	16 (10.2)	32 (7.4)
2 - 5	66 (46.8)	93 (68.4)	65 (41.4)	224 (51.6)
6 - 10	63 (44.7)	32 (23.5)	76 (48.4)	171 (39.4)
> 10	4 (2.8)	3 (2.2)	0	7 (1.6)
Education				
None	10 (7.1)	31 (22.8)	23 (14.6)	64 (14.7)
< 6	57 (40.4)	27 (19.9)	45 (28.7)	129 (29.7)
6 - 12	54 (38.3)	52 (38.2)	67 (42.7)	173 (39.9)
> 12	20 (14.2)	26 (19.1)	22 (14.0)	68 (15.7)

TABLE 11
NEW DELHI
CHARACTERISTICS OF DRUG USE AT TREATMENT ADMISSIONS
JULY 1992 - MARCH 1993

Characterictics	July-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Total
	(N = 183)	(N = 195)	(N = 224)	(N = 602)
Primary drug of abuse				
Opium	14 (8.7)	1 (0.8)	10 (8.5)	25 (6.2)
Morphine	3 (1.9)	1 (0.8)	-	4 (1.0)
Heroin	86 (53.7)	66 (53.6)	64 (54.7)	216 (54.0)
Codeine/ pethedine	1 (0.6)	9 (7.3)	8 (6.8)	18 (4.5)
Cannabis	8 (5.0)	2 (1.6)	-	10 (2.5)
Sedative	4 (2.5)	2 (1.6)	-	6 (1.5)
Solven	-	2 (1.6)	-	2 (0.5)
Alcohol	37 (23.1)	30 (24.3)	31 (26.4)	98 (24.5)
Benzodiazepines	-	10 (8.1)	4 (3.4)	14 (3.5)
Other	7 (4.4)	-	-	7 (1.6)
% poly drug user	60 (32.7)	17 (8.7)	40 (17.8)	117 (19.4)
Route of use				
Inhalantion	33 (17.5)	40 (29.4)	31 (19.3)	104 (21.5)
Injection	10 (5.3)	13 (9.5)	33 (20.6)	56 (11.6)
Oral	53 (28.1)	20 (14.7)	90 (56.2)	163 (33.7)
Smoking	40 (21.2)	56 (41.1)	3 (1.8)	99 (20.4)
Sniffing	21 (11.1)	-	-	21 (4.3)
Other	31 (16.4)	7 (5.1)	3 (1.8)	41 (8.5)
Drug sources				
Street sales	35 (83.7)	124 (91.1)	150 (95.5)	309 (92.2)
Diversion of prescription	2 (4.7)	9 (6.6)	3 (1.9)	14 (4.2)
Other	5 (11.9)	3 (2.2)	4 (2.5)	12 (3.6)

TABLE 12
COLOMBO
QUANTITY OF DRUG SEIZED BY DRUG TYPE
JANUARY 1992 - MAY 1993

Drug Type	Jan-Mar 1992	Apr-June 1992	Jul-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-May 1993	Total
Opiate (kg)	3.95	3.02	3523.62	98.40	93.15	5700.31	9422.46
Cannabis (kg)	384.95	229.17	9122.15	45002.59	58072.89	13006.93	126818.68

TABLE 13
DHAKA
QUANTITY OF DRUG SEIZED BY DRUG TYPE
JANUARY 1992 - JUNE 1993

Drug Type	Jan-Mar 1992	Apr-June 1992	Jul-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-May 1993	Total
Opiate (in kg)	0.475	1.615	4.8	8.07	1.07	7.63	23.66
Cannabis (in kg)	232	180.5	172	527.8	270	553	1.935
Cocaine (kg)	1.5	-	-	-	0.22	-	1.72
Sedative (pills)	-	-	-	18	95	-	113
Solvent		-	-	1577	332.4	293.2	2202.6
Codeine	357.1	605	169.6	299.6	752.4	703.1	2886.8
Illicit distillation (in litres)	14265	4353	4843.4	-	-	-	10622.4
Country liquor	783	52	104.5	2507.8	9877.2	7993.9	21381.4
Spirits	13801	2260	690.4	-	-	-	4330.4
Foreign liquor	330	214	232	10	-	-	784
Pethedine	2.3	-	-	-	-	-	2.3

TABLE 14
DHAKA
HEALTH INDICATORS
JANUARY 1992 - JUNE 1993

Indicators	Jan-Mar 1992	Apr-June 1992	Jul-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-May 1993	Total
Traffic Accidents							
Alcohol-related	3	6	2	-	2	5	18
Narcotic-related	18	16	26	8	22	20	110
Other psycho substances	-	-	10	3	5	4	22
Drug-related psychological cases	6	8	8	12	5	11	50
Drug-related emergency room cases	30	190	113	NC	NC	NC	333
Drug-related death	-	-	1	-	-	-	-

NC - Not collected

TABLE 15
DHAKA
SOCIAL INDICATORS
JANUARY 1992 - JUNE 1993

Indicators	Jan-Mar 1992	Apr-June 1992	Jul-Sept 1992	Oct-Dec 1992	Jan-Mar 1993	Apr-May 1993	Total
No. of person disharged	8	16	11	12	7	18	72
No. of spouse separations	3	4	4	10	1	4	26
No. of student dropouts	12	19	20	15	17	9	96

TABLE 16
VARANASI
SOCIAL INDICATORS
JANUARY 1992 - SEPTEMBER 1993

Indicator	Jan-Mar 1993	Apr-Jun 1993	Jul-Sept 1993	Total
Family member expelled	-	-	4	4
Spouse separations	-	-	1	1
Other family disruptions	-	1	-	1
No. of persons fined/discharge	2	1	-	3
Students expelled	-	4	-	4
Student dropouts	-	3	-	3

TABLE 17
NEW DELHI
SOCIAL HEALTH AND INDICATORS
JULY 1992 - MARCH 1993

Indicators	Jan-Mar 1992	Apr-Jun 1992	Jul-Sept 1993	Total
Health				
Drug-related psychological cases	62	52	54	168
Drug-related deaths	-	6	6	12
Social				
Persons fired/ discharged	195	NA	NA	195
Family disruptions	117	113	80	310

AN ANALYSIS OF DRUG ABUSE PATTERNS AND TRENDS OF SELECTED EAST ASIAN CITIES

Centre for Drug Research
Universiti Sains Malaysia

ABSTRACT

Drug use patterns varied between the three East Asian cities: Kuala Lumpur, Jakarta and Manila. Drug treatment and law enforcement data were collected using a standardised instrument. Heroin was the most widely used illicit substance in Kuala Lumpur. In Jakarta, abuse of cannabis, sedatives and alcohol among adolescents was a common feature. Opiate use was rare. Polydrug use of amphetamines, alcohol, cannabis and cough syrups was widespread in Manila. The socio-demographic profile of drug dependents reported also differed between the cities. Drug abusers detected in Kuala Lumpur were older (above twenty) and were primarily heroin users, while in the other two cities a significantly larger proportion of treatment admissions were adolescents. Law enforcement indicators varied between the cities. The types and quantity of drugs that were seized differed between Kuala Lumpur and Manila.

METHOD

Using a standardised instrument, members of the Asian Multi-City Epidemiology Work Group collect information on a number of epidemiological indicators. These include drug treatment and law enforcement data, drug-related health indicators and social factors. Data in these core categories are reviewed on a quarterly basis.

SOURCES AND TYPES OF DATA REPORTED

The number of quarterly reports received from participating cities varies. Manila has provided the most up to date reporting (July 1992 - March 1994). Kuala Lumpur has submitted reports from July 1992 to December 1993. Jakarta on the other hand only reported annual figures for year 1993.

Data sources differed between the three cities. Kuala Lumpur reported aggregated data on all drug dependents who were contacted by governmental agencies (i.e. police, prison, treatment centres, etc.). Jakarta and Manila had submitted data of patients admitted into specialised drug treatment centers. Comparability of drug abuse between the cities was limited due to this variation in sources of information. Nevertheless the use of a standardised instrument had facilitated the collection of data of selected core drugindicators. In spite of the difference in data source some common features, as well as city variations, could be inferred from the available information.

Data on social and health indicators were lacking in all three cities. Manila was the only city that has records on psychological cases.

DEMOGRAPHIC CHARACTERISTICS OF CITIES

A comparison of selected demographic characteristics of the cities is presented in Exhibit 1. Jakarta has the largest population size of over eight million. The distribution of males and females are similar between Kuala Lumpur and Jakarta with each having a larger percentage of males. Manila has a larger proportion of females. There are some variations in the distribution of age groups. Manila has a comparatively larger percentage (53.5%) of total population that are less than twenty years old and are married (54.8%) when compared to the other cities. On the distribution of years of education, there is a significant difference between the three cities. Jakarta has a larger percentage (46%) of people who have seven or more years of education. The number of people in the household varies among the cities where data is available. In Manila, majority have more than five people in the household while in Jakarta, majority have 2-5 people. Information on other indicators such as occupation, and per capita income were not reported by most of the cities.

CROSS-CITY COMPARISON

Total Number of Drug Dependents Reported

Reporting sources varied between the cities. Kuala Lumpur had reports of all drug dependents identified by both treatment and law enforcement agencies. No distinction was made between the two categories. In the case of Jakarta and Manila, information was obtained from treatment admissions.

A total of 5,086 cases (or 449.7 per 100,000 population) were identified from July 1992 to December 1993, in Kuala Lumpur, of which 1,741 (or 34.2%) were new cases and the rest (3,345) were old cases. The numbers that were identified fluctuated over the quarters with a peak of 1156 cases in the quarter of July - September 1993 (Exhibit 2). There was a gradual increase in new cases contacted.

In Manila, a total of 736 treatment admissions were reported over the period July 1992 to March 1994. A majority (87.5%) were new admissions. There were some minor fluctuations in total numbers admitted for treatment over the various quarters from July 1992 to December 1993. However, a very drastic increase was observed for the first quarter of 1994, i.e. from 42 cases in last quarter of 1993 to 288 cases (Exhibit 3).

A total of 2,238 cases were admitted into specialised drug treatment facilities in 1993 in Jakarta. There was no break-down by quarters.

Patient Socio-Demographic Characteristics

Although the overall population showed that the proportion of male and female citizen in each city were almost equal (52%: 48%), the distribution of patients admitted into specialised drug treatment centres showed a predominance of male. More than 95%, except Manila (89%), of the patients were male (Exhibit 4).

