Faculty of Health Sciences

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An Examination of the Factors in the Policy Enabling Environment that Influence the Formulation and Implementation of Harm Reduction Policy in Thailand

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"We shall not cease from exploration, and the end of all our exploring will be to arrive where we started and know the place for the first time."

(Eliot, 1942, p. 3)

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Thank you

Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

(Include where applicable)

Human Ethics (For projects involving human participants/tissue, etc.) The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # **HR139/2015**

Signature: ....

Date: ....12/10/2016..........

Commonly-used Abbreviations

ATS	Amphetamine-type substances
ART	Antiretroviral Therapy
ASEAN	The Association of Southeast Asian Nations was formed in 1967 by Indonesia, Malaysia, the Philippines, Singapore, and Thailand to promote cultural, economic and political development in the region. Its membership later expanded to include Brunei, Cambodia, Laos, Myanmar, and Vietnam.
BBV	Blood-borne viruses (e.g. Hepatitis B, Hepatitis C, HIV)
CBO	Community-based Organisation
CCDU	Compulsory Centres for Drug Users
CND	Commission on Narcotic Drugs
CSO	Civil Society Organisation
DfID	UK Department for International Development
FSW	Female Sex Workers
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	The human immunodeficiency virus (HIV).
HRI	Harm Reduction International
IDPC	International Drug Policy Consortium
IDU	In this thesis, IDU only refers to injecting drug use.
INCB	International Narcotics Control Board
MMT	Methadone Maintenance Therapy
MSM	Men Who Have Sex with Men
NGO	Non-Government Organisation
NSEP	Needle and Syringe Exchange Programs
NSP	Needle and Syringe Programs
ONCB	Office of Narcotics Control Board, the Department of Justice, Royal Thai Government
OST	Opioid Substitution Therapy
PEA	Political Economy Analysis
PSI	Population Services International
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
TNI	Transnational Institute
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	The United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNODC	The United Nations Office on Drugs and Crime
UNRTF	United Nations Regional Task Force on Injecting Drug Use & HIV/AIDS in Asia & the Pacific
WHO	The World Health Organization
World Bank	The World Bank
WTO	The World Trade Organisation

In addition to the abbreviations above, if the reader would like to refer to a list of definitions of terms commonly used in this thesis this can be found in Appendix One.

Abstract

Background: Just prior to the new millennium Thailand was lauded internationally for its dramatic reversal of a rapidly escalating HIV epidemic among female sex workers. The country also received praise for its audacious policy of compulsory licensing of antiretroviral medication, making these lifesaving drugs available to hundreds of thousands of people who may not otherwise have been able to afford them. Thailand was held up as a model for other countries to emulate. Despite that, when this research began, Thailand had the highest population prevalence rate of HIV and the greatest number of people living with HIV (530,000) of any country in South-east Asia region (UNAIDS, 2010b). Furthermore, prevalence estimates of HIV among people who injected drugs had remained around 40% for more than two decades (Perngmark, Celentano, & Kawichai, 2004). This intriguing difference in policy approach and outcome between sub-populations at risk of HIV deserved further investigation.

Aims: This research aimed to identify and analyse the major national, regional and international factors which influenced the Thai policy environment, or which impacted upon key Thai institutions or ideologies which in turn affected national drug policy formulation and implementation.

Methodological Approach: This study incorporated a mixed methods approach, and predominantly a qualitative inductive theoretical approach. It sought to combine existing theories in the analysis and interpretation of primary and secondary data. The mixed methods approach of this research used different sources of data (interrogation of the literature, expert interviews and a survey) to triangulate data and to strengthen findings and their interpretation through comparison and contrast of the analysed data from each source. Firstly, comprehensive and critical explorations of the relevant literature were undertaken to identify the context, previous work in the area, the main themes, key concepts, and knowledge gaps in the areas of policy analysis and implementation, HIV/AIDS, illicit drug use and harm reduction. The literature reviews were used to develop the in-depth semi-structured interviews and data from the interviews subsequently informed the development of the survey instrument. The reviews were also used to guide the interpretation and presentation of the findings. A review of the literature identified major models of policy analysis and considered their characteristic interpretative strengths. Political Economy Analysis (PEA) was the primary model of analysis used, supported by Kingdon's three streams model (Kingdon, 2010)and, to a lesser extent, social construction theory (Schneider & Ingram, 1993).

Semi-structured interviews were conducted with experts from national government departments, national implementing agencies, national civil society organisations, regional and/or international stakeholders (e.g. international non-government organisations and United Nations agencies engaged in harm reduction policy dialogue, advocacy, development or service provision). Finally, a survey was distributed among international harm reduction stakeholders who had participated in illicit drug policy advocacy, dialogue, formulation, implementation or service delivery in around 20 different countries.

Deductive Content Analysis was used to systematically and objectively identify, describe and quantify key patterns, categories and themes about the policy factors of interest from the survey responses and the semi-structured interviews. NVivo Version 10 software program was used for textual data management and to assist with content and thematic qualitative analysis.

An examination of the data through the framework of PEA and augmented with other relevant analytical models, in particular social construction theory and Kingdon's three streams policy analysis model, identified a dynamic interplay of key national and international actors, as well as national culture, values and ideologies. The data analyses and interpretation of those analyses revealed an influential coalition of national institutions which supported and benefited from the status quo as well as a historically less powerful and less cohesive grouping of national institutions which had been working towards substantial drug policy reforms. International institutions which sought to influence Thai drug policy were also identified and their significant, though distal and thus less substantial, contributions to the drug policy debate and policy implementation were described. After nearly half a century of pursuing strict prohibitionist drug policy, it appeared that there was general agreement among drug policy experts and the general public that drug use in Thailand and its associated consequences had not diminished. It also appeared that, although general agreement about the best course of action to address this situation had not yet been reached, nevertheless a window of opportunity for drug policy reform had begun to open as the Thai Government undertook public consultations on drug policy and a review of its national drug legislation.

Chapter 1: Introduction

Understanding illicit drug use and related harm in any one country or region, and responding effectively, requires some understanding of the broader context, which warrants an exploration of current global patterns of use as well as policy responses. Consequently, this study will provide context through a brief description of those global domains followed by a discussion of the past and current trends in international and national drug policy responses. It will also identify the major criticisms of, and debates in, the international response to illicit drugs. The review will describe the connection between drug use and drug-related harms, in particular, the transmission of the human immunodeficiency virus (HIV). It will also examine the implications for creating effective responses to both illicit drug use and its related harms. To achieve this the review will explore types of drug use and drug-related harms as well as harm reduction in policy and practice, an approach which has attracted considerable contention. The literature review was structured such that consideration of each of the key components, drug use, HIV, drug policy, and harm reduction, will begin with a global overview, then focus down to Asia and South-east Asia and then finally concentrate on Thailand as a specific case. Thailand was selected because it had received international acclaim for its record of HIV prevention among female sex workers (FSW) and was cited as a model for other countries to emulate. It also received praise for its bold policy of compulsory licensing of antiretroviral medication, making these essential medications available to hundreds of thousands of people who may not otherwise have had sufficient access to them. Yet, at the time this study commenced, Thailand had the highest population prevalence rate (1.0-1.6%) and the greatest number of people living with HIV (530,000) of any country in South-east Asia region. Even more compelling, for this study, estimates of HIV prevalence among people who inject drugs (PWID) remained high, at around 40% for the past two and half decades. This intriguing apparent discrepancy between policy approaches towards HIV treatment and HIV prevention, as well as between policy responses to the epidemic among FSW and among people who use drugs (PWUD), warranted further investigation.

This thesis aimed to identify and examine the prominent influences on Thailand's drug policy environment as well as major international and regional factors which affected the Thai national environment, or impacted upon key Thai institutions or ideologies which subsequently affected policy formulation and implementation. This dissertation has been informed through a series of literature reviews of the published and grey literature and primary data collection methods: a series of interviews with recognised national and

international experts in Thai drug policy; and completed survey responses from harm reduction policy advisors and implementers from 19 countries. The methodology, along with ethics processes, is described in detail in Chapter Two.

Chapter Three investigates trends and issues related to the of psychoactive substances. This includes sections on the harms which have resulted from drug use to both the community and the individual, especially harms resulting from injecting drug use. The emergence of the HIV epidemic has been associated with drug-related harm and a key consideration in driving and determining drug policy responses globally. This chapter also examines the emergence of HIV and epidemiological trends in its relation to drug use, with a particular focus on South-east Asia.

Harm reduction has been an important drug policy response to the harms related to drug use, such as HIV transmission. Chapter Four therefore, undertakes a detailed investigation of the philosophy of harm reduction, its implementation, the operationalisation of harm reduction services, and the debates and contestation of harm reduction, both globally and in South-east Asia.

Chapter Five examines the theoretical foundations for policy analysis, public policy implementation, and an analysis of the policy environment. In addition, it takes a closer look at the historically more recent policy responses to drug use and the associated harms. This includes a particular focus on the evolution, current status and contentions associated with international drug policy and drug policy instruments, including the United Nations drug treaties.

Chapter Six then refines the focus of the previous chapters directly onto Thailand. This chapter provides a critical review of the historic and contemporary trends in drug use in Thailand, associated health, legal and social problems, and highlights the relationship between injecting drug use (IDU) and the transmission of blood-borne viruses (BBV), especially HIV. The chapter then examines Thai drug policy responses, including debates around harm reduction and harm reduction service provision.

Chapter Seven describes the thematic analysis of the survey and interview data, providing discussion and interpretation of these analyses and subsequent findings. Finally, the last chapter provides a triangulation and synthesis of the analyses, interpretations and findings. It provides a summary of the key findings, their implications

and suggests directions for future drug policy activities, including research. Chapter Eight also discusses some of the main strengths and limitations encountered in the study.

1.1   Research Significance

A review of HIV/AIDS policy processes in developing countries in Anglophone Africa stated unequivocally that, "*A supportive policy environment is crucial to the implementation of successful programs that prevent the spread of HIV…*" (Stover & Johnston, 1999, p. 1). The systematic identification and analysis of critical macro-environmental factors or drivers, which either facilitate or constrain the formulation and implementation of harm reduction policy in Thailand, would provide an explanation for the course of national harm reduction policy formulation and implementation. This would: assist harm reduction advocacy work; enhance purposeful contributions to the further development of an enabling policy environment; assist in harm reduction strategy risk management and mitigation; and, promote monitoring and evaluation of harm reduction policy implementation for the prevention of HIV in Thailand. Furthermore, lessons learnt may also have implications for harm reduction policy more broadly and its implementation in other ASEAN country contexts.

It was also of significance that this study used an innovative application of PEA and Kingdon's policy model. A review of the literature uncovered limited application of Kingdon's policy model in the analysis of national drug policy or the policy environment. Furthermore, the literature found no evidence for the prior use of PEA for the analysis of factors which influence national drug policy. Although the term 'political economy' could be traced back to the works of Adam Smith (1776) and Karl Marx (1867), a review of the literature indicated that PEA had only recently been used in the scrutiny of the policy environment for formulation and implementation of policies and programs. Moreover, this recent use of PEA appeared confined to the field of international development and was neither widespread nor routine within that field.

The intent of this study was to identify and examine the key factors in the enabling environment which influence the formulation and implementation of harm reduction policy in Thailand. There were many models or theories available for examining or evaluating policy formulation and implementation. Nevertheless, to date there was not an individual model or framework which comprehensively and systematically captured and analysed data on all the major factors in the macro-environment which influenced or impacted on the policy processes. A comprehensive approach for the analysis of the

policy macro-environment has been achieved by combining, adapting and extending existing approaches to policy analysis (such as those of Kingdon's three streams model, PEA, etc.) for the analysis of the policy enabling environment in this specific context. This comprehensive approach could also be able to be applied to overcome the limitations of methods for systematically identifying the key factors that constrain or facilitate the formulation and implementation of other policies in Thailand or drug policy elsewhere.

1.2 Aims

The aims of the thesis were to:

I. Identify the key factors which constrained or facilitated the formulation and implementation of harm reduction policy for the prevention of HIV and other BBV transmission among PWID in Thailand.

II. Identify, adapt and utilise relevant policy analysis models to develop a comprehensive approach to systematically identify, understand and address the key factors which comprised the enabling environment for the formulation and implementation of harm reduction policy for the prevention of HIV and other BBV transmission among PWID in Thailand.

III. Contribute to improving the relevance, efficiency, effectiveness and sustainability of health-focussed policy approaches to reduce the harmful consequences of drug use in Thailand.

1.3 Objectives

The objectives of the research project were to:

I. Determine the current situation with regards to harm reduction policies, their implementation and harm reduction practices among PWID in Thailand and, where relevant, to its geo-political neighbours in ASEAN countries;

II. Identify and describe the major macro-environmental factors in the Thai national policy environment which either enabled or inhibited the formulation and implementation of harm reduction policy for the prevention of HIV and other BBV transmission among PWID;

III. Identify important factors in the global or regional policy environments, which, also impacted on the course of national harm reduction policy implementation in Thailand; and in particular, how international funding and convening organisations i.e. United Nations, Donors, Development Banks and Development Funds have influenced harm reduction in Thailand and its immediate geo-political region;

IV. Identify key stakeholders in Thai harm reduction policy, and engage them as key informants in the study to determine their assessment of:

    a. What the key factors that influence Thai harm reduction policy implementation were;

    b. How these factors impacted upon Thai harm reduction policies and strategies;

    c. How these factors affected PWID risk behaviours, adoption of harm reduction practices and associated rates of HIV in Thailand; and,

    d. The relative importance of each of these factors.

V. Critically review and contribute to the international literature on harm reduction policy for the prevention of HIV and other BBV transmission among PWID; and,

VI. Consider the implications for harm reduction policy more broadly.

1.4 Research Design

This section describes the overall research design used in this study, and the methods employed for data collection and analysis. An exploratory approach was used in the planning and implementation of the research consistent with the study's overall purpose and research objectives of eliciting abundant descriptive information as well as ensuring that rigour was maintained. A particular characteristic of the design was the use of a mixed methods approach to advance the conceptual understanding of the complex area of investigation, that is, the formulation and implementation of Thai drug policy to reduce drug-related harm.

1.5 Theoretical Frameworks

A result of the mixed methods approach meant a diversity of information was generated to illuminate the complex and multiple facets of the phenomena under study and enable the research to achieve its objectives. The complexity of the subject required broad and

multiple perspectives on 'real world' phenomena occurring within complex (or often chaotic) environments, and thus needed to progress beyond simple linear causality. This provided comprehensive explanatory power which may not have been produced through narrowly conceptualised research designs (Johnson & Onwuegbuzie, 2004; Onwuegbuzie & Johnson, 2006).

While this study has embraced a mixed methods approach, it has used a predominantly qualitative inductive theoretical process. Rather than testing specific hypotheses, it sought to develop a model underpinned by existing theories and informed by primary and secondary data collection and analyses. As will be further explained in the literature review under the policy analysis and other section headings, there was a great deal of literature and a broad theory base for the evaluation of policy implementation and the influence of policy implementation on features of the external environment but there appeared to be little literature and a dearth of existing theories which could provide the necessary framework or tools for an examination of the converse, that is, the key factors in the external environment which influenced policy implementation. This exploratory and descriptive approach to the study research has been delimited or focussed by the research questions, aims and objectives previously described.

1.6 Chapter Summary

This first chapter has introduced the aims and objectives, theoretical framework, design and significance of this research. The key personal observation of the researcher which perplexed the researcher for years and which eventually impelled him to embark on this research project was that:

> *Nearly 30 years (a generation) ago Thailand did exceptionally well in dramatically reducing the transmission of HIV by female sex workers, and they did so in only a year. Yet their response to HIV transmission by PWUD (or lack thereof) has seen HIV prevalence among PWID remain exceptionally high (around 40%) during that same 30-year period. Why?*

The researcher's interest in this conundrum was eventually focussed on learning more about the major relevant factors in the Thai drug policy environment. Chapter Two provides a detailed description of the methodology and succeeding chapters will provide the reader with enough background to contextualise this research, its methods and findings.

Chapter 2: Methodology

This chapter details the methodology used to achieve the aims and objectives of the research described in the first chapter. The mixed methods approach used in this study included an interrogation of the literature and use of semi-structured interviews with key informants who had an involvement in or who were affected by policy advocacy, development and implementation of drug and harm reduction policy in Thailand. The survey component incorporated both qualitative and quantitative elements of data collection and analysis. The survey questionnaire provided data for descriptive statistical analysis. Each of these methods was conducted in sequential phases rather than concurrently. In this way, the literature reviews were used to inform the development of the in-depth semi-structured interviews and the initial analysis of the data from the interviews guided the development of the survey instrument. Data from each method were analysed separately using qualitative thematic analysis. Descriptive statistical analyses were also used with quantitative data from survey responses. These analyses were presented separately in the relevant sections and the findings were combined and drawn upon to develop interpretations, which were subsequently integrated into the discussion of the overall study findings and consideration of their implications as well as the resultant recommendations.

Mixed methods research rejects traditional quantitative/qualitative dualisms and is sometimes seen as the third research paradigm (Johnson & Onwuegbuzie, 2004). It recognises that both quantitative and qualitative research approaches are important and both have advantages, which are often complementary. Drawing on both types of methods can strengthen access to relevant information and data thereby enhancing the relevance of the findings and minimising the weaknesses inherent in single method studies. Furthermore, in both approaches the "*…tasks and aims are the same: describe their data, construct explanatory arguments from their data, and speculate about why the outcomes they observed happened as they did*" (Sechrest & Sidani, 1995, p. 78). In addition, both types of research were concerned with avoiding threats to validity (or credibility) such as confirmation bias and so develop methodological safeguards to minimise these occurrences during the course of their studies (Johnson & Onwuegbuzie, 2004; Onwuegbuzie & Johnson, 2006).

It has also been argued that a mixed methods approach endorses a strong and practical empiricism, thus offering the ability to move beyond ontological and epistemological debates and so the researcher can take *"…a pragmatic and balanced or pluralist*

position" that will offer the best opportunities for answering important research questions, and "…*help improve communication among researchers from different paradigms as they attempt to advance knowledge…and, importantly, to help in deciding which action to take next as one attempts to better understand real-world phenomena…*" (Johnson & Onwuegbuzie, 2004, pp. 16-17). Some go even further, stating "*Methodological pluralism is an absolutely necessary strategy in the face of overwhelming cognitive limitations and biases inherent in human mental processing and responding*" (Sechrest & Sidani, 1995, p. 80).

2.1   Step 1 – Literature Reviews

The research was informed and directed through a comprehensive and critical exploration of the relevant literature in the areas of policy formulation and implementation, HIV, illicit drug use and harm reduction. These literature reviews assisted in identifying the context, previous work in the area, the main themes, key concepts, and knowledge gaps. As a result, they guided all subsequent stages and were used to focus data collection and analyses as well as the interpretation and presentation of the findings (Coughlan, Cronin, & Ryan, 2007; Ryan, Coughlan, & Cronin, 2007). This included a focus on historical development of drug policy in Thailand as this context has relevance for current policies and strategies. The literature reviewed included a substantial quantity of grey literature because there was limited systematic peer reviewed analysis available to inform examination of policy development in Thailand.

The processes outlined below were used for finding and obtaining published and grey literature for each of the literature reviews subsequently described and so rather than repeat them under every literature review section they are described here once. The key search terms for each literature review were distinctly different so those terms have been described separately under each literature review section. The researcher used Curtin University Library physical (hardcopy) books, journals and references but principally used the Curtin University Library electronic search engines and electronic journal access. Also, other academic library resources were used, for example, the Public Health Libraries of Chulalongkorn University and Mahidol University, in Bangkok. The researcher was also able to access unclassified Australian Government documents either in hardcopy or an electronic copy through his employers (e.g. the Australian International Development Agency, Victorian Government Department of Health, etc.) when working with them for various periods during the research and during periods of

leave from the research. In addition, a snowballing-type technique was used in the literature search process as follows:

- When an author or a co-author was identified as writing one journal article or report then the authors' names (and variants of their last name, first name and initials) were used as search terms to find whether they had written other relevant publications;

- Agencies, websites or individuals mentioned in the body text or the acknowledgement section of a publication were copied and used as search terms in Google, Google Scholar, or Curtin University library databases and search engines (including Emerald, Medline, ProQuest, Scopus, ScienceDirect, and Wiley);

- Websites of key agencies or 'think tanks' and International Non-Government Organisations[1] associated with publication of reports were accessed for further publications, and whole publications or the citation details of other publications were downloaded from these websites;

- Hard copy and electronic copies of relevant publications were often sought from or offered by colleagues and professional acquaintances engaged at organisations mentioned previously;

- Hard copy publications were requested from agencies when the researcher visited their offices, sometimes for the expressed purpose of obtaining copies of specific publications, sometimes speculatively requesting to look through their shelves or stores of publications;

- The names and other details of relevant meetings, seminars, conferences, workshops, etc. were used in Google, Google Scholar, or the Curtin University electronic library to find documents or websites which might store publications from those events or other relevant publications;

- The reference lists of publications found through various means already mentioned were then used to identify further publications by using identifying relevant citations from their reference lists, and using those citation details to search by means of the Curtin University search engines, Google, Google Scholar, the publishing agency (e.g. The World Bank), the authoring agency (e.g.

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[1] For example, UNODC, UNAIDS, WHO, ADB, World Bank, IDPC, TNI, Beckley Foundation, Open Society Foundation, Human Rights Watch, etc.

> Harm Reduction International) or the publishers' websites (e.g. Sage
> Publications); and,

- Personal professional library: over many years of working in the fields of public health and drug use treatment and prevention specifically and working in Thailand, the researcher had accumulated a large personal library of hardcopy and electronic journal articles, reports and other publications.

While the literature on public health policy analysis focused on the political and, to a lesser degree, economic factors, rarely did it acknowledge the importance of social factors in the policy making process. There was limited literature on Policy Analysis (or Policy Assessment, Policy Evaluation and Policy Cycles) that has undertaken a comprehensive assessment of factors in the external environment which support or constrain the formulation and implementation of a specific policy. The candidate critically reviewed the literature on Policy Analysis, Policy Assessment, Policy Evaluation and Policy Cycles relevant to the implementation of harm reduction and drug use in general globally, regionally and nationally in Thailand.

The literature review of Policy and Policy Analysis was undertaken using the search methods previously described. It was also undertaken in three stages, each using terms to progressively narrow the focus. Step One: Analysis of Policy, Government Policy, Policy Analysis, Policy Assessment, Policy Dialogue, Policy Evaluation, Policy Formulation, Policy Framework(s), Policy Implementation, Policy Model(s), Policy Planning, Policy Process, Policy Review and Public Policy. Step Two: Macro-Environment Analysis, Policy AND Enabling Environment, Policy AND Macro-Environment, Policy Decision, Policy Macro-Environment, Policy Making, Political AND Economic, Political Economy Analysis, Political Economy, Social AND Technological. Step Three: Drug Policy, Harm Reduction Policy Health Policy, HIV Policy and Public Health Policy.

The candidate reviewed relevant reports and current literature on HIV/AIDS in Thailand to determine the incidence, prevalence, morbidity, mortality, transmission modes, sub-populations at risk and other relevant trends of the epidemic in Thailand. The grey literature included reports by government organisations providing services or monitoring HIV activities, International NGO providing services or monitoring HIV activities, international donors funding HIV activities, and United Nations agencies such as UNAIDS, United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC) and The World Health Organization (WHO) (a full list and a description

of all the United Nations agencies is provided in Appendix Two). Literature search terms for HIV in Thailand were:

AIDS AND Drug Use, AIDS AND Incidence, AIDS AND Prevalence, AIDS, HIV, HIV AND Drug Use, HIV AND Harm Reduction, HIV AND Incidence, HIV AND Incidence, HIV AND MARP, HIV AND Most at Risk Groups, HIV AND Most at Risk Populations, HIV AND Prevalence, HIV AND Prevention as Treatment, HIV AND Prevention, HIV Testing and Counselling, HIV/AIDS, Human Immunodeficiency Virus, PrEP, and Transmission of Human Immunodeficiency Virus.

The candidate reviewed relevant reports and current literature on IDU in Thailand to determine: the characteristics of the injecting drug users; trends in the type, quality and quantity of the drug used; and the behaviours associated with drug acquisition, administration and effects (e.g. intoxication/withdrawal). IDU policy and program responses were also assessed in an overview at the global and regional levels and in detail at the national level in Thailand. Grey literature included reports by government departments, International NGO, policy institutes, research institute international donors, United Nations agencies, development banks and international development funds which may have been monitoring drug use, or funding, supporting or providing drug prevention treatment services. This also included analysis of the Thailand National Household Drug Survey. Thailand has engaged in the collection of a National Household Drug Survey since the early 2000s. This survey gathered data from a substantial sample (for example, the 2007 survey was conducted in over 11,000 households with over 26,000 respondents (Assanangkornchai et al., 2008). The latest survey included assessment of demographic data, drug use (type, quantity and frequency), the consequences of drug use, sexual health data and HIV risk behaviours (Assanangkornchai, Sam-Angsri, Rerngpongpan, & Edwards, 2010). Literature search terms for drug use in Thailand were: Amphetamine(s), Amphetamine-type Stimulants, ATS, Cathinones, Compulsory Centres for Drug Users, Compulsory Detention Centres for Drug Users, Compulsory Treatment Centres for Drug Users, Drug(s) AND Closed Setting(s), Drug(s) AND Inmates, Drug(s) AND Interdiction, Drug(s) AND Legalisation, Drug(s) AND Overdose, Drug(s) AND Prevention, Drug(s) AND Prison, Drug(s) AND Prisoners, Drug(s) AND Production, Drug(s) AND Recovery, Drug(s) AND Supply, Drug(s) AND Trafficking, Drug(s) AND Treatment, Ecstasy, Heroin, Illicit Drug Use, Ketamine, Khat, Kratom, Methadone Maintenance Therapy, Methadone Maintenance Treatment, Methadone, Methamphetamine(s), Morphine, Narcotic Drugs, Narcotic Substances, Narcotic(s), New Psychoactive Substances, Opiate(s), Opioid Substitution Therapy, Opioid Substitution Treatment, Opioid(s), Opium, Patterns of Drug Use, Models of Drug Use,

Phenethylamines, Piperazines, Psychoactive Drug Use, Psychoactive Drugs, Psychoactive Substance Use, Substance Use, Psychoactive Substance(s), Psychotropic Drugs, Psychotropic Substances, Substitution Pharmacotherapy and Yaba.

The candidate reviewed the literature on harm reduction policy and programming in the overview at the global and regional levels and in detail at the national level in the region to ensure a comprehensive understanding of context and progress to date in Thailand. Especially relevant were the roles of international funding and convening organisations i.e., United Nations, Donors, Development Banks and Development Funds at the regional and national levels, and the degree and type of influence these organisations have had, relative to national actors. A systematic literature review of harm reduction was undertaken of published and grey literature. The latter included documents/reports by government departments, International NGO, international donors, United Nations agencies, Development Banks and International Development Funds who may be monitoring, funding, supporting or providing harm reduction policies and services. When searching for literature, search terms used were: Drug-Related Harm, Demand Reduction, Drug Risk Reduction, Harm Minimisation, Harm Minimization, Harm Reduction, HBV, HCV, Hepatitis B, Hepatitis C, Injecting Drug Use AND Hepatitis, Needle and Syringe Exchange Programs, Needle and Syringe Programs, NSEP, NSP, Sharing AND Injecting Equipment, Sharing AND Needles, Supply Reduction. Also, search terms for drug-related policy were: Abstinence, Decriminalisation, Decriminalization, Drug AND Policy, Drug AND wars, Drug Control, Drug(s) AND Convention, Incarceration AND Harm Reduction, Incarceration AND Drug Use, Incarceration AND Inject*, Opium Convention, Prohibition, Single Convention, and War on Drugs.

The literature searches did initially result in an enormous volume of literature, so this was filtered down in steps. For example, the stepwise process described in the searches on policy and policy analysis. Furthermore, nearly all the search results on policy and policy analysis were related to analysis <u>of</u> policy but there was very little literature which was specific to analysis <u>for</u> policy formulation or policy implementation. In other words, most of the literature was concerned with, for example, the evaluation of policy implementation rather than identifying the factors in the policy environment that influenced how a policy (or proposal for policy reform) was contested and shaped. The research was most interested on the confluence of these issues (HIV, harm reduction and drug use) and searching for literature in which these all overlapped (and included their policy implications) acted as a series of filters which greatly reduced the number of credible

papers of practical application to the thesis. Then bringing the geographical focus to Thailand and its immediate region further culled the available literature. Finally, restricting the publications and reports on these issues in Thailand to English language further narrowed the useable documentation. This last practical matter also created a methodological limitation which has been acknowledged in the methodology and later in Chapter Eight.

2.2   Step 2 - Semi-structured Interviews

Most of the semi-structured interviews were conducted in person and, with consent of the interviewees, were audio recorded. In two cases, at the request of the interviewee, interviews were not audio recorded and instead extensive handwritten notes were used to keep a record. Only two of the interviews were not done in person and these were undertaken using Skype, which still enabled a virtual 'face to face' process and these Skype interviews were also audio recorded following consent by the interviewee. Generally semi-structured interviews are undertaken when the researcher is familiar enough with the topic or area of interest to identify all the necessary questions but does not yet know enough to create all of the answers (McIntosh & Morse, 2015). The data from the interviews provided rich detail, nuance and scope for extended and/or unanticipated responses which may not have been possible to be obtained through the more structured and less immediate process of a survey questionnaire. Morse (2015) described the process, thus:

> *The semi-structured questions are asked in a logical order…, semi-structured interviews use a categorical analysis by item (or groups of items). As participants have some freedom to respond to each question, and the researcher may use probes to obtain additional information, these interviews are more restricted than unstructured interviews and less restricted than a closed ended questionnaire* (p. 1318).

An interview protocol for the semi-structured interviews was developed to ensure accuracy and consistency in delivery. The protocol included information for participants and a list of guide questions to be used to direct the interviewer (copies are provided in Appendices Three and Four). All interviews were conducted by the primary researcher and no assistants were engaged. Each interviewee was interviewed only once.

2.2.1   Sampling for the Interviews

To ensure a broad and relevant range of perspectives, key stakeholders were purposively drawn from four groups broadly-defined as government and non-government

sectors, and service providers and those not engaged in direct service provision. The stratification of the sample described ensured inclusion of relevant target groups, such as national government departments (e.g. the Departments of Health and Justice), national implementing agencies, national CSO, regional and/or international stakeholders as appropriate e.g. International NGOs and United Nations Agencies (UNODC, UNAIDS, UNFPA, WHO, etc.) who were or had been engaged in harm reduction policy dialogue, advocacy, development or services provision.

A key strategy in sampling and conducting the interviews was the development of a list of potential interviewees who were experts in the field. That is, those people who had been engaged in the formulation or implementation of Thai drug policy, including for example, advocacy, service delivery and law enforcement work. At this point it should be noted that the researcher was resident in Thailand for several years prior to the research, had worked in international development health programs throughout South-east Asia during that period, and as a result had professional networks which included many potential interviewees. The researcher also had a good knowledge of the Thailand national context, culture as result of long-term residency in Thailand and had functional Thai language skills (though not proficient enough to conduct an interview on such a technical and complex topic).