On the other hand, distributions of age and occupation differed substantially between the three cities. Adolescent substance abuse was a main feature in Jakarta. Slightly more than half (52%) of admissions were less than 20 years of age. In Manila, a sizeable proportion (28%) of patients treated were also teenagers (Exhibit 5). Kuala Lumpur, on the other hand, had reported only 5% of drug dependents who were less than 20 years of age. A great majority (95%) were above twenty with the largest proportion (67.6%) of those who were between 20 and 34 years. Jakarta and Manila had significantly less of the older age groups (48% and 73% respectively). Most of the drug abusers in Jakarta were students (62.6%). Another one-third were unemployed. In the case of Manila, the employed addicts that were treated were 44%, 45.4% unemployed and 10.6% students. Kuala Lumpur had the largest proportion of employed (85.5%) with the rest unemployed (14.5%) (Exhibit 6). These contrasting characteristics (in terms of age and occupational background) suggest the substantial

difference in the background of abusers and the nature of the drug abuse problem between the cities. This is an indication of the types of drug dependents that were contacted by treatment facilities or other governmental agencies in each city. They may or may not represent the general drug abuse population within each city.

Information on years of educational attainment was available for Kuala Lumpur and Manila. A majority (69.1%) in Manila had between six and twelve years of education. Manila had a larger (21.5%) percentage of those who had more than twelve years of education when compared to Kuala Lumpur (Exhibit 7).

Jakarta and Manila had collected data on marital status of their patients. Ninety five percent of admissions in Jakarta were unmarried. In Manila a larger (26.5%) percentage were married (Exhibit 8).

Pattern of Drug Use

The types of drugs that were abused varied substantially between the cities (Exhibit 9). Heroin was the primary drug of abuse of a great majority (about 90%) of addicts reported in Kuala Lumpur. A small percentage were cannabis users. This is an indication that addicts that were contacted and registered in Kuala Lumpur were hard drug users who had progressed from use of other gateway drugs such as cannabis to heroin. Primary abusers of other drugs such as amphetamines, solvents, etc. are not recorded in this register.

The common drugs used by the adolescents in Jakarta were tobacco (41.1%), cannabis (22.1%) and sedatives (27.8%). Opiate use was rarely mentioned. Polydrug use was reported by 23.3% of patients. This involved the use of various combinations of cannabis, sedatives and alcohol.

Polydrug use of a wide range of drugs was the main feature of drug abuse among patients treated in Manila. One hundred percentage had reported such a habit. Among the various types of drugs that were mentioned, amphetamines (57.9%), alcohol (43.8%), cough syrups (39.4%) and cannabis (38.2%) recorded the highest numbers. Solvents (9.0%) and benzodiazepines (5.1%) were reported by a smaller proportion of patients.

Route of Drug Administration

Comparison of the modes of drug administration is limited because the available information is not drug specific. In cities where the types of drugs are not diverse, such as heroin in Kuala

Lumpur this indicator is useful. For example, in Kuala Lumpur, "chasing the dragon" was reported by more than half (55.6%) of the drug dependents contacted over the reporting period (Exhibit 9 and Exhibit 10). Injecting drug use was found among a sizeable percentage (23.9%) of abusers followed by smoking (16.1%). This pattern was observed over the whole reporting period (July 1992 to December 1993). There were some discrepancies in the quarter of January - March 1993. Twenty percent did not specify their mode of drug use. The route of drug administration reported by patients in Jakarta was characteristic of the types of drug that were used. Smoking (of tobacco and cannabis), and oral use (of sedatives) were most frequently mentioned. A sizeable proportion (23.5%) did not specify the mode of drug administration.

Drug Sources

Information on drug sources was available in Kuala Lumpur and Manila. Street sales was the primary source reported in Manila (i.e. 72-81%). In Kuala Lumpur, street sales and friends were the two major sources over the various quarters (Exhibit 11).

Drug-Related Offences

Information on drug-related offences was reported by Kuala Lumpur and Manila. The total number and rate per 100,000 of persons arrested for drug-related offenses varied significantly between these two cities. These differences may be a reflection of the extent of policy activity or law enforcement in each city. The wider policy and legal aspects relating to drug abuse may also be influencing factors.

Between July 1992 and December 1993, 3,417 persons (or 302.1 per 100,000) were arrested for drug-related offences in Kuala Lumpur. About 42 percent were for drug possession. Arrests for sales (22.6%) and trafficking (14.3%) and use (9.2%) were other major categories. The fluctuations in number of person arrested over the various quarters was most likely influenced by the change in police activity (Exhibits 12 and 13).

The total number of drug offences reported was substantially smaller in Manila. A total of (837) persons (or 44.6 per 100,000) were arrested between July 1992 to March 1994. Most were arrested for consumption (33.7%) and sales (27.1%). Possession and trafficking of drugs were also common. The numbers varied substantially over the different quarters, with a majority being arrested over the last two quarters of 1992 and 1993 (Exhibits 14 and 15).

Drug Seizures

Data on quantity of drugs seized were reported by Kuala Lumpur and Manila. Information on number of seizures varied between the two cities. A wide range of drugs were seized in Kuala Lumpur over the reporting period (Exhibit 16). They include opiate (29.5 kg), cannabis (56.1 kg), hallucinogen/amphetamine type (about 13,673 pills), sedatives (1110 pills) and other psychotropic pills (14,144). The amounts of non-opiates (excluding cannabis) were concentrated in certain quarters. For example, hallucinogen/amphetamine type and sedatives were seized in the last two quarters of 1992 and the first quarter of 1993. Other psychotropic pills were dominant in the last three quarters.

In Manila, cocaine was the major drug seized followed by cannabis (66 kg and 45.9 kg, respectively). A small amount of amphetamines were also seized. Most seizures of cocaine and cannabis were concentrated in a certain quarter, with very little in the rest of the other quarters (Exhibit 17).

Health and Social Indicators

Information on these indicators was lacking in all three cities. Only Manila reported data on psychological cases detected over July 1992 to March 1994. A total of 102 such cases were recorded over the whole reporting period. It ranged from five to as high as twenty three cases identified in a quarter (Exhibit 18).

EXHIBIT 1

GENERAL POPULATION DEMOGRAPHIC INDICATORS

CHARACTERISTIC	K. LUMPUR 1986	MANILA 1991	JAKARTA 1990
TOTAL POPULATION	1,131,000	1,876,195	8,222,515
	%	%	%
SEX			
MALE	51.6	47.8	51.0
FEMALE	48.4	52.2	49.0
AGE			
<15	36.7	43.4	35.0
15 - 19	13.2	10.1	10.0
20 - 34	37.3	22.9	25.0
35 +	12.8	23.5	30.0
MARITAL STATUS			
SINGLE	50.6	44.8	NA
SEPARATED	0.8	0.5	NA
MARRIED	44.8	54.8	NA
WIDOWED	3.8	3.9	NA
OTHER			
OCCUPATIONAL			
PROFESSIONAL	9.1	NA	NA
MANAGERIAL	2.4	NA	NA
CLERICAL	15.0	NA	NA
SALES WORKERS	1.1	NA	NA
SERVICE WORKERS	18.2	NA	NA
AGRICULTURE	13.7	NA	NA
PRODUCTION	33.1	NA	NA
OTHER	7.4	NA	NA
NUMBER OF PEOPLE IN HOUSEHOLD			
1	NA	3.0	0.4
2 - 5	NA	41.7	76.0
6 - 10	NA	48.2	23.0
11 +	NA	7.1	0.6
NUMBER OF YEARS OF EDUCATION			
0	24.7		
1 - 6	34.2 (0-6)	65.9 (0-6)	54.0
7 - 12	37.5	21.9	41.0
13 +	3.6	11.9	5.0

EXHIBIT 2

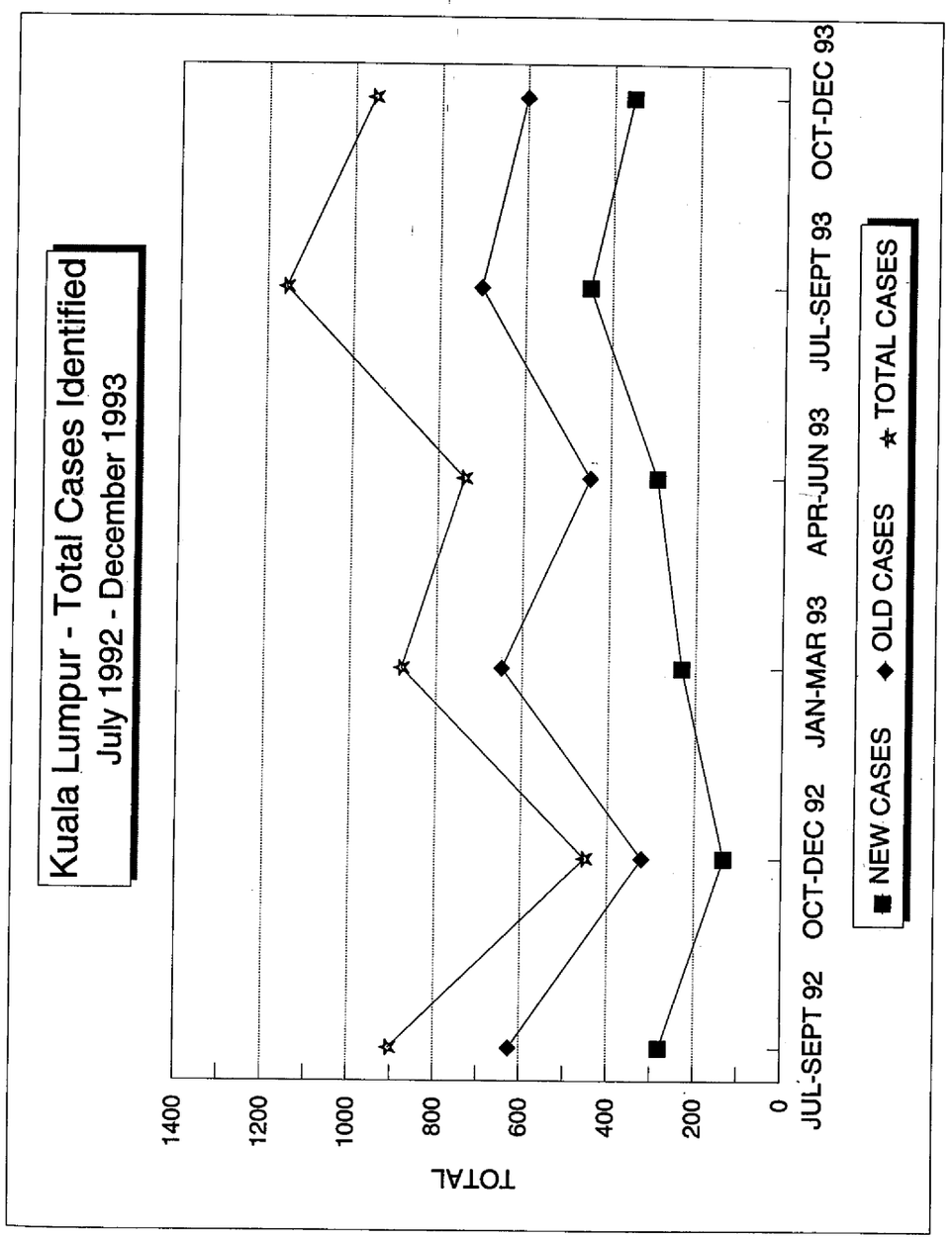


EXHIBIT 3

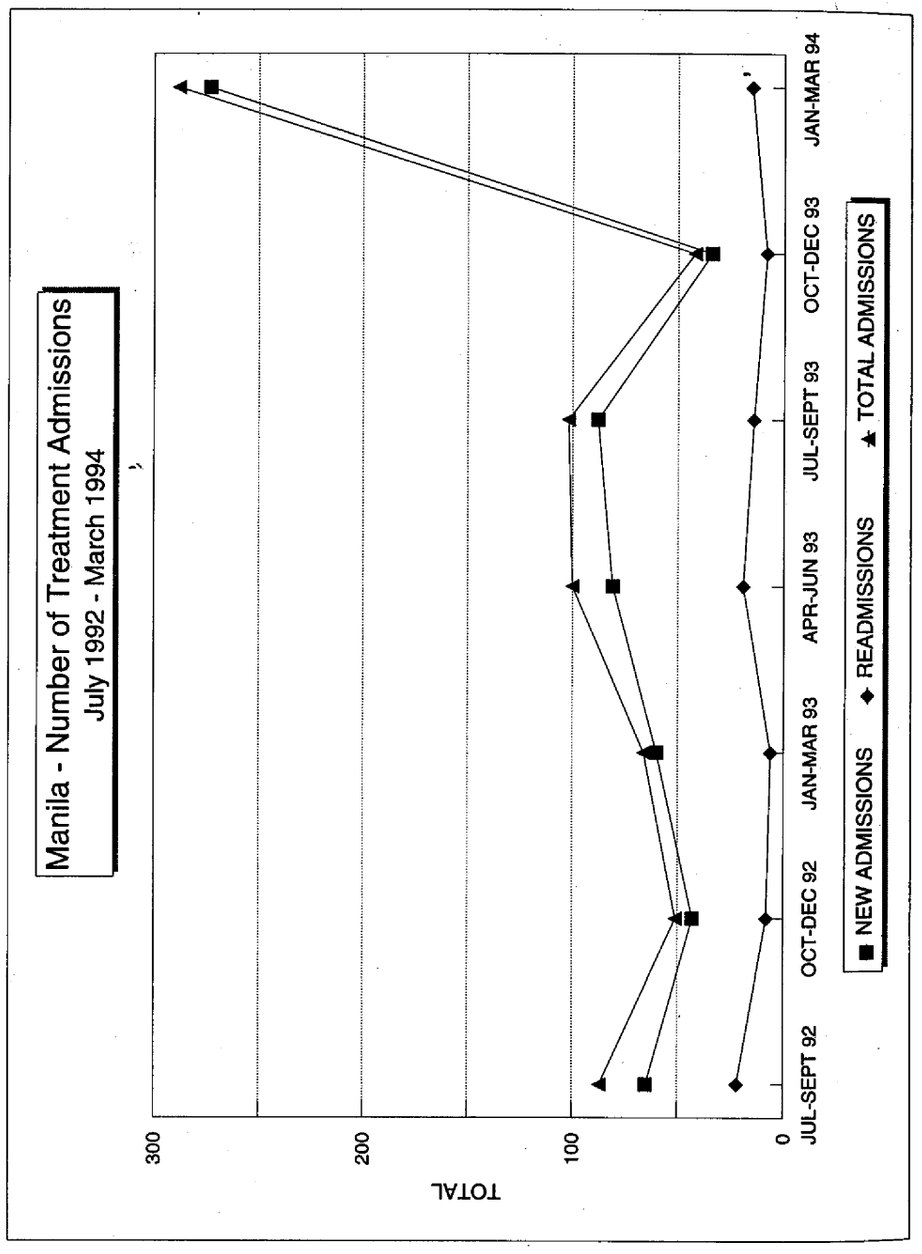


EXHIBIT 4

Demographic Characteristics of Drug Abusers Reported By City

CHARACTERISTIC	K.LUMPUR	JAKARTA	MANILA
	N = 5086 %	N = 2238 %	N = 644 %
SEX OF PATIENT			
MALE	96.8	95.5	89.4
FEMALE	3.2	4.5	10.6
PATIENT AGE			
< 15	0	10.6	5.1
15 - 19	4.5	41.4	22.8
20 - 34	67.6	43.9	57.8
> 34	27.8	4.0	14.9
N/S	0.1	0	0
PATIENT OCCUPATION			
EMPLOYED	85.5	5.4	44.0
UNEMPLOYED	14.5	32.0	45.4
STUDENTS	0	62.6	10.6
NUMBER OF YEARS OF EDUCATION			
< 6	25.7	NA	7.3
6-12	58.7	NA	69.1
> 12	11.9	NA	21.5
0	3.7	NA	0
N/S	0	NA	2.1
PATIENT MARITAL STATUS			
SINGLE	NA	95.1	60.8
SEPARATED	NA	0.1	6.7
MARRIED	NA	4.7	26.5
WIDOWED	NA	0	0.2
LIVE-IN	NA	0	5.9