Initially the literature review was instrumental in identifying potential interviewees, for example, by identifying the agencies and individuals who contributed to relevant reports or were listed as members of committees involved in policy formulation, implementation, review and evaluations, or grant applications service provision and so forth. Other potential interviewees were identified from published works and the grey literature (e.g. authors and contributors to research and reports), many names were suggested as referrals from colleagues and some were already known by the researcher, having met through work or professional events prior to the research. Organisational charts and contact lists were accessed, usually through the organisations' websites, and staff in relevant departments were added to the list. The candidate deliberately attended several meetings and conferences as a strategy to help identify and access key stakeholders. A key Thai senior academic, who had worked for many years in the field of Thai drug use, also helped identify key potential participants. Early drafts of the list were shared with some colleagues in the field for their perusal and thus people no longer available were removed, errors corrected and some new names were added. and used in the data collection and analysis. The initial list compiled for targeting potential interviewees was added to during the interviews with names of people referred by interviewees, i.e.

snowballing technique. Ultimately the list comprised approximately 250 possible individuals or organisations but the list often included multiple people at the bigger agencies, of whom the researcher would contact all in an attempt to get one interview. The researcher attempted 234 contacts of which approximately half either didn't respond or the contact details did not work (they turned out to be incomplete, inaccurate or no longer valid). Some responded that they did not think they were knowledgeable enough to speak on the issue and about half of those referred the researcher to someone else (a colleague or superior) and that person would in turn either decline, respond or further refer. There were approximately equal numbers of men and women on the list of potential interview candidates. Nevertheless, generally women seemed more reluctant to agree to an interview and so only four of those who agreed to be interviewed were women. This will be discussed in greater details under the section on limitations.

Many of the details obtained through the approaches described above turned out to be out of date and the many initial contacts attempted resulted in failed contact due to: errors in recorded contact details; obsolete contact details because staff had changed positions or changed organisations; no response to the first and second contact attempts; or, a negative response to a contact for an interview. The reason most frequently cited for not wanting to participate appeared to be humility. That is, where the person said they felt that they were not qualified or experienced enough to provide a sufficiently informed opinion or commentary which would be of value to the research. In these situations, the person contacted often suggested someone else whom they felt was better qualified and usually this resulted in the same well-known people repeatedly being suggested. Sometimes the researcher was able to convince the person contacted that they were selected exactly because they were well informed, but more often this was not successful. This may have been a limitation of the methodology because, had all people contacted subsequently participated, additional information might have been obtained.

The researcher also used a snowball sampling technique (also known as chain-referral sampling) to increase the number of potential informants and to ensure representation of the relevant types of stakeholders (Biernacki & Waldorf, 1981). All participants were fluent in English language, even though restricting potential participants to English may have created some limitations to the data collection process. This limitation is acknowledged in the interpretation of the findings sections of this thesis. Despite this, through a combination of utilising established professional networks, snowballing techniques, persistence and some measure of serendipitous timing, the researcher was

able to speak with some of the most senior and influential people in government (including department heads or deputy department heads in key ministries), senior representatives in United Nation agencies, and leaders of civil society organisations (CSO). The sample included approximately equal proportions of people from both government and non-government sectors, and from national and international non-government sectors. A qualitative approach was used for data collection and analysis of both the survey and interviews. The aim of the survey was to obtain enough responses to reach data saturation. Bowen (2008, p. 140) described the process of reaching saturation as:

> Data saturation entails bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy. In other words, saturation is reached when the researcher gathers data to the point of diminishing returns, when nothing new is being added.

Therefore, quantitative statistical calculations such as power analyses calculations would not have been appropriate in this specific situation. Recruitment for interviews was completed when information saturation was reached. Twenty-three interviews were completed. The following table presents a simple matrix to provide further description of the four broad areas from which the sample of respondents were drawn.

Table 1: Four Areas of Respondents Sampled

	Government	Non-Government
Direct service provision	Government personnel engaged in direct service provision *e.g. drug treatment services*	Non-Government personnel engaged in direct service provision *e.g. HIV counselling and testing*
Non-service contributions	Government personnel not engaged in direct service provision *e.g. strategic planning or epidemiological analysis*	Non-Government personnel not engaged in direct service provision *e.g. program planning or funding*

2.2.2   The Interview Process

Each interview varied in duration from approximately 20 minutes to two hours. The duration of the interviews was largely determined by the interviewees. Interviewees were asked a set of questions but were also encouraged to expand on areas of interest and provide additional information or perspectives as they thought relevant and appropriate. While the interviewer used the prepared set of open-ended questions as a guide to ensure that the key areas were covered and to keep the interview on track, he nevertheless empowered the interviewees to determine how they responded to the

questions, what other topics or issues they felt were salient to include, and how little or how much time they wanted to respond. On a few occasions, interviewees asked to speak 'off the record'. In these cases, the voice recording was turned off until the interviewee was ready to continue recording and the information exchanged during the off the record portion of the discussion was not included in the data documented and analysed.

The interview consisted of 15 questions focussed on identifying the major factors that influenced Thai drug policy, at the international and national levels. Full details are provided in the Interview Question Guide (Appendix Four) but examples included:

> *2.   In your opinion, at the international level who are the major organisations/people which influence drug policy in Thailand?*
> *Prompts: Only individuals, agencies or departments you think have a major or significant impact on drug policy in Thailand*

> *3.   How influential do you think each of these major influencers is?*
> *Prompts: 1 – Not at All Influential   2 – Slightly Influential 3 – Somewhat Influential   4 – Very Influential,   5 – Extremely Influential*

The questions also explored the type, direction and impact of those factors, for example:

> *4.   What type of influence you believe they have?*
> *Prompts: consider types of influence like political, economic, social, information, technological, or some other kind of influence e.g. powerful allies or spiritual authority?*

> *6.   What is has been the effect of their influence on Thai Drug policy?*
> *Prompts: Did their influence slow/accelerate/stop/start/changed direction etc. of drug policy debate or implementation?*

The interviewing component of the research was concluded after the 23rd interview. This determination was made for a number of reasons, including: it appeared that the pool of people identified as suitable willing and available for interview was just about exhausted; it was becoming increasingly difficult to obtain commitment and confirmation for an interview from the diminishing number of people on the potential interview candidate list (previously described in the methods section); the interviews had taken place over approximately four-five months, and there was a need to move onto the analysis phase. Most importantly, the information elicited from interviewees had reached saturation. That is, the content from different interviewees was becoming increasingly similar and shed

no further light on the area of investigation. Furthermore, the interview answers given about the issues of concern (the influencing factors and the key stakeholders involved) were becoming so similar as to be predictable. This was also consistent with Margaret Mead's purported "…*note that one index of saturation was the boredom that occurred when investigators had heard it all*" (Morse, 1995, p. 147).

2.3   Step 3 - Survey of Key Stakeholders

A survey of international harm reduction stakeholders who had participated in illicit drug policy advocacy, dialogue, formulation, implementation or service delivery was central to the data gathering process. The survey tool was constructed and modified after piloting (see below) and consisted of 15 questions. The steps in sampling and piloting are described in the following subsections. It was designed to provide basic (but non-identifying) information on the respondents' country and organisational experience, knowledge of harm reduction and to elicit their perceptions about:

I.   What they thought had been the most effective harm reduction strategies implemented in the past five years in the country in which they were currently working/studying;

II.   What ways they thought these harm reduction strategies had demonstrated that they have been effective;

III.   What they thought were the main influencing factors that helped the formulation of effective national harm reduction policy in their country;

IV.   What they thought were the main influencing factors that helped the implementation of effective national harm reduction policy in their country;

V.   What they thought were the main influencing factors that hindered the formulation of effective national harm reduction policy in their country;

VI.   What they thought were the main influencing factors that hindered the implementation of effective national harm reduction policy in their country; and,

VII.   Any other comments they wanted to make about harm reduction policy in their country.

The survey was constructed to provide in-depth open-ended questions for qualitative analysis and data for descriptive statistical analysis. The development of the survey questionnaire was based on an analysis of the responses to the semi-structured interviews. The survey was based on the same four areas of questioning (i.e. factors which hindered or helped the formulation or implementation of drug policy) and a few additional refinements were also added as a result of the interviewing experience. For

instance, questions were added to identify the country context in which the participants were working, for example:

> *In the country in which you work/study now, what do you think have been the most effective harm reduction strategies that have been implemented in the past five years?*

Written prompts and guidance were also added to the questions, for example:

> *When answering the following questions, you might consider particular organisations (international, regional or national) that you think play a very important role for/against harm reduction; and/or you might consider specific political, economic, social, cultural infrastructural, technological factors that you think play a very important role. It will be helpful if you are quite specific in your answers. For example, if you think that resources are important please mention the type of resources, where they should come from and where they need to be used.*

Participants were also given the option to provide any additional information they considered important, even if it was not specific to the four main research questions, as they might in a semi-structured interview situation. For example:

> *If you would like to, you are welcome to add any other comments about harm reduction policy in your country in the space below.*

Each survey respondent completed only one survey. The ethics approved *Information about the Survey for Participants* forms are provided in Appendix Five and a copy of the approved *Drug Policy Survey* which was distributed is provided in Appendix Six.

2.3.1   Pilot Testing

The survey instrument underwent a number of phases including appraisal by: the Australian PhD supervisor and co-supervisor, and the Thai PhD co-advisor; by colleagues working outside the field of illicit drug policy; and, by colleagues who currently worked, or had worked, within the field of illicit drug policy. Several people read the documents, and three attempted to complete the questionnaire, subsequently providing both written and verbal feedback on its clarity and utility, and recommendations for its improvement. In addition, the survey was pilot tested by three volunteers with similar professional demographics to those selected for the target respondent groups. The tests included three rounds of testing and survey revision. The comprehensive responses from

pilot testing of the survey subsequently led to substantial revision and redrafting through several versions.

These procedures helped to ensure the utility of the tools as well as their face and content validity. The processes of review with supervisors and colleagues tested and verified content validity, ensuring that the data collection tools (survey questionnaire and interview question guide) could reliably assess for the key variables and constructs which had been identified through the literature reviews. In other words, the tools could provide a critical data to identify the factors in the policy environment which facilitated or constrained drug policy reform. Feedback from these pilot trials on preliminary versions of the survey instrument identified issues with face validity, i.e. these were problems associated with the comprehensibility and appropriateness of the language; the fidelity, sequencing and completeness of questions; the utility and clarity of instructions. Perhaps most importantly, they also assisted with content validity ensuring the survey questions would ultimately provide the information necessary to answer the research questions. As result a multiplicity of minor revisions were made to a series of drafts before instruments were finalised.

An additional phase in the testing was later added to the methodology. An opportunity presented for the researcher undertake interviews with drug policy and HIV experts in Cambodia, a few people who had similar experience and positions to those with whom the researcher planned to interview in Thailand. This enabled the researcher to obtain a great deal more feedback about the methods and tools without contaminating the pool of people in Thailand the research planned to access. It also provided insights and information about the Cambodian experience of drug policy change for HIV prevention, which provided very useful background, much of it which had relevance to the Thai context.

2.3.2   Sampling for the Survey

As described under the section on interviewee sampling, the survey participants were purposively selected from the common list of potential informants for both the semi-structured interviews and the survey questionnaire. After initially contacting some of the experts listed, it became evident that many of them would be attending the International Harm Reduction Conference, October 2015 in Malaysia. In addition, the Harm Reduction Conference would also meet the other criteria of the sampling technique. That is: they were engaged in harm reduction policy dialogue, advocacy, development or services

provision; they were drawn from four strata representing people at the provincial, national, regional and international levels of policy formulation and implementation; and, they included personnel from NGOs working on provincial service delivery, staff of national government departments, and personnel from multilateral or United Nations agencies. In addition, most conference participants were fluent in English. It was decided that conducting the survey at the Harm Reduction Conference would be a more efficient and effective way to access a very large sample of the planned target respondents as the conference hosted approximately 1000 delegates from 70 countries. This required an amendment to the research ethics application and a further ethics approval to distribute 'hardcopy' surveys at the conference. This approval was sought and granted.

A qualitative approach was used for data collection and analysis of both the survey and interviews. As described earlier this approach aimed for saturation in both the interview and survey data collection. Saturation also involves the coding and categorisation of the data until these data sets or codes are complete as Strauss and Corbin noted (2008, p. 82) "*It also denotes the development of categories in terms of their properties and dimensions*". Morse and colleagues (2002, p. 18) further explained this process, "*Saturating data ensures replication in categories; replication verifies, and ensures comprehension and completeness*". This process not only ensures the adequacy and completeness of the data but represents the point "…*when no new data are emerging*" (Strauss & Corbin, 2008, p. 82). The exact number of interviews required to reach saturation would vary for example, depending on the scope of the study, the nature of the topic, the quality of the data, the study design and so forth (Morse, 2000). A recent review of the literature on sample size in PhD qualitative research has suggested between 15 to 30 responses may be sufficient to achieve saturation (Mason, 2010). This was also consistent with Guest, Bunce and Johnson's (2006) recommendation of around about 25 completed responses. Therefore, the researcher's original plan was for at least 100 possible recipients to receive the survey on the assumption that the response rate may be as low as 25% and so ensure the return of at least 25 completed surveys with usable data. At the time of implementation of the survey, the strategy of using the conference as a source of respondents enabled the researcher to distribute 300 surveys and receive 51 survey responses of which 44 were complete, fully legible and useable.

2.4 Step 4 - Data Analyses

Deductive Content Analysis was used to systematically and objectively identify, describe and quantify key patterns, categories and themes about the policy factors of interest from

the survey responses and the semi-structured interviews. The material from each interview was de-contextualised and a coding procedure used to reduce the information to categories and themes, and then re-contextualised. Elo and Kyngas (2008) stated that a deductive approach is used when the structure of the Content Analysis is operationalised on the basis of previous knowledge and the purpose of the study. The triangulation and convergence of sources of information from the literature reviews, document reviews, key stakeholders survey and the semi-structured interviews provided the ability to verify, and enhance data, build plausible explanations for observations and results and, where possible, identify causal links (Onwuegbuzie & Johnson, 2006; Onwuegbuzie & Leech, 2004, 2005).

The interviews were transcribed verbatim. It became apparent that a single word could make a difference in nuance or even meaning to a statement, especially when working with people who used English as a second language. The verbatim transcription also ensured that the unique 'voice' (or the idiomatic personal expression) of each person was preserved. The interviewer familiarised himself with the interview content by listening to the audio recordings and reading the transcriptions of each interview multiple times during the transcription and then coding phases. Following the transcription, the interviews were analysed and coded categorically. That is, the researcher identified data or topics with similar characteristics and ascribed categories to organise the information to later compare and contrast with other categories. Following analysis by category, the researcher used thematic analysis, in which broader themes running through segments of interviews, or occasionally whole interviews, were identified using interpretive processes (Morse, 2008, 2015).

The NVivo Version 10 software program was used for textual data management and to assist with qualitative analysis of the interview contents and themes. NVivo is a qualitative data analysis software package that allows users to import, sort and analyse a wide range of electronic files including text documents, PDFs, audio files, bibliographical data, spread sheets, digital photos, and social media data. NVivo was used as a primary tool for analysis of both the interview transcripts and the survey data results. The codes (called 'Nodes' in NVivo) were neither exclusive of each other nor complete collectively (since the number of possible nodes or codes is probably infinite). Approximately 80 nodes were created in NVivo and they were subsequently clustered further thematically. For example, the node which accounted for both the greatest number of individual references (83) and comments by the greatest number of experts (18) was the node or category titled 'Thai Culture and Society'. This 'Parent' node was further divided in to the

following five subcategories or child nodes: Public Attitudes; Culture; Stigma and Discrimination; Religion; and, Hierarchy. In addition, many comments were common to more than one node and sometimes multiple nodes (e.g. human rights and CCDU and the Thai "War on Drugs"). The transcripts were, in effect, double coded or cross coded. That is, thematic nodes were created initially in one systematic coding process. After that, a second systematic coding process was undertaken to code transcript material to directly match the four research questions by coding for factors that either facilitated drug policy formulation, facilitated drug policy implementation, hindered drug policy formulation or hindered drug policy implementation. During the data analysis matrix, queries were run to crossmatch each of these four factor categories against every other thematic node.

During the analysis, themes which emerged strongly were often connected to sub-themes. In the NVivo Analysis Software Version 10, the coded themes were called 'Nodes' and the relationship between themes and sub themes was termed 'Parent' and 'Child' Nodes. For example, United Nations constituted one theme of coded responses within which various United Nations agencies were discussed. Most prominent among these agencies discussed was the UNODC which was coded under the parent United Nations theme as a subtheme or 'Child' node. Nodes were also coded based on which of the four queries they related to:

1. Facilitated drug policy formulation;
2. Facilitated drug policy implementation;
3. Hindered drug policy formulation; and,
4. Hindered drug policy implementation.

See Appendix 12 where a four-quadrant matrix is used to visually represent the Parent and Child Nodes as they relate to each query.

Most of the coding was done manually, once the researcher had stored the coded data as nodes, NVivo version 10 allowed the user to explore the data in the nodes by using analysis tools to run queries. For example, while the clear majority of the nodes for this research were created by the researcher based on themes and frequency of responses (e.g. Law Reform, Role of the Military), one node resulted from running a word frequency query and finding many responses discussed perceived needs, thus several nodes were created around commonly-perceived needs in relation to drug policy in Thailand, such as the need for education, or the need for resources to provide harm reduction services. Microsoft Excel was also used for analysis of some of the data about the respondents (such as demographics) and analysis of the semi-structured interview material based in

grounded theory (Corbin & Strauss, 1990; Glaser, 2006; Glaser & Strauss, 1999) which used both categorical and thematic analysis.

In summary, both the survey responses and the interview transcripts were coded using two processes, first with NVivo software and then again manually. In addition, during each of these processes the content was double coded or cross coded. Firstly, thematic nodes were created initially in one systematic coding process. Secondly, another systematic coding process was undertaken to the code transcript material to directly match the four research questions by coding for factors which facilitated drug policy formulation or implementation, and factors which hindered drug policy formulation or implementation. To assist the reader, during the discussion of analysis and finding and interpretation in the later chapters the people who participated in the survey were referred to as survey respondents and those who participated in the interviews were referred to as expert interviewees.

2.5   Ethical Issues

Researchers are responsible for ensuring that harmful consequences (devaluation of personal worth, social harms, economic harms, or legal harms) that could potentially arise from participation in, or the conduct of, a research project are identified, evaluated and minimised (National Health and Medical Research Council, 2007). All participants were at all times treated with respect and with regard to their cultural values and individual circumstances. Some people surveyed may have been providing potentially sensitive information for this research and it was also possible some respondents, particularly those drawn from civil society, may have been (at that time or previously) people who used drugs (PWUD). Moreover, experienced experts and activists working on drug policy in Thailand represented a relatively small sphere of people who may be readily identifiable to others. For these reasons, in the analysis and discussion of findings, caution was taken to avoid identifying the speakers, including not using unique identifiers (such as numbers) which would allow readers to identify and piece together multiple separate statements by an individual and, by that means, identify the speaker through their use of language and or a composite of their ideas and statements. On the other hand, being able to make some distinctions about the respondents, for example whether or not the participant or respondent was Thai, added to the descriptive power of the analysis and improved understanding. Therefore, some very general devices were used to differentiate or provide context, for example, statements were identified as being made by an international, regional or Thai respondent.

No information was collected in either the survey questionnaires or the semi-structured interviews which focussed on an individual's illicit behaviour or any other activities which would leave a participant vulnerable to legal or social sanctions as result of the information disclosed about drug-related activities. Therefore the researcher did not anticipate any instances in which the research could inadvertently discover " *…illegal activity (including notifiable activity) by participants or others, or may discover information indicating future illegal activity*" (National Health and Medical Research Council, 2007, p. 67). Furthermore, the candidate consulted with and was guided by the ethical procedures used by Curtin University but also those used by Chulalongkorn University, a Thai university which had extensive experience conducting ethical research with people affected by drug use in Thailand.

Participant Information Sheets were prepared in plain language (English and Thai) and was provided prior to participation in either the survey questionnaire or the semi-structured interviews (See Appendix 3 - Information for Interview Participants and Appendix 5 – Information about the Survey for Participants). These described: the purpose of the research; the type of involvement required of participants; who was conducting the research; funding and other relevant declarations of interests of the researcher; assurances that confidentiality was respected; and, that the study had been approved by the Curtin University Human Research Ethics Committee and by The Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University. The information sheet also assured the participant that involvement was voluntary, and that at any stage of the research, participants could choose to withdraw their consent to participate in the research and, where consent has been withdrawn, data relating to the participant would be destroyed unless the participant gave permission for it to be retained. Participants were given the opportunity to ask questions and to discuss the information and their decision with others, if they wished. Consent to participate was obtained verbally for the semi-structured interviews and was passive in the case of the questionnaire survey (completion of the survey implied consent). Consent of the interviewee was obtained for the interviews to be recorded. If the participant was not comfortable with audio-recording and did not provide consent, then the researcher relied on detailed hand written notes. Interview appointments were made well in advance by the researcher and scheduled at the time and place most convenient for the interviewee. Cancelled appointments were rescheduled as necessary (Schmeer, 2000).

Respecting the confidentiality and anonymity of the drug policy experts who volunteered as interviewees was critical to the ethical conduct of this research. survey questionnaire and the semi-structured interview responses did not include names, positions or other personal identifying information and the identity of the participants was not known by anyone other than the researcher. The research results may be published in articles in peer-reviewed journals, but no identifying information about individual participants would be used in these publications. No data collection commenced until approval was granted by the Ethics Committees in both Australia and Thailand. Copies of the ethics committee approval certificates are provided in Appendix Seven.

The data were stored in a non-identifiable form, identified by code only, and master lists of codes and names were kept on the candidate's laptop, with backup copies on an external hard drive both of which were password protected and only accessible by the candidate. The data were stored on a secure Curtin University controlled data server and will remain there for a period of seven years after the end of the research project (30 November 2016) and then it will be destroyed. The candidate will not seek specific, extended or unspecified consent for future use of the data.

2.6 Chapter Summary

This research occurred at the confluence of three different yet interacting streams of expertise: policy analysis; HIV epidemiology; and, responses to illicit drug use. At this conflux or meeting point was the knotty issue of policy responses for halting the transmission of HIV by PWUD, among themselves and into the broader community. The methodology had to examine each of these areas and bring them together for investigation. Therefore, the methodology was multifaceted involving four separate literature reviews, a survey and a series of expert interviews. Subsequent chapters provide a detailed description of each literature review, however, in brief they collectively they supported the research with an essential foundation which included:

- Firstly, a detailed investigation of drug use and responses to drug use;
- Secondly, an appraisal of the epidemiological trends and impact of HIV globally, regionally and nationally;
- Thirdly, consideration of harm reduction and policy and service responses to reduce drug-related harms;
- Fourthly, an examination of policy and policy analysis to determine the appropriate analytical frameworks for analysis and interpretation of the data collected; and,

- Finally, a critical review of the published and grey literature on the drug use, drug harms and drug policies in Thailand.

The expert interviews were core to the investigation and provided extensive, rich and detailed data for analysis. Finally, the survey data enabled the findings from the other methods to be triangulated, compared and contrasted with information from national experts working in drug policy advocacy and implementation from a diverse range of countries all around the world. The following five chapters will detail the findings of the literature reviews on drug use, HIV, harm reduction, policy analysis, international drug policy and then Chapter Eight will offer a critical review of the how each of these areas are related to drug use and drug policy in Thailand.

Chapter 3: Drug Use

In the first two chapters the purpose and approach of this research was described in detail. The chapter on the methodology explained importance of a thorough and critical review of the literature in each of the four major areas which converge in this research: drugs and drug use; the epidemiology of the HIV epidemic globally, regionally and nationally; harm reduction; and, policy and models for policy analysis. This third chapter presents the first literature review which examined psychoactive drugs and drug use (historic and current) as well as the harms associated with the use of those drugs.

The use of different psychoactive substances appeared to have been universal human experiences, that is, they had occurred across cultures and throughout history. Indeed, Goode (2006, p. 416) stated that "*People have been writing about psychoactive drug use and drug effects for at least 6,000 years...*". As far back into human history as anthropologists and archaeologists have been able to investigate, across diverse cultures, they have found evidence of the use of psychoactive substances for purposes of religion, economics, medicine or simply pleasure. Nevertheless, the focus of the following section is on the present: current trends in drug use; production and distribution; and, policy and legislative responses. The section will firstly consider the global picture and subsequent sections will 'drill down' to the regional and then national levels. Before proceeding, however, it is worth briefly discussing the data and the methods of data collection and analysis which inform the description of current drug trends and responses.

3.1   The Data on Drug Use

There were obvious challenges to determining with accuracy the exact scope and dimensions of the production, distribution and use of illicit drugs. The fact that these drugs were illegal relegated them to the *black market* where their production, distribution, sale and use were largely hidden. The countries that were most likely to be engaged in the production of a drug were also often those with the least developed systems for policing, monitoring or controlling drug production. Many of these low-income developing countries also had high levels of corruption and poor governance mechanisms and so were unlikely to be in a position to be able to report accurately on drug production, trafficking and consumption. Afghanistan, was a prime example, the lead producer of opium globally (accounting for 74% of the world's illicit opium production in 2012), had weak governance, law enforcement, and monitoring systems (United Nations Office on Drugs and Crime, 2013d). The situation in Afghanistan was complex but major factors

undermining its stability included corruption, ethnic and political tensions and armed conflicts (Katzman, 2014).

The drug use estimates presented here were determined using various methods and each method had its limitations, such as sampling bias or the incorporation of outdated or inaccurate information. While a detailed investigation of the range of relative strengths and weakness of each method was beyond the scope of this study, it was important to consider some of the important limitations of the major approaches used in drug use prevalence estimates, such as household surveys, surveys of school students, capture-recapture methods, convenience sampling, and government treatment and arrest statistics. Household surveys are usually the largest and most expensive undertakings to determine drug use prevalence estimates and are often held to be one of the most accurate methods. Even so, household survey estimates may under-represent drug use. Problematic drug use is uncommon and even in surveys involving tens of thousands of people, only a few hundred people will report problematic drug use (Hickman et al., 2002). PWID often congregate in small geographic areas (e.g. low-cost inner city areas) which may not be specially targeted in broad national surveys. In addition, PWUD are more likely than other members of the general population to live in non-conventional households or to be homeless, and so they could be missed or under-sampled in household surveys. Finally, PWUD may be reluctant or even fearful of disclosing behaviours considered to be socially undesirable, immoral, illegal and where detection can result in social condemnation, enforced treatment, and/or severe legal penalties (Law, Lynskey, Ross, & Hall, 2001).

A person's willingness to disclose their engagement in an illegal and socially stigmatising activity may be affected by how confident the person surveyed was that their anonymity and confidentiality would be respected. It would also be highly likely to be influenced by the person's perceptions of the interviewer, for example, they may feel less comfortable divulging drug use to a government official or person from law enforcement (Degenhardt et al., 2013). This would probably also vary across countries and cultures. People in one country might be more willing to disclose information about illicit drug use compared to citizens of some other countries *"Moreover, social and cultural may contribute to some communities being willing to divulge information about illegal activities such as drug use, while others may be suspicious of divulging information to government services, resulting in response and reporting biases"* (Beatty & Allsop, 2009, p. 149). These concerns can make the comparison of patterns of drug use among countries quite challenging.

An unwillingness to disclose drug use can also create bias or error in data collected through other self-reporting methods, such as surveys of school students. While the ease of accessing students and the lower costs in undertaking such surveys might make these types of surveys attractive, students' responses may be restrained by concerns about the social or legal consequences of confessing to drug use. In addition, there was evidence that those students who were most likely to use illicit drugs, particularly those who were initiated into drug use early, were also more likely to be excluded from such surveys because they were absent, truant, or are more likely have left school system at an earlier age (Degenhardt, Bucello, Mathers, Briegleb, & Ali, 2011). Another critical limitation of school surveys has been that, although they provide data on adolescent drug use, they do not capture data from the age group where the highest frequency use occurs, that is, youth aged 18-25 years (Degenhardt, Bucello, Mathers, et al., 2011). In general, it is highly likely surveys underestimate drug use, as was illustrated by US research which indicated that surveys substantially underreported alcohol consumption, accounting for only 22% to 32% of state alcohol sold during the same period (Nelson, Naimi, Brewer, & Roeber, 2010). It is arguable that the hidden nature of illicit drug use may contribute to similar or larger levels of under-reporting.

Comparison, or triangulation, of data from various methods including: drug use questionnaires; behavioural surveillance; police seizures and arrests; capture-recapture; and, multiplier methods can be used to check data validity and strengthen the accuracy of estimates. Common techniques used to triangulate data include the use of a multiplier or multivariate indicator, capture-recapture and back-projection estimate methods (Smit, van Laar, & Wiessing, 2006). These approaches combine an indicator (e.g. the number of people in drug treatment during a specified period) with a multiplier (e.g. the proportion of a sample of opioid dependent people who report receiving treatment within the past year). In 1991, a two-sample study was undertaken in Bangkok, in which one sample consisted of 4,064 heroin users in methadone treatment, and the other sample was 1,540 PWID arrested for opioid use. The 171 people listed in both samples produced an estimate of 36,600 opiate users for that year in Bangkok (Hickman et al., 2002; Mastro et al., 1994). Some researchers advise that these methods are more likely to produce accurate estimates of dependence than direct surveys (Degenhardt, Bucello, Calabria, et al., 2011; Kraus et al., 2003; Smit et al., 2006) and in some cases have produced estimates of the number of dependent heroin users that are seven to 10 times greater than estimates derived using survey-based methods (Maag, 2003). The "…*major limitations are uncertainty about the quality of indicator data and the validity of commonly used multipliers*" (Degenhardt, Bucello, Calabria, et al., 2011, p. 98). Furthermore,

extrapolating population drug use estimates from administrative data collected from captured populations, such as those in drug use treatment centres or prisons, was usually technically convenient and cost-effective but introduced sampling bias which was likely to over represent drug use and its long-term consequences. Furthermore, using medical records or coroners' reports may result in distorted findings because, for example, the causes of drug-related deaths are often misattributed or obscured (e.g. deaths in drug dependent people are often characterised as accidental poisonings) (Degenhardt et al., 2013).

These issues can become even more confounding when attempting country comparisons or making aggregated regional or international estimates. There are often definitional variances between different jurisdictions making comparison and aggregation difficult. For example, in estimates for stimulant-use (or stimulant use disorders) stimulants may be defined by some countries as either amphetamine, methamphetamine, MDMA or cocaine. Other countries may include only the use of amphetamine and methamphetamine, or combine the use of amphetamine, methamphetamine and cocaine (W. Hall, Teesson, Lynskey, & Degenhardt, 1999). Another practical issue was that data quality was sometimes poor or incomplete because some countries simply lacked the capacity or resources to undertake drug use prevalence estimates regularly or at all (Degenhardt, Bucello, Mathers, et al., 2011). Notwithstanding these complexities and limitations with data and subsequent estimates, a recently completed expert review of online sources of global, regional and national information on drug use prevalence and harms found that, while there was a need for greater consistency and improved quality in the data on which global drug use estimates are made "*…the World Health Organization (WHO) and United Nations Office on Drugs and Crime (UNODC) provide the most comprehensive data on addictive behaviours globally, both as downloadable data sets and through regular publications*" (Gowing et al., 2015, p. 904). For this reason, prevalence data from these two sources will be used consistently throughout this study along with an extensive variety of other relevant published and grey literature.