EXHIBIT 5

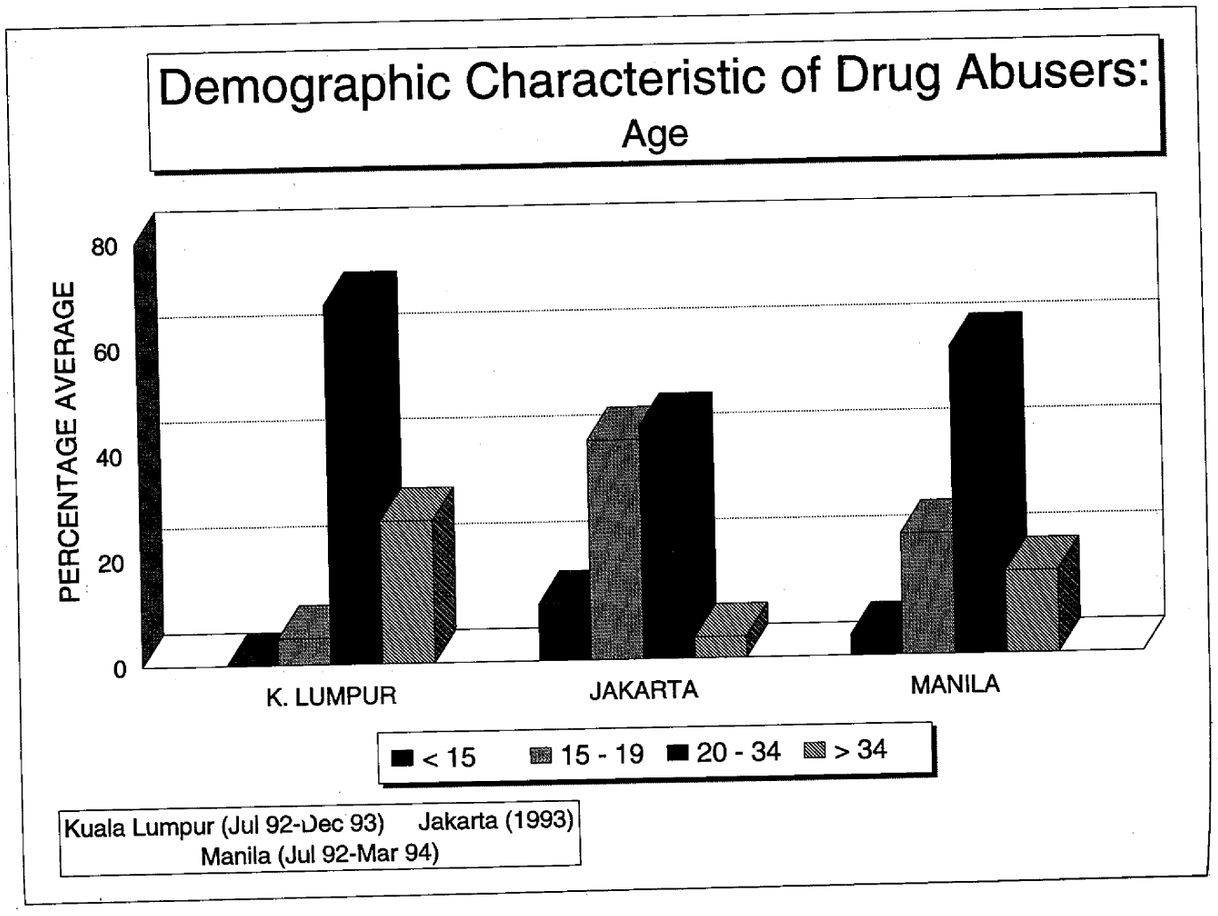


EXHIBIT 6

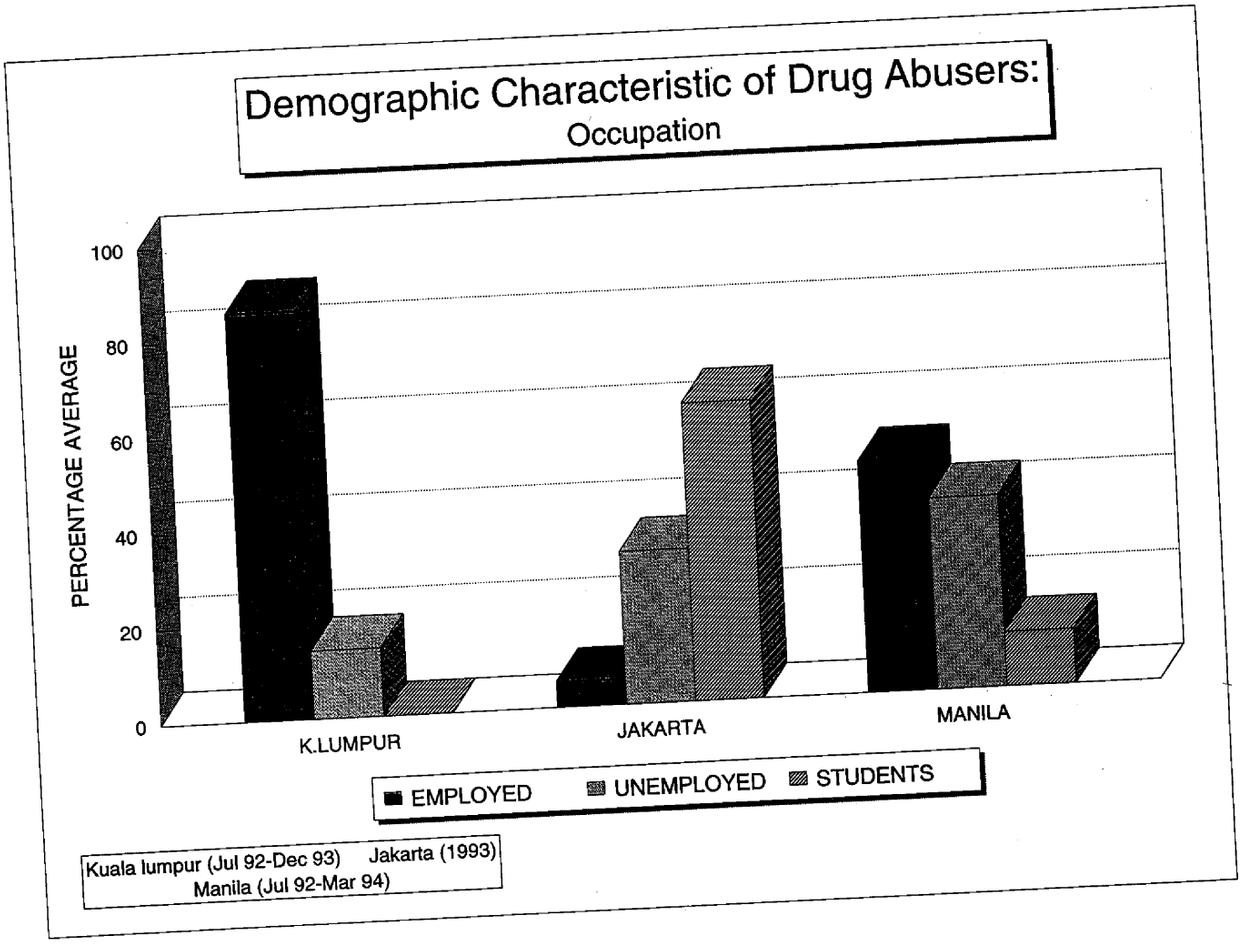


EXHIBIT 7

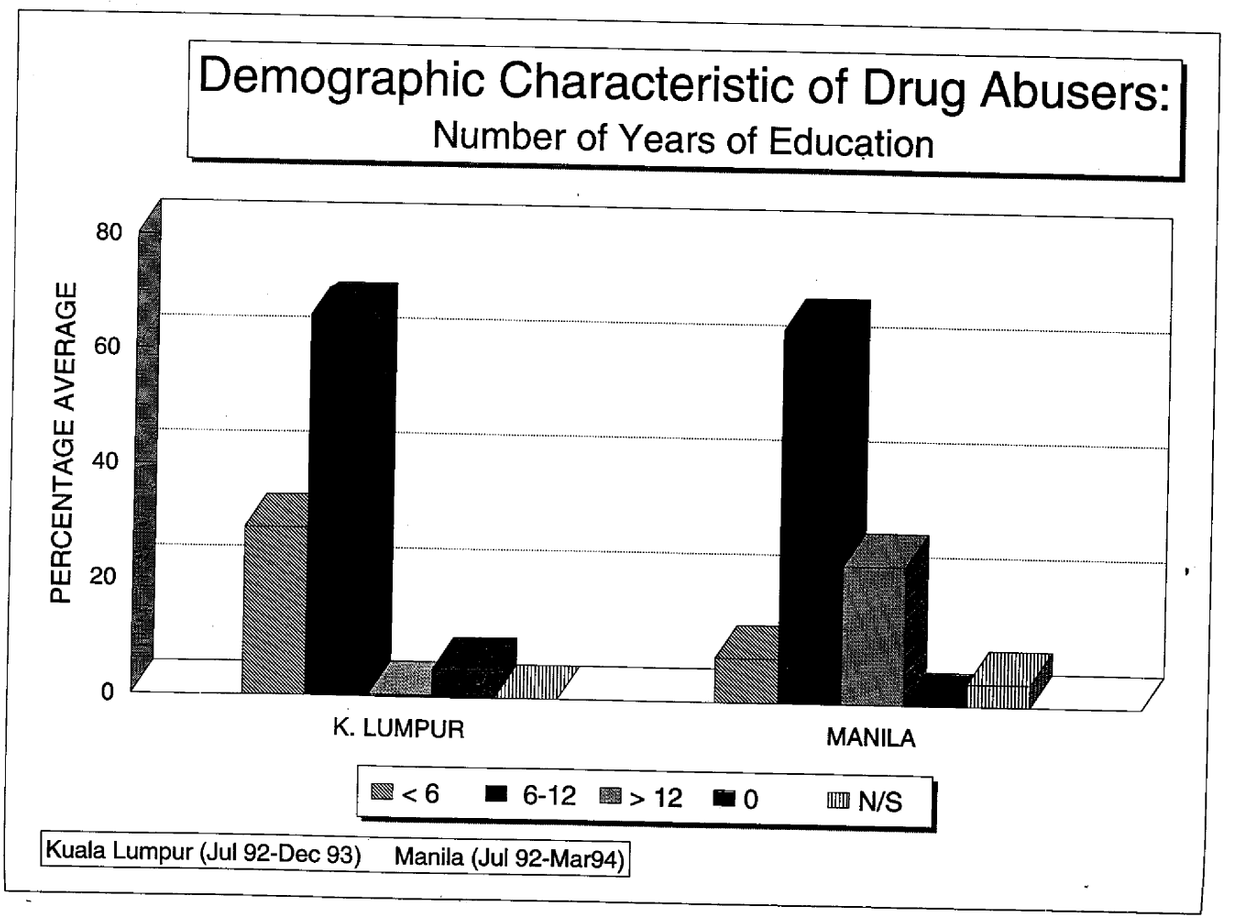


EXHIBIT 8

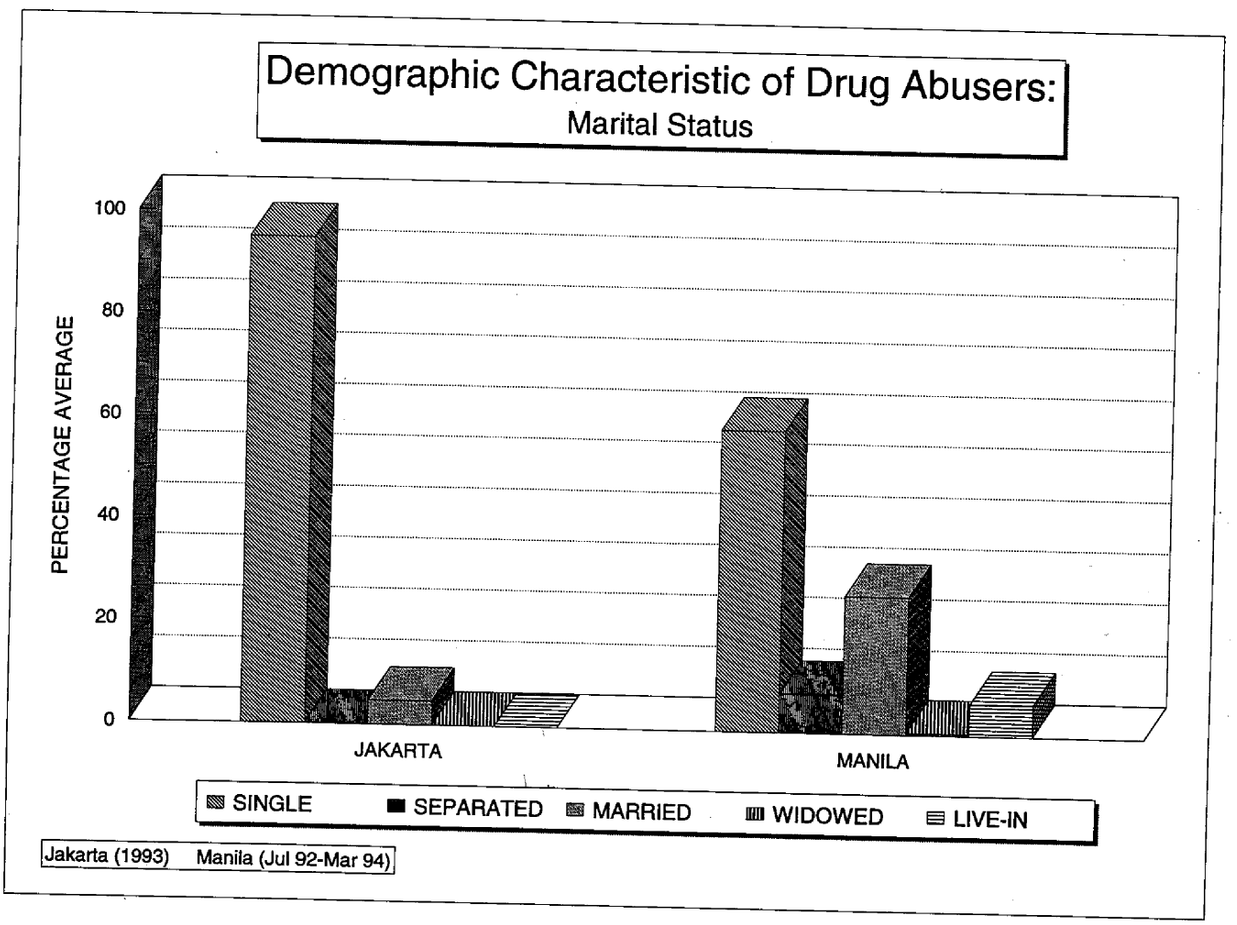


EXHIBIT 9

Types of Drugs Abused and Route of Drug Administration By City

CHARACTERISTIC	K.LUMPUR	JAKARTA	MANILA
	N = 5086 %	N = 2238 %	N = 644 %
PRIMARY DRUG OF ABUSE			
OPIATE TYPE		1.1	
OPIUM	0.1	-	0
MORPHINE	0.2	-	0
HEROIN	91.9	-	0
OTHERS	0	-	0
CANNABIS TYPE	7.7	3.5	38.2
COCAINE TYPE	0	0.1	2.5
HALLUCINOGENS	0.005	0	0.2
AMPHETAMINES	0.02	0	57.9
SEDATIVE TYPE	0	27.8	0.5
MINOR TRANQUILISERS	0.005	0	0.3
SOLVENTS	0.03	3.0	9.0
ALCOHOL	0.05	0	43.8
PSYCHOTROPIC SUBSTANCES	0.02	-	-
BENZODIAZEPINE	-	-	5.1
COUGH SYRUPS	0	0	39.4
OTHER	-	-	0.3
POLYDRUG USERS	-	23.3*	100.0
TOBACCO USERS	-	41.1	-
ROUTE OF ADMINISTRATION			
INHALATION	0.2	0	NA