3.2   Global View of Contemporary Drug Use

Despite the challenges mentioned previously about data collection and interpretation, and even after considering the variations in figures published, the estimates produced consistently indicated that the world's contemporary psychoactive drug use was extensive. In addition, continuing improvements in the capacity of countries, particularly

in Africa and South America as well as refinements in survey methodology have resulted in changes in annual national and international estimates which may reflect ongoing progress in improving the accuracy of the estimates. For example, the worldwide estimate of the number of PWUD reported by the UNODC in 2013 was reduced from their previously reported figure of 15.9 million to 14 million (range: 11.2 million to 22.0 million) not because of changing trends in drug use but because of improvements in behavioural surveillance data meaning that many countries revised earlier estimates downward (United Nations Office on Drugs and Crime, 2013d).

The UNODC 2013 World Drug Report estimated that in 2011 approximately 241 million people aged 15–64 years (estimated range 167-315 million or 3.6-6.9% of the adult world population) had used an illicit substance in the preceding year (United Nations Office on Drugs and Crime, 2013d). An estimate by the Transform Drug Policy Foundation[2] (TDPF) was higher at 270 million people worldwide. TDPF also estimated the associated financial expenditure on illicit drugs to be $330 billion per annum (Rolles, Murkin, Powell, Kushlick, & Slater, 2012). According to the same UNODC report (2013d) the most frequently used illicit drugs were cannabis, amphetamine-type substances (ATS), cocaine, heroin and opium. Cannabis remained the most widely used illicit drug in the world with 180.6 million users or 3.9% of the population aged 15-64 years. An estimated 33.8 million people (0.7% of the global population aged 15-64) had used ATS in the preceding year and 19.4 million people aged 15-64 years had used 'ecstasy'. In 2011, an estimated 16.5 million people aged 15-64 worldwide used opiates (i.e. morphine, heroin and opium). UNODC reported only a minor increase in world cannabis use over their 2009 estimate and stated ATS use appeared to be increasing in most regions of the world; the estimated annual prevalence of ATS use in Asia was 0.7%. In Europe, there was a recently reported decline in the use of heroin and it was proposed this may have been due to the ageing of the population of PWUD, drug treatment uptake and increased interdiction of supply. Conversely, in Asia opiate use has been increasing since 2009, particularly in East, South-East, Central and South-West Asia. Degenhardt and colleagues' rigorous systematic review of the epidemiology of drug dependence and analysis of the 2010 Global Burden of Diseases (Murray et al., 2012) using Bayesian meta-regression technique supported UNODC prevalence estimates finding approximately 0.3% of the world's adult population (15 million people) injected

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[2] An independent international drug policy "Think Tank" based in the UK

psychoactive drugs. A recent phenomenon which has been receiving increasing attention internationally has been the increasing number of reports about the growth in the production, trafficking and use of drugs termed new psychoactive substances (NPS). These are generally *"…psychoactive substances that mimic the effects of illicit drugs and are produced by introducing slight modifications to the chemical structure of controlled substances to circumvent drug controls"* (United Nations Office on Drugs and Crime, 2013d, p. 1). The commonest groups of NPS were: synthetic cannabinoids; synthetic cathinones; ketamine; phenethylamines; piperazines; and, plant-based substances (particularly khat and kratom). Strictly speaking, some of these substances were not new. Some were first synthesised decades ago. For example, ketamine has long been used as an approved veterinary pharmaceutical and the plant-based substances have been used for historically extensive periods although confined culturally and geographically. Part of the confusion in nomenclature was that these substances were generally being defined as 'new' in policy terms, that is, they were often referred to as new because they were not currently included under the international drug control conventions, rather than because they had only recently been produced. What brought these substances to the attention of drug policy experts and service providers and constructed them as a 'new' problem was their relatively sudden commercialisation (on the black market), a rapid increase in the number of users, and their swift spread via international trafficking. In 2011, a survey of 12,000 randomly selected young people (aged 15-24) across 27 EU Member States found five percent of the participants reported having used NPS. Youth in Ireland ranked the highest in terms of rate of use at 16% and those in Italy ranked at the lower end at 0.8%. Sixty-one of 80 countries (76%) included in a UNODC review reported seizures of trafficked NPS; 75% of these seizures were for synthetic cannabinoids and ketamine. The most significant seizures of ketamine occurred in Asia, the largest being 5.3 tonnes in China in 2009. Even so, at the time of the UNODC 2013 report, estimates on the prevalence of use of NPS were limited to data collected on some specific substances and/or subpopulations in only a few countries and the global trends in NPS were yet to be determined (United Nations Office on Drugs and Crime, 2013d).

3.3   Patterns of Illicit Drug Use

In any discussion of illicit drug use it is important to note that there are many different patterns of use. This is also quite germane to later discussions on policy responses. Patterns of drug use may vary dramatically according to: the particular drug used; its quality or potency; quantity; combination with other substances; the frequency and the

route of administration; the physical constitution and psychological state of the person using, along with the intention of the user and the function drug use serves; the social, religious and cultural context of the user; and, the environment in which the drug use occurred (Fountain, Hartnoll, Olszewski, & Vicente, 2000). These patterns or types of drug use will be examined further in the following section.

A critical point especially relevant to this discussion and one often misunderstood and/or misrepresented in the discussions (and sometimes passionately contested debates) on drug policy was that not all drug use results in dependence. In fact, dependent use has been the least common form of drug use overall. Over 40 years ago, in 1973, the 20th WHO Expert Committee on Drug Dependence noted that the complex and diverse interaction between drugs, users and environments resulted in great differences in how an individual may be affected by drug use and how sensitive an individual may be to the development of a dependence. Furthermore, the committee made clear distinctions between experimental, recreational and dependent drug use (World Health Organization, 1973). Yet in many policy debates drug use, drug related problems and drug dependence are often conflated or used interchangeably.

There are a variety of models analysing or explaining the different patterns of drug use and it was beyond the scope of this research to systematically review them all. The work of Erich Goode (2006, 2012) is one reputable and practical model that will be briefly described here to explain the diversity in types of use and so emphasise why diverse policy responses might be required. Goode's work, based on large-scale US National Drug Use Surveys, and verified by surveys conducted in other countries, noted consistent trends in the data which he claimed supported the following generalisations about patterns in drug use:

1. Experimental use is the rule and most people discontinue their use;
2. For all illicit drugs, episodic or occasional use is more common than heavy, chronic use;
3. The use of the legal drugs, alcohol and tobacco, is vastly greater than the use of the illegal drugs;
4. Regular use is much greater for the legal drugs than for the illegal drugs;
5. The more people use the legal drugs, the greater is the likelihood that they will also use illegal drugs; and,
6. Generally, drug use rises sharply from age twelve through adolescence, reaches a peak in the twenties, and then subsequently declines, year by year.

Goode also made four practical distinctions about the function of drug use based upon the legal status of the drug and the intention of the user, as described in the following table.

Table 2: Goode's Four Drug Use Categories - Legal Status and Use Intention
(Goode, 2006)

1	Legal Instrumental Use	Occurs when one consumes prescribed drugs and over the counter drugs to relieve or treat symptoms.
2	Legal Recreational Use	Involves using legal drugs e.g. tobacco, alcohol or caffeine to achieve a certain mental state.
3	Illegal Instrumental Use	Is when one takes a non-prescription drug to accomplish a task or goal, e.g. a truck driver taking ATS to maintain alertness during an overnight drive.
4	Illegal Recreational Use	Occurs, for example, when one uses an illegal drug simply for fun or to experience euphoria.

It should be acknowledged that there may be a multiplicity of nuances in drug use beyond the four categories described by Goode. Nevertheless, Goode's four broad categories were a useful framework to refer to in subsequent exploration of policy responses to drug use. While drug dependence is a major concern when considering drug-related harm, route of administration may be of even greater concern. In terms of route of administration, IDU is an especially high-risk practice as will be examined in the following sections.

3.3.1   *Injecting Drug Use*

In theory, most drugs could be prepared for intravenous injection and in practice, a diverse range of pharmaceutical preparations have been injected illicitly, including substances never intended for injection and often this has resulted in medical complications and sometimes death. Nonetheless, the illicit drugs most commonly injected have been heroin and to a lesser extent ATS, with many countries having consistently reported that IDU was almost exclusively of heroin. The 2012 UNODC World Drug Report found "*There is no injection of cannabis, and 'ecstasy' injection is uncommon. With a few exceptions, cocaine is also rarely injected*" (United Nations Office on Drugs and Crime, 2012d, p. 83). Although there have been reports of drug users injecting a range of drugs, such as cocaine, fentanyl, buprenorphine, methadone, preparations of opium, benzodiazepines and prescription analgesics, these have been

usually localised geographically and temporally, often in response to restrictions in supply of heroin (Kerr et al., 2010; United Nations Office on Drugs and Crime, 2013d).

As previously mentioned, the UNODC estimated in 2011 a total of 14.0 million people injected drugs worldwide, which corresponded to 0.31% (range: 0.24-0.48%) of the population aged 15-64. This appeared to be conservative given the range UNODC cited for the estimate, 11.2 million to 22.0 million and other researchers e.g. Mathers and colleagues (2010; Mathers et al., 2008) estimated that worldwide 15.9 million people inject drugs. The latter study included UNODC reported data, but also involved a systematic search of databases, publications, grey literature and information requested from various government and multilateral agencies, and such triangulation of data may have produced a more robust estimate than that of the UNODC World Drug Report. On the other hand, this estimate was based on data that are now several years old. Since the period when Mathers and his colleagues' research was undertaken, in many countries the monitoring and reporting systems which produced these data have been further developed, with the financial and technical assistance of international donors and multilateral agencies and the ongoing efforts of national governments, and these national and international agencies have made credible claims of incremental gains over time in the accuracy, validity and reliability of the data and the systems which produced them (United Nations Office on Drugs and Crime, 2007b).

3.4   Harms Related to Illicit Drug Use

Illicit drug use is a potentially high-risk activity which can result in a range of negative consequences for the individual, those around them and the broader community. The United Nations estimated that there were 210,546 (between 102,040 and 247,336) drug-related deaths worldwide in 2011, corresponding to a mortality rate of between 22.3 and 54.0 deaths per million in the population aged 15-64. This represented between 0.54% and 1.3% of mortality from all causes globally among those aged 15-64 (United Nations Office on Drugs and Crime, 2013d). Drug overdose is one of the most serious acute drug-related harms and is often fatal. The UN estimated that in 2010 there were as many as 100,000 illicit drug deaths worldwide, of which opioid overdose was the main cause.

UNODC reported that globally in 2012, 52% of PWID were living with hepatitis C. At the time this corresponded to 6.6 million people aged 15-64. They also estimated that 850,000 PWID aged 15-64 were living with hepatitis B. They further assessed that:

The burden of disease from acquiring HIV through injecting drug use was estimated to be 2.1 million years in 2010, of which 2.0 million were from years of life lost through premature death. The burden of disease from hepatitis C acquired through injecting drug use is also high and was estimated to be responsible for 494,000 years of life lost in 2010 through premature death.
(United Nations Office on Drugs and Crime, 2014b, p. 12)

UNODC estimated the global prevalence of hepatitis C virus (HCV) among PWID to be 51.0%, or 7.2 million people in 2011 (United Nations Office on Drugs and Crime, 2013d) while Harm Reduction International (2012) put the figure at approximately 10 million PWID worldwide, which exceeded the rate of HIV infection among the same population. In addition, the global prevalence of the hepatitis B virus (HBV) in 2011 among PWID was estimated at 8.4%, or 1.2 million people. People living with HIV who also inject drugs commonly have co-infection with HCV and/or HBV. PWID living with HIV also have up to a six-fold increased risk of developing TB compared with non-injectors (Harm Reduction International, 2012). Notwithstanding these issues, it has been the harm associated with HIV transmission, and subsequent morbidity and mortality from AIDS, that has had the most profound around the world on the way policy debates, formulation and implementation have been framed as well as subsequent service provision.

3.5   The HIV/AIDS Epidemic

Since the beginning of the epidemic, almost 70 million people have been infected with HIV and about 35 million of those people subsequently died from AIDS. The global incidence of HIV infection peaked in 1997 and has been slowly declining since. There were an estimated 2.1 million new HIV infections in 2013, a decline of 38% from 2001 when there were 3.4 million (UNAIDS, 2014). Despite this decline in incidence, prevalence has remained high, and at the end of 2013, there were 35 million people living with HIV (UNAIDS, 2014). One important contributor to these high prevalence rates is scaled-up access to antiretroviral therapy (ART) which has reduced the number of people dying from AIDS-related causes. Access to treatment, however, was not universal and effective HIV treatments have reached only a fraction of people in low and middle-income countries, which suffered 90% of the global HIV burden (UNAIDS, 2013a)

The characteristics of the HIV epidemic have varied from country to country. In some countries, the epidemic was driven by heterosexual transmission, whereas in many others homosexual transmission was the primary driver. Consistently, the highest

prevalence and incidence rates were found within the three most-at-risk populations (MARP): those who engage in commercial sex, especially FSW; men who have sex with men (MSM) whether or not they self-identify as homosexual; and, PWID (predominantly heroin users but increasingly users of amphetamine and other drugs) (Monitoring the AIDS Pandemic Network, 2004; UNAIDS, 2011c).

Injecting drug use is a very effective method for transmission of HIV, and PWID typically have one of the highest HIV prevalence in countries with either concentrated or generalised epidemics. Mathers and colleagues (2008) estimated that four out of five PWID *"…live in low and middle income countries, particularly in Asia and Eastern Europe, and in many of these countries people who inject represent the largest share of HIV infections"* (Stimson et al., 2010, p. 5). Of the estimated 14.0 million (range: 11.2 million to 22.0 million) of PWID worldwide, UNODC estimated that 1.6 million (range: 1.2 million to 3.9 million) were living with HIV. That represented a global HIV prevalence of 11.5% among PWID. The UNODC (2015, p. 13) estimated that "*About 1.65 million (range: 0.92-4.42 million) PWID were estimated to be living with HIV worldwide in 2013, which would correspond to 13.5 percent of PWID being HIV positive"*.

Furthermore, prevalence rates could vary widely among groups of PWID, for example, international data showed that rates of HIV prevalence were much higher among prison inmates than the general population. In most countries, the rates of HIV infection among prisoners were significantly higher than those in the general population and there was an extremely high risk of being infected in prison, primarily through sharing of contaminated injecting equipment and through unprotected sex (consensual or forced). The high degree of mobility between prison and community meant that communicable diseases and related illnesses transmitted in prison did not remain there. When people living with HIV were released from incarceration and return to their sexual and/or needle-sharing partners in the community, their partners faced increased risk of HIV infection and may not even have been aware that they were at risk (Jürgens, 2007; World Health Organization, 2007). It was estimated that in 2012 there were 10.9 million people in prison worldwide[3] and almost half of these were in the United States (2.24 million), Russia (0.68 million) or China (1.64 million sentenced prisoners) (Walmsley, 2015). The reported prevalence rate of HIV in the prison population varied between countries from

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[3] These figures did not include political or 'administrative' detention camps, such as, those in China and North Korea.

between two to 36 times higher than in the general adult population (United Nations Office on Drugs and Crime, 2013d).

Although contested, there also appeared to be an association between whether national drug policies were focussed on 'tough' law enforcement approaches and higher rates of HIV transmission among that country's PWID population. Conversely, there also appeared to be a correlation between lower rates of HIV among PWID and the implementation of more harm reduction-focussed approaches (Moszynski, 2012). Harm reduction will be explored in depth in the following chapter later, however, initially the following comparison is offered. Although harm reduction policies have been implemented for decades in Australia and parts of Western Europe, harm reduction strategies, including for example the provision of opioid substitution therapy (OST) and needle and syringe programs (NSP), remain controversial in many parts of the world, including most American countries, most notably the USA[4]. HIV trends among PWID have consistently reflected this difference in approach. This was particularly notable in earlier responses to the epidemic, for example, in 1994, Australia and the USA had a similar prevalence of drug use yet their respective rates of HIV within populations of PWID were significantly different. For example, among Australian PWID, HIV prevalence was less than five percent, while in the USA the figure was 14%. Even though the progress from HIV infection to AIDS is multifactorial there was also a dramatic difference between the two countries in the number of AIDS cases among PWID, which was only 2.5% in Australia but as high as 28% in the USA (Wodak & Lurie, 1997). Substantial differences in HIV prevalence have also been documented between countries before and after the introduction of harm reduction strategies. In some countries there have even been substantial differences documented between cities which did and did not offer harm reduction services, as in the Scottish cities of Edinburgh, Glasgow and Dundee (McKeganey, 1998).

3.5.1 HIV Treatment as Prevention

Relatively recently there has been advocacy and research about the role of ART in preventing HIV transmission among high risk groups, particularly MSM. Even more recently there has been discussion of treatment as prevention for PWID and this

[4] It was common in the international literature (including peer reviewed publications and reports by reputable international organisations) for discussions of drug use, drug policy and associated issues in America to be USA-centric. Yet there were vast differences in the context and responses in the other 22 independent countries and 32 territories in the two American continents.

appeared to have generated even greater controversy. In the early 1990s, early treatment of asymptomatic HIV infection was considered controversial. While some clinical trials had shown administration of Zidovudine[5] in infected but asymptomatic patients slowed the clinical progression to AIDS and other trials indicated an increase in the CD4 cell count, there seemed to be mixed results and the studies did not appear to offer clear evidence of longer survival rates (Ho, 1995). The introduction of combination treatments, triple-combination ART, in 1995 began to significantly change both clinical outcomes and opinions about the desirability of early treatment. It was now conclusive that ART reduced the viral load, which not only helped keep people well longer but also provided a compelling rationale for early testing and early treatment to control the epidemic (M. Cohen et al., 2011). Hosseinipour and colleagues (2002) cautiously suggested that ART had the potential to decrease sexual transmission of HIV type-1 by reducing levels of HIV RNA and thus decreasing the risk that infected persons would transmit the disease. Nearly a decade later, a large-scale randomised control trial in nine countries, of 1,763 serodiscordant couples (couples in which one partner was HIV-1 positive and the other was HIV-1 negative) demonstrated early initiation of antiretroviral therapy reduced rates of sexual transmission of HIV-1. Furthermore, the reduction in the number of transmissions was dramatic; representing a 96% reduction compared with conventional delayed therapy (M. Cohen et al., 2011).

In 2012, WHO published a set of guidelines in which it *"…recommend increasing the offering of HIV testing and counselling (HTC) to couples and partners, with support for mutual disclosure. They also recommend offering antiretroviral therapy (ART) for HIV prevention in serodiscordant couples*" (World Health Organization, 2012a, p. 1). Despite this, the debate about the efficacy of treatment as prevention remained. The arguments were many and complex, some of which centred on the stages in the natural history of the virus. For example, one important issue concerned transmission in the early stages of HIV infection, i.e. the first three to six months after infection during which the body had not yet developed antibodies to HIV but when the concentration of virus in the plasma spiked. During this period, an individual was unlikely to be diagnosed with HIV and so would be unlikely to start receiving treatment. Yet treatment at that stage could lower the risk of the person transmitting the virus to others. Some experts estimated that 38% of HIV transmission events occurred during this period. As a consequence, for treatment as

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[5] Zidovudine (brand name is Retrovir), also known as Azidothymidine (AZT), is an antiretroviral medication used to prevent and treat HIV/AIDS. Zidovudine prevents HIV from multiplying and so can reduce the amount of HIV in the body. This results in improvements in both symptoms and blood tests.

prevention to be effective at a population level, individuals would have to start ART even though they would return a negative test result for HIV antibodies (M. Cohen, Dye, et al., 2012; Powers et al., 2011).

In addition to the science of immunology, other considerations have been raised for careful appraisal including: increasing the risk of drug resistance; side effects; behavioural disinhibition; and, the resource and cost implications of HIV treatment as prevention (Powers et al., 2011). A compelling pragmatic concern was the cost of implementing a population-based approach to treatment as prevention. The costs of expanding access to ART were likely to be considerable and determined by many factors including: the size of the groups accessed; the expense of identifying and reaching group members; retention in care; and the longevity of members. These factors would, in turn, affect the duration of treatment, the success of other HIV prevention interventions, economies of scale, available delivery technologies and infrastructure and so forth. This has led to discussions about prioritisation, including statements that expanded access to ART for HIV should be determined according to clinical and behavioural factors as well as feasibility, affordability, and acceptability. Existing guidelines suggested, for example, that ART should be prioritised for individuals with active TB and for pregnant women irrespective of CD4 cell count (Delva et al., 2012). Another issue raised has been that overall effectiveness of treatment as prevention through viral suppression may be compromised if poor treatment compliance, retention or access resulted in the development of drug-resistant strains of HIV (Delva et al., 2012). It was, therefore, imperative to assiduously monitor the dynamics of drug resistance, especially in resource-limited countries where treatment compliance and retention could be most challenging (Wu, Norris, Jia, & Wang, 2014). Furthermore, the cost of providing ART to individuals who were not in immediate clinical need was significantly more expensive and complex than other existing methods for reducing HIV transmission, such as male circumcision, voluntary confidential counselling and testing (VCCT) and other behaviour change interventions (HIV Modelling Consortium Treatment as Prevention Editorial Writing Group, 2012) in other words, interventions commonly associated with harm reduction approaches.

Epidemiologists also pointed out that transmission of infection depended not just on infectiousness but also on patterns of risk behaviour (M. Cohen, Holmes, et al., 2012). Studies using mathematical modelling among MSM identified changes in risk behaviour as a result of treatment which clearly impacted on prevention outcomes. High levels of risk behaviour may occur in a number of ways. Firstly, an increase in risk behaviour over

time may occur simply because patients in a high-risk population on ART have a longer and higher quality of life than before and continue their previous behaviours. Secondly, sexual disinhibition related to beliefs about the protection afforded by ART may offset the effectiveness of ART or even mitigate its preventive benefit. The authors of these studies warned that it was critical to tackle such risk behaviour disinhibition to avoid diminution of prevention gains or resurgent HIV epidemics among high-risk populations (Hosseinipour et al., 2002; Wu et al., 2014).

Others have stridently advocated for non-discriminatory universal access to ART for both treatment and prevention as a basic human right (Amon, 2010) and public health pragmatists have pointed to substantial reductions in new diagnoses in their particular jurisdictions which they attribute, in greater or lesser degree, to viral load suppression achieved by ART or Highly Active Antiretroviral Therapy (HAART) (Montaner, 2010). For example, population-level longitudinal data from province-wide registries in British Columbia showed that HAART expansion between 1996 and 2012 was associated with a sustained and profound population-level decrease in HIV transmission, morbidity and mortality. The researchers stated their findings supported the long-term effectiveness and sustainability of HIV treatment as prevention with the stipulation that this occurred, *"…within an adequately resourced environment with no financial barriers to diagnosis, medical care or antiretroviral drugs.*" (Montaner, 2010). Other studies have also linked greater rates of HIV testing, treatment access and treatment retention to social and economic structural factors, such as: higher education level; having a regular health care provider or clinic; higher levels of social support; housing stability; and insurance coverage. Conversely, HIV-related stigma, denial, social isolation, and substance use were barriers to HIV testing and treatment (Surratt, O'Grady, Kurtz, Buttram, & Levi-Minzi, 2014). This highlighted the fact that clinical outcomes for treatment as prevention could either be enhanced or compromised by positive or negative socio-economic factors. Indeed, the sources of poverty and inequity, if overlooked, would continue to exacerbate the devastation caused by HIV and thwart even the most promising therapeutic responses.

Finally, Holtgrave and colleagues (2012) cautioned that HIV should not become an academic debate of 'combination prevention' versus 'substitution prevention'. They stated clients should receive the best array of behavioural, biomedical, and structural interventions to address their specific HIV prevention needs and policy and strategy that should:

> *…move more toward "complementary prevention" in which the best prevention interventions from all domains are chosen to address clients' specific clinical needs and address public health needs of averting new infections in a way that is truly synergistic resulting in an effect more than the sum of the intervention's parts.* (Holtgrave et al., 2012, p. 1089)

Specifically, a biopsychosocial perspective which embraced a diverse range of contextually appropriate harm reduction strategies would complement ART and would remain essential for the prevention of HIV.

These recommendations on the most appropriate utilisation of HIV treatment as prevention, i.e. as part of a comprehensive and integrated approach, were consistent with evidence and advocacy for a health-focussed drug policy. They were also consistent with the promotion of strategies to reduce drug-related harms to the community and individual, and therefore, especially relevant to the prevention of HIV transmission among PWID as well as from PWID via sexual transmission into the general community. Furthermore, such interventions need to be targeted appropriately to match behaviours and needs of beneficiaries. For example, a meta-analysis of randomised controlled trials of behavioural interventions for using ATS by Colfax and colleagues (2010) supported comprehensive harm reduction strategies for HIV prevention in general but cautioned that some harm reduction services such as OST or NSP were not likely to be as effective in reducing HIV transmission for: those who were using ATS; not injecting; non-dependent users; and for those whose main HIV risk was sexual transmission. They emphasised the importance of intensive behavioural interventions along with attention to the developmental, psychological, social, and environmental factors contributing to ATS use. They also pointed out that with MSM high-intensity behavioural interventions reduced the use of ATS but found no evidence that those interventions reduced sexual risk behaviour. This suggested there was a role for ART in the prevention of sexual transmission of HIV among HIV-positive MSM.

3.5.2   The HIV Epidemic Asia and South-east Asia

Arguably the most compelling event throughout the world that drove advocacy for policy reform on drug use was the emergence of the HIV epidemic. This has also been the case in Asia. While the HIV epidemics across Asia varied from country to country, they were generally initiated from and remained concentrated in the most at-risk populations (i.e. MSM, FSW, and PWID). As of the time of writing, no country in Asia had

experienced the spread of HIV as a generalised epidemic, as had occurred in many countries in other regions, most notably for example in Sub-Saharan Africa.

In Asia, it was the poor who suffered the greatest impact of HIV and, in 2008, it was estimated that based on income loss alone resulting from HIV, another six million Asian households would fall below the poverty line by 2015 (Commission on AIDS in Asia, 2008). Furthermore, women and children endured a disproportionate impact of the epidemic in Asia, as "*…children often abandon education to care for parents; wives caring for HIV-infected husbands are ostracized, and widows are forced to leave their homes and land*" (Commission on AIDS in Asia, 2008, p. 8). In Asia during 2009, an estimated 4.8 million adults were living with HIV and 160,000 under-15-year-old children. In the same period, the number of people newly infected with HIV was estimated at 360,000 and approximately 300,000 people died from AIDS-related causes (UNAIDS, 2011b). While the number of new infections declined 20% between 2001 and 2009, the incidence of HIV infection across the region was 8.7%. In Asia and the Pacific the overall numbers of new infections remained largely unchanged over the five years prior to the UNAIDS 2013 report with a number of countries experiencing emerging epidemics concentrated among key populations at higher risk, which included PWID (UNAIDS, 2013c).

The HIV epidemics in Asian countries have been diverse in their severity and timing, although they followed a typical chain of transmission. That is, HIV entered the population first among PWID where its prevalence increased rapidly. This was usually followed by rapid dissemination among FSW, and subsequently into the general population via the clients of FSW. Ruxrungtham, Brown and Phanuphak (2004, p. 69) divided the HIV trends of Asian countries into three categories:

> *(1) those where HIV hit early and hard, and where adult HIV prevalence now exceeds 1%-e.g., Cambodia, Burma, Thailand, and some states in India;*
> *(2) those currently in transition, with HIV epidemics growing noticeably in the past 5 years-e.g., China, Indonesia, Nepal, and Vietnam; and*
> *(3) those having very low levels of infection such as: Bangladesh, Laos, the Philippines, and South Korea.*

Overall trends of the epidemic in Asia could hide important variations. Only five countries in the South-east Asian region[6] (India, Indonesia, Myanmar, Nepal and Thailand) accounted for 99% of the HIV burden and Thailand was the only country with prevalence over one percent, reported by the WHO Regional Office for South-east Asia to be 1.4%. The WHO report said of Asia that "*Substantial progress has been made in expanding surveillance systems in the Region, leading to a better understanding of the national epidemics*" (2012b, p. viii). They also acknowledged there was scope to improve routine program monitoring systems and that many countries suffered from limited capacity of health systems, including weak monitoring and evaluation systems. As a result, information on HIV incidence was very limited in the region. WHO further stated that "*…routine reporting of HIV/AIDS and STI cases remained incomplete in most countries, except Sri Lanka and Thailand*" (2012b, p. 115). The report added that Thailand was the only country that conducted regular incidence surveys among FSWs and antenatal clinics. This highlighted two considerations. Firstly, some of the difficulties associated with attempting cross-country comparisons of data, and secondly, that Thailand had (in comparison with many other countries in the region) a relatively robust and effective public health infrastructure for monitoring and surveillance.

3.5.3   HIV and PWID in South-east Asia

HIV and IDU are enmeshed. Of the three million PWID thought to be HIV-positive across the globe, one in five (Mathers et al., 2008) or 22%, lived in East and South-east Asia (PEPFAR, 2010). In addition, PWID and their sexual partners were at high risk of transmission of HIV through unprotected sex, particularly when the sexual behaviour occurred under the influence of drugs or in exchange for drugs. This vulnerability was often cited as the potential 'bridging effect', whereby an epidemic, initially fuelled by the sharing of contaminated injecting equipment was spread through sexual transmission from PWIDs to non-injecting populations and through the perinatal transmission to new-borns (PEPFAR, 2010). The following table lists HIV/AIDS estimates for ASEAN countries in order of highest number of people living with HIV. Note that estimates of national HIV prevalence among PWID can vary greatly depending upon the location of the sample population (UNAIDS, 2010c, 2011b).

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[6] The WHO South-East Asia Region (SEAR) comprises 11 countries: Bangladesh, Bhutan, Democratic People's Republic of Korea (DPR Korea), India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste (World Health Organization, 2012b).

Table 3: HIV/AIDS Estimates for ASEAN countries (UNAIDS, 2010b)

Country	People living with HIV	Annual Deaths due to AIDS	National prevalence	PWID Prevalence
Thailand	532,500	28,200	1.3%	30%-50%
Indonesia	305,200	8,252	0.2%	42%-50%
Vietnam	278,100	14,200	0.4%	32%-58%
Myanmar	240,000	18,000	0.6%	28-36%
Malaysia	101,400	5,757	0.5%	22%
Cambodia	62,900	3,095	0.5%	24.4%
Philippines	8,718	183	0.1%	Not available[7]
Lao PDR	8,537	129	0.2%	Not available
Singapore	3,407	85	0.1%	Not available
Brunei Darussalam	Not available	Not available	Not available	Not available

In South-east Asia, the HIV epidemic remained largely concentrated in the most at-risk groups (PWID, MSM, FSW, clients of sex workers and their immediate sexual partners) and effective prevention coverage among these populations remained inadequate (UNAIDS & World Health Organization, 2004). According to a United Nations analysis, the total number of PWID living with HIV in a particular region was a function of three variables: the prevalence of HIV among PWID; the prevalence of PWID; and, the total population in the region aged 15-64 (United Nations Office on Drugs and Crime, 2013d). The UNODC reported an aggregated average of approximately 661,000 (16%) of Southeast Asian PWID had been also living with HIV (United Nations Office on Drugs and Crime, 2012d). Although this method hid large variations and according to UNAIDS estimates, all the ASEAN countries with available data available had considerably higher rates than the aggregated average and HIV levels among PWID in these countries was described as alarming. For example, in Thailand, the 2011 estimate was 30%-50% and in Vietnam, it was 32%-58%. In Vietnam, Burma and China injecting continues to be a significant driver of HIV epidemics. In Cambodia and Laos PWID was a less critical driver, with sexual transmission accounting for the clear majority of cases (UNAIDS, 2010c). Yet there remained a significant risk in Cambodia and Laos that an increase in

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[7] National figures for HIV prevalence among PWID were not available but there have been figures for some provincial 'hotspots' e.g. PWID HIV prevalence in Cebu, the Philippines, was 53% in 2011. This was a dramatic increase from 0.6% only two years earlier.

HIV prevalence amongst PWID could rapidly trigger a generalised epidemic. Recent studies in Laos, for example, identified HIV prevalence among PWIDs in border areas at much higher levels than government partners had expected. The efficiency of transmission through injecting and the overlap of populations of PWIDs, MSM, FSW and their clients meant that PWID would continue to be a significant factor in Asian and South-east Asian country epidemics for the foreseeable future (Chan, Stoove, Sringernyuang, & Reidpath, 2008). The key message from many of these reports has been the need for a multifaceted response that includes harm reduction strategies (approaches that are not without contention, particularly in some political contexts).

3.6   Chapter Summary

The use of psychoactive drugs has been widespread as far back as history can determine and it is worth reiterating this important point: just because someone has used an illegal drug it does not always follow that they were doing so because they were dependent upon that drug. In their 2012 report, while still acknowledging the challenges of obtaining accurate data particularly from Africa and parts of Asia, UNODC restated that only 12% of illicit drug users developed dependence and become 'problem drug users' (United Nations Office on Drugs and Crime, 2012d). This does not mean they have been used without risk.

This chapter briefly explained some of the harms related to drug use and specifically provided a detailed examination of the epidemiology, impact and responses to HIV globally and regionally. HIV/AIDS has had a profound impact on population health, health services and health funding around the world. It has also had a significant impact on the way drug policy responses have been framed and implemented. HIV/AIDS has killed on average about one million people per year since it emerged as an epidemic around 35 years ago. Although the characteristics of the HIV epidemic have varied from country to country, frequently national epidemics began among PWID then quickly spread via sexual transmission into the general population. While the recent implementation of 'treatment as prevention' shows some promise, behavioural change remains the primary strategy for prevention of HIV infection and transmission.

This discussion provides essential context for the subsequent examination of harm reduction responses as well as some of the major contentions related to these harm reduction responses in Chapter Four which investigates harm reduction policies and services in much greater detail. A comprehensive harm reduction approach continues to

be a key behaviour change tactic for prevention of HIV transmission among PWID. The following chapter will examine harm reduction, its definitions, implementation and some of the associated hotly-debated contentions.

Chapter 4: Harm Reduction

In the field of injury prevention and control, interventions which reduce harm, such as seat belts for motorists or helmets for cyclists, enjoy widespread support and in many countries, are legal requirements. These measures neither prevent crashes nor attempt to reduce the high-risk behaviours that lead to negative events and yet are essential elements within a suite of strategies which were designed to prevent injury or other harm. These interventions are examples of what are commonly referred to as secondary prevention or harm reduction and have also long been used to describe the prevention of harm associated with drug use, for example limiting smoking tobacco in public buildings or places (Erickson, 1995). Indeed, a range of other terms have also been used including; damage limitation, risk management, risk reduction, casualty reduction, vulnerability reduction and harm minimisation, which all seem to add to the confusion rather than clarity (Des Jarlais, 1995; D. Duncan, Nicholson, Clifford, Hawkins, & Petosa, 1994). For decades now in AOD use prevention and treatment fields the most commonly used terms to discuss these concepts of reducing risk or harm have been 'harm minimisation' and 'harm reduction'.

4.1   Definitions and Development of Harm Reduction

These terms and how they have been interpreted have, at times, however, created strong contention and confusion in the AOD field. While some people use the terms harm reduction and harm minimisation interchangeably, there are distinctly different interpretations of each term, for example, many consider harm reduction, to be a critical but lesser component of harm minimisation. Australia's Drug Strategy (Commonwealth of Australia, 2011), for instance, defines harm reduction as one of three components within an overarching harm minimisation approach to drug use (the other two components being supply reduction and demand reduction). Similarly, the Swiss Federal Office of Public Health has implemented a drug policy since the early 1990s, in which it has defined four distinctive elements within its drug policy: law enforcement; prevention; treatment; and, harm reduction (Csete, 2010). Despite some differences in the specifics of the interpretation of the term 'harm reduction', both countries have successful national programs using very similar strategies based on similar broad principles.

Unfortunately, distinctions between the two terms were often not clearly differentiated in either policy or practice, and obfuscation of the term 'harm reduction' was widespread. It was not uncommon for the term to be misappropriated to support arguments and activities which were fundamentally supply reduction or prohibitionist approaches. For

example, in his 2008 speech to the 51st session of the Commission on Narcotic Drugs (CND) the UNODC Executive Director Antonio Maria Costa said *"I see no contradiction between prevention and treatment on the one hand, and reducing the health and social consequences of drug use on the other. They are complementary"* (2008, p. 5). Initially this statement appeared consistent with the position of WHO and other United Nations agencies, however, he then went on to say:

> *I urge you not to get caught up in sensitivities about words. Everything we do at UNODC is meant to reduce harm: helping farmers switch to licit crops; assisting countries identify, monitor and disrupt drug trafficking; developing educational campaigns in favour of drug prevention; helping governments to deal with drug law offenders in a humanitarian way.* (Costa, 2008, p. 5)

He concluded by suggesting that harm reduction had been appropriated by a vocal minority giving it a narrow and controversial interpretation.

But definitions are not simply intellectual exercises for pedants; they are critically important for directing resources and services. Although in its broadest sense, harm reduction might be used to refer to any policy, or intervention that endeavours to reduce the detrimental effects of drug use to the individual or society, such a description is so inclusive and imprecise that it could include practically any drug policy, program, or intervention; whether it was supply interdiction or abstinence programs, since these all intend to reduce some of the negative consequences of drug use. A narrower definition of harm reduction is necessary for meaningful dialogue and to allow adequate focus for the formulation, implementation and evaluation of policies and interventions. How drug policy and strategy is defined also has obvious implications about how resources are allocated. In other words, the definition of a policy will influence who gets how much money to implement which activities targeting whom.

Early Australian commentators unequivocally defined harm reduction policies and programs as *"… designed to reduce the adverse consequences of mood altering substances without necessarily reducing their consumption"* (Wodak, 1995, p. 339). Later definitions were a little more cautious in reassuring audiences that, even though:

> *…abstinence may be neither a realistic nor a desirable goal for some, especially in the short term. This is not to say that harm reduction and abstinence are mutually exclusive but only that abstinence is not the only acceptable or important goal.* (Riley & O'Hare, 1998, p. 8)

Furthermore, policy analysis assured that harm reduction did *"… not involve 'giving up' on reducing prevalence. In many situations, reducing the overall level of drug use (or of a*

*particular pattern of use) will be the most effective way of achieving [*harm reduction*]'* (Trace, Roberts, & Klein, 2004, p. 2).

In 1992, Newcombe (cited in Ritter & Cameron, 2005b) identified a two-dimensional framework of three different levels of harms (to the individual, the community, and the society) and three different types of harms (health, social and economic). This enabled a more precise focus on who was affected, the type of harm which was likely to occur and formulation of appropriate interventions. In the first evaluation report of the 1985 Australian National Drug Strategy (Single & Rohl, 1997) the authors identified a third type of definition, the empirical definition in which the pragmatic test of harm reduction was not if it was intended to reduce harm, but if it actually did reduce harm. From this standpoint, it was argued that the criminalisation of drug use was potentially harm maximisation because it unintentionally created more harm than it averted. This empirical approach estimated costs and benefits of a policy or program to determine the net gain, whereupon if the policy had a net gain or net effectiveness (i.e. it did more good than harm) then it was determined to be harm minimisation. While this conceptualisation has an alluring utilitarian logic, the authors pointed out that it would be extremely difficult to undertake the complex cost-benefit analysis required. In addition, before calculating the net effectiveness an agreement would have to be reached on an assigned value for each of a multiplicity of factors. Furthermore, Single and Rohl advised that the empirical definition was so broad that policies which were not clearly harm reduction in intent or prosecution, for example, money laundering laws that restrict the ease with which organised crime were able to traffic in illicit drugs, would be included. A final word of caution on this type of definition; utilitarianism, calling for "…*the greatest good for the greatest number"* (Pojman & Fieser, 2012, p. 121) could be used to justify the implementation of interventions which resulted in some types of harm or harm to some people (e.g. the most at-risk minority groups) if there was a net benefit to the broader community.

Single and Rohl recommended a practical way forward through the consideration of the various definitions - a general definition as any policy or program aimed at reducing drug-related harm, while at the same time spelling out a set of six underlying strategic principles which, at a minimum, should include the following:

1. First, do no harm. A primary goal of any policy should be to avoid exacerbating the harm caused using psychoactive substances;
2. Focus on the harms caused by drug use rather than use per se. The key indicator of success is whether a given set of policies and programs reduce the

harms associated with drug use whether or not there is a decline in the number of citizens who use drugs;

3. Maximise the intervention options, by providing those in treatment, law enforcement and other front-line services dealing with drug-related problems with a maximum range of options for intervention;

4. Give priority to those outcomes that were immediate, practical and realisable and yet this need not conflict with an eventual goal of abstention;

5. Respect the rights of persons with drug-related problems. Drug-dependent citizens should be accepted and treated as part of the general community, rather than marginalised and dealt with in a manner that exacerbated their problems and those of the community; and,

6. Harm minimisation or harm reduction should not be equated with indicating support for liberalised drug laws. Harm reduction policy should be neutral regarding broader policy issues such as the criminalisation of drug use.

An important distinction within the debates about what constitutes harm reduction is that "*…while drug policies and programs may be aimed at reducing drug-related harm, not all policies and programs with a goal of harm reduction are harm reduction strategies*" (Riley & O'Hare, 2000, p. 11). There is evidence that international drug prohibition measures focussed on supply reduction to reduce drug-related harm to some sectors of the population, can sometimes lead to unintended yet severe health consequences for other members of the community. For example, criminalising drug use has been associated with high-risk behaviours such as injecting drugs, and reusing or sharing contaminated injecting equipment as a consequence of low product availability, high costs, a need to avoid detection (Griffin, 2009) and laws against possessing injecting paraphernalia, including sterile needles and syringes (Lakhdar & Bastianic, 2011). Accidental overdose and poisoning are high risks for consumers since the black market is by definition unmonitored and unregulated, and therefore, not subject to regulation or quality controls (Rolles et al., 2013; Rolles et al., 2012). Reusing or sharing contaminated injecting equipment has resulted in epidemics of HIV, HBV and HCV in many countries, and the illegality of the drugs and the behaviours associated with their illicit use can hinder access to PWID for the testing, prevention and treatment of BBV. Furthermore, some observers have stated that government efforts to reduce illicit drug supply or sales can sometimes punish people excessively for minor drug offences (such as possession for personal use) resulting in prison overcrowding, which then leads to serious health and human rights harms (Global Commission on Drug Policy, 2012; Human Rights Watch, 2010; Murkin, 2011).

Despite the confusion and conflation discussed there appeared to be a sufficiently large and long-standing agreement in most of the literature reviewed which could be ultimately distilled down to two key concepts within any working definition of harm reduction:

    i.   It need not require a reduction in drug use to produce a reduction in harm; and,

    ii.   Working to reduce harm does not exclude working towards abstinence.

In the AOD field there are a wide range of activities that might be classified as harm reduction, depending upon the drug, the drug user, and the drug using environment. For example, with respect to alcohol these might include the provision of alternatives to glass containers in alcohol sales outlets, banning glass from venues and/or events, random alcohol breath testing of drivers, thiamine enriched food to prevent alcohol-induced brain damage brain and so on. While harm reduction approaches can be used to address problems associated with either licit or illicit drug use, much of the debate internationally has been in response to illicit drug use and it is harm reduction responses to illicit drug use which are of most relevance to this research.

A number of researchers, while recognising harm reduction as an attempt to ameliorate health, social or economic consequences associated with drug use without necessarily requiring a reduction in their consumption, went further and proposed some form of cost/benefit analysis or calculus of the consequences of risk/benefits as part of the definition of harm reduction (Einstein, 2007). More recently, definitions of harm reduction seem to presume that abstinence-oriented interventions fall within the hierarchy of harm reduction as a given and have then expanded to include human rights principles and *"… to embrace the need to protect the rights to health and access to services of people who use drugs, and to protect them from harmful drug policies"* (Rhodes & Hedrich, 2010, p. 19). Working definitions of harm reduction have developed and expanded over time. Single and Lenton (1998, p. 219), for example, argued that:

> *A policy program or intervention should be harm reduction if, and only if:*
>
> *(1) the primary goal is the reduction of drug-related harm rather than drug use per se,*
>
> *(2) where abstinence-orientated strategies are included, strategies are also included to reduce the harm for those who continue to use drugs; and*
>
> *(3) strategies are included to demonstrate that, on balance of probabilities, it is likely to result in a net reduction in drug-related harm.*

One further important consideration of terminology and definition that is frequently overlooked is that much of the debate on terminology occurs in relation to the English-language terminology (Ball, 2007b). It is not obvious how easily 'harm reduction' translates into other languages and to what extent different translations have different cultural meanings or how they influence the type policy or strategy and how these have been subsequently implemented through programming. For example, does the translation describe any intervention that reduces potential risk or actual harm? Does the translation distinguish between those approaches that reduce the risk of and vulnerability to drug use, (prevention of initiation and abstinence), or exclusively describe those interventions that aim to reduce harm without intending to reduce drug use? The Thai language translation of harm reduction (การลดอันตรายจากการใช้ยาเสพติด) and its focus on drug dependence will be discussed in Chapter Six.

Harm reduction is a philosophy, or an overarching strategy which consists of many different tactics for decreasing or minimising adverse consequences of tobacco, alcohol or other drug consumption. Beirness and colleagues (2008) gave the example of the popular support for the use of nicotine patches compared with the strong negative reactions to medically-supervised drug consumption facilities to make the point that it is commonly the type of drug use behaviour being targeted and the specific nature of the harm reduction measure which were the focus of disagreement not the principle of harm reduction *per se*. On the other hand, Ball (2007a, p. 687) took a pragmatic approach stating with regard to HIV/AIDS prevention for drug users: "*There is little ambiguity over what works...*" and defining a model package of harm reduction interventions, minimum standards for services and optimal levels of service coverage that aimed not only assist countries but in effect provided an operational definition and strategy for harm reduction. Defining a model package for harm reduction could help to address the dilemma of narrow versus broad definitions. The effectiveness of harm reduction initiatives in this sphere then may lie not with the question of whether it is possible to reduce drug-related risk behaviours per se, but by how much such behaviours can be reduced (McKeganey, 2006).

There is now well documented international agreement on what constitutes harm reduction for PWID. In 2009, the WHO published a technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (World Health Organization, United Nations Office on Drugs and Crime, & UNAIDS, 2009). The Technical Guide was further revised in 2012 and endorsed by high-

level political bodies including the UN General Assembly, the Economic and Social Council, the United Nations Commission on Narcotic Drugs, and the UNAIDS Programme Coordinating Board (World Health Organization, United Nations Office on Drugs and Crime, & UNAIDS, 2012). This Guide was intended to assist government agencies, non-government organisations (NGO), communities and service providers involved in developing, implementing, monitoring and evaluating HIV prevention, treatment and care programs for PWID. The Comprehensive Package comprises:

1. NSP;
2. OST and other evidence-based drug dependence treatment;
3. HIV testing and counselling;
4. Antiretroviral therapy;
5. Prevention and treatment of sexually transmitted infections;
6. Condom programmes for PWID and their sexual partners;
7. Targeted information, education and communication for PWID and their sexual partners;
8. Prevention, vaccination, diagnosis and treatment of viral hepatitis; and, prevention, diagnosis and treatment of tuberculosis.

4.2   The Contentions

The complex and intense debate surrounding drug policy and harm reduction has evoked extremes of approach and ideology, which in the words of one observer *"…has often generated more heat than light.*"(Ball, 2007b, p. 684). Criticisms of harm reduction commonly fall into concerns about its effectiveness, its effects and its ulterior intentions.

4.2.1   Harm Reduction Does Not Work

Critics of harm reduction claim that it does not work and this is indeed a claim which deserves investigation (N. Hunt, 2001; N. Hunt et al., 2003). Critics of harm reduction point out continuing high rates of drug use as evidence of the failure of harm reduction. On the other hand, supporters of harm reduction use the same evidence as proof that it is prohibition or the War Against Drugs which has failed. A UK report claimed while there had been no fall in the number of drug dependent persons in Britain from 2004-2011, drug deaths had continued to rise and the number of referrals to rehabilitation units had fallen to an all-time low of 3,914. The report claimed that the harm reduction approach was extremely expensive with the total social and economic burden for drug dependents over £3.6 billion per annum.

> *The cost to the state of maintaining addicts on methadone has doubled since 2002/03 to £730 million a year. Drug users are estimated to receive £1.7 billion in benefits a year, while the welfare costs of looking after the children of drug addicts are estimated at a further £1.2 billion a year...* (Gyngell, 2011, p. 1)

Nevertheless, rates of drug use may not necessarily be the most credible measures of the effectiveness of harm reduction policies and services. As previously discussed, even though harm reduction advocates proclaim that harm reduction and abstinence are not mutually exclusive (Riley & O'Hare, 1998) and that harm reduction does not involve abandoning efforts at reducing prevalence of drug use (Trace et al., 2004) the foundation of harm reduction is the reduction of the adverse consequences of mood altering substances without necessarily reducing their consumption (Wodak, 1995; Wodak & Saunders, 1995). On the other hand, harm reduction programs have consistently demonstrated impressive reductions in HIV transmission and subsequent health costs. For example, a reduction of nearly one million new HIV infections and savings in healthcare costs of US $11billion in China over 30 years from implementation of harm reduction programs alone (Li et al., 2012). Perhaps this argument shows in some sense that harm reduction could now be the victim of its own success. That is, where harm reduction has been introduced, HIV incidence has usually remained low which has led some people to conclude that low HIV transmission meant that harm reduction measures were unnecessary. For example, in the UK many people in the 1980's feared that HIV might become a national epidemic amongst PWID in the UK and argued that HIV and AIDS represented a greater threat to individual and public health than drug use itself. In fact, HIV/AIDS has remained at a relatively low prevalence rate among PWID in the UK even though drug use has become more widespread. A 2003 report to the Blair government stated "*In the UK, heroin and cocaine consumption has at least doubled over the last 10 years whilst real purity adjusted prices have halved*" (UK Government Strategy Unit, 2003, p. 98). Yet by some, this has been used as confirmation of the argument that the need for prevention of drug use rather than prevention of drug-related harm is greater now than in the past (McKeganey, 2006).

4.2.2   Harm Reduction Delays Recovery

Another criticism sometimes made of harm reduction policy is that it impedes and delays addicts' recovery from addiction. Some even claim that harm reduction 'keeps addicts stuck'. In other words, deploying a harm reduction approach may enable drug use and so keep people trapped within a pattern of drug dependence from which they would

otherwise escape if they had hit 'rock bottom'. This popular idea appeared to be based on the early alcohol research work of Jellinek (1960) in which he described distinct phases in the progression of what he proposed was the Disease of Alcoholism. Jellinek's description of the progression and recovery included the supposition that a drug dependent person must hit rock bottom before they would develop the insight and motivation required for recovery (P. Page, 1988).

Others have argued that harm reduction strategies support early intervention (McLellan & Marsden, 2002; United Nations Office on Drugs and Crime, 2009a). Harm reduction approaches, such as NSP provide a low threshold for facilitating access to drug treatment and other health services, especially when it is provided in combination with other interventions (Rhodes & Hedrich, 2010; Wodak & Cooney, 2004). The ability of NSP to facilitate improved access to treatment *"…could be attributed to the ability of health workers to offer health information, drug education and referral into treatment"* (Dolan, MacDonald, Silins, & Topp, 2005, p. 4), as well as the repetition of individual contact at NSP facilitating opportunities for engagement in behavioural change counselling and HIV service referral, in addition to simply getting clean needles (Valente, Foreman, Junge, & Vlahov, 2001). In addition, NSP have provided education and referral to hepatitis C treatment (Dolan et al., 2005).

4.2.3   Harm Reduction Promotes Drug Use

The criticism that harm reduction promotes drug use is most often levelled at one aspect of harm reduction and possibly the most contentious component of a harm reduction package of interventions, that is, the provision of sterile injecting equipment. NSP were often of particular concern for people who feared that harm reduction activities may encourage drug use or suggest that the government condoned IDU but research did not appear to support this idea. Following a review of the evidence, the World Health Organization concluded:

> *There is no convincing evidence of any major, unintended negative consequences. Specifically and after almost two decades of extensive research, there is still no persuasive evidence that needle syringe programmes increase the initiation, duration or frequency of illicit drug use or drug injecting.* (Wodak & Cooney, 2004, p. 28)

On the other hand, for example, in Australia, over a 10-year period from 1995 to 2004 following the introduction of NSP climbing injecting rates initially stabilised and then

declined (Dolan et al., 2005). *Prima facia* this seems to suggest that NSP did not encourage a continuing increase in injecting over the same period.

4.2.4 *Harm Reduction Sends the Wrong Message*

Linked to the previous argument is the criticism that harm reduction 'sends the wrong message' and people who do not use drugs will regard drugs as safe and decide to start using drugs themselves thus undermining primary prevention efforts. An alternative argument has been that harm reduction interventions have long been positioned to provide low-threshold access to a range of health and counselling services in addition to harm reduction services (Marlatt, 1996). It provides an opportunity to offer information, education and brief counselling interventions which not only aim to reduce harm but also assist the client in assessing their needs and goals, which can include supporting them in reducing or stopping their drug use (Carey, 1996; Castro & Foy, 2002). One systematic review of harm reduction concluded that "*The efficacy and effectiveness of motivational interviewing and other brief intervention approaches in the context of alcohol and drug use has been well-established*" (Ritter & Cameron, 2005a). Both methadone and buprenorphine substitution therapies are key treatment and harm reduction strategies for which there is a large body of evidence demonstrating positive outcomes for clients and the community such as reduced mortality and morbidity, reduced involvement in crime and increased employment (Langendam, van Brussel, Coutinho, & van Ameijden, 2001). Another outcome for many people engaged in OST has been the reduction and cessation of illicit drug use (Centers for Disease Control and Prevention, 2002; Connock et al., 2007; National Institute for Health and Clinical Excellence, 2007).

The 'wrong message' argument generally appeared to be invoked against specific forms of harm reduction, specifically NSP and MMT, while ignoring a multiplicity of other, often commonly accepted, harm reduction activities (examples such as nicotine patches have been previously mentioned). The argument also appeared to be based on a dichotomy in which harm reduction and abstinence were positioned as mutually exclusive options, but a number of commentators and research have demonstrated this dichotomy is at best overstated (Stoker, 2010a, 2010b). This false dichotomy between harm reduction and abstinence may well be an extrapolation from (or simply a confusion with) a parallel but distinctly different dichotomy, where it is believed the two key options are prohibition or drug legalisation.

4.2.5   Harm Reduction is a 'Trojan Horse' for Drug Legalisation

The issue that appeared to have created the most contention has been the concern that harm reduction approaches were simply a 'Trojan horse' for wholesale legalisation of drugs prohibited under international law. Some of the most vocal critics of harm reduction have stated they believed harm reduction has been used as camouflage or a diversion by those whose agenda is to decriminalise and/or legalise drugs. Furthermore, they have expressed concern that legalisation of drugs (brought in under cover of harm reduction) would lead inevitably to a greater number of drug dependent persons, and increased burden on health and social services. Some have gone as far as to describe a global movement, influenced by those that might make profit from legalised drugs, which is devoted to overturning the United Nations Conventions and secure the legalisation (Oliver, 2006, 2008). There is little doubt some advocates of harm reduction also support law reform towards less punitive sanctions, or decriminalisation, and some even support legalisation for personal use and possession of some illicit drugs, even so, among those who support harm reduction there are a wide range of views and debate about the appropriate legal status and regulatory frameworks for both legal and illegal drugs.

In addition to the complexity of debate on the legal status of drugs there also appeared to be confusion between decriminalisation and legalisation, and arguments frequently failed to adequately define or explain what exactly was meant by drug law reform. Discussions on the topic suggested that decriminalisation essentially substituted civil penalties (such as a fine) rather than criminal penalties for possession for personal use even though the drug would remain illegal and formal prohibition would remain in place (Campero et al., 2013; Chiu & Burris, 2011). On the other hand, the term depenalisation usually indicated that drug violations (for possession and consumption) remained criminal offences but with imprisonment sentences reduced or with alternative punishments to imprisonment. At the other end of the legal spectrum, legalisation involved the complete removal all drug-related offences (use, possession, cultivation, production, trading, and so on) from the sphere of criminal law with no legal sanctions applying. Finally, regulation referred to the administration a controlled legitimate market for the production, distribution and sale of drugs. Such regulations would determine parameters for quality control, availability, access, pricing and taxation; as has been used variously for pharmaceutical drugs, caffeine, alcohol, tobacco and so forth (Campero et al., 2013; Jelsma, 2011).

While it was evident that the policy and legal environment could constrain or enable harm reduction implementation, harm reduction could exist without legal reform. The

reverse was also true; drug law reform could occur without support for harm reduction strategies. Harm reduction already occurred in many countries in the absence of decriminalisation and any change in legal status could occur without public health approaches to address harms related to drug use. Furthermore, some of the most prominent statements of harm reduction's principles have been explicit about harm reduction's neutrality regarding legalisation or decriminalisation (Lenton & Single, 1998; Single & Rohl, 1997).

4.3   International Policy Environment for Harm Reduction

As a consequence of their signature, ratification or accession to international HIV/AIDS conventions and agreements, United Nations member states have committed themselves to specific standards and principles in the conduct of their national HIV/AIDS and harm reduction responses[8]. Significantly, these agreements highlighted the importance of human rights in all HIV activities and a participatory role of affected communities, including PWUD, in policy and program responses to HIV/AIDS. Most significant among these was the 2001 United Nations General Assembly Declaration of Commitment on HIV/AIDS which reaffirmed prevention as the mainstay of the global HIV response and specifically: "*By 2005, ensure: that a wide range of prevention programmes…is available in all countries, … including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use*" (United Nations General Assembly, 2001, p. 28*).*

The Declaration of Commitment by the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS required governments to regularly consult and report to the United Nations on progress against an internationally agreed set of indicators, including National Policy Composite Indicators that relate to drug users and other vulnerable populations. The Declaration of Commitment called for an expansion of access to sterile injecting equipment and to harm reduction efforts related to drug use (United Nations General Assembly, 2001). The UNGASS Guidelines on the Construction of Core Indicators intended to monitor the implementation of the Declaration, noted that "…*safer injecting and sexual practices among IDUs* [injecting drug users] *are essential*"

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8 Even though in some cases slightly different terminology to "Harm Reduction" may have been used, such as "*reducing the adverse health and social consequences of drug use*" (United Nations Office on Drugs and Crime, 2009a).

(UNAIDS, 2013b, p. 52). This was reiterated at the June 2006 United Nations General Assembly High-Level Meeting on HIV/AIDS, where United Nations member states agreed to work *"…towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010"* (United Nations General Assembly, 2006, p. 3) and by logical extension, in order to achieve universal access, countries must commit to expanding services for all PWIDs.

In 2009, noting the uneven and relatively low coverage of services among PWIDs, the UNAIDS Programme Coordinating Board requested the UNAIDS Secretariat and its cosponsors to significantly expand and strengthen the work with national governments to address the uneven and relatively low coverage of services among PWIDs and to develop comprehensive models of appropriate service delivery for PWIDs in line with relevant national circumstances and the *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for Universal Access to HIV prevention, treatment and care for injecting drug users* (World Health Organization et al., 2009). As discussed in the previous chapter, a Comprehensive Package of Interventions for the Prevention, Treatment and Care of HIV Among People Who Inject Drugs (detailed in the previous chapter) was endorsed in 2009, (World Health Organization et al., 2009) and further revised in 2012 (World Health Organization et al., 2012).

In addition, the UNAIDS Programme Coordinating Board called for: the expansion of resources for work with PWID; requested to intensify the work with and support for civil society; the Member States to harmonise public health and drug control laws; defined harm reduction in accordance with the nine interventions of the WHO/UNODC/UNAIDS Target Setting Guide; Member States to address specific subgroups, such as female PWID and non-injecting drug users; improving data collection; improving surveillance for viral hepatitis; and requested to strengthen work with stimulant users. Despite this 2009 UNAIDS 'call to arms',10 years after the UN General Assembly Declaration of Commitment on HIV/AIDS, the 2011 UN General Assembly resolution on HIV and AIDS "*Note[d] with alarm the rise in the incidence of HIV among people who inject drugs…*". It also noted that *"…many national HIV-prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, PWID and sex workers...*" and then outlined a series of commitments including to "*Commit to working towards reducing transmission of HIV among people who inject drugs by 50% by 2015…*" (UNGASS, 2011, p. 10). Despite the long-term and extensive international support for harm reduction described earlier the term 'harm reduction' remained controversial in international drug policy fora.

There appeared to be ambivalence, and at times direct conflict between HIV prevention and drug control approaches; and within the debate on appropriate responses to drug use, there is a widely-acknowledged tension between the approaches of harm reduction and demand reduction. In 2009, the CND, struck the term harm reduction from the final version of the Political Declaration on Drugs, a situation about which 26 states formally expressed their disagreement (Bewley-Taylor, 2012b). Harm reduction also failed to be included in a resolution on universal access to HIV services in March 2010. Where harm reduction was omitted, agreed text included terms such as 'comprehensive' services, specifically those in line with guidelines from WHO, UNAIDS and UNODC, which include NSP and OST (Bewley-Taylor, 2005).

4.3.1. Policy Practice Internationally

The progress of harm reduction seemed to be restrained by continuing international and national ambivalence and resistance. This was evidenced by the slow progress of harm reduction policy and expansion of services such as NSP, OST, and overdose response services. In 2012, 97 countries and territories supported a harm reduction approach, either explicitly in national policy documents (83 countries), and/or through the implementation or tolerance of harm reduction interventions such as NSPs (86 countries) or OST (77 countries). There was considerable variation between countries in the number of operational NSP sites, as well as the coverage of these services. In general, coverage was higher in high-income countries, with only a few countries reaching the international recommended coverage of 200 needles and syringes distributed per person per year. In low and middle-income countries, the average coverage level was considerably lower, with countries in Latin America, the Caribbean, the Middle East and Africa distributing less than one needle per person per year (Harm Reduction International, 2012).

In the countries which provided OST, methadone and buprenorphine were the drugs of choice for substitution, but in some countries other medications were provided, including, for example, slow-release morphine and codeine. The latest global estimates of OST coverage, from 2010, indicated that only six to 12% of PWID received OST and most of them were in high-income countries. Available data suggested that less than three percent of PWID received OST in countries such as Cambodia, Myanmar and Vietnam, where PWID had contributed significantly to HIV epidemics and OST remained unavailable in 81 countries with reported PWID (Harm Reduction International, 2012).

Similarly, research on overdose mortality rates and overdose prevention service coverage showed that while this was a leading cause of death among PWUD, especially for those who injected, the numbers in receipt of prevention information or life-saving naloxone remain very low. An especially contentious harm reduction strategy is the establishment of 'Safe Injecting Rooms', also called 'Drug Consumption Rooms'. A major rationale for these facilities was to prevent and rapidly respond to drug overdose. Drug Consumption Rooms allowed PWUD to inject in a safe place and under medical supervision. In 2012, there were 86 operational DCR in 58 cities around the world (i.e. Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain, Switzerland and Australia) (Harm Reduction International, 2014).