INJECTION	23.9	0	NA
ORAL	0.5	31.9	NA
SMOKING	16.1	44.6	NA
SNIFFING	0.02	0	NA
CHASING THE DRAGON	55.6	0	NA
DRINKING	0.1	0	NA
OTHER	0	23.5	NA
N/S	3.5	0	NA

Note: * Mostly combined cannabis and sedatives/alcohol

EXHIBIT 10

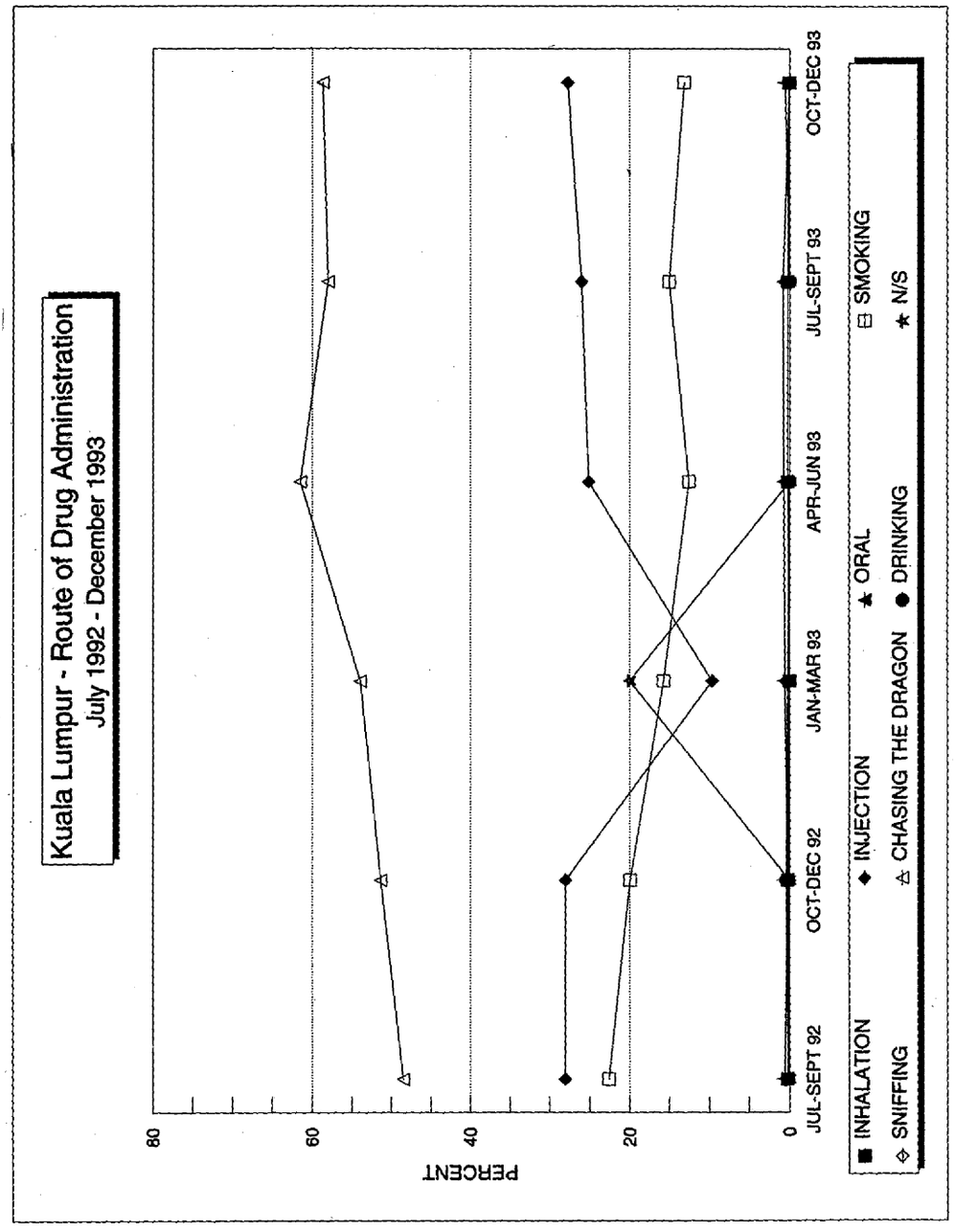


EXHIBIT 11

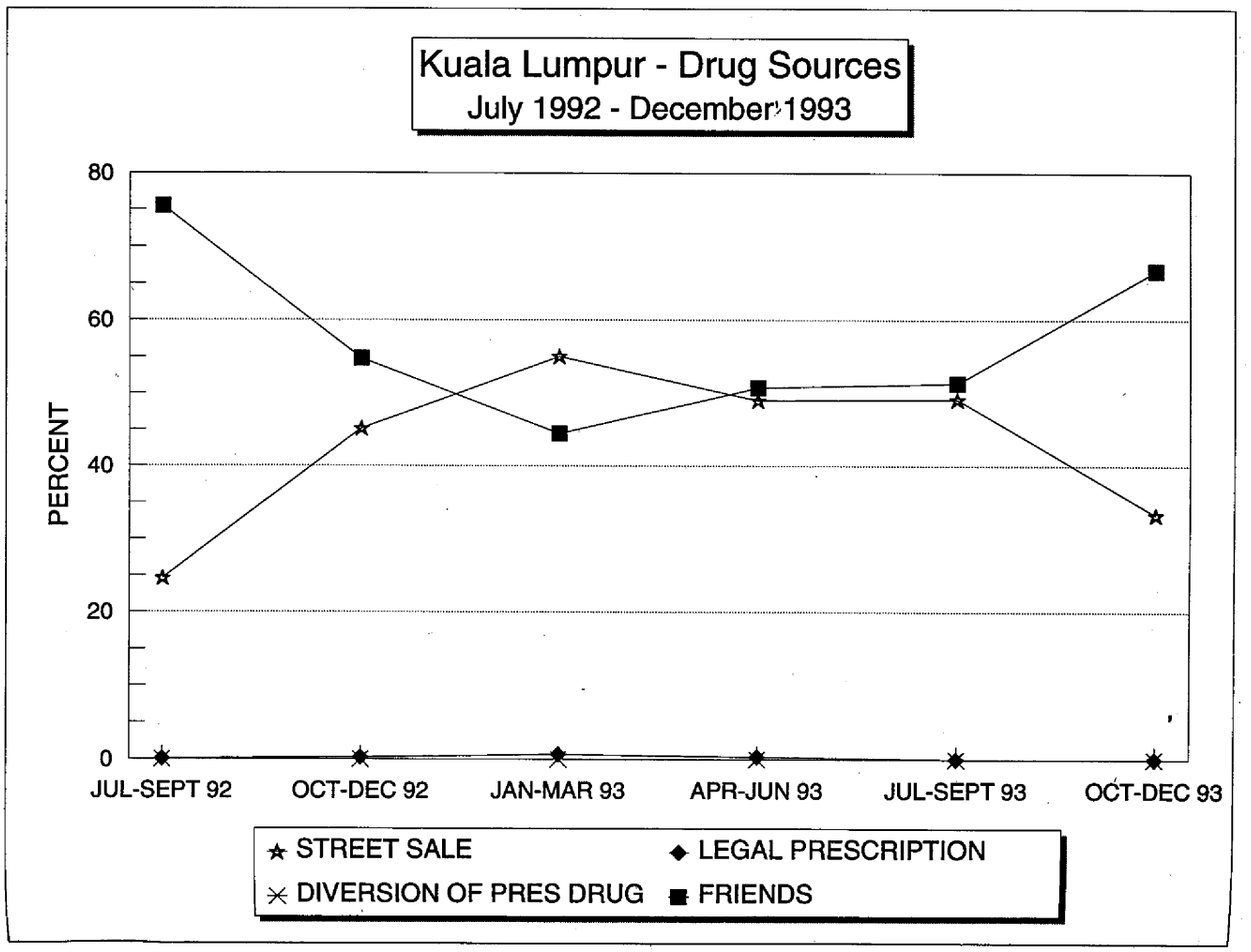


EXHIBIT 12

K. Lumpur: Number of Persons Arrested For Drug Related Offences

OFFENSES	JUL-SEPT 92	OCT-DEC 92	JAN-MAR 93	APR-JUN 93	JUL-SEPT 93	OCT-DEC 93	TOTAL
	N = 342 %	N = 426 %	N = 369 %	N = 857 %	N = 745 %	N = 678 %	N = 3417 %
ARRESTS FOR USE/CONSUMPTION	32.2	0	0	23.0	0.8	0.4	9.2
ARRESTS FOR POSSESSION	46.5	28.4	0	39.0	57.2	58.0	41.9
ARRESTS FOR SALES	0	0	45.3	26.0	25.6	28.5	22.6
ARRESTS FOR TRAFFICKING	21.3	16.4	19.0	9.3	16.0	11.5	14.3
ARRESTS FOR CONSPIRACY	0	23.0	0	0	0	0	2.9
OTHER	0	32.2	35.8	2.7	0.4	1.6	9.0