Prisons and other custodial settings remained high-risk environments for drug-related-harm and in general were critically under serviced with harm reduction options. To date, only 10 countries had NSP operating in at least one prison and less than 40 countries had some form of OST available in at least one prison. Many of these interventions reached very small numbers (Harm Reduction International, 2014).

In the broader picture, there has been an encouraging general trend globally towards less punitive responses for PWID in some countries and regions, with between 25 and 30 countries adopting some form of decriminalisation of possession of drugs for personal use. On the other hand, there have been notable counter trends, for example, on 16 December 2011 the US Congress reinstated the ban on federal funding for NSP, just two years after the 21-year-old ban was repealed and signed into law by President Barack Obama in December 2009. The decision included reinstatements of bans on both domestic and international use of US federal funds for NSPs as part of the 2012 omnibus spending bill (Harm Reduction International, 2012).

4.4 Chapter Summary

An important consideration when investigating drug use in general or IDU in particular, is that, while the prevalence of IDU is one useful indicator of the extent of the drug problem in a country, these results were limited in what they revealed about problems relating to drug use because they did not distinguish between dependent use and other types of use, such as experimental, occasional or recreational drug use. This lack of distinction or misunderstanding which results in the assumption that any drug use indicated dependence requiring treatment was consistently reflected in national laws and policies,

which could result in misguided policy objectives such as requiring that all PWUD to be referred to residential treatment centres for drug withdrawal and rehabilitation. Such policies did not appear to be guided by evidence, given the finding by UNODC that only *"…about around 12% of illicit drug users …develop drug dependency and become 'problem' drug users"* (United Nations Office on Drugs and Crime, 2012d, p. 70).

This chapter discussed harm reduction as a rational public health strategy, which recognised that there would always be some people who engaged in risky or illegal behaviours, including the use of licit and illicit drugs. It explained that harm reduction initiatives accepted that at any given time not everyone is ready, willing, or able to cease drug use. It demonstrated that there was substantial evidence world-wide that harm reduction has been both efficacious and cost-effective in reducing mortality and morbidity from drug-related harms, including as an HIV prevention strategy. This chapter also described many evidenced-based harm reduction strategies including several which comprise the WHO Comprehensive Package for the prevention of HIV among PWUD. Yet harm reduction has remained contentious and it seemed that advocates must fight the battle for its acceptance a new in every country they wanted to introduce it. This will be explained more fully in subsequent chapters. This chapter also examined the major arguments against harm reduction, including that harm reduction does not work, it delays recovery, harm reduction promotes drug use, it sends the wrong message and that harm reduction is a 'Trojan Horse' for drug legalisation.

Furthermore, as was mentioned earlier, the prohibitionist policies date back to the 19th century and their fractious relationship with harm reduction is widely recognised. To gain a better understanding of the resistance to harm reduction and, therefore, why the progress of harm reduction has been so slow, particularly in South-east Asia, one must more fully appreciate the crushing weight history brings to any debate on drug use or drug policy responses.

Thailand has been no different in this respect and Chapter Six will examine the course of that contention in Thailand in some depth. The next chapter will focus on policy and policy analysis to build a foundation for an investigation of international and national drug policy responses including harm reduction policies. The literature review on policy, policy analysis and international drug policy will also provide the frameworks and theoretical models for use in the subsequent analysis of the research data.

Obviously, the international policy environment comprising the key institutions and instruments of international drug policy would have been critical, if distant, influences on the Thai national drug policy environment. Especially important among these international influences were the international drug treaties and agreements to which Thailand was a signatory and was committed to monitor and implement. The Thai national drug policy environment will be examined in Chapter Six.

Chapter 5: Policy

The central focus of this study and the phenomena under investigation are drug policy responses. Therefore, it is worth defining and examining: policy; the analysis of its formulation, implementation, and evaluation; and, the enabling environment in which these policy processes occur. This literature review examined definitions of policy, compared and contrasted various models of policy analysis and examined some of the major influences which determine how policy problems and solutions were defined.

5.1   Public Policy

The focus of this research was on government policy, usually referred to as public policy. Public policy can be made at any level of government (international, national, provincial, or local) and is usually administered through government departments and government institutions which manage the tools of policy implementation (economic incentives, taxation, law enforcement or other service provision, such as schools or hospitals). On the other hand, public policies are sometimes also referred to as programs. For example, a government might implement a program of malaria eradication. A classic and frequently cited definition of public policy was Dye's (1972, p. 2) *"Anything a government chooses to do or not to do"*, which places government authority centrally and suggests a simple top-down decision making process.

Policy may be explicit or evident by use of policy instruments such as strategy, legislation, programs or services. Public policies are usually documented in political manifestos, government policy briefs, 'white papers', government strategies, government regulations and so forth, however, they may not always be as concrete or obvious. Buse, Mays and Walt (2005, p. 4) also mentioned this aspect in their very goal-focussed definition that *"Policy is a broad statement of goals, objectives and means that create the framework for activity. Often take the form of explicit written documents, but may also be implicit or unwritten"*. These written or verbal statements are usually in the form of a strategy or a plan to achieve a particular goal and may be either: problem-focussed, such as the prevention or eradication of a problem such as illicit drug use; or, solution-focussed, i.e. describing the accomplishment of a particular goal, such as the introduction of universal health care. In their definition, Swanson and Badwhal (2009) distinguished between policy as being an intention as distinct from the policy instruments, or the mechanisms with which those intentions are implemented:

> *A policy can be thought of as a broad statement of purpose and process for addressing a particular social, economic or environmental issue. The intent of a*

policy is implemented via policy instruments such as regulatory (for example, laws and regulations); economic (for example, taxes, subsidies); expenditure (for example, research and development, education and awareness, targeted projects and programmes); and institutional instruments (for example, sector strategies). (p. 13)

Althaus, Bridgman, and Davis (2012) were more comprehensive when describing three key domains which they asserted defined policy, i.e. a policy is:

1. An authoritative framework of a government's intentions and choices;
2. A structured means towards the objective of government action; and,
3. A hypothesis which expressed the government's theories and assumptions about the cause and effect of a particular public phenomenon.

Furthermore, they pragmatically pointed out that "*Public policy is …the instrument of governance, the decisions that direct public resources in one direction but not another*" (Althaus et al., 2012, p. 3). In other words, it was not simply the statement of an ideal but the allocation of funds which provided the means to achieve a public goal. This last definition leads the discussion into the necessity of considering economic imperatives, resource allocation and incentives when considering policy; whether that was during policy dialogue, formulation or implementation. PEA is an emerging area of study which is particularly relevant to a more in-depth examination of the interaction of policy and economic factors, and this will be discussed further in later sections of this chapter.

5.2   Policy Analysis

This section of the literature review provides a comprehensive and balanced account of previous work in policy analysis, identifying, where appropriate, the relevant themes, conceptual models and theoretical frameworks that provided a background to this research. Broadly speaking, policy analysis can be approached with two distinctly different intentions. Arguably the most common approach researched and written about would be *analysis of policy*, which attempts to understand the policy process retrospectively, to explore for example, how policies were initiated, formulated or implemented. The other broad intention is analysis *for* policy. This is usually prospective, to determine the conditions for the introduction of a policy and anticipate the consequences of its introduction (Buse et al., 2005). Analysis for policy formulation and implementation were the concerns of the current research. Within these two general approaches, or purposes, the theoretical models or frameworks used to describe and analyse the policy process were many and varied. Since policy was a central

phenomenon under scrutiny in this research, it is worth briefly describing these major theoretical approaches to the study of policy which enable policy analysis.

The incremental or punctuated-equilibrium theories, such as The Science of Muddling Through (Lindblom, 1959, 1979), posited that policy changed gradually, in small steps (increments) as policy-makers and others who influence policy built on existing information including their knowledge of what had and had not worked in the past, rather than re-analyse everything from the beginning as in the rational/comprehensive model. Yet while it is relatively easy to note examples of policies that had evolved in increments over long a period, there were also many policy changes that had been rapid and dramatic, i.e. revolutionary. For example, immediately following the fall of communism in the Czech Republic penalties were rapidly abolished for the possession of illegal drugs in small quantities for personal use (Zabransky, Radimecky, & Belackova, 2016).

Social actor and advocacy coalition theories (Altman & Petkus, 1994; Sabatier, 1998) focused upon various advocacy coalitions with shared values and beliefs and interest groups which were or became organised policy communities within a policy domain (Birkland, 2001). This viewpoint speculated that the policy context combined stable aspects (e.g. culture, resources) and dynamic (changing) aspects (e.g. public opinion, policy decisions in other areas) and within this domain, policy brokers tried to find solutions that satisfied the various advocacy coalitions through negotiations and compromises. As will be discussed later, social actor and advocacy coalition theories were taken up and integrated into the later development of PEA.

Institutional rational choice theories and principal-agent models (Kassim & Menon, 2003; Ostrom, 2011) assumed individuals acted in rational ways to determine policies which were motivated attempts to maximise benefits and minimise costs for the individuals concerned. Yet, it acknowledges that the process can be distorted by the rules and goals of the institutions within which they operate. Furthermore, it appeared this theory was not used a great deal beyond economists, although some key elements of the theory could be identified in contemporary policy instruments. For example, the use of incentives such as conditional payment transfers in international development programs.

In policy diffusion or policy enlightenment models (Weiss, 1993, 1998) it was argued that policy decisions were driven by political imperatives and were not always based on research or even good quality data. It was stated that in the political arena of policy formulation, and policy evaluation, the value placed on data, the credibility ascribed to

those data, and the meaning given might vary tremendously with the position, role and intent of the particular stakeholder. It is important to highlight that Weiss did not describe the process out of cynicism or fatalism, but elucidated what she described as the harsh realities of policy making, and therefore counselled patience, pragmatism and the strategic use of research and evaluation data to influence the political process of policy making.

Multiple streams theory, such as that of Kingdon's three streams model (Kingdon, 2010) have focussed on the analysis of the political conditions for policy development i.e. focusing on problem definition, the formulation of policy alternatives, the political bargaining and persuasion processes, and the characteristics of participants who were actively engaged in the political process (within or external to government). Kingdon stated that a confluence of at least three streams - the *Problem Stream*, *Policy Stream*, and *Political Stream* provided the precondition for policy agenda setting during a *Policy Window* i.e. a brief period of opportunity for moving the policy process forward. These Policy Windows overlapped with the factors noted in the Problem Stream including, for example, government budgets, government crises, international agreements, or government strategy and priority-setting exercises. He also described certain individuals as *Policy Entrepreneurs*, those (including parliamentarians, lobbyists and other advocates) who were willing to invest their resources (time, energy, reputation, money) in hope of a future return. Kingdon's analysis of policy making focused predominantly upon political factors. Table Four provides examples of policy enablers or influencers within each of Kingdon's three policy streams.

Table 4: Kingdon's Three Policy Streams (Kingdon, 2010)

Problem Stream	Policy Stream	Political Stream
Advocacy of citizens and Interest groups	Debate by politicians & policy advisors inside government	Elections
Journalists & media	Debate by leading experts outside government	Issue/cause champions
Government Budgets	Policy entrepreneurs (lobbyists & advocates)	Changes of administration
Governmental monitoring & feedback – indicators, polls	Swings of national mood	Jurisdiction & competition amongst government agencies
Critical incidents - a death, scandal, disasters, crises	Organised political forces	Swings of national mood
External events and international agreements	Technical feasibility	Political parties/forces

Heuristic staged models have long been popular models for planning, analysing and teaching about the creation and operation of public policy. These models have described the policy process as occurring in a sequence of defined functional activities, and both linear and cyclical models have been described (and contested) in the literature. There has long been a debate about whether such heuristic schemas presented the policy process through a positivist, rationalist, and neo-liberal lens (Buse et al., 2005; Jenkins-Smith, 1988; Sabatier, 1998). Even though each staged model had distinct features there was a remarkable convergence and similarity between the sequences of the stages in the models proposed, each sequenced through variants of Problem Identification, Agenda Setting, Policy Formulation, Implementation and Evaluation. Table Five offers a more comprehensive comparison of the more recent policy making models from the published literature.

Table 5: Comparison of Policy Making Models

Stages in the Policy Process							Authors
1	2	3	4	5	6	7	
Problem Identification & Issue Recognition		Policy Formulation		Policy Implementation	Policy Evaluation		(Jenkins-Smith & Sabatier, 1993)
Problem Identification	Agenda Setting				Policy Evaluation	Termination, Modification or Continuation of Policy	(Anderson, 2000)
	Agenda Setting	Policy Formulation		Policy Implementation	Policy Evaluation		(Mooij & de Vos, 2003)
Issue Identification	Policy Analysis	Policy Instruments & Consultation [9]	Decision & Coordination	Implementation	Evaluation		(Althaus et al., 2012)
	Agenda Setting	Policy Formulation	Public Policy Decision Making	Policy Implementation	Policy Evaluation		(Howlett, Ramesh, & Perl, 1995)
Problem Selection	Inclusion in the Agenda	Policy Design	Decision Making & Adoption	Implementation or Administration	Policy Evaluation		(Henriques & Larédo, 2013)

Kingdon's study in policy analysis was predominantly focused on the earlier stages of the policy process i.e. Problem Identification and Agenda Setting. It was also most concerned with political activities and actors during this process (Kingdon, 2010). The following table (Table Seven) illustrates a comparison against other previously described staged models of the policy process. Like Kingdon, Collins' (2005) eight-stage framework also focussed on the earliest stages, based largely on the earlier work of Bardach's (2000) eight-fold path, it stopped at 'Decision Making' that is, it was concerned only with policy formulation, not implementation.

Collins' model was unusual when compared with policy making models of contemporaries because it began by 'Defining the Policy Context' prior to 'Problem Identification or Issue Recognition'. This is significant because it gave prominence to an

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9 To facilitate ease of comparison Althaus & colleagues' eight-stage model is presented in six stages, with Policy Instruments & Consultation and Decision & Coordination each presented as two stages rather than four. Other models also mention these functions but as sub-components within one stage e.g. selection of policy instruments as a part of the policy formulation stage.

assessment of the policy context or environment - in other words a greater focus on the analysis for policy rather than analysis of policy. Collin's model underscored the importance of policy context to the achievement of each stage of the process and the transition from one stage to the next. A schematic representation is provided in the following table (Table Six). In this model, the policy context largely determined the strategies which must be employed and which shaped the specific characteristics of the policy. Policy context would be especially critical in the earlier stages before strategy was formulated or resources were committed; and this seemed to be supported by the greater attention paid by leading policy theorists, as such Kingdon and Collins, to the earlier stages of policy making.

Table 6: Collins' Eight Stage Policy Making Model

1	2	3	4	5	6	7	8	Author
Define the Context	State the Problem	Search for Evidence	Consider Different Policy Options	Project the Outcomes	Apply Evaluative Criteria	Weigh the Outcomes	Decision Making	(Collins, 2005)

5.2.1 Models of Policy Analysis and Assessment of the Policy Macro-Environment

Traditionally, models of policy analysis have described the policy cycle, and participants and political factors which persuaded or dissuaded decision makers to commit to the policy of interest (Banks, 2009; Cheung, Mirzaei, & Leeder, 2010; Hardee, Feranil, Boezwinkle, & Clark, 2004; Kingdon, 2010; Miller, 2005). Still, in these models any environmental factor analysis for policy formulation and implementation was generally limited to those factors which fell within the domains of politics. For example, the great strength of Kingdon's detailed analysis was the breadth and depth of its explanatory power about the political machinations, challenges and opportunities of the policy making process. On the other hand, the strength of Kingdon's model could also be considered a shortcoming. That is, the focus of the model on political participants and processes has missed the significance of a more holistic approach inclusive of the multiplicity of factors in the environment in which policies are formulated, legislated, implemented and evaluated. The shortcomings or gaps in the analysis of the broader policy macro-environment could be overcome by using standard tools which are routinely and successfully used in other fields. Furthermore, despite the apparently seductive linear simplicity of staged heuristic models, there has long been an acknowledgment of the

iterative, incremental and 'messy' reality of policy making (Buse et al., 2005; Jenkins-Smith, 1988; Sabatier, 1998). Conversely, it was well understood that these schemas could be used for guidance through complexity rather than to refute the impact of complexity (Cheung et al., 2010; Thomas & Grindle, 1990; Weiss, 1979). Significantly, even policy theorists who have drawn on complexity theory and chaos theory in analysing policy making have still acknowledged that the models offer a good description of the links and transactions among decision makers (John, 2003). The following two sections on social construction and complexity will broaden the exploration of policy beyond what is usually considered the domain of policy analysis but will be both important and practical in the later analysis of primary data collected in this research.

5.2.2 Social Construction, Political Power and Policy

Schneider and Ingram (1993) stated that an examination of the way particular groups were socially constructed could add much to both the explanatory and predictive power of established policy models, such as those of Kingdon (2010), Sabatier (1991), Wilson and Dilulio (2008), and Lowi (1972). Schneider and Ingram advanced the argument that social constructions could be categorised into four quadrants based on the two dimensions of political power and social construction. That is, a specific group may have weak or strong political power and a positive or negative social construction. The following table shows Schneider and Ingram's Social Constructions and Political Power including the types of target populations.

Table 7: Social Constructions and Political Power (Schneider & Ingram, 1993)

		Social Construction	
		Positive	**Negative**
Political Power	**Strong**	*Advantaged* • *The elderly* • *Business* • *Veterans* • *Scientists*	*Contenders* • *The rich* • *Big unions* • *Minorities* • *Cultural elites* • *Moral majority*
	Weak	*Dependents* • *Children* • *Mothers* • *Disabled*	*Deviants* • *Criminals* • ***Drug addicts*** • *Communists* • *Flag burners* • *Gangs*

The positive or negative social perceptions of a specific group along with its relative political power, they argued, determined the type of policy interventions targeted towards them. For example, those groups perceived as socially positive and with access to political power were more likely to receive policy benefits. On the other hand, in this schema PWUD would be categorised as 'Deviants' who have negative social constructions and weak political power. Schneider and Ingram (1993, p. 336) contended that:

> *…public officials commonly inflict punishment on negatively constructed groups who have little or no power, because they need fear no electoral retaliation from the group itself and the general public approves of punishment or groups that it has constructed negatively.*

Their social construction theory also described a two-way relationship between policy and constructs. That is, social constructions influence the policy agenda, design, implementation and tools or instruments. On the other hand, those policies also influence how social groups are constructed on the basis of the policy rationale and implementation tools selected.

Policy decisions and formulations are the outcomes of the competition of ideas, interests and ideologies that impel political systems and the actual results of policy are unknown until after implementation. The definitions of public policy so far have placed agency with government and seem somewhat disassociated from the diverse multiplicity of stakeholders who may be engaged in a multifarious interplay of negotiation and

disputation. Policy is created amid uncertainty and complexity. Good policy, therefore, must be dynamic, responsive and iterative. So, it is worth reflecting briefly on Complexity Theory which, although a relatively recent area of study, has provided a great deal of practical insight into the way complex systems work, even though they may be as varied as weather events, biological ecologies or financial markets.

5.3   Complexity

Traditionally, policy theorists have been fond of setting out linear models and series of stages to describe the progress of policy through 'the policy cycle'. In the 'real world' environment of policy dialogue, formulation and implementation there is a multiplicity of interdependent and interacting factors at play. There is a vast array of contexts, actors and actions which produce a highly complex situation for the study of policy. Some researchers are therefore highly of critical of simple heuristics;

> *The move to simplicity may simply impose a tautology or overextend a set of plausible and partial models of political action to the whole of the policy process. But if complexity is the theme, then the models become redundant and degenerate to description—not poor description, such as lists of committees, laws, and public decisions, but "good" description, which provides an account of human action based on a contextual understanding of the links and transactions among decision makers…* (John, 2003, p. 483)

The World Bank put it much more succinctly stating, "*Policy design and implementation is a complex, multi-directional, fragmented and unpredictable process*" (World Bank, 2008, p. i). Therefore, a brief consideration of complexity and complexity theory would better inform the approach to policy analysis in this study.

Although Agar (1999) cautioned that they should not be considered the same thing, complexity theory originated from chaos theory and he suggested they could be both be referred to as 'nonlinear dynamic systems'. Complexity arises in non-linear systems through non-linear dynamics which create unstable relationships between variables, and these interrelationships are subject to positive feedback which amplifies changes. This can result in *"…novel forms of increasing complexity; or even temporal behaviour that appears random and devoid of order*" (Sanderson, 2000, p. 442). These also usually involve events which could not be predicted readily. In explaining complexity and its relevance to policy and program planning Glouberman and Zimmerman (2002) made a useful distinction between 'Simple', 'Complicated' and 'Complex' problems. Simple problems encompassed basic issues of technique and terminology but, it was argued,

once these were mastered then following the plan carried a very high promise of success. Complicated problems contained subsets of simple problems but were not simply an ensemble of simple components. They also included issues of the scale of a problem, matters of coordination and technical expertise. Complex problems could include both complicated and simple subsidiary problems, but also involve their interdependency and interaction. In addition, they demanded knowledge of and adaptation to local contexts, required the capacity to transform as conditions altered, and significantly were non-linear. To explain this distinction a little more intuitively, the following examples have often been used: applying a recipe; sending a rocket to the moon; and, raising a child (Glouberman & Zimmerman, 2002). Table Eight illustrates the distinction between these Simple, Complicated and Complex Problems and describes some of their key characteristics.

Table 8: Characteristics of Simple, Complicated and Complex Problems
(Glouberman & Zimmerman, 2002)

Simple	Complicated	Complex
Following a Recipe	*Sending a Rocket to the Moon*	*Raising a Child*
The recipe is essential	Formulae are critical and necessary	Formulae have a limited application
Recipes are tested to assure easy replication	Sending one rocket increases assurance that the next will be OK	Raising one child provides experience but no assurance of success with the next
No special expertise is required but cooking expertise increases success rate	High levels of expertise in a variety of fields are necessary for success	Expertise can contribute but is neither necessary nor sufficient to assure success
Recipes produce standardized products	Rockets are similar in critical ways	Every child is unique and must be understood as an individual
The best recipes give good results every time	There is a high degree of certainty of outcome	Uncertainty of outcome remains

5.3.1 Domains of Complexity

Complexity can be classified into three different domains, which each could affect planning, implementation and evaluation (Stame, 2004). These domains account for complexity in an operating environment, within a policy or program implementation, and among the multiple actors involved. Firstly, complexity occurs within the operating environment (reality). Stame (2004, p. 63) asserted that reality:

> …*is stratified, and actors are embedded in their own contexts; and each aspect that may be examined and dealt with by a program is multifaceted. Therefore, it is always difficult to say whether a single input (an incentive, a service) caused a given output: an input never works alone.*

Secondly, complexity may occur within the policy or program implementation process itself. Increasingly, in recognition that reality is complex, 'integrated' programs have been designed. Key to these types of policy or program design were expectations that a wide range of stakeholders including implementers (public and/or private sector), CSO, industry representatives, and program beneficiaries would act in various partnerships, coalitions or networks to tackle diverse aspects of a problem simultaneously.

Thirdly, complexity involves the actions of multiple agents in diverse contexts, through disparate mechanisms, and for different motivations. Stame (2004) specifically discussed multi-level governance complexity, which involves the 'principal/agent theory' whereby the 'implementer-agent', in pursuing their own interests would act in such a way that fulfilled what the 'government-principal' had planned but did not have either the technical background to design nor the expertise to implement. This could be especially pertinent where attempting to meet the needs of diverse constituencies. This multi-level system meant a government could set goals, articulate objectives, formulate indicators and allocate public resources, yet hand over the delivery of services to non-governmental organisations (NGO), multi-lateral organisations or private-sector groups.

This brief diversion into complexity theory highlighted the challenges of adequately examining policy formulation and implementation processes in multifaceted dynamic environments. It discredited any notion that successful policy could be created or truly understood by simply following a model or 'recipe'. It also demonstrated that the policy process was non-linear, requiring knowledge of and adaptation to local contexts, and the capacity to transform as conditions alter.

5.4   The Policy Enabling Environment

As was demonstrated in the previous section, complex policy environments involve actions of multiple agents in diverse contexts, through disparate mechanisms, and for different motivations. Complexity theory, therefore, emphasised that a sophisticated examination of influencing factors in the policy environment is crucial to understanding how and why a policy progresses as it does and how a policy might be better enabled. As noted this nonlinear perspective will be important in later analysis of the factors influencing the drug policy environment of Thailand. The term 'enabling environment' is commonly used to describe the broader system within which individuals and organisations function when they debate, formulate and implement policy, and it creates the context which can facilitate or impede the efficiency and effectiveness of their

activities. In some definitions the enabling environment was defined so broadly, however, that it was almost synonymous with general socio-economic development; while in others, it was discussed within such a narrow context that it was difficult to generalise factors beyond a specific case-study (e.g. financial regulatory frameworks) (Brinkerhoff, 2004). A frequently cited and more useful definition was that provided by Thindwa (in Brinkerhoff, 2004, p. 3), as follows:

> *An enabling environment is a set of interrelated conditions - such as legal, bureaucratic, fiscal, informational, political, and cultural - that impact on the capacity of development actors such as CSO* [Civil Society Organisations] *to engage in development processes in a sustained and effective manner.*

While this definition provides a good beginning for examining the enabling environment, to be more useful it needs greater detail. Collins (2005) contended that profiling the national geography, politics, economics, culture and organisation of service systems was important for understanding the determinants of policy analysis. This standpoint was not new and Leichter's model (Leichter, 1979) delineated the contextual factors into four domains to better comprehend policy enabling environment. This was perhaps most clearly described in the following description from Buse and colleagues review (2005) as follows:

1. Situational factors - transient but 'focusing' (e.g. natural disasters or conflicts);
2. Structural factors - relatively stable elements of the society (e.g. type of political system, or economy);
3. Cultural factors – the influence of social hierarchies, ethnic minorities or religious beliefs; and,
4. International or exogenous factors – such as the emergence of regional cooperation or transnational threats.

Leichter's categories are highly consistent with more recent explications of PEA. Brinkerhoff (2004) synthesised commonly agreed-upon features of the enabling environment from the development literature and proposed an expanded schema divided into five categories of factors: economic; political; administrative; socio-cultural; and, resources. He then provided further detail of important factors for consideration when examining the enabling environment. The following table (Table Nine) was taken from Brinkerhoff (2004) and it details the key enabling features for examining the enabling environment under five categories as well as providing illustrative examples of government actions to support the policy environment.

Table 9: Key Enabling Features of the Policy Environment (Brinkerhoff, 2004)

Category of Environmental Factors	Key Enabling Features	Illustrative Government Enabling Actions
Political	Democratic system that supports pluralism, accountability, transparency, & responsiveness. Processes that encourage participation, social contract, & state legitimacy. Rule of law, contract enforcement, respect for human rights & property rights.	Conducting free & fair elections. Making information widely available, promoting free media. Devolving power & resources to subnational levels of government. Limiting power & influence of interest groups. Supporting civil society. Assuring judicial independence.
Administrative	Presence of social capital & trust. Tolerance of diversity. Norms of inclusiveness, equity, & fairness. Belief in the value & efficacy of individual effort.	Curbing abuse & corruption. Creating incentives for performance. Separating service provision from financing. Building cross-sectorial partnerships. Establishing monitoring & evaluation systems. Improving coordination across agencies & sectors.
Economic	Non-distortionary policy framework. Encouragement of free markets & open competition. Supportive of investment (including security). Low transactions costs, credible commitment.	Reducing red tape & unnecessary regulation. Managing macro-economic policy to control inflation, deficit spending, & assure stability. Reducing tariffs & barriers to investment. Investing in physical infrastructure (roads, transportation, etc.). Controlling criminality (e.g. mafias) & violence.
Resources	Policies & investments in health, education, workforce development, information technology, science & research. Adequate funding & institutional capacity.	Setting policies & incentives that encourage private investment & corporate social responsibility. Allocating public resources to assure maximisation of social & economic potential.
Socio-cultural	Presence of social capital & trust. Tolerance of diversity. Norms of inclusiveness, equity, & fairness. Belief in the value & efficacy of individual effort.	Supporting marginalised & disadvantaged groups - pro-poor affirmative action, subsidies, safety nets. Encouraging civic dialogue, social compacts, & consensus building. Discouraging ethnic-based politics & policies. Controlling violence (e.g., ethnic cleansing).

Recent analytical work by the OECD Development Assistance Committee (OECD-DAC) on the policy enabling environment was consistent with Leichter's model describing structural and institutional factors, but it placed a greater emphasis on actors or

stakeholders. Furthermore, they proposed six areas for analysis of the environment that were of particular importance in international development policy:

1) The strength of society, state and economy;

2) Informal institutions;

3) Stakeholder interests and politics;

4) Incentives and capabilities for sector coordination;

5) The voice of non-state and state stakeholders; and,

6) The quality of broader systems in the public sector (Boesen et al., 2011).

This greater focus on the role of state and non-state actors was congruent with trends in international development of increasingly inclusive and participatory practice in international development policy and programming and was also linked to the work of social actor theorists. The social actor theorists are another major school of policy analysis, typified by the Advocacy Coalition Approach which focussed primarily on the actors involved in the policy process (Sabatier, 1991, 1998). Even so, this framework remains structurally quite similar to Leichter's and it viewed change over time as a function of three sets of factors:

1. The interaction of competing advocacy coalitions within a policy subsystem/community;

2. Changes external to the subsystem in socioeconomic conditions, system-wide governing coalitions, and decisions from other policy subsystems; and,

3. The effects of stable system parameters, such as basic social structure, constitutional constraints and resources of various actors (Sabatier, 1991).

5.5   Political Economy Analysis

Earlier understandings of PEA appeared to have a much narrower focus on the contestation of politic powers for the acquisition or maintenance of economic resources. For example, as described in Collinson's definition (Collinson et al., 2003, p. 3):

Political economy analysis is concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time.

Nonetheless, this research has taken a somewhat broader view of the application of PEA and so is more closely aligned with the works of DfID (The UK Department for International Development), and the World Bank which are concerned with elucidating how PEA can provide "*..insights into underlying interests, incentives, rules and*

institutions" (Haider & Rao, 2010, p. 4). They also note that a complete assessment of the political economy for reform of the macro-environmental context requires an understanding that *"…includes historical and cultural background, ideological climate, the settings of political institutions, distribution of domestic political power, and the economic and social make-up of the country"* (Haider & Rao, 2010). Norton and colleagues (2008, p. 11) described PEA for policy reform as "*...the societal 'rules of the game' that shape and constrain human interaction and individual choices*"; and, described the reform process of *"… change through information flows, voice and public debate, prompting the question: Who sets the agenda, and how and when are proposed policy changes communicated, by whom and to whom?"*

Contemporary definitions have centred on the interaction of the political and economic factors in the policy environment and how political, economic and social actors and institutions influence each other and drive policy direction. PEA examines the formal and informal 'rules of the game' that operate in a particular context: the distribution of political or economic resources; the power or influence of various actors; and how they build coalitions and negotiate to protect or strengthen interests, or to support new policies, and new institutions (Norton et al., 2008). PEA has acknowledged the multiplicity of actors, institutions and incentives involved in policy making. The work of Haider and Rao in PEA (2010, p. 4) placed a greater focus on the interaction between these players particularly in elucidating *"…how power and resources are distributed and contested in different contexts, and provide*[ing] *insights into underlying interests, incentives, rules and institutions…"*. Drawing heavily on the work of international development organisations, such as the Swedish International Development Agency (SIDA), *Nederlandse Organisatie Voor Internationale Bijstand (*NOVIB or in English - Netherlands Organization for International Development Cooperation), DfID, and the World Bank, Haider and Rao identified commonalities in the general features of their approaches in the analysis of the political economic and social dimension of the enabling environment to for development policy and programs:

1. *Emphasising the centrality of politics.*
2. *Downplaying the normative and instead of trying to understand country realities and to ground development strategies in these.*
3. *Identifying underlying factors that shape the political process (local history, society and geography).*
4. *Focusing on institutions to determine the incentive frameworks that induce patterns of behaviour.*

5. *Recognising that development agencies are political actors* (Haider & Rao, 2010, p. 5).