EXHIBIT 13

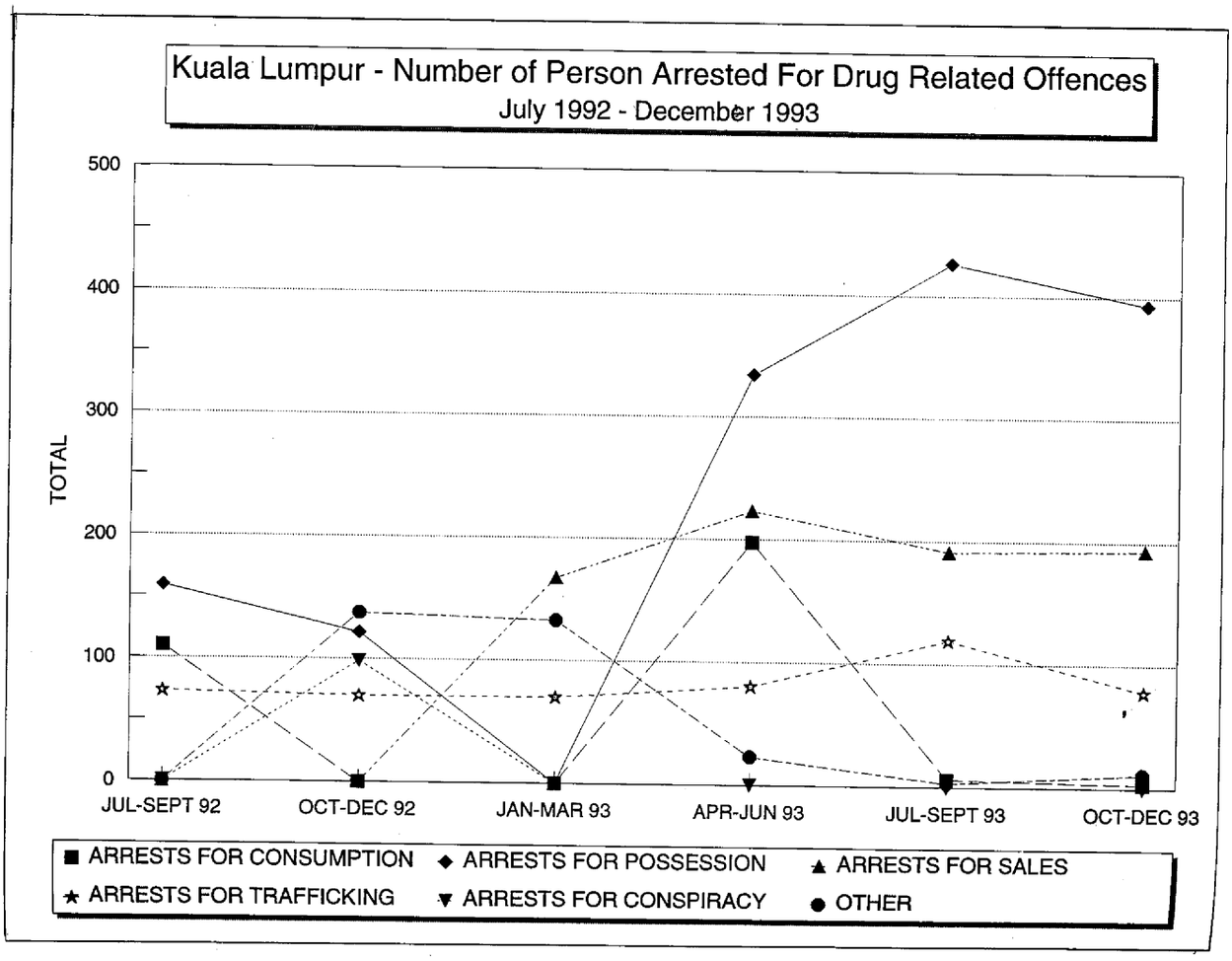


EXHIBIT 14

Manila : Number of Persons Arrested For Drug Related Offences

OFFENSES	JUL-SEPT 92	OCT-DEC 92	JAN-MAR 93	APR-JUN 93	JUL-SEPT 93	OCT-DEC 93	JAN-MAR 94	TOTAL
	N = 111 %	N = 198 %	N = 9 %	N = 1 %	N = 295 %	N = 187 %	N = 36 %	N = 837 %
ARRESTS FOR USE/CONSUMPTION	56.8	74.2	0	0	16.3	6.4	33.3	33.7
ARRESTS FOR POSSESSION	0	0	100.0	100.0	9.8	26.7	66.7	13.5
ARRESTS FOR SALES	13.5	25.8	0	0	29.2	40.1	0	27.1
ARRESTS FOR TRAFFICKING	24.3	0	0	0	20.7	21.9	0	15.4
ARRESTS FOR CONSPIRACY	5.4	0	0	0	24.1	4.8	0	10.3
OTHER	0	0	0	0	0	0	0	0

EXHIBIT 15

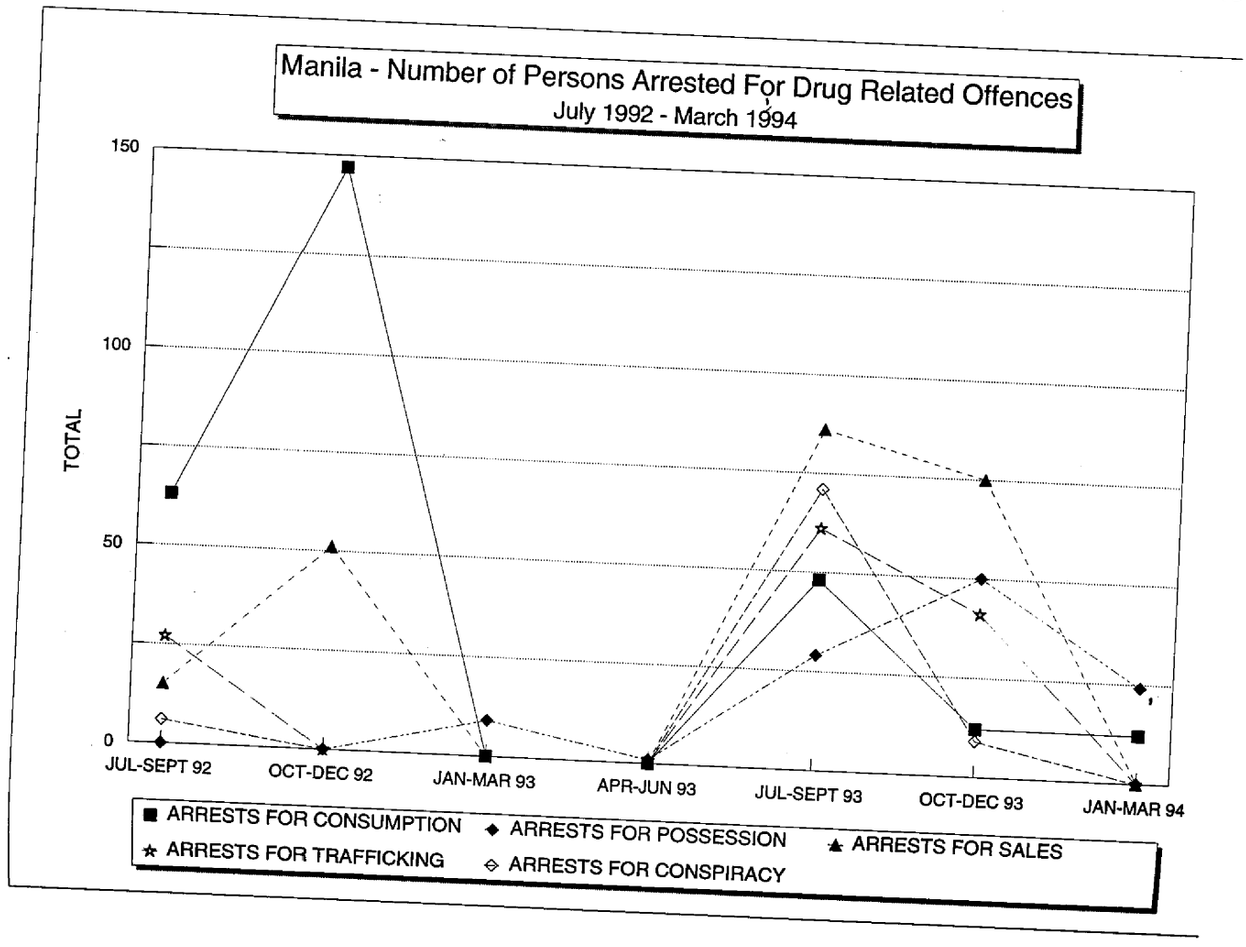


EXHIBIT 16

K. Lumpur : Quantity of Drug Seized By Drug Type

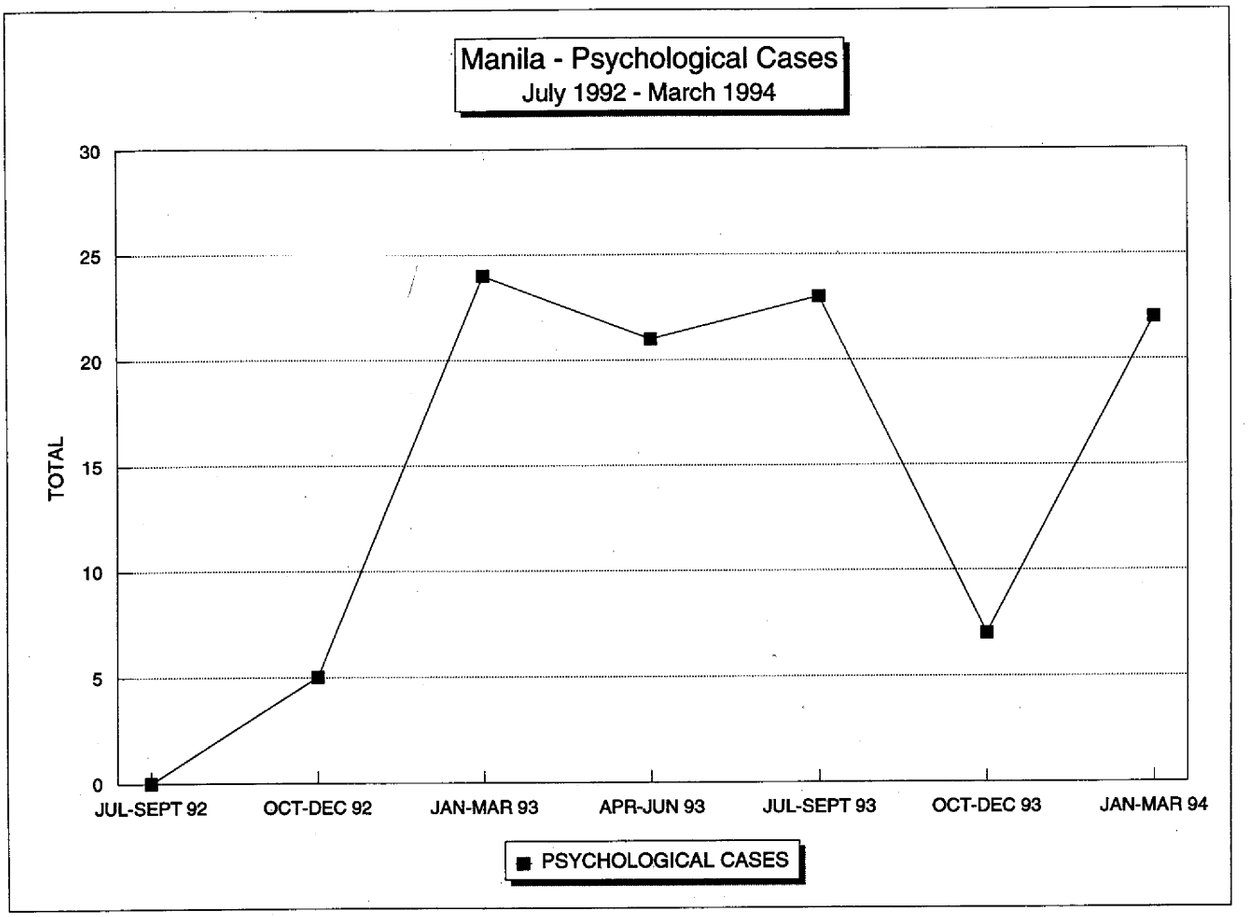
DRUG TYPE	JUL-SEPT 92	OCT-DEC 92	JAN-MAR 93	APR-JUN 93	JUL-SEPT 93	OCT-DEC 93	TOTAL
	N	N	N	N	N	N	N
OPIATE TYPE (kg)	11.10569	3.51258	1.17196	5.959	5.922	1.845	29.51623
CANNABIS TYPE (kg)	0.168	3.98552	9.27525	10.535	14.769	17.348	56.08077
COCAINE TYPE (Kg)	0	0	0.001	0	0	0	0.001
HALLUCINOGEN / AMPHETAMINE TYPE (pills)	8789	2664	2220	0	0	0	13673
SEDATIVE TYPE (pills)	0	0	1110	0	0	0	1110
SOLVENTS/INHALANTS	0	0	0	0	0	0	0
OTHER (PSYCHOTROPIC PILLS)	0	0	0	10228	2228	1688	14144

EXHIBIT 17

Manila : Quantity of Drug Seized By Drug Type

DRUG TYPE (in kg)	JUL-SEPT 92	OCT-DEC 92	JAN-MAR 93	APR-JUN 93	JUL-SEPT 93	OCT-DEC 93	JAN-MAR 94	TOTAL
	N	N	N	N	N	N	N	N
OPIATE TYPE	0	0	0	0	0	0.0008	0	0.0008
CANNABIS TYPE	0.15	0.2214416	0.0022044	42.543074	0.00281	2.4869876	0.2895375	45.69606
COCAINE TYPE	0	66.005	0	0.0002	0.000071	0.0000023	0	66.00527
HALLUCINOGEN TYPE	0	0	0	0	0	0	0	0
AMPHETAMINE TYPE	0.163	1.874643	0.1428723	2.4925864	0.000238	0.002064	0.0031835	4.678587
SEDATIVE TYPE	0	0	0	0	0	0	0	0
SOLVENTS/INHALANTS	0	0	0	0.038	0	0	0	0.038
OTHER	0	0	0	0	0	0	0	0

EXHIBIT 18



SECTION FOUR

(1) DRUG ABUSE INDICATOR REPORTING INSTRUMENT

(2) QUESTIONNAIRE FOR STUDY ON ABSTINENCE AND RELAPSE

(3) LIST OF PARTICIPANTS

ASIAN COUNTRIES

MULTI-CITY EPIDEMIOLOGY STUDY

City/Metropolitan Name: _____

Period of Reporting: _____

Complied by: _____

Name of Agency: _____

_____

_____

Please return completed questionnaire to:

The Director
Centre for Drug Research
Universiti Sains Malaysia
11800 Penang, Malaysia

Tel. No. : 604-6577888
Telefax : 604-6577957
Telex : MA-40254
Cable : UNISAINS

A. GENERAL POPULATION DEMOGRAPHIC INDICATORS*

* (data from most recent Census. State year _____
(To be completed once/year)

1. Total Population of City/Metropolitan _____

			N	%
2.	Sex	Male	_____	_____
		Female	_____	_____
3.	Age**	Under 15 years old	_____	_____
		15 - 19 years	_____	_____
		20 - 34 years	_____	_____
		35+ years	_____	_____

(** or specify other similar age brackets)

4. Ethnic Groups
(specify for major groups)

Ethnic "A"	_____	_____	_____
Ethnic "B"	_____	_____	_____
Ethnic "C"	_____	_____	_____
Other (specify:	_____)		

5. Marital Status

Single, never married	_____	_____
Separated/divorced	_____	_____
Married	_____	_____
Widowed	_____	_____
Other	_____	_____

6. Occupational Categories [List according to Census]

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	N	%
7. Number of People in Household		
1 (alone)		
2 - 5		
6 - 10		
11 +		
8. Number of Years of Education		
Zero		
1 - 6		
7 - 12		
13 +		

9. Annual Per Capita Income (local currency) (please define it as in Census Report) _____

10. Other Comments: _____

B. DRUG TREATMENT INDICATORS

	TYPE OF TREATMENT FACILITY			
	Prison	Specialised Drug Treatment	Primary/Gen. Health Care	Other
1a. Total Number of Available Treatment Facility in the City				
1b. Total Number of Treatment Facility from which Information is Collected				

B. DRUG TREATMENT INDICATORS

	TYPE OF TREATMENT FACILITY			
	Prison	Specialised Drug Treatment	Primary/Gen. Health Care	Other
2. Total Number in Drug Treatment				
3a.i Number of Institutional Admissions				
- New admissions				
- Readmissions				
Total Admissions				
ii No. of Non-institutional Admissions				
- New admissions				
- Readmissions				
Total Admissions				
3b. Number of Patients by Primary Drug of Abuse				
Opiate type				
Opium				
Morphine				
Heroin				
Others (e.g. codeine, pentazocine, pethedine)				
Cannabis type				
Cocaine type				
Hallucinogens (e.g. LSD)				
Amphetamines				
Sedative type				
Minor tranquillisers				
Solvents/Inhalants				
Alcohol				
Other (specify)				
3bi Poly-drug users				

3c. Sex of Patients

B. DRUG TREATMENT INDICATORS

TYPE OF TREATMENT FACILITY

	Prison	Specialised Drug Treatment	Primary/Gen. Health Care	Other
Number of Males				
Number of females				

3d. Patient Age

Under 15 years				
15 - 19 years				
20 - 34 years				
35+ years				

3e. Patient Ethnicity (specify)

a				
b				
c				

3f. Patient Marital Status

Single, never married				
Separated/divorced				
Married				
Widowed				
Other				

3g. Patient Occupation

Professionals				
Administrators				
Sales & clerical workers				
Drivers/Transport workers				
Cultivators				
Unemployed				
Small business				
Students				
Others (specify)				

B. DRUG TREATMENT INDICATORS

TYPE OF TREATMENT FACILITY

	Prison	Specialised Drug Treatment	Primary/Gen. Health Care	Other
3h. Route of Administration/Use				
Inhalation (gases, volatile substances)				
Injection				
Oral (through the mouth				
Smoking/'chasing'				
Sniffing/snorting (nasal)				
Other (specify)				
3i. Drug Sources				
Street sale				
Legal presciption				
Diversion of prescription drugs				
Other (specify)				
3j. Number of People in Patient Household				
Alone				
2 - 5				
6 10				
11+				
3k. Number of Years of Education				
Zero				
Less than 6 years				
6 - 12 years				
More than 12 years				

4. Other Comments/Observations: _____

_____

_____

_____

C. LAW ENFORCEMENT INDICATORS

1. Total Number of Persons Arrested for Criminal Offences _____

2. Number of Persons Arrested for Drug-Related Offences

a.	Arrests for use/consumption	_____
b.	Arrests for possession	_____
c.	Arrests for sales	_____
d.	Arrests for trafficking	_____
e.	Arrests for conspiracy	_____
f.	Other drug-related offences (Please specify: _____)	_____

3. Number and Quantity of Drug Seized by Drug type

		No. of seizures	Quantity (kg/# of pills/vol.)
a.	Opiate - Type	_____	_____
b.	Cannabis - Type	_____	_____
c.	Cocaine - Type	_____	_____
d.	Hallucinogen - Type	_____	_____
e.	Amphetamine - Type	_____	_____
f.	Sedative - Type	_____	_____
g.	Solvents/Inhalants	_____	_____
h.	Other drugs	_____	_____

4. Drug Production Crimes

	a	b	c	d	e	f
Amount of drug seized in a manufacturing facility (kg/# of pills/volume)	_____	_____	_____	_____	_____	_____
Number of labs. destroyed	_____	_____	_____	_____	_____	_____
Amount Destroyed (kg/#/vol. acreage)	_____	_____	_____	_____	_____	_____
Arrest for cultivation (person)	_____	_____	_____	_____	_____	_____
Arrest for manufactures (person)	_____	_____	_____	_____	_____	_____

Note:

a - Opium
b - Heroin
c - Marijuana
d - Amphetamines
e - Other psychotropics
f - Other drug, specify: _____