While acknowledging the aforementioned complexities, this researcher has framed a definition using a distillation and synthesis of the work of Mosco (2009) with that of the World Bank (2009b) and Fritz, Kaiser and Levy (2009) aligned with PEA use in international development work. The following succinct definition is offered to provide clarity and utility:

> Political economy is an interdisciplinary study which draws upon economics, sociology, and political science to examine the social relations, particularly the power relations, of organisations and individuals, to explain how resources are distributed and used.

PEA has been used to assess the impact of external drivers on domestic governance and political processes and to systematically account for and understand the functions of:

- Interests and incentives of different groups in society (and particularly political elites);
- Formal institutions (e.g. rule of law, elections) and informal social, political and cultural norms; and,
- Values and ideas, including political ideologies, religion and cultural beliefs.

Again, clear similarities can be seen with Leichter's categorisation of the policy environment into situational, structural, cultural and international or exogenous factors domains. It appeared highly likely that the development of current PEA frameworks may have been strongly influenced by his earlier work.

Examining relevant social actors and institutions as well as the incentives and values that drive their actions also offers congruency with the accounts of social constructivists, draws on the work of social actor theorists like Sabatier, and adds depth and greater explanatory power to Kingdon's Policy Streams (DfID, 2009; Drazen, 2000; Harris, 2013; Unsworth & Williams, 2012). But most specifically, it merges the work of political policy analysts with international development practice, particularly in the area of improving good governance and identifying unintentional consequences of international development interventions (Copestake & Williams, 2012a, 2012b; A. Duncan & Williams, 2012; Fritz et al., 2009; Serrat, 2011; Unsworth, 2009).

5.6 Gaps in the Literature on the Factors Which Influence Drug Policy

This review was not able to identify any published literature that demonstrated the use of PEA or similar macro-environmental analyses in the public health sector generally or in drug policy specifically. Furthermore, research by Ginter, Duncan and Capper (1991, p. 134) found that *"…the use of macro-environmental analysis, the foundation of effective strategic planning, appears to be almost non-existent in public health organizations"*. In addition, they claimed that the external focus generated through systematic macro-environmental analysis was critical due to the effects of largely uncontrollable forces on the public health system at the national, provincial, and local levels. Their research revealed that many people, "*…protest that problems in the public sector are unique and that the experience of private sector firms cannot be applied to public health*" (Ginter et al., 1991, p. 135). Nevertheless they concluded that "*…research consistently confirms that managerial behaviors required to respond to uncontrollable environmental forces are remarkably similar in both settings"* (Ginter et al., 1991, p. 135).

A UK Governance and Social Development review of PEA found that "*The use of PE analysis in development is a relatively recent phenomenon, beginning in the early 2000s*" (Haider & Rao, 2010, p. 4) and, while PEA appeared to have been used relatively recently in some areas of international development policy planning and program design (particularly around governance and anticorruption initiatives) there was little evidence yet that its use has become routine or widespread.

Over the past three or four decades the debate for and against drug policy reform has been conducted at all levels: at the global; regional; national; provincial; and, local community levels. Investigators have made contributions at each of these levels. Bewley-Taylor's extensive historical analysis of international drug policy and the bi-directional influence between the so-called 'Global Drug Prohibition Regime' and harm reduction, focussed on politics at the highest-levels and in particular the role of international institutions including the United Nations General Assembly Special Session (UNGASS), UNODC, the World Trade Organization (WTO) and the International Narcotics Control Board (INCB) to name a few of the key players (Bewley-Taylor, 2012b). Harm reduction is one example of drug policy reform which has been seen as particularly controversial and highly contested. In 2009 the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (UNRTF) undertook a regional level review of policies, resources and services for PWID across South and South-east Asia making a series of recommendations for supporting and evaluating

harm reduction services in the region and for promoting an enabling policy environment (Hagarty, 2010).

Nevertheless, most reviewers of harm reduction policy enabling environments have been primarily interested in the barriers to program-based harm reduction activities i.e. service provision at the local community level. One example undertaken in Vietnam, following the government's 2006 endorsement of harm reduction, elicited the views of senior key informants inside Vietnam about major barriers to progress of harm reduction implementation on the ground (Reid & Higgs, 2011). Key challenges identified were: insufficient understanding and acceptance of harm reduction; lack of skilled resources, training programs and technical capacity; poor coverage of interventions; and gaps in the sharing of information. This example demonstrates the general focus on environmental analysis for service provision yet it was evident that there was a gap in the literature when it came to work on macro-environmental analysis for policy processes.

Even when publications and unpublished reports have been detailed in their analysis, they rarely explicitly referenced the policy analysis theories (such as those previously explicated) or the frameworks they utilise for the systematic collection and analysis of data on the full range of factors which might influence the enabling environment. One of the few exceptions to this would be the Risk Environment Approach (Rhodes, 2002, 2009). This model was a comprehensive framework and a key rationale of this approach was to shift the focus of change from issues of drug use specifically onto wider socio-economic and environmental issues of vulnerability. Rhodes sought to identify risks of drug-related harm by examining multiple elements: the types of environment (physical, social, economic, policy); the levels of environmental influence (micro and macro); and the mechanisms of environmental influence (susceptibility and vulnerability). Similar to previous examples discussed, although Rhodes' framework did consider the macro level environment his primary concern was not so much the policy enabling environment, but rather the community level and immediate physical, social and economic environment of the drug user.

While the literature on public health policy analysis has focussed on the political and, to a lesser degree, economic factors, rarely did it acknowledge the importance of social factors in the policy making process, and there was limited literature on policy analysis (or policy assessment, policy evaluation and policy cycles) that has undertaken a comprehensive assessment of factors in the external environment which supported or constrained the formulation and implementation of a specific policy. In addition, there has

been little systematic analysis of the macro-environmental factors affecting harm reduction policy in South-east Asia, and where this has been undertaken often it was focussed on barriers to program-based activities, such as service provision. On the other hand, macro-environmental analysis has long been an integral part of successful strategic planning in business management. It involves a systematic approach to scanning, monitoring, forecasting, and assessing key social, economic, technological, and political/regulatory factors and trends in the operating environment. This shows a stark contrast between how international business and international development practices attend to macro-environmental analysis as essential preparation for strategy formulation and implementation. It also demonstrates that a gap in the literature remains in relation to utilisation of macro-environmental analysis approaches such as PEA for the formulation and implementation of health policies and program generally and drug policy specifically.

5.7 International Drug Policy

Drawing on the preceding examination of policy and its analysis the following sections will focus on the construction of drug use as a policy problem and the policies formulated and policy instruments implemented to solve drug use as policy problems. Previous chapters explored the potential negative economic, social and health effects of drugs on people and societies as well as threat that HIV posed for PWID. It was not surprising that societies would attempt to regulate, ameliorate or control the impacts of these substances through policies, laws or other governmental modes of social regulation. During different periods in history, each of the drugs previously described have been subject to various attempts to suppress, restrict or regulate their production, sale and use. This chapter will briefly describe some of the early historical attempts at regulation to complete this section and to illustrate that while some drug use has been tolerated during some periods, which drugs were or were not regulated and how they were regulated has varied greatly throughout history. The chapter will then go on to examine in some depth contemporary issues and responses globally and regionally.

5.7.1   Brief Historical Background to Drug Suppression and Regulation

The history of binding international agreements used as mechanisms influencing national policy, strategy and legislation to control the supply and prohibit the non-medical use of drugs began with the opening session in Shanghai of The International Opium Convention 2nd February 1909, the subsequent signing of the International Opium Convention League of Nations Treaty at The Hague on January 23, 1912, and its

implementation in 1915 (Foster, 2010; The League of Nations, 1912). This treaty was an initiative of the USA and, through their persistent and skilled diplomatic pressure, resulted in the acceptance by other nations involved in major opium production and supply at that time[10]. Subsequent treaties and amendments broadened the scope of these agreements to include other drugs e.g. cocaine, cannabis, and an increasing number of newer synthetic derivatives, such as heroin and morphine.

Over the next half century a series of increasingly stringent multilateral instruments culminated in the Single Convention on Narcotic Drugs of 1961 (and its subsequent 1972 amendment) which was widely recognised as the most influential international agreement on national drugs policy and legislation (United Nations, 1972). As with previous agreements, the Single Convention set out provisions to limit the production, trade, distribution and possession of scheduled drugs. It also gained a strong role in requiring member states to provide data on the production or manufacture, stocks, consumption, imports and exports, seizures and disposal of scheduled drugs. In addition, it established the INCB an independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions and which, upon the advice of WHO, had the power to add drugs to the existing schedule of restricted or prohibited drugs.

Significantly, the Single Convention (United Nations, 1972) increased the authority of the United Nations to compel member states to take action against illicit trafficking (Article 35), to enforce penal provisions (Article 36) and to implement measures against the 'abuse' of drugs (Article 38). Article 35 also required member states to: establish national level co-ordination of preventive and repressive action against the illicit traffic; designate an appropriate agency responsible for such co-ordination; and, to co-operate closely and assist each other in the campaign against the illicit traffic in narcotic drugs. Article 36 set out penal provisions for the cultivation, production, manufacture, extraction, preparation, possession, distribution, purchase, sale, delivery, brokerage, transport, importation and exportation of drugs. The convention also stated that its provisions should be taken as minimum standards, with Article 39 declaring that member states:

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[10] Originally signed by the German Emperor, the President of the United States of America; the Emperor of China; the President of the French Republic; the King of the United Kingdom; the King of Italy; the King of Japan; the Queen of the Netherlands; the Shah of Persia; the President of the Portuguese Republic; the Emperor of Russia; and (of relevance to this research) the King of Siam.

shall not be, or deemed to be, precluded from adopting measures of control more strict or severe than those provided by this Convention …as in its opinion is necessary or desirable for the protection of the public health or welfare. (United Nations, 1972, p. 20)

Notably, the Single Convention compelled Asian countries, including Thailand, *"…to abolish all non-medical and non-scientific uses of the…plants [Indian hemp and the opium poppy] that had for centuries been embedded in social, cultural and religious traditions*" (Bewley-Taylor & Jelsma, 2011, p. 1). Further agreements such as the Convention on Psychotropic Substances (United Nations, 1971) and United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (United Nations, 1988) further expanded the mandate of the Single Convention. The influence of the Single Convention and subsequent agreements on signatory countries should not be underestimated. Countries bound by these agreements must ensure that their national drug policies are in line with their international obligations and the United Nations continuously monitored the execution of these responsibilities (United Nations, 1971, 1972, 1988).

5.7.2   Criticism of the International Drug Control Conventions

The international agreements outlined above were sponsored to achieve public health goals. Nevertheless, they have been operationalised primarily as prohibitionist policies intended to suppress production, interdict supply, and punish users. Furthermore, they have been executed largely through police and military enforcement. This approach has often been framed in public debate by both sides as 'The War on Drugs', a term first attributed to US President Nixon, who also declared it should be a global war, stating "*To wage an effective war against heroin addiction, we must have international cooperation. In order to secure such cooperation, I am initiating a worldwide escalation in our existing programs for the control of narcotics traffic…*" (Nixon, 1971, p. 7). History has shown that this approach has not achieved its intended results, and even at time of his declaration of war Nixon acknowledged "*But as long as there is a demand, there will be those willing to take the risks of meeting the demand"* (Nixon, 1971, p. 4)*.*

As Nixon and others predicted, over the long-term the production and supply of drug crops and synthetic drugs has kept pace with increasing demand, availability has increased and prices, in real terms, have fallen. United Nations data collection and analysis of global illicit drug use as reported in the annual Global Illicit Drug Trends

Reports and World Drug Reports have consistently shown continuing and substantial increases in the consumption of illicit drugs over recent decades (United Nations Office for Drug Control and Crime Prevention, 1999, 2000, 2001, 2002; United Nations Office on Drugs and Crime, 2003, 2004, 2005, 2006, 2007b, 2008c, 2009b, 2010b, 2011c, 2012d, 2013d, 2014b, 2015). Table 10 provides a comparison of United Nations reported figures over a 14 year period from 1997 (United Nations Office for Drug Control and Crime Prevention, 1999, 2000; United Nations Office for Drugs Control and Crime Prevention, 2000) to 2011 (United Nations Office on Drugs and Crime, 2013d) demonstrating substantial increases in the use of all major illicit drugs monitored.

Table 10: United Nations Reported Drug Use over 14 years,1997-2011 (United Nations Office on Drugs and Crime, 2013d)

Drug	ATS		Cannabis		Cocaine		Opiates (heroin/opium)	
Reporting period	**1997**	**2011**	**1997**	**2011**	**1997**	**2011**	**1997**	**2011**
Annual Prevalence in millions of people aged 15-64	30.2	* 33.8	141.2	180.6	13.3	** 17.0	8.0	16.5
Annual Prevalence as % of global population	0.52 %	0.7%	2.45 %	3.9%	0.23 %	0.37%	0.14 %	0.4%

Note: In the figures presented in the table above: the World Drug Report and Global Illicit Drug Tends data for periods prior to 1997 were not accessible in a reporting format which would allow for ready comparison or analysis of trends; the 2011 figures for annual the prevalence of ATS use did not include the use of 'ecstasy' and reported these figures separately as 19.4 million people or 0.4% of the global population; and, the 2011 figures for cocaine consumption were reported to be a significant decline over previous years (e.g. there was a 40% fall from 2006 in the United States, the world's biggest market for cocaine).

Criticism of the international drug control conventions and their implementation has been increasing and broadening. An extensive range of organisations have been particularly critical and their participation in the debates surrounding these conventions increasingly well organised. These have included harm reduction organisations, such as Harm Reduction International and the Asian Harm Reduction Network, policy 'think tanks' (e.g. the Global Initiative for Drug Policy Reform and the International Drug Policy Consortium), drug user groups (e.g. the International Network of People Who Use Drugs and the Australian Injecting and Illicit Drug Users League) law enforcement (e.g. Law

Enforcement Against Prohibition, and Law Enforcement and HIV Network) and other professional organisations such as International Doctors for Healthy Drug Policies. Significantly, it was not only harm reduction advocates and opponents of drug prohibition who have been critical of the implementation of the international conventions. Increasingly, commentators on both sides of the debate have argued that the current approach has not worked and that the so-called 'War on Drugs' has been lost (Barton, 2013; Becker & Murphy, 2013; Branson, 2012; K. Hunt, 2013; Shultz, 2013; Steketee, 2012). Critics said the US has spent more than $51billion per year on drug control efforts and has spent $1 trillion since Nixon's 1971 declaration of a war against drugs (Drug Policy Alliance, 2013). Furthermore, they claimed that even though global enforcement of the 1961 UN Single Convention cost more than $100 billion a year it had failed to eliminate production, supply or use (Drug Policy Alliance, 2013) and one of the more recent estimates indicated that around 270 million people used illicit drugs worldwide (Rolles et al., 2012).

In addition, many unintended negative consequences have been identified. These have been identified as including placing control of the international drug trade in the hands of organised crime, and criminalisation of many drug consumers (United Nations Office on Drugs and Crime, 2013d). Prohibition has been associated with the creation of a global drug black market which undermined legitimate economies through corruption, money laundering and the fuelling of regional conflicts (Rolles et al., 2012; United Nations Office on Drugs and Crime, 2009a). In 2004, the United Nations High-level Panel on Threats, Challenges and Change estimated criminal organisations' revenue from narcotics trafficking was US$500 billion annually. The UN High-level Panel further noted that drugs revenue was organised crimes' single largest source of income and that profits generated through drug trafficking were large enough to rival the GDP of some countries (United Nations, 2004).

Commentators have noted that the inevitable result of drug markets being entirely controlled by organised criminals has been to trap vulnerable producing or transit countries into underdevelopment, further undermining governance and exacerbating conflict and violence (Jahangir et al., 2011; Rolles et al., 2013; Rolles et al., 2012). The reallocation of resources from programs for basic sanitation, education and healthcare, to policing prohibition or other misallocation of public funding, or because of corruption, traps developing countries in poverty. When drug cartels have bought legal protection, political support and votes, or when they can intimidate politicians, police, judiciary and other government officers, then democracy has been undermined and effective

government seriously impaired (Obot, 2004; Rolles et al., 2012). The illicit drug industry has been associated with conflict and violence and the production and distribution of illicit drugs has also been a key source of funding for separatist, insurgent or terrorist organisations, either through their own distribution chains or by supplying criminal organisations in exchange for funds or arms (Rolles, Murkin, & MacKay, 2011). Many developing countries in Asia, Africa and Latin America have been particularly hard-hit by the corruption and violence associated with the operation of criminal drug syndicates as well as the efforts to suppress them. The Fraser Institute recently undertook a defence and security impact evaluation of Mexico in which it estimated more than 80,000 people had been killed in drug wars between government forces and cartels run by drug lords. The evaluation described systemic graft, corruption and intimidation and how entire towns had been depopulated as government forces and drug cartels competed for control. The report went on to state that so great was the impact of these 'drug wars' that the US had begun to have serious concerns that they may see a 'failing state' on their border (Dowd, 2014).

Human rights organisations have also been vigilant and vocal about what they have seen as the undermining of human rights through the implementation of the international drug conventions. It has been claimed, with some evidence, that state sponsored violence including corporal and capital punishment (P. Smith, 2011) as well as extrajudicial killings have frequently been associated with drug enforcement (J. Cohen, 2004). For example, recent figures indicated over 30 countries maintain the death penalty for drug-related offences with around 1000 or more such executions taking place annually. In addition, many claimed that punishments for minor drug offences were disproportionate, they overwhelmed criminal justice systems and caused prison overcrowding which subsequently resulted in further health and human rights harms (Global Commission on Drug Policy, 2012; Human Rights Watch, 2010; Murkin, 2011).

It was the health consequences of international drug prohibition which were of specific interest in this research. Criminalising drug use, especially IDU, has been associated with high-risk behaviours. Due to the high cost of black market drugs, low accessibility and clandestine nature of use, many illicit drug users were more inclined to use means of administration which maximised bioavailability and minimised police detection (i.e. injecting) (Griffin, 2009). This was even more likely during periods of recession or reduced product availability, for example, resulting from successful interdiction and seizure operations (Lakhdar & Bastianic, 2011). Possessing injecting paraphernalia, including sterile needles and syringes, has been illegal in many countries and this has

resulted in many PWID routinely re-using and sharing injecting equipment, which has led to epidemics of HIV, HBV and HCV among drug consumers and, in many countries, subsequently facilitated the entry of these BBV into the general community (Harm Reduction International, 2012, 2014). The illegality of the drugs, and the behaviours associated with their use can hinder access to PWID for the testing, prevention and treatment of BBV. Furthermore, there have been many reports of PWID experiencing discrimination when they do attempt to access healthcare and treatment for BBV (Harm Reduction International, 2012; Rolles et al., 2012). In addition, the lack of 'quality control' in the illicit drug market contributed to overdose because the potency of any given batch of drugs was difficult to determine, increasing the risk of accidental overdose. Poisoning was a high risk, associated with the adulterants and bulking agents added to drugs by criminal suppliers in order to maximise profits (Rolles et al., 2013; Rolles et al., 2012).

Those who favoured supply reduction measures pointed out that increasing the price of a drug would produce a corresponding reduction in demand. Weatherburn (2014a, p. 204) for example, put this argument lucidly, saying *"…supply control measures do not need to create a literal 'shortage' to produce a benefit. They simply need to make prohibited drugs much more expensive than they would otherwise be"*. On the other hand, this argument was based on two economic assumptions: firstly, that demand remains elastic; and, secondly, that there were no feasible substitutes. The degree to which demand for a strongly addictive substance remains elastic may depend on a variety of factors. In addition, the viability of the use of one psychoactive drug as a substitute for another has been postulated by some, for example a dramatic increase in alcohol and benzodiazepine consumption which corresponded with a sudden reduction in supply of ATS and heroin during the Thai 'War on Drugs' (Assanangkornchai, Sam-Angsri, Rerngpongpan, & Lertnakorn, 2010). Therefore, caveats and limitations may apply to the strict application of these rudimentary economic assumptions to such a complex phenomenon as illicit drug use. Furthermore, this model also implied a closed system, one in which once one supply chain was removed another source of supply would not 'balloon out', i.e. quickly expand to take advantage of the market opportunity.

Weatherburn also called anti-prohibitionists to task for their inability to provide a counterfactual argument. That is, while acknowledging there have been some negative consequences of drug prohibition, it is not known what the situation would be like in terms of health, economic and other consequences if it had not been in place for the past century. He reasoned that the situation may have been much worse (Weatherburn, 2014a). In addition, Weatherburn claimed that, so far, there had not been any definitive

or unambiguous evidence from large-scale studies that decriminalisation of cannabis, heroin or cocaine use lead to an acceptable reduction in negative consequences or was more cost-effective than prohibition (Weatherburn, 2014b). He argued that it was unacceptable to simply dismiss these two critical questions and risk possible calamity without a thorough appreciation of the unintended and unanticipated consequences an alternative approach to drug policy may cause (Weatherburn, 2014a, 2014b).

Nevertheless, since the UNODC 1998 declaration of 'A drug free world: we can do it!' (Bewley-Taylor, 2012a), global opium production doubled from about 3,765 metric tonnes in 1998 to 6,883 metric tonnes in 2013; the number of cannabis users increased from 141 million to 180.6 million (or 3.9% of the population aged 15-64) and, the estimated number of ATS users rose from 30 million to 34.4 million people aged 15-64, despite a dramatic increase in seizures of ATS from 10.8 metric tons to 144 metric tons during the same period (United Nations Office for Drug Control and Crime Prevention, 1999; United Nations Office on Drugs and Crime, 2014b). Furthermore, illicit drug prices have continued to fall. For example, in the USA between 1990 and 2007, the average inflation-adjusted and purity-adjusted prices of heroin, cocaine and cannabis decreased by 81%, 80% and 86%, respectively. This was despite substantial increases in drug enforcement, for example, a 1000% increase in the number of people serving drug-related sentences in USA (from 50,000 to 500,000), and an eight-fold increase in expenditure on international drug control, from US$0.5 billion to US$4 billion per year (Wodak, 2014). On the surface, it would appear that this approach has not been effective and, as discussed earlier may have contributed to an increase in the types and volume of drug-related harm. Wodak (2014, p. 190) recently summarised this point of view by saying "*Drug prohibition has proved to be an expensive way of making a bad problem worse*".

5.7.3   The 'Soft Defection' from the International Drug Control Conventions

A number of UN member states have expressed dissatisfaction with the punitive approach promoted by the international conventions and growing concern that they were no longer capable of providing the responses needed to ameliorate and resolve national drug problems (Bewley-Taylor, 2012c; International Drug Policy Consortium, 2012). Since the 1990's an increasing number of countries have engaged in what has been termed a 'soft defection' or an accelerating 'de-escalation' from the zero-tolerance approach of the international drug conventions. That is, rather than withdrawing from these international agreements, many countries have diverged from its prohibitionist

stance while technically remaining within their legal limitations. It has been argued by proponents on both sides of the argument that this normative attrition has weakened the international prohibition agenda and begun a policy evolution from within rather than a created substantive transformation (Bewley-Taylor, 2013; Transnational Institute, 2006). For decades, some countries have successfully experimented with approaches that focus less on prohibitionist and punitive legal approaches, and include a stronger focus on public health approaches to drug use. The methods taken have been as diverse as the political economies they have occurred within, but commonly these have involved some form of decriminalisation, depenalisation, or regulation (Transnational Institute, 2006). These terms were explained in detail in Chapter Four. In the discussion to follow, examples from a range of EU countries will be used to provide further details on some of these different approaches to implementing drug policy.

A report by the European Monitoring Centre for Drugs and Drug Addiction (2002) offered an instructive glimpse of the varied policy and legislation responses to drug use by a range of European countries at the time. At the most austere end of the policy and legislative spectrum were Greece, Norway, Finland and Sweden where the law prohibiting use was reported to be applied 'to the letter' and punishments were severe. At the other end of the policy and legislative spectrum, Spain, Italy and Portugal, did not apply criminal sanctions to the possession of any drugs for personal use but used only administrative sanctions such as a warning or fine (European Monitoring Centre for Drugs and Drug Addiction, 2002).

In July 2001, Portugal became the only EU member state to decriminalise all illicit drugs, including cocaine and heroin. This meant that while these drugs were still illegal, drug use and possession of small amounts for personal use were considered to be simply administrative violations and did not usually result in criminal penalties or records. Drug trafficking, however, continued to be prosecuted as a criminal offence. Seven years after the change in law, the initiative was evaluated. Forecasts by some critics that the changes would fuel endemic increases in national drug use and that Lisbon would become a sanctuary for so-called 'drug tourists' proved erroneous. In fact, the data showed drug usage rates decreased slightly and by 2010 Portuguese illicit drug use rates were amongst the lowest in the EU. Furthermore, drug-related negative health outcomes, such as STD and deaths due to drug overdose decreased dramatically. The evaluation also indicated decriminalisation enhanced treatment uptake due to an increased capacity of the Portuguese government to offer treatment programs as well as legislative provisions to impose no sanction where an alleged offender agreed to

undergo treatment (Hughes & Stevens, 2010 ; Hughes & Stevens, 2012a, 2012b). Since July 2001, Portugal has received both praise and condemnation internationally for pursuing this liberal approach. Domestically, the approach has increased in popularity (Greenwald, 2009).

On the other hand, INCB and UNODC have highlighted Sweden as an exemplar in the successful and faithful implementation of the international conventions on drug control. For the past few decades, Sweden has pursued increasingly restrictive drug control strategies with the ambitious goal of a drug-free society. One illustration of this approach is that minimum and maximum sentences for, what they refer to as, 'non-serious' and 'serious' drug-related offences climbed consistently from 1969 to 1993 (e.g. the maximum sentence for serious offences went from four to 10 years of imprisonment and minimum sentences were doubled in 1981). Sweden invested heavily to finance their drug control policies and in 2006 drug-related expenditures were equivalent to 0.5% of GDP, the second highest among all EU countries. At the time of the UNODC 2007 Review (Mathers et al., 2010), Sweden's life-time prevalence and regular use of drugs was lower than it had been in the three decades previously, was considerably lower than in the rest of Europe and heavy drug use levels were below the EU average. For example, in 2003 average levels of life-time prevalence of drug use among 15-16 year olds in Europe amounted to 22% on average, whereas in Sweden, the rate was eight percent and this fell further to six percent in 2006. Sweden was also among the European countries with low levels of injecting drug-use-related HIV/AIDS infections. UNODC argued Swedish drug policy was highly effective in preventing drug use, but seemed to be less effective in preventing drug users from becoming dependent drug users. Nonetheless, the report acknowledged additional factors which may have played a role, including: standards of health and social care that were among the highest in the world; promotion of equal access to these predominantly tax-funded services; the unusually health conscious attitudes of Swedes; relatively high incomes and income equality; and, the fact that Sweden is not located along any of the major drug trafficking routes. It is also important to note that PWID in Sweden had access to OST (methadone and buprenorphine) and it was one of the first countries to introduce needle exchange programs to prevent HIV infection among PWID (United Nations Office on Drugs and Crime, 2007a).

United Nations member states attempting less prohibitionist and more tolerant policy approaches to national drug use issues have not only had to persuade national constituents that innovative and flexible approaches to drug use needed to be tried, they

have also had to contend with the conservative international prohibitionists. These countries have, for instance, been regularly criticised by the INCB and targeted for INCB missions to monitor, negotiate and cajole them into more rigorous compliance (Bewley-Taylor, 2003; International Narcotics Control Board, 2012). In its annual reports, for example, the INCB regularly insisted that the international community must advance shared responsibilities in drug control and singled out nations which it considers have been recalcitrant in their responsibility in ways that were "*…contrary to the fundamental object and spirit of the Convention…[even]… while that course of action is technically permitted under the Convention…*" (International Narcotics Control Board, 2011, p. 37). Recent examples of the INCB using its national reports to single out for censure countries moving away prohibitionist and punitive approaches to drug use included: criticism of Canada for allowing its cannabis laws "*…to be o*f *no force or effect*" (International Narcotics Control Board, 2011, p. 38); the Australian Government for allowing the state of New South Wales to establish a medically supervised injecting room; Canada, for similarly allowing a drug injection room facility to stay open; and, the federal government of the United States of America for allowing 17 states to decriminalise either medical or recreational use of cannabis (International Narcotics Control Board, 2011). INCB further noted *"…with serious concern the ongoing move towards the legalization of cannabis for non-medical purposes in … the states of Colorado and Washington in November 2012*" (2012, p. 11).

In December 2013, Uruguay became the first nation in the world to fully legalise cannabis; including legalising growing and possession of cannabis for personal use. President Jose Mujica, who initiated the proposal, stated the intent of the legislation was to regulate and tax a market that already existed and remove it from the hands of organised crime (Castaldi & Llambias, 2013; Hetzer, 2013). Nevertheless, INCB expressed "*deep concern"* over the proposed legislation and stated that not only was Uruguay in breach of the 1961 and 1988 Conventions but their actions *"…could have far-reaching negative consequences for the functioning of the entire international drug control system*" (2012, p. 36). Revisions in the ways various sovereign states respond to cannabis use appear to be at the forefront of the contention and dispute of international drug control, indeed it appeared that policy and legislative change, for example, on cannabis use were at the vanguard of new responses to drug use in general. Furthermore, rethinking the implications of the international drug control conventions on national policy and legalisation has not been restricted to a focus on cannabis.

Recently (9 December 2015) it appeared that there may have been some significant reassessment occurring within INCB. At a special event on public health approaches for drugs policy the President of INCB, Werner Sipp, made a statement which appeared supportive of Portugal's new approach to drug use, stating that: offering education, treatment and/or rehabilitation as an alternative to criminal sanctions for possession of small amounts of illicit drugs for personal use was within the provisions of the United Nations conventions on drugs. He stressed the Portuguese system was sometimes misrepresented as legalisation, but in fact, drug use there remained prohibited and the decriminalisation, which allowed for exempting small quantities from criminal prosecution, was consistent with international drug control treaties (Sipp, 2015). Even though it had come 15 years after Portugal's 2001 introduction of the decriminalisation of drugs, this public statement was significant and may have foreshadowed further changes in the interpretation and implementation of the United Nations drug conventions in the near future.

While it is beyond the scope of this research to evaluate the evidence and impacts of every country's policy response to drug use, or even those countries mentioned thus far, it is important to establish the current context and trends in international and national responses, key stakeholders in these responses and some of the accompanying debates occurring in response to these different attempts to deal effectively with drug-related issues. The focus of this research, however, is the relationship of drug use to HIV/AIDS and the impact of drug policy and strategy on this.

5.7.4   The UN General Assembly Special Session (UNGASS) on Drugs

Globally, there appeared to have been deep divisions between countries on issues of harm reduction, the death penalty and the drug policy and legislative reform as well as growing dissatisfaction by an increasing number of countries with the current state of global drug policy and its implementation. In 1998 the United Nations convened a 'UN General Assembly Special Session (UNGASS) devoted to Countering the World Drug Problem Together' at which member states agreed to a Political Declaration on Drugs (United Nations General Assembly Special Session, 1998). Ten years later, member states met in Vienna to discuss progress and agreed on a renewed Political Declaration and Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (International Drug Policy Consortium, 2014a; United Nations Office on Drugs and Crime, 2014a). In March 2014, UN member states attended a High-Level Segment of the annual CND to review progress, and the challenges

encountered in implementing the 2009 Political Declaration. During this mid-term review, strong divisions appeared between governments wishing to promote openness and progress towards reform (for example, the European Union, Norway, the Netherlands, Switzerland, Mexico, etc.), and others who argued for status quo and a recommitment to existing efforts (i.e. China, Pakistan and the Russian Federation) (International Drug Policy Consortium, 2014b). Soon after the mid-term review, the presidents of Colombia, Guatemala and Mexico called on the UN to bring forward the next UNGASS global drug policy summit meeting to 2016. This resolution was supported by 95 other countries (International Drug Policy Consortium, 2014a). The next UNGASS on Drugs was scheduled to be held in 2019.

5.7.5   The Rise of Illicit Drugs Markets, Producers and Suppliers

Throughout the 19th and into the 20th century the world's opium supply continued to chase the increasing demand for the drug and in 1906, just prior to the first International Opium Convention in Shanghai, world production had reached a historic high of 41,000 tons (McCoy, 2000). The opium trading western nations progressively complied with the Shanghai convention and subsequent international agreements restricting the production and use of opium for medical and scientific purposes. While this led to a sharp decline in the legal opium trade, the enormous demand for the drug remained. As a result of the western nations' rapid reduction of opium production and the relatively inelastic demand for the drug, the world price for illicit opium rose. Rising prices, in turn, stimulated opium production outside India, particularly in South-east Asia, where the climate was temperate and extensive land was available for cultivation. In other words, the simple economics principles of demand, supply and price prevailed.

This produced an enormous and very lucrative business opportunity and in response new criminal syndicates emerged in Europe and Asia, taking over the global trade in this now illicit commodity. The high demand for the drug, now no longer supplied by government endorsed legal businesses, and the potential for high profits attracted and sustained criminal producers and smugglers of illicit opium. It was a business model in which both supply and demand were assured. Opium could be grown anywhere in temperate or highland Asia and production was rudimentary and inexpensive. Attempts at crop suppression simply shifted cultivation to a new location (McCoy, 2000). The Golden Triangle (the mountainous region where Burma, Laos, and Thailand share common borders) was especially well-suited for opium cultivation (Drug Enforcement

Administration, 1992). Furthermore, the mountainous and heavily jungled areas made access for crop monitoring and suppression extremely difficult.

While many western nations complied with the suppression of the opium trade, in Asia non-medical opium use continued, particularly in China, as well as among the Chinese diaspora settled throughout South-east Asia. After the trade and consumption of opium became illegal it became even more difficult to quantify the extent of illicit opium use, however, *"In 1930, South-east Asia had 6441 government opium dens serving 272 tons of opium to 542,100 registered smokers"* [Emphasis added] (McCoy, 2000, p. 321). During this period, another particularly significant trend began to emerge that was to have far reaching ramifications.

From its launch by the German Pharmaceutical company Bayer in September 1898, 'Heroin' grew rapidly in popularity as a readily available 'over the counter' remedy for respiratory complaints and pain relief (Brownstein, 1993; McCoy, 2003). In 1912, a publication raised concerns about heroin's propensity for addiction and from 1914 restrictions applied to its use. Ten years later, in 1924, it was banned in the US in many other countries (Sneader, 1998). Nevertheless, despite increasing restrictions on its legal use, heroin proved to be an excellent alternative product to opium for illicit traders. Even though opium had been outlawed under the 1912 Hague International Opium Convention, the 1925 Geneva Opium Conventions and subsequent treaties great demand for opiates remained and the high profits the opiates trade offered incentivised and sustained the involvement of criminal syndicates in this trade. On the other hand, opium was bulky, perishable and has a distinctive odour, and this aroma became even more noticeable when it was smoked. These characteristics began to become problematic when its distribution and use had to be undertaken covertly. By comparison, heroin had a high value for weight, was compact, odourless, far more potent, and with a high potential for dependence, making it an ideal black market commodity. These were characteristics that criminal suppliers increasingly valued as drug prohibition, suppression and interdiction intensified in subsequent decades. Heroin enabled criminal syndicates to meet the extensive consumer demand for opiates, increase their profits and lower their risk because compared with the bulky and odorous opium, it was much easier to conceal the transport, storage and use of heroin from detection (McCoy, 2000, 2003). From this period onwards, heroin began to replace opium as the opioid of choice for hundreds of thousands, and eventually millions, of drug consumers. Concomitantly, injecting of heroin began to replace smoking as the preferred method of administration.

By the mid-20th century opium smoking in South-east Asia had been almost completely replaced by heroin injecting (McCoy, 2000; Westermeyer, 1976).

5.8   Contemporary Drug Use in South-east Asia

Having examined contemporary drug use and responses to drug use at the global level the following section will now bring the focus closer to the geographical area of interest for this research, South-east Asia. Recent UNODC global estimates indicated the number of people (aged 15-64 years) who used illicit drugs during the year 2012 to be between 162 million and 324 million people, corresponding to between 3.5% and 7.0% of the world population aged 15-64. UNODC regional estimated that prevalence rates for most illicit drugs were similar in East and South-east Asia to global averages except for ATS use, which was significantly higher than the global average. In East and South-east Asia during the year 2012, an estimated 10,140,000 people had used cannabis, an estimated 8,980,000 people used ATS and 8,510,000 had used opioids or opiates. Recent estimates of the prevalence of the use of various illicit drugs have been only available for a few countries in Asia. At that time, Asia was home to an estimated 45-40% of all illicit drug users worldwide, as well as 60% of opiate users and between 30-60% of ATS users. Harm Reduction International estimated there were 4.5 million PWID living in Asia with over half of those in China (2012). The UNODC estimated more than three million people in East and South-east Asia injected drugs, predominantly opioids, and to a much lesser extent, methamphetamine (2013d). UNODC further estimated that there were 3,260,000 PWID in East and South-East Asian or 0.16% prevalence of the general population during 2012 (United Nations Office on Drugs and Crime, 2013d). The following table shows the figures for annual prevalence of the use of illicit drugs in 2012 for East and South-East Asia.

Table 11: Prevalence of illicit drug use in East and South-east Asia 2012 (United Nations Office on Drugs and Crime, 2014b)

Drug Used	Best Estimate	Lower Estimate	Upper Estimate
Cannabis	10,140,000	5,910,000	23,440,000
ATS	8,980,000	3,440,000	20,400,000
Ecstasy	3,180,000	1,630,000	6,630,000
Cocaine	480,000	370,000	1,100,000
Opioids	5,190,000	3,880,000	6,540,000
Opiates	3,320,000	2,410,000	4,440,000

This 2014 UNODC World Drug Report further cautioned that it was difficult to access reliable regional prevalence data on drug use for countries in Asia generally and particularly in South-east Asia. Few countries had sufficiently developed health information systems to enable them to collect and report drug epidemiology data. Regardless of the exact figure, it was clear that IDU remained a serious public health concern in many countries in East and South-East Asia, with this region accounting for approximately one-third the global total.

The World Drug Report 2012 stated, *"South-east Asia is in the midst of an epidemic initiation phase with regard to the use of ATS, notably methamphetamine"* (United Nations Office on Drugs and Crime, 2012d, p. 92). The increasing production, trafficking and use of ATS in the ASEAN region was a growing concern to national governments, health and law service providers and NGO's. Two years later, the 2014 World Drug Report stated that ATS use in the region continued to climb and seizures of methamphetamine in pill and crystalline forms in East and South-east Asia had reached record levels in 2012, accounting for approximately a quarter of the total of 144 tons of ATS seized globally that year. This was extremely significant for harm reduction efforts as ATS use continued to climb in many countries. Yet despite these concerns *"… and increased research attention in some countries, the harm reduction response* [to ATS] *has remained underdeveloped when compared with the response to opiates..."* (Harm Reduction International, 2010, p. 97).

5.9 The ASEAN Region

As this literature review progressively refines its focus from a global overview, to the vast region of Asia, and then South-east Asia, the next logical step is to subsequently consider the specific group of countries which were bound by the strategies, policy objectives and agreements of ASEAN.

In October 2003, ASEAN decided to establish an ASEAN Economic Community (AEC) by 2020. The AEC was to facilitate greater cooperation and regional integration within the region on political, security, economic, social and cultural affairs. Ultimately the ASEAN leaders envisaged the region would become a single market and production base competing in the global economy. In January 2007, at the 13th ASEAN Summit, the ASEAN Leaders adopted a Blueprint to Accelerate the Achievement of the AEC by 2015 (ASEAN Secretariat, 2009b; Chia, 2013). This espoused demand for close integration and greater cooperation may have significant implications for all major national policies

and strategies including how each individual country, and the regional architecture they formed collectively, responded to illicit drug production, distribution and consumption. Notably in 2000, at the 33rd ASEAN Ministerial Meeting in Bangkok the attending Ministers issued a Joint Communiqué calling for 'A Drug Free ASEAN by 2015' (ASEAN Secretariat, 2000) which has been reiterated many times at subsequent ASEAN fora (ASEAN Secretariat, 2012; Office of the Narcotics Control Board, 2012; United Nations Office on Drugs and Crime, 2008a).

5.9.1 Policy Responses to Drug Use in the ASEAN Region

5.9.1.1 Supply Reduction in ASEAN

Many of the international conventions and treaties to which ASEAN members were signatories have focused almost exclusively on supply reduction and run counter to comprehensive and effective harm reduction implementation. Primary among these agreements were the Memorandum of Understanding (MOU) on Drug Control, A Drug-Free ASEAN by 2015, and the ASEAN and China Cooperative Operations in Response to Dangerous Drugs (ACCORD). The MOU on Drug Control from the ASEAN Senior Officials on Drug Matters was initiated in 1993 by China, with Lao PDR, Myanmar, Thailand, UNODC and later Cambodia and Viet Nam. It provided a regional drug control agenda for creating a drug control framework that encompassed the Greater Mekong Region (Sheng, 2006). The ACCORD was endorsed in October 2000 at the International Congress 'In Pursuit of a Drug-Free ASEAN and China 2015' held in Bangkok, and resulted in the development of a regional framework to suppress and eradicate illegal drugs. Furthermore, one of the stated aims of the 2009 ASEAN Socio-Cultural Community Blueprint for an integrated ASEAN Community in 2015 was *Ensuring a Drug-Free ASEAN* and the Blueprint made a commitment to promoting Social Welfare and Protection by *"…enhancing the well-being and the livelihood of the peoples of ASEAN through alleviating poverty, ensuring social welfare and protection, building a safe, secure and drug free environment"* (ASEAN Secretariat, 2009a, p. 6).

Across the region, a War on Drugs approach to policy remained strong and was reinforced through agreements such as the target of a *Drug Free ASEAN by 2015* (ASEAN Secretariat, 2000). Responses have been grounded in the long history of the Asian burden of opioid use, strongly linked to UN conventions, and the need to be perceived as taking strong action grounded in an unambiguous moral position. In addition, criminal intelligence indicated strong connections between drug production and trafficking with other regionally endemic transnational organised crimes including:

trafficking in persons; trafficking in small arms and ammunition; the illegal wildlife and logging trades; production of substandard or counterfeit medicines; illicit trade in e-waste and ozone-depleting substances; and the trade in counterfeit consumer goods. Furthermore, often the same criminal groups were involved in multiple activities and used funds from one operation to finance another (United Nations Office on Drugs and Crime, 2013c). So, it was understandable that drug policy might have developed predominantly as a security issue in the ASEAN region, with a strong focus on supply reduction and interdiction.

Yet it was clear that supply reduction in the ASEAN region had not had the impact that might have been hoped. Illicit drug supply has continued to escalate and examples of increased production and supply, of both opium and ATS, suggested support for this widely-held view. The UNODC 2010 Myanmar Situation Assessment on ATS revealed a massive increase in seizures from 1.1 million amphetamine pills in 2008 and 20 kilograms of methamphetamine in crystal form (in the three years from 2006-2008) to 23.9 million pills and 125 kg of crystal methamphetamine in 2009. UNODC stated the alarming increase in seizures was indicative of a corresponding increase in supply, which would inevitably then result in much higher rates of demand and use (United Nations Office on Drugs and Crime, 2011a). In its annual South East Asia Opium Survey Reports, UNODC described that opium production in the Golden Triangle had continued to increase each year since 2006, particularly in Myanmar and Lao PDR. The areas under cultivation had increased and new methods, such as multi-cropping, had also increased yields, for example, in 2010 Myanmar yields increased by 46% over the previous year (United Nations Office on Drugs and Crime, 2010a, 2011b, 2012a, 2013d).

Illicit drug consumption also continued to climb. Recent World Drug Reports observed that within East and South-east Asia opiate and opioid use had increased (United Nations Office on Drugs and Crime, 2012b, 2012d, 2013b, 2013d, 2014b, 2015). They also reported increasing diversions of ATS chemical precursors (such as ephedrine, pseudoephedrine and 1-phenyl-2-propanone), the manufacture of ATS and seizures of ATS product for market. During the 2013 reporting period, seizures of crystalline methamphetamine in South-east Asia were at the highest level in the previous five years (8.8 tons) and the region had a higher estimated annual prevalence of ATS use than the global average. It also revealed the emerging use of new synthetic psychoactive substances, such as cathinones and phenethylamines in the region (United Nations Office on Drugs and Crime, 2013a).

In addition, ASEAN's tough supply reduction policy focus did not seem to have reduced harm related to drug use. The UNODC 2014 World Drug Report highlighted concerns that IDU remained a serious public health concern in East and South-east Asia and, as previously mentioned, UNODC estimated the region accounted for around one-third of the global total of PWID. Some commentators conceded that supply reduction and demand reduction strategies were not sufficient to solve the problem of the proliferation of drug-related harm citing as evidence, for example, the ASEAN region's high rates of IDU, drug-related deaths and alarming transmission rates of HIV, HVB and HVC among drug users. These increases appeared to have occurred despite apparently successful supply reduction outcomes, such as record seizures of illicit drugs by law enforcement, as well as rapidly increasing numbers of drug users sent for compulsory treatment. A growing number of international experts have gone as far as to state that these types of prohibitionist policies were actually a part of the problem. The Guardian (Rolles, 2008, para. 1) represented this increasingly popular view stating "*Prohibition and its enforcement not only fails to restrict the availability of drugs but is itself the root cause of many of the most significant drug-related harm*".

5.9.1.2 Demand reduction in ASEAN - Drug Prevention and Treatment

In ASEAN countries drug treatment options were limited and in the public sector, the clear majority were involuntary abstinence-based programs run by the military, police, or public security departments. These drug treatment centres were usually referred to as Compulsory Centres for Drug Users (CCDU) in the international literature (without any reference to treatment) and have consistently been described by CSO and international observers as 'boot camps', lacking evidence-based treatment modalities or adequately trained staff. In Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam drug users have been routinely rounded up, arrested and, after a period in jail for processing, sent to CCDU. A recent review of official records in East and South East Asia found that approximately a quarter of a million people were detained in over 1000 compulsory drug detention centres (Amon, Pearshouse, Cohen, & Schleifer, 2014; Lewis, 2012). Conversely, independent reports put the figure much higher. A multistage systematic review of published and unpublished literature between 2004-2009 found that at any point in time there were 300,000 people in China undergoing compulsory drug detention, in excess of 60,000 in Vietnam and more than 40,000 people in Thailand (Mathers et al., 2010). Other reviews, including a situational analysis by the WHO of CCDU in Cambodia, China, Malaysia and Viet Nam, stated similar figures for South-east

Asian countries and reported a range for China of between 300,000 and 500,000 people (Elliott, Symington, Lines, & Schleifer, 2011; World Health Organization, 2009a).

Incarceration in closed settings, including CCDU, is a known risk for HIV infection in drug users. Due to sharing of injecting equipment, unprotected sex, sexual violence, tattooing and other high-risk activities, CCDUs create an environment which promotes higher rates of HIV and other BBV transmission than would otherwise occur among this sub-population if they were to remain in the community (Thompson, 2010). Although many of these CCDU routinely tested residents for HIV, at the time of writing few offered HIV education, counselling or treatment, with the exception of some CCDU in Thailand (Elliott et al., 2011; World Health Organization, 2009a).

In 2009, Human Rights Watch conducted 11 weeks of field research in Cambodia during which they interviewed 74 key informants. They found that drug users were typically sent to these centres involuntarily and with no due process, that is, without representation, a trial, or an appropriate medical or psychological examination (Human Rights Watch, 2010). Other reports have supported these findings and have further stated that even when screening was undertaken it often did not differentiate between recreational or dependent use (Elliott et al., 2011). The Human Rights Watch research reported that often CCDU were overcrowded, housing both adults and juveniles together and often, perhaps due to lack of adequate assessment, PWUD, the mentally ill, street children and the homeless all resided together. These centres were commonly under-resourced, with only rudimentary amenities, poor hygiene, and malnutrition was common among inmates (Human Rights Watch, 2010). Research conducted over 2008-2009 involving 30 interviews with representatives of government ministries, UN agencies, and NGOs from Thailand, Cambodia, and Laos, reported that evidence-based pharmacological or psychological drug treatments, such as OST or cognitive behavioural therapy were rarely available in CCDUs or the community due to resource constraints, lack of trained staff or legislation restrictions (Thompson, 2010). Treatment was abstinence-based and many of the centres practised 'cold turkey' withdrawal, in which patients did not have access to medications to alleviate withdrawal symptoms (Elliott et al., 2011; World Health Organization, 2009a).

International agencies and NGOs reviews have repeatedly described that the practices offered as treatment in these CCDU commonly involved military drills, physical exercise, lectures on the harms of drug use and 're-education through labour'. A number of reports indicated that detainees were used as cheap or free labour for industry and concerns

were raised by international observers that this created economic incentives for not considering evidence-based alternatives (Amon et al., 2014; Dekker, O'Brien, & Smith, 2010; Elliott et al., 2011; Human Rights Watch, 2011b; Thompson, 2010). There were also many corroborated reports of cruel and degrading treatment and of a wide range human rights abuses in CCDU in the countries of the Greater Mekong Sub-region (Amon et al., 2014; Csete & Pearshouse, 2007; Elliott et al., 2011; Human Rights Watch, 2010, 2013; Thompson, 2010). Many former detainees also reported sexual assaults by other inmates and by staff in the centres. Not surprisingly, attempts to escape these centres were frequent (Elliott et al., 2011; Human Rights Watch, 2013). A number of former detainees reported witnessing suicide attempts and successful suicides in these centres (Human Rights Watch, 2011b).

Generally, people were released after a three to six-month stay, but they could remain as long as two years (Elliott et al., 2011), and there were reports of people being detained up to four or five years (Thompson, 2010). Rates of relapse and recidivism were very high. The methodology used in the analysis of these data varied as did the rates reported (75-100%) (Csete & Pearshouse, 2007; Dekker et al., 2010; Elliott et al., 2011; Human Rights Watch, 2010, 2011b; Thompson, 2010). The greatest variation in reported recidivism figures appeared to be between national government reports and those of international agencies and NGOs, with government sources consistently reporting rates at the lower end of the range.

An increasing number of United Nations agencies, human rights organisations, and other international and national actors have expressed concerns about rights abuses associated with CCDU, and have called for their closure (Amon et al., 2014; Csete et al., 2011; Csete & Pearshouse, 2007; Dekker et al., 2010; Elliott et al., 2011; Gerra & Clark, 2010; Haber & Day, 2014; Human Rights Watch, 2010, 2010 2011a, 2011b, 2013; International Harm Reduction Development Program, 2011; Pearshouse, 2009b; Thompson, 2010; United Nations Office on Drugs and Crime, 2012c; World Health Organization, 2009a). In March 2012, UNICEF released a position statement stating there was no evidence for the effectiveness of CCDU and their use for young people under the age of 18 was in direct conflict with the United Nations Conventions on the Rights of the Child (UNICEF East Asia and the Pacific, 2012). In March 2012, 12 United

Nations Agencies[11] released a joint statement condemning the continued existence of CCDU and called for their immediate replacement with voluntary, evidence-informed, human rights-based community treatment programs for drug dependence (United Nations, 2012).

At this stage, it appeared that in many South-east Asian countries, particularly those which comprised the Greater Mekong Sub-region, that significant political will, comprehensive policy frameworks and substantially enhanced technical capacity were required to make the transformation from a system of compulsory drug detention to community-based treatment and rehabilitation service options informed by contemporary scientific evidence. Published and grey literature suggested that thus far CCDU have been demonstrable failures as treatment services. They contributed to stigma and marginalisation of PWIDs, few offered any evidence-based drug treatment options, they demonstrated high rates of relapse and recidivism, and many had corroborated records of human rights abuses. They were not an effective response to implementation of prevention and treatment policy and further exacerbated drug-related harm. Moreover, their implementation appeared to persist and intensify despite advocacy effort and evidence that these were not effective policy instruments. This important issue of drug policy implementation will be explored further in subsequent chapters.

5.10 Chapter Summary

In addition to describing important policy concepts and approaches this chapter highlighted a key distinction which defined the research objectives and approach. This distinction was, that while a great deal has been researched and published on analysis of policy and how these policies were initiated, formulated or implemented, very little was found on analysis for policy (formulation and implementation) which seeks to determine the environmental conditions for the introduction or reform of policy. This review of the predominant models and theories of policy analysis (for example Kingdon's Three Streams Model and Sabatier's advocacy coalition theories) illustrated some of their distinctive interpretative strengths which could be brought to this analysis. PEA was deemed to be the model which offered most in terms of practical application for this research task. The literature review did not find any evidence for the previous use of PEA specifically for the examination of the policy environment to determine the factors

[11]ILO; UNHCR, UNDP, UNESCO, UNFPA, UNICEF, UNODC; UNWomen, WFP, WHO, UNAIDS and OHCHR.

which have influenced public health policy formulation and implementation. This thesis explicitly and systematically drew upon the work of scholars, such as Kingdon, Collins, Schneider and Ingram, but most especially PEA to guide a detailed examination of the macro-environmental factors which constituted the enabling environment in Thailand and that either hindered or supported the formulation and implementation of Thai harm reduction policy.

Policy environments are complex and at times chaotic systems involving multiple interacting stakeholders, events, institutions and ideologies. A brief consideration of complexity theory provided some necessary perspective in understanding how these multifactorial processes interact, as well as an appreciation of the limitations of what could be expected from such an investigation. This chapter's review of policy analysis was not only for assessment of models and theories to be used in the analysis of the data collected in the course of this research, but also to assist in better understanding the development, application and contentions associated with drug policy as described in the following chapter.

This chapter then applied the lens of policy analysis to establishment of a framework of international agreements, laws and monitoring bodies (such as the INCB) which established and maintained international policy instruments against the cultivation, production, possession, distribution, importation and exportation of drugs throughout the world. It also considered criticism of the international drug control conventions. Critics argued that despite extravagant national budgets for drug prohibition and eradication, this approach had not achieved its intended results and conversely, the production and supply of drugs had kept pace with increasing demand while prices, in real terms, had fallen. Furthermore, many argued that international drug prohibition had contributed to a growing global black market, corruption, money laundering and violence.

This research has focussed on the unintended health consequences of the international prohibition of drugs, especially epidemics of BBV (HIV, HBV and HCV) among or initiated through PWUD. As a result, an increasing number of nations have been examining and experimenting different approaches to drug use, including decriminalisation, and depenalisation, often accompanied by improvements in the quality and accessibility of drug prevention and treatment interventions. Finally, this chapter briefly examined the international drug control conventions from the point of view of harm reduction and considered how, paradoxically, some responses such as law enforcement and CCDU which were intended to reduce the negative impacts of drug use had

increased many drug-related harms. This harm reduction perspective will be examined further in subsequent chapters. This chapter took a global overview, refining the focus to Asia, South-east Asia, and then down to ASEAN. The next chapter will concentrate on Thailand, examining in detail historical and contemporary trends in drug use, associated harms and Thai national drug policy responses.

Chapter 6: Drug Use, Harms and Policies in Thailand

This chapter will first describe the historical context essential to a comprehensive appreciation of contemporary issues associated with the production, distribution and use of illicit drugs in Thailand. It will then examine the three convergent streams of policy, HIV and drug use in a contemporary Thai national context. This will provide the necessary foundation for understanding the focus of this research contemporary, the Thai policy environment, and will also will be critical in interpreting the findings from the data analysis in Chapter Seven.

6.1   History of Opioid Use in Thailand

During the 19th century, successive waves of Chinese immigrated to South-east Asia including Siam as indentured labourers. They often used opium to endure long work hours in harsh conditions and as a medicine for the many tropical diseases which afflicted them. By the 1850s around 300,000 had settled in Bangkok, where many worked as 'coolie' labour in the port (Baker & Phongpaichit, 2014, p. 30). Most of the opium used in Siam during the 19th century, and early part of the 20th century was grown in Bengal, imported by the British, sold to and distributed by the Chinese secret societies and was consumed mostly but not exclusively by the Chinese, who at that time outnumbered the Siamese in Bangkok by two to one (Booth, 2007). For more than 200 years, up until the current millennium, the primary drug of concern in Siam was opium and its derivatives. During the 19th century Siam made a number of attempts to eradicate the opium problem beginning in 1811 with a decree by King Rama II which banned the sale and consumption of opium (Skinner, 1957) and under the 1822 Burney Treaty negotiated between Siam and Britain the import of opium was made a crime. In 1839 his successor, Rama III issued a Royal Siamese Decree which reiterated the prohibition on opium and further mandated the death penalty for opium traffickers. Rama III initiated many raids against opium and Chinese secret societies circulating it, however, national laws and international treaties did little to stop the distribution or consumption of the drug. Nor did they prevent the expansion of the Chinese opium syndicates or the continuing smuggling by the British colonial merchants (Frankfurter, 1904; Koizumi, 2008; Seviset & Qun, 2013).

When King Mongkut (Rama IV) took the throne in 1851 he determined that prohibition against opium had not been effective and in one of his first royal decrees legalised its sale and consumption. He established a state controlled Royal Opium Franchise which, along with royal franchises for lotteries, gambling and alcohol, was managed by Chinese

middlemen (in a modern sense one might say he outsourced or privatised these monopolies) and taxation from these franchises soon provided 40-50% of all government revenues. The drug consumption rooms ('opium dens') were government registered and monitored, as were their consumers. More than 150 years before similar policies in contemporary European and South American countries, it appeared the intention of Rama IV's policy was not to stop drug use directly but to contain and monitor it; and to minimise some of its negative social impacts, in particular by removing it from the domain of organised crime (Trocki, 2002). Nevertheless, Rama IV forbad the use of opium by Siamese subjects and decreed:

> *…those of his Siamese subjects who smoked opium should wear the Chinese queue and dress, and should be liable to pay the Chinese poll tall, a tax which, apparently at that time, carried in the way it was levied, contempt with it.*
> (Frankfurter, 1904, p. 204)

King Rama IV also appraised European imperialism in the mid-19th century as increasingly aggressive and, rather than see his country colonised, he allowed negotiation under the British-Siam Bowring Treaty of 1956 for lowered commodity tariffs, rescinded the ban on rice exports and admitted opium as a duty-free import so long as it passed through a royally licensed franchise (Tagliacozzo, 2004). The opening of Siam in 1856 to free trade fundamentally changed the Siamese economic system. Importantly, it put an end to the state monopoly trading system and meant that the King could no longer depend on royal trade monopolies in commodities such as rice or tin as major direct sources of revenue. Alternative sources of revenue were necessary for the crown to prosper and it appeared the 'sin' franchises of opium, liquor and gambling more than compensated for income lost to the state from royal commodities monopolies (Wannamethee, 1990). This suggested that in addition to the reduction of social harms and the harms associated with criminality there were also economic benefits gained from government drug regulation. Not all opium users in Siam were Chinese or male or labourers. In the 1800's Christian missionaries treated many for opium dependence and among those seeking treatment were wealthy Chinese and Siamese men and women but generally these appeared to have been noteworthy exceptions (Farrington, 2001).

In 1907 the Royal Government of Siam took over direct control of the county's opium monopoly (Lintner, 2000) and under government administration, the domestic opium trade continued to thrive. In 1913, a record 147 tons of opium was imported from India and in 1917 the number of dens and retail shops had soared to 3,000, more than double what it had been under Chinese management. Furthermore, by 1929 there were an

estimated 200,000 opium 'addicts' and opium profits provided around 10% of all government tax revenues (McCoy, 2003). It is also significant that these figures were likely to have grossly underestimated the number of opium consumers and the amount of opium used - even during the height of the government monopoly, there was substantial smuggling of cheaper Chinese opium over the northern borders of Siam and Laos from Yunnan in Southern China by Chinese Muslim traders. While the official records of Royal Siam Opium Monopoly were available to historians and other scholars there were no records available for the illicit opium traders. Although it is not known how great a volume was smuggled and how many consumers this trade serviced, the smuggling was substantial enough for both Siam and French Indochina to engage in military campaigns with the Muslim Chinese (referred to as the *Haw*) on a number of occasions during the 19th and 20th centuries in order for Siam and colonial France to protect their respective opium monopoly revenues (Lintner, 2000; McCoy, 2000, 2003).

Conversely, in the 1920's international opposition to legal opium trade in South-east Asia was intensifying and the Royal Government of Siam began to reduce the capacity of its opium business. By 1930 almost 2,000 shops and/or dens were closed. By 1938 Siam's royal monopoly had reduced opium imports to 32 tons and profits were down to eight percent of total government revenues (McCoy, 2003). Yet a large unmet demand remained and was quickly serviced by a growing black market of opium smuggled overland from southern China. This Chinese opium was soon supplemented by the beginnings of opium cultivation on a commercial scale in the 'Golden Triangle', the mountainous area where Myanmar, Thailand and Laos's borders meet (Lintner, 2000). In 1946, at the first United Nations Narcotics Conference, Siam was censured for being the only country in South-east Asia still operating a legal government opium monopoly. Even more significantly for Siam at that time, the United Nations member states agreed that all non-medical opium exports should cease worldwide as soon as possible. As a result, in 1947 the Royal Government of Siam authorised poppy cultivation in the northern hills for the first time in order meet their projected domestic needs for raw opium. During the next few decades, Siam (renamed Thailand from 1949) was viewed by some as engaging in a complex and constantly shifting dual track of contradictory behaviours. On the one hand, Siam was a signatory to the proliferating international agreements against illicit drugs and professed compliance with the increasingly stringent international prohibition regime, while on the other hand it became criticised as a hub for the production and distribution of both opium and heroin. For example, by the end of the 1950s, Burma, Laos, and Thailand had become massive producers of illicit opium for domestic and international consumption. Yet during the same period, the Royal Government of Thailand passed

national legalisation in line with their international treaty obligations, such as the 1959 Harmful Habit-Forming Drugs Act prohibiting the production, use and trade in narcotics (Lintner, 2000; McCoy, 2003). In 1956 Thailand also restored the death penalty as mandatory for: manufacturing or trafficking in narcotics; possession of more than 20 grams; or the use of deception, coercion or intimidation to force any woman to take narcotics. Since 2003, 47% of death sentences were for drug offences and in 2014 alone Thailand handed down over 55 new death sentences. At the time of writing an execution for a drug offence had not occurred since 2009 (Cornell University Law School, 2016).