5. Traffic Accidents

			Source(s) of Information
a.	Total Number of Traffic Accidents	_____	_____
b.	Number of Crashes Caused by Drivers under the Influence of:		
	Alcohol	_____	_____
	Narcotic drugs	_____	_____
	Other psychotropic substances	_____	_____

6. Other Comments: _____

_____

D. HEALTH INDICATORS

			Source(s) of Information
1a.	Number of HIV - Positive cases	_____	_____
	AIDS cases	_____	_____
1b.	Number of Drug-Related HIV-Positive Cases	_____	_____
	AIDS Cases	_____	_____
2a.	Number of Psychological Cases	_____	_____
2b.	Number of Drug-Associated Psychological Cases	_____	_____
3a.	Number of Emergency Room Cases	_____	_____
3b.	Number of Drug-Related Emergency Room Cases	_____	_____
4a.	Number of Deaths	_____	_____
4b.	Number of Drug-Related Deaths	_____	_____

5. Other Comments: _____

_____

E. SOCIAL INDICATORS

			Source(s) of Information
1.	Number of Persons Who Lost Their Jobs Due to Drug Use	_____	_____
2.	Family Disruptions Due to Drug Use		
	Number of family members expelled (from the home)	_____	_____
	Number of spouse separations	_____	_____
	Number of other disruptions (specify)	_____	_____

3. Upper Secondary/High School Disruptions Due to Drugs

		Sources of information
- Number of students expelled	_____	_____
- Number of student dropouts	_____	_____
- Average daily absenteeism rate	_____	_____

4. Other Comments: _____

_____

ASIAN MULTI-CITY EPIDEMIOLOGY STUDY

INSTRUCTIONS FOR COMPLETING THE REPORTING FORMS

General

1. City/Metropolitan Name:- Each reporting City is identified by this item. If data available to you covers a larger area than the city limits than please report data for the metropolitan area. Specify whether report is on city or metropolitan area.

2. Period of Reporting. This refers to the period when information is collected.

3. Where no information is available, use NA

4. Where information is available but not accessible or not collected use NC

5. When reporting numbers, do not use - for missing or for zero (0). If missing indicate NA and if no cases reported, 0 (zero).

6. Please ensure all items in the reporting forms is completed to the best of your ability. Where gaps occur; please send other sources of information which may include a small area survey or survey among students, etc.

7. Please provide all sources of information.

REPORT FORM INDICATORS

	Item	Explanation
A.	GENERAL POPULATION DEMOGRAPHICS	All the data referred to under this section (A1-A10) is City/Metropolitan data and not national data and needs to be provided only once a year. Bear in mind this is a city epidemiology study and all the relevant demographic variables reported should be for the city. This data should be available from the census, and where information is outdated, please provide latest estimates if available. Please give the numbers and percentage for all items.
1.	Total Population of City/Metropolitan	This refers to the residential population. Please give latest year of census or estimate.

2.	Sex	Please indicate as required.
3.	Age	Please use categories provided as far as possible. If it is not similar to your city's census, please specify age brackets according to your census data.
4.	Ethnic Groups	This refers to race and not <u>religion.</u>
5.	Marital Status	Provide data according to given categories.
6.	Occupational Categories	List categories as used in your census.
7.	No. of People in Household	Data to be provided as categorised
8.	Number of Years of Education	Please indicate accordingly
9.	Annual Per Capita Income	Please provide per capita income data. If this is not available to provide alternately household income or personal income figures and this has to be clearly stated.
10.	Other Comments/ Problems	Please specify source of information and give details of problems encountered in data collection. If you need clarification on any of the items in this section, please indicate.
B.	DRUG TREATMENT INDICATORS	Should try to include all forms of drug treatment facilities; private or government. <u>Specialised drug treatment</u> centres are facilities solely for drug treatment. <u>Primary health/General health care</u> refers to medical facilities which provide some treatment for drug related cases.
1a.	Total Number of available treatment facility in the city	Please indicate according to prison specialised drug treatment, primary/ general health care, or other.
1b.	Total number of treatment facility from which information is collected.	Specify as in 1a

2.	Total Number in Treatment	Please indicate total number of clients treated in treatment facilities, etc. over the whole of reporting.
3ai.	Number of Institutional Admissions	This is the total for the whole period. If possible, indicate if they are new or readmissions. New admissions are persons admitted for the <u>first time</u>
3aii.	Number of Non-Institutional Admissions	This is the total for the whole period. If possible, indicate if they are new or readmissions. New admissions are persons admitted for the <u>first time</u>
3b.	Number of Patients by Primary Drug	To indicate only <u>primary</u> drug of abuse. If patients are poly-users to indicate under 3b(i).

ALL INFORMATION FOR ITEMS 3c TO 3k TO BE COLLECTED FOR ALL ADMISSIONS (NEW AND OLD)

3c.	Sex of Patients	Please indicate as required.
3d.	Patient Age	Please use categories provided.
3e.	Patient Ethnicity	This refers to race and not <u>religion.</u>
3f.	Patient Marital Status	Please indicate according to categories provided.
3g.	Patient Occupation	Please indicate according to categories provided.
3h.	Route of Administration	Please indicate according to categories provided.
	Inhalation	Refers to inhalation of gases/volatile substance, e.g. glue.
	Injection	Refers to all types of injections, i.e. I.V., intramuscular, under the skin, etc.
	Oral	Refers to chewing or swallowing.
	Smoking	Includes 'chasing the dragon' method.
3i.	Drug sources	To specify <u>primary source</u> of drugs for patients

3j.	No. of people in patient household	Refers to total number of people eating from the same kitchen.
3k.	Number of years of education	Please indicate accordingly.
C.	LAW ENFORCEMENT INDICATORS	This set of indicators refer to drug-related police activities and other information on sales, production and trafficking of drugs.
1.	Total persons arrested for criminal offences	Please provide information if available. Data can be reported for the reporting period. If this is not available, total cumulative figure for the year could be reported.
2.	Number of Drug-Related Arrests	Please provide information according to types of arrest.
3.	Number and Quantity of Drug Seized by Drug Type	Please provide data according to drug type and indicate the measure for quantity, i.e. kg or number (#) or litres
4.	Drug Production Crimes	
	Amount of Drug Seized in a Manufacturing facility	Please provide data according to drug type and indicate the measure for quantity, i.e. kg. or number (#) or litres.
	Number of Lab. Destroyed	Please indicate the number of labs. destroyed for the reporting period.
	Amount Destroyed	Please state the amount destroyed and indicate the measure per quantity.
	Arrest for Cultivation	Please state the number of persons arrested for cultivation for the reporting period.
	Arrest for Manufacture	Please state the number of persons arrested for manufacture for the reporting period.

5.	Traffic Accidents	a. If available, please provide data on total number of traffic accidents. b. Please provide data for the number of accidents caused by drivers under the influence of drugs according to the categories provided.
D.	HEALTH INDICATORS	If information on these items are not systematically collected, please report on any information available and source of information.
1a.	Number of HIV Positive/AIDS cases	Number of cases who have been found to be HIV - positive or having AIDS.
1b.	Drug-Related HIV-Positive/AIDS cases	Number of drug-related cases who have been found to be HIV-Positive or having AIDS.
2a.	Number of Psychological Cases	This refers to total psychological cases/mental disorders.
2b.	Drug Associated Psychological Cases	Drug associated mental disorders such as drug psychoses, depressions, etc. (Please exclude drug withdrawal or intoxication cases).
3.	Drug-Related Emergency Room Cases	Cases related to drug over-dose and poisoning as well as other drug-related medical complications.
4.	Number of Drug-Related Deaths	Deaths related to the above.
E.	SOCIAL INDICATORS	If information on these items are not systematically collected, please report on any information available and state source of the information

ASIAN MULTI-CITY EPIDEMIOLOGY WORK GROUP
POST-TREATMENT ABSTINENCE AND RELAPSE
AMONG HEROIN ADMISSIONS

DEMOGRAPHIC CHARACTERISTICS

1. Age (specify): _____years

2. Sex : Male
Female

3. Marital Status:
1. Single/never married
2. Separated/divorced
3. Married
4. Widowed
5. Other

4. Occupational status: (Country census)

5. Residential status:
1. Living alone
2. Living with family/relatives
3. Living in institutional settings
4. Living with partner (female)
5. Living with partner (male)
6. No permanent residence
7. Others (specify: _____)

6. No. of years of education

1. Zero
2. 1 - 6 years
3. 7 - 12 years
4. 13 + years

DRUG USE

7. a. At what age did you start using heroin for the first time?
_____years old.

8. Generally how often do you use?

1. Daily use
2. More than once/week
3. More than once/month but less than once/week

9. How do you use?

1. Smoking
2. Chasing the dragon
3. Injecting
4. Sniffing/snorting
5. More than one (specify: _____)

10. Before coming into treatment this time for how long have you been using heroin?

_____years _____months _____days

11.a How many times have you NOT used heroin or any other substitute (including alcohol) for longer than 2 weeks?

1. One time
2. Several times

11.b What is the longest time period you have NOT used heroin or any other substitute (including alcohol)?

_____months _____years

12. Reasons for NOT using heroin or any other substitute (including alcohol) for longer than two weeks?

_____

_____

_____

_____

13. Which factors contribute to relapse/reuse?

1. Past memories
2. Withdrawal
3. Craving
4. Peer pressure
5. Complacency
6. Rejection by family
7. Distrust
8. Loss of job
9. Sexual dysfunction
10. Emotional trauma
11. Physical discomfort
12. Others (specify: _____)

14. What was the type of your LAST treatment?

1. Inpatient
2. Outpatient
3. Rehabilitation
4. Spiritual
4. Others (Specify: _____)

15. Who motivated/referred you to treatment?

1. Self
2. Relative/family
3. Friend
4. Law enforcement (incl. criminal justice
5. Social organization
6. Other (ex) users
7. Other (Specify: _____)

16. Reasons for seeking treatment this time?

_____

_____

_____

_____

ASIAN MULTI-CITY EPIDEMIOLOGY WORK GROUP
(SOUTH ASIA)

CENTRE FOR DRUG RESEARCH
UNIVESITI SAINS MALAYSIA
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ASIAN MULTI-CITY EPIDEMIOLOGY WORK GROUP
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ASIAN MULTI-CITY EPIDEMIOLOGY WORK GROUP
(EAST ASIA)

CENTRE FOR DRUG RESEARCH
PENANG
MALAYSIA

8-12 AUGUST 1994

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