6.2   Heroin

A further development which occurred during the post-WWII period was the introduction of heroin. Within the decade following a ban on opium in the late 1950s heroin dependence surpassed opium dependence and Thailand's first heroin epidemic commenced (World Health Organization, 2010b). During the 1960s and 1970s, as in most of the rest of Asia, the majority of Thailand's opium users switched to heroin smoking and soon after to heroin injecting (Rahman & Crofts, 2013). It appeared that significant levels of heroin use, first by smoking and soon after by injection, occurred in Thailand soon after the Royal Thai Government banned the smoking and selling of opium in 1959. Some experts proposed a causal relationship between these two phenomena (M. Barrett, Thomson, & Aramrattana, 2010; McCoy, 2000, 2003; Westermeyer, 1976). The anti-opium laws quickly resulted in *"…increased prices for narcotic drugs, (2) a heroin "industry," (3) corruption of the law enforcement system, and (4) major health problems involving parenteral drug use"* (Westermeyer, 1976 , p.1135). The introduction of heroin not only changed trends in drug use and drug administration methods it also transformed the criminal drug trade. Previously, the farmers who grew opium also processed it from its crude form to its smoking form using only simple equipment. Conversely heroin manufacture required large amounts of chemical supplies, provision of modern laboratory equipment and was complex enough to attract attention. Thus, bribes to police and customs officials were necessary. Heroin manufacture could deliver enormous profits but required well organised and well capitalised criminal operations. So for countries like Thailand, the change from opium to heroin meant a change from a 'cottage industry' where the profits were kept primarily by farmers and small merchants to a large industrial complex where large profits were made by organised crime and government officials (Westermeyer, 1976). Furthermore, some sources stated at that time Bangkok became one of the largest heroin production centres in the world and remained so until as late as 1998, when Thai authorities stated that they

had eradicated the last remaining heroin refineries (McCoy, 2000, 2003). In support of this claim the Thai Office of the Narcotics Control Board (ONCB) referred to the steady declines in reported heroin seizures over the following 10 years (M. Barrett et al., 2010).

6.3 The Cold War and Thai Drug Policy

This Cold War was a crucial period of concern for Thailand's geo-political security and both relevant and important to the understanding of the historical context of Thailand's drug policy. During the 1950's, 1960's and 1970's Thailand was a constitutional monarchy surrounded (some said isolated) on all sides either by Communist countries or by countries torn by civil wars involving Communist insurrections. On Thailand's north-western border Laos fought a civil war from 1953 to 1975 between the Communist *Pathet Lao* and the Royal Lao Government which resulted in a Communist victory. Both sides received substantial external support as a proxy war between the global cold war superpowers (M. Hall, 2008). On Thailand's western and north-western borders, the Burma Socialist Programme Party, formed by Ne Win's military regime, seized power in 1962 and was the sole political party allowed to exist legally in Burma during the period of military rule from 1964 until its demise in the aftermath of the popular uprising in 1988. In addition, the Myanmar/Burma Communist Insurgency lasted 50 years, from 1939 to 1989 (Callahan, 2004). On Thailand's western border, the Cambodian Civil War lasted eight years (1967-1975) and resulted in a Khmer Rouge victory (Conboy, 2013). On Thailand's southern border Malaysia fought a guerrilla war from 1948 to 1960 during which 6,700 Communist guerrillas, 1,800 Malayan and Commonwealth troops, and more than 3,000 civilians died in the conflict. Small Communist Party of Malaysia guerrilla units remained on both sides of the southern Thailand border and did not finally lay down arms until 1989 (Pye, 2015). Further south, Thailand's South-east Asian neighbours were also involved in political and military communist conflicts. The Indonesian Communist Party (*Partai Komunis* Indonesia or simply PKI) with a membership of approximately two million was a key partner in the Sukarno Government and was the subject of coups, countercoups and the systematic massacre of between 500,000 to three million of Indonesians alleged to have been Communists (Gellately & Kiernan, 2003; Hasibuan, 2012; Pamuntjak, 2015). In the Philippines, the New People's Army, established in 1969, fought in 69 of 81 Philippine provinces which resulted in the deaths of 40,000 people (Caouette, 2004; Rocamora, 1994).

During the same period, Thailand was experiencing its own domestic communist political and military conflict. In 1960's the Communist Party of Thailand (CPT) grew in

membership and support and launched a guerrilla war against the Thai Government in 1965 which lasted until 1983. The CPT rural support was estimated to have been at least four million people; its military support consisted of 10,000-14,000 armed fighters and by the early 1970s was the second largest communist movement in mainland South-east Asia (after Vietnam). Its influence was concentrated in the North-Eastern, Northern and Southern regions of Thailand (Battersby, 1998).

These extensive and serious armed threats to Thailand's borders and national security impacted on policy in a number of ways. Four particularly relevant considerations involved drug finance, conflict zones, the location of insurgents, and the rural support on which they depended. There was a well-documented relationship between armed conflict and the drug trade in the region, especially the north east and north west border areas. Firstly, the production and sale of opium was one of the sources of finance for military personnel and equipment for both Communist and Nationalist insurgents; so widely recognised as drug funded military groups they were sometimes referred to as 'narco-armies' (Kramer, Jelsma, & Blickman, 2009). Secondly, many of the insurgents' bases and areas of operation coincided with areas of opium production in and around the Golden Triangle. Thirdly, the ethnic groups of these areas were often a source of recruits for communist guerrilla forces, for example the Meo Hill tribes people of Thailand and from across the Thai-Laos border (Marks, 1973). Finally, in the mountainous regions of Thailand many of the impoverished villagers were ethnic minorities who felt excluded from mainstream Thai society, political life and economy and, either as a consequence or correlation, were involved in the cultivation, production and sale of opium (Lintner, 2000; Marks, 1973; McCoy, 2000, 2003). In the early 1960's, the Thai military believed the use of forceful military tactics would quickly break the resolve of insurgents and their supporters and began a campaign of ambushing militia and destroying villages using artillery and napalm strikes. These attacks resulted in the destruction of a large area the northern rural economy and served to increase the number of both refugees and enemies of the government willing to join the guerrillas. Lieutenant General Saiyud Kerdphol (Director of the Communist Suppression Operations Command) soon determined the aggressive military strategy had only exacerbated problems of national security. Consequently, he suggested a new approach of trying to eliminate grievances of the northern peoples, assist the people in bettering their lives and thus win their confidence in the government (Marks, 1973; Windle, 2016).

In 1969 His Majesty, King Rama IX attempted to address the underlying drivers in opium crop production when he initiated The Royal Project, promoting alternative crops in

Thailand's northern opium growing region. He described the objectives t initiative as follows:

> *One of the reasons underlying the creation of the project was humanitarianism; the desire that these people living in remote areas should become self-supporting and more prosperous. Another reason, and which has received support from all sides, was to solve the problem of heroin…If we help them, it is tantamount to the country in general having a better standard of living and security.* (His Majesty King Bhumibol Adulyadej of Thailand, 1969, para. 3)

Sustainable alternative development was not just an example of a Thai drug policy focussed on supply reduction policy but was also a strategy which sought a long-term humanitarian solution to rural poverty and marginalisation, as well as for improving national security in the border regions. It was reportedly the world's first sustainable development project to replace drug crops with legal crops and Thailand was one of only a few countries to have successfully suppressed illicit opium production (Windle, 2015, 2016). The Royal Project remains a centrepiece of Thai drug policy, especially when presented on the international stage. The historical context of its development shows that in addition to reducing opium supply, this strategy also met political and national security objectives. This approach was also heavily supported by technical assistance, equipment, intelligence and finance from foreign allies, predominantly from the US government, and primarily via their military. Evidence produced later in the data analysis section will further support this assessment. These foci of national security and supply reduction, supported by the US, have remained an important feature of Thai drug policy.

6.4   HIV in Thailand

Another major public health threat which converged with drug use in countries throughout the world was the emergence of HIV. HIV transmission has been a critical concern which has become incorporated into advocacy campaigns, risk assessments, as well as policy and service responses for drug use. Thailand was affected early in the global HIV pandemic and its impact was extensive.

The emergence and rapid spread of heroin use via injection in Thailand soon became one of the primary drivers of HIV transmission among PWUD, between PWUD and other high-risk groups (e.g. FSW) and into the general community. The advent of the HIV epidemic had a major impact on Thai policy, public expenditure and health programming. "*The first case of HIV infection in Thailand was reported in 1984*" (Celentano, 2003, p. 99) and the HIV epidemic in Thailand was initiated among PWID in the mid-1980s. By

1988, transmission among PWID was driving the epidemic with 61% of new infections occurring in this group, while another 30% occurred among FSW and their clients (Celentano & Beyrer, 2008). Just a year later in 1989, the transmission among FSW and clients was dominating the epidemic; accounting for more than 80% of new infections (Celentano, 2003; Celentano & Beyrer, 2008).

In six months from June to December 1989, sentinel surveillance surveys of FSW HIV prevalence leapt from one percent to 13% in Bangkok and up to 43% among brothel-based FSW in Chiang Mai. Unlike her ASEAN neighbours Thailand's response was rapid and pragmatic. Thailand's well-organised public health infrastructure focused on preventing HIV transmission through commercial sex and this approach was supported by *"… focussed political commitment, the active roles adopted by top political leaders, the high public spending, the mobilization of sectors and partners well beyond the health ministry, and the active involvement of non-governmental organizations (NGO) and communities"* (Marais, Phoolcharoen, Posyachinda, & Teokul, 2004, p. 1) as well as an intense media campaign. Thailand's *100% Condom Program*, was piloted in Ratchaburi Province in 1989 then expanded nationally in 1991-1992. Under the program, the Thai Government supplied almost 60 million free condoms per year and enlisted the cooperation of sex business owners and FSW to encourage clients to use condoms. Businesses that failed to comply were penalised or shut down. This resulted in an 80% reduction in new HIV infections (Punpanich, Ungchusak, & Detels, 2004). The Thai public health response was internationally acclaimed as a success story and an example for other countries to emulate. Researchers stated unequivocally, "*The effectiveness of the Thai response to the heterosexual HIV epidemic is without reproach*" (Celentano, 2003, p. 100), and citing for example, that "*…data from national STD centers and self-reports of female sex workers on rates of condom use over time show a nearly perfect inverse relation between rates of bacterial STDs reported nationally and increased condom use in commercial sex"* (Celentano, 2003, p. 100).

Thailand was lauded internationally for its response to HIV among FSW, but has been criticised internationally for the inadequacy of its response to HIV among its, approximately 80% male, population of PWID (Celentano, 2003). Among many others, United Nations Development Programme (UNDP) praised Thailand's response to heterosexual transmission of HIV: "*Thanks to political will and concerted government, NGO and community action that deftly implemented a well-funded national response over ten years ago, new HIV infections plummeted to about 19,000 in 2003*" (United Nations Development Programme, 2007, p. 5). This represented a massive reduction in

new infections per year from the Thai epidemics peak of 143,000 in 1993. In the report of their 2006 study Kaplan and Schleifer called Thailand *an HIV/AIDS Success Story*, citing three primary proofs in support of this claim: an 80% reduction in incidence from 1991:

> *More than 80 percent of people in need of ART in Thailand are receiving it, making it one of three developing countries worldwide–and the only one in Asia– to achieve this level of coverage.* [and] *Thailand has also been hailed as a model with regard to its efforts to provide antiretroviral drugs to HIV-positive women to prevent mother-to-child transmission, reaching 89 percent of women who need it.*
> (Kaplan & Schleifer, 2007, p. 10)

Conversely, these same authors and others described Thailand's response to HIV among FSW was in stark contrast to its record of HIV prevention among drug users (Celentano, 2003; Kaplan & Schleifer, 2007). Thailand's HIV epidemic among PWID was first noted among patients treated at the Thanyarak Hospital[12] drug treatment centre. HIV prevalence among PWID increased from approximately one percent in January 1988 to around 40% in less than one year (Razak et al., 2003). During the 1990s, PWIDs gradually came to account for more than 10% of new infections, owing to the absence of strong prevention efforts focussing on them. No targeted response was formulated or supported despite the fact that prevalence continued to climb rapidly "..*rising from 40 to 57% (between 1995 and 2001), and remaining above 40%, since 2001*" (Perngmark, Vanichseni, & Celentano, 2008, p. 184). Thailand now faced the challenges of sustaining behaviour change in commercial sex to prevent a resurgence in the HIV epidemic and simultaneously expanding prevention to other high-risk groups that were more difficult to reach and/or socially more controversial (indirect or informal sex workers, PWID, MSM and prisoners) (Ainsworth, Beyrer, & Soucat, 2003).

Looking at HIV trends in Thailand from regular rounds of surveillance, it was clear that the country has had a long-concentrated epidemic within PWID since the infection first became known in Thailand and this had continued at worrisome levels, remaining well above 30% over the past 20 years. Despite efforts to control the HIV epidemic and,

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[12] Thanyarak Hospital, built in 1967 by ONCB in Pratumtani province, was assigned to take care of 5 provincial addiction treatment centres. It provided both outpatient and inpatient services with 200 beds for treatment and 600 beds for rehabilitation It was renamed Thanyarak Institute when it established as a Regional Training Centre and more recently re-named the Princess Mother National Institute on Drug Abuse Treatment.

according to Thailand's 2010 UNGASS Country Progress Report, the latest Bureau of Epidemiology surveillance data available indicated nearly half of Thailand's PWID had HIV at that time, with a 46% HIV prevalence rate among PWID nationally (National AIDS Prevention and Alleviation Committee, 2010) there was little to no change in infection rates. Despite its rapid and effective early response to heterosexually transmitted HIV by 2008 1,115,000 adults had been infected with HIV in Thailand since the start of the epidemic and 585,800 of those people had subsequently died of AIDS and a little under half (532,500 people) were living with HIV. Over the course of that year 12,800 people were newly infected and by the end of the year, 48,000 people had developed serious HIV-related illnesses (Celentano, 2003). In 2009 Thailand had the highest HIV prevalence rate (1.0-1.6) and the greatest number of people living with HIV (530,000) of any country in South-east Asia, and 9,500-14,000 more Thais were becoming HIV-infected every year. Thailand had an estimated adult HIV prevalence rate of 1.3%, or 530,000 people living with HIV/AIDS. The age group most affected by drug use and by HIV, youth aged 15-24 years comprised 15.1% (male 5,181,468 and female 4,975,083) of the total population (UNAIDS, 2010b). This is also the age range from which Thai military recruits were conscripted. HIV/AIDS was a major cause of mortality and morbidity in Thailand and population estimates for this country explicitly considered the effects of excess mortality due to AIDS. The impact of HIV/AIDS on national public health figures was so significant that Thailand's life expectancy and population growth figures were lower and infant mortality and death rates by age and sex were higher than would otherwise have been expected (Central Intelligence Agency, 2016).

6.5   Contemporary Thailand – Demographics, Economics and Politics

Some analysis of Thailand's political economy is essential to understand both the context and influences that have shaped Thai drug policy. Thailand borders Burma, Cambodia, Laos, and Malaysia. The country's population of approximately 69 million is 94.6% Buddhist, 4.6% Muslim and Christian 0.7% and is still predominantly rural, with a rapidly increasing urban population (34.1%) (Central Intelligence Agency, 2016). It is a newly industrialised country, with exports accounting for more than two-thirds of its gross domestic product (Beuran, Raballand, & Kapoor, 2011). Thailand's Gini index[13] was 39.4 ranking 89th of 187 countries for inequity and data showed that the top 10% of families

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[13] Income Gini coefficient is a measure of the deviation of the distribution of income among individuals or households within a country from a perfectly equal distribution. A value of 0 represents absolute equality, a value of 100 absolute inequality

enjoyed more than 51% of the wealth while the bottom 50% controlled only 8.5%, and just 10% of the population possessed about 90% of the privately-owned land. In 2015, the national GDP was US$373.5 billion with a 2.5% estimated real growth rate. Thailand per capita GDP was US$16,100, however, this figure did not reflect the enormous disparities between Thailand's rich and poor (Central Intelligence Agency, 2016). In 2012, Thailand had the fourth lowest overall unemployment rate in the world (2012 estimate was 0.7%) and recently the government implemented a nation-wide 300 baht (approximately US$9) per day minimum wage policy, which was considered relatively high by comparison to wages in neighbouring countries. As a result of these two factors, Thailand attracted very large numbers of both registered and unregistered (informal) low-wage migrant workers from neighbouring countries. In 2010, there were one million registered workers from neighbouring Mekong countries and an estimated three million or more working informally in the country (International Organization for Migration, 2011). As was described earlier, the scarcity of labour to maintain and expand Thailand's economy and the country's subsequent reliance on low-cost immigrant workers has been an issue for hundreds of years. Furthermore, the large formal and informal immigrant labour population has been associated with high-risk drug use, commercial sex, and HIV transmission which has been further exacerbated by a lack of access to prevention, testing and treatment, as well as healthcare services more generally (International Organization for Migration, 2005, 2011).

It was not the purpose of this thesis to engage in detailed analysis of the landscape of Thai politics and the integral role that the military had played both at the centre of political power as government or on the periphery. On the other hand, an understanding of the Thai policy environment would not be complete without some appreciation of the role of the Royal Thai Military. Thailand was a constitutional monarchy, with the Prime Minister as the head of government, a patrilineal monarch as head of state, and the judiciary ostensibly independent of the executive and the legislative branches. Since 2005 the country had experienced increasing political polarisation with several rounds of civil turmoil, including a military coup in 2006 and large-scale street protests by competing political factions in 2008, again in 2009, and on an even larger scale in 2010, which culminated with armed clashes resulting in at least 92 deaths (Central Intelligence Agency, 2012). Following another period of political demonstrations during 2012-13, General Prayuth Chan-ocha, led a successful coup on 22 May 2014 (Fisher, 2013; Harlan & Samuels, 2014) and was endorsed as Prime Minister (Harlan & Samuels, 2014). At the time this research was undertaken it was unclear how the substantial changes which were occurring to the mechanisms of government, senior leadership

positions and government policy decisions would influence areas relevant to this research (i.e. policies and programs related to illicit drug use and HIV responses).

6.5.1 Thai Culture, Collectivism and Hierarchy

A brief examination of Thai culture will assist in better understanding the context within which drug policy problems and solutions are described and discussed. It will also assist in improving the interpretation of findings from data collected in this research. The Thai cultural characteristics of high levels of hierarchy and a marked preference for collective harmony were of particular interest in this analysis and have been described in Geert Hofstede's work on culture as the dimensions of Individualism versus Collectivism and Power Distance relationships. Hofstede's research in the 1980's of more than 100,000 employees of the multinational IBM in 40 countries produced an explanatory theory to describe national and organisational cultures along several dimensions: Power Distance; Uncertainty Avoidance; Individualism versus Collectivism; and, Masculinity versus Femininity (Hofstede, 1983, 1988, 1989). These cultural dimensions were further redefined and developed over time with the addition of two other dimensions - Long-Term versus Short-Term Orientation, and Indulgence versus Restraint (Hofstede, 2003, 2004; Minkov & Hofstede, 2010). Hofstede's cultural dimensions have been used extensively since in understanding organisational and national cultures (Fang, 2010).

The Thai reverence and respect for hierarchy in general and people in senior positions, in particular, were described as an obstacle to advocacy and dialogue for policy and social change in Thailand. Power Distance was defined as the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally. Thailand scored 64/100 on the Power Distance index (Australia by comparison has approximately half of Thailand's score). According to Hofstede's model (Hofstede, 2016, para. 3) this score indicated:

> It is a society in which inequalities are accepted; a strict chain of command and protocol are observed. Each rank has its privileges and employees show loyalty, respect and deference for their superiors in return for protection and guidance. This may lead to paternalistic management. Thus, the attitude towards managers are more formal, the information flow is hierarchical and controlled.

This would be consistent with the observations of a policy environment and policy decision-making processes which were centrally controlled, where decisions were made through a 'top-down' hierarchy, and this chain of command was required to be respected. Cultures characterised by strongly hierarchical social structures which

operated more on centralised decision-making rather than horizontal or decentralised decision-making would be less likely to facilitate voices of dissent and participatory decision-making. Pimpa (2012a) undertook research of the public sector in Thailand, distributing 400 questionnaires, comprising 25 items based on Hofstede's theory, to sector officers under the Thai Ministry of Education and concluded that public sector culture in Thailand did exhibit a large Power Distance dimension in which "*superiors and subordinates consider each other as existentially unequal … [and] subordinates are expected to be told what to do*" (Pimpa, 2012, p. 37). Thai staff expected and accepted a clearly defined hierarchical order and appreciated strong leadership. She further confirmed Thai society featured large Power Distance relationships in which inequality and external locus of control were accepted as a norm; and "*people were more likely to ascribe control of events to outside forces, such as more powerful others*" (Pimpa, 2012, p. 37). The researcher also found that:

> *In fact, they may be reluctant to express their ideas and feelings because they do not want to be perceived as those who challenge the leaders. Arguing with superior or colleagues may be seen as trouble-maker of the organization* [sic]. *Perhaps, being quiet and obedient is a sign of good follower in the Thai public system.* (Pimpa, 2012, p. 40)

More contemporary research on internet and social media use in Thailand reported similar findings, despite the relative anonymity offered by these media (Buriyameathagul, 2013). The researcher surveyed 432 Thai individuals (over 18 years of age) who were active in these virtual communities for at least an average of seven hours each week. The research found that even the online Thai community "…e*xhibits high power distance where there is considerable dependence on subordination to bosses and where subordinates respond by preferring such dependence in the form of an autocratic or paternalistic boss*" (Buriyameathagul, 2013, p. 214). Moreover, the findings described the boss as a father figure (presumably most or all were male) who exhibited a significant "*...degree of centralization of authority and the degree of autocratic leadership*" (Buriyameathagul, 2013, p. 214). The research also confirmed the importance in Thai social culture and organisational culture of prioritising friendly relationships within the collective over procedural or outcome goals, such as policy outcomes.

6.6   Contemporary Drug Use in Thailand

As has been previously described, Thailand implemented a long and successful eradication campaign against opium cultivation, but the country remained an important

transit point for illicit heroin and methamphetamine from Burma and Laos *en route* to international drug markets (Central Intelligence Agency, 2016). The 2007 Thai National Household Survey on Substance Use provided data on respondents' self-reports of their use of illicit substances; cannabis, ecstasy, kratom[14], ketamine, cocaine, heroin, ice, inhalants, opium, and *yaba*[15]. The data from the national survey suggested that 0.32% of people in Thailand had 'ever used' heroin in the year prior to the survey and 1.79% had 'ever used' ATS (Assanangkornchai et al., 2008). The following table (Table 12) shows the number and percentage of the population who reported that they had ever used a specific substance in their lifetime and in the year prior to the survey based on data taken from 2007 Thai National Household Survey of Substance Use.

Table 12: Thais Who Had Used Illicit Drugs in 2006 or Ever Used Previously
(Assanangkornchai et al., 2008)

Substance	Ever used		Used in past year	
	number	%	number	%
Heroin	151,029	0.32	3,907	0.01
Yaba	788,948	1.70	66,320	0.14
Ice	41,814	0.09	2,220	0.005
ATS Combined	981,791	1.79	72,447	0.145

These aggregated data hide substantial variations by location. For example, drug usage rates in the rural areas of the Bangkok Central province were much lower than those in metropolitan Bangkok (4.07% compared with 10.92%) for reports of lifetime use of an illicit substance. In addition, drug use in the national capital was again much higher than in other Thai cities. For example, lifetime use in urban centres of the Northern provinces was only 3.73%. Using data that were also taken from the 2007 Thai National Household Survey on Substance Use, Table 13 shows variations by location in the number and percentage of the population who reported that they had used a specific substance ever in their lifetime and in the year prior to the survey.

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[14] *Kratom* (Mitragyna speciosa) is a plant, commonly grown in southern Thailand and used traditionally as an herbal medicine and to relieve work-related fatigue. Kratom is classified as an Addictive Substance under the drug laws of Thailand.
[15] *Yaba* is a Thai word which is used for amphetamine and methamphetamine; it translates literally as 'Crazy Drug' and the name is thought to have been coined due to the high number cases of amphetamine-induced psychosis reported during the early period of the yaba use epidemic in Thailand.

Table 13: Thai Illicit Drug Use in 2006 and Prior by Location (Assanangkornchai et al., 2008)

Region	Total population	Ever used		Used in past year	
		number	*%*	*number*	*%*
Bangkok	4,274,757	466,622	10.92	128,707	3.01
Rural	7,556,320	307,599	4.07	28,901	0.38
North Urban	1,740,069	64,830	3.73	4,901	0.28

The authors of the report on the National Household Survey cautioned that these data should be interpreted with care because underreporting of illegal drug use was to be expected due to a range of factors including: public attitudes to use; law enforcement activity; social and cultural background of the respondents; and the local context of the study area (Assanangkornchai et al., 2008). The most significant factor influencing self-reporting of illegal drug use may well have been the highly-publicised Thai War on Drugs Campaign, a zero-tolerance policy first implemented in 2003, under then Prime Minister Thaksin Shinawatra.

6.7 Injecting Drug Use in Thailand

Obtaining national values for the number of PWIDs in Thailand has proven consistently difficult. For the earliest parts of the epidemic, the number of PWIDs was estimated using AIDS case reporting. Between the mid-1980s to the mid-1990s it was reported there were 160,000 PWID, and it was assumed that thereafter this number was to have decreased by 13% annually (World Health Organization, 2010b). In 1994, a capture-recapture method was used in Bangkok to obtain an estimate (Mastro et al., 1994) and estimates using other data sources, such as clinic records, arrest records, PWID in-treatment data from the ONCB, and Respondent Driven Sampling have been used but each has its limitations such as potential reporting biases in AIDS case data, failure of some individuals to admit to drug use, and low numbers of PWID willing to participate in the population size estimate studies, especially following the Thai Government War on Drugs policy.

The World Health Organization South-east Asia Regional Office (WHOSEARO) complained of a lack of transparency in government responses causing vulnerable populations, such as PWID, to be under-represented in monitoring systems, which often subsequently resulted in inaccurate size estimates of high-risk groups and thus created difficulties for planning and monitoring targeted interventions (World Health Organization, 2008). In addition, it appeared that there was a substantial discrepancy between the

nationally reported statistics and those cited by international organisations, which were often almost double those reported nationally. For example, in 2010 the Thai Government reported there were an estimated 30,000 PWID in Thailand. The report acknowledged that this was a conservative estimate and that *"…because injection of illicit drugs is a secretive behaviour, it is difficult to estimate the number of drug addicts, whether by field surveys or counting those admitted to rehabilitation centers"* (National AIDS Prevention and Alleviation Committee, 2010, p. 94). Yet FHI 360[16,] reported that in 2004, the PWID population size in the country was estimated to be approximately 38,380 (Family Health International & Bureau of AIDS TB and STIs, 2008). Furthermore, the Research Institute for Health Sciences at Chiang Mai University placed the figure somewhat higher, stating the official figure reported by the Royal Government of Thailand has remained remarkably stable over the following decade and was 40,300 in 2012 (Aramrattana, 2013). Although this figure is the lower end of the estimate range (40,300 and 97,300) of prevalence research by the Chiang Mai University (MacDonald & Nacapew, 2013). An even greater discrepancy occurred in the WHO published surveillance data from 2010 indicating the number of PWID in Thailand was 68,000, substantially more than the figure reported by the Thai National AIDS Committee for the same period (World Health Organization, 2012b).

It is difficult to determine from the 2007 Thai National Household Survey exactly how much drug use involved injecting. While data on the method of drug use were not presented, the authors acknowledged that generally, intravenous injection was the preferred method of taking heroin and other researchers of Thai drug use have stated that heroin use is "*almost exclusively by injection*" (Razak et al., 2003, p. 260). Most recently, the 2015 estimate published by Thailand's National AIDS Management Centre gave the range of the population size estimate for PWID as 71,083-75,441 and recommended using the figure of 75,000 (National AIDS Management Center, 2015).

6.7.1 Injection of Amphetamine-type Substances (ATS)

ATS are usually inhaled, either as powder or vapour. In Thailand, there was some evidence of injecting and anecdotal reports stated that injecting was increasing,

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[16] *"FHI 360 is a non-profit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. We serve more than 70 countries, including the U.S. …[and]… representatives from 130 countries participated in our international exchange program activities in 2013"*(FHI 360, 2014)*.*

however, more research was needed to define with any accuracy the numbers of people who injected ATS (or 'yaba' as it was called in Thai). Many people working on responses to illicit drug use stated they believed that methamphetamine injection was becoming more common. Some research showed that the highest rates were found in Bangkok where one-third of PWID use methamphetamine. A Respondent Driven Sampling study in Bangkok in 2009 found that PWIDs in Bangkok and Chiang Mai were generally poly-drug users, injecting various opioids, ATS and benzodiazepines (see Table 14) (Aramrattana, 2013) and a recent Integrated Biological and Behavioural Survey (IBBS) in Thailand indicated a significant number of methamphetamine injectors in some provinces, for example, 30.3% of PWID surveyed in Central Thailand, 29.9% in Chiang Mai (MacDonald & Nacapew, 2013). A further IBBS study conducted by the Institute for Population and Social Research, Mahidol University, found 67.4% female and 72.3% male PWID had injected yaba in the previous 12 months. It may be difficult to generalise from these findings though because the sample was small, 322 respondents in a de-identified provincial capital city (Institute for Population and Social Research, 2013). Another study (Hayashi, Wood, et al., 2011) of 311 PWID (29.3% women) residing in Bangkok or adjacent provinces revealed 114 (36.7%) participants reported having injected methamphetamine twice or more per week in the past six months and that methamphetamine injection was independently associated with syringe sharing. Participants were recruited through peer-based outreach workers and were asked to attend the Mitsampan Harm Reduction Center where they were interviewed and completed a survey, for which they were reimbursed 350 baht (approximately US $10). This suggested that the participants may have been engaged in longer term IDU and possibly might have been from lower socio-economic strata. It is, therefore, difficult to determine how representative this sample may be of other ATS users. Nevertheless, it does seem to support other evidence of injecting poly-drug use in Thailand and suggested harm reduction and treatment services for PWID should incorporate efforts to address methamphetamine use.

6.7.2 Injection of Other Drugs

The same study at the Mitsampan Harm Reduction Center also investigated the injection of midazolam[17] (Kerr et al., 2010) and the findings, published separately found extremely high rates of midazolam injection among PWID in Bangkok, 170 (67.5%) participants

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[17] Midazolam (trade names include Dormicum, Hypnovel, Versed) is a rapid onset potent benzodiazepine or tranquiliser.

reported ever having injected midazolam, and 144 (57.1%) reported daily midazolam injection in the past six months. Midazolam injection was most commonly used in combination with both opiates and methamphetamine, creating a high risk of overdose. In addition, midazolam filtrate is highly acidic and damaging to veins frequently resulting in abscesses and other soft-tissue infections. This was evidently a serious problem but was difficult to generalise from this study how widespread this practice was in Thailand.

In their 1998 study of Thai PWID, Kitayaporn and colleagues found the frequency of injection to fall in the range of twice to three times per day. When the mean of this range was taken as the rate of daily injection it produced a rate of 913 injections per person per year (Kitayaporn, Vanichseni, & Mastro, 1998). Table 14 indicates the types of substances injected in Bangkok and Chiang Mai, 2009.

Table 14: Types of substances injected in Bangkok and Chiang Mai, 2009

Characteristics and behaviours of PWID	Bangkok	Chiang Mai
Age < 25 years	3%	42%
Male	83%	83%
Heroin used	34%	34%
Methamphetamine used	63%	32%
Midazolam used	42%	4%
Methadone used	13%	6%
Opium used	NA	14%
Sharing needle at last injection	5%	48%
HIV prevalence	24%	11%

An important consideration when investigating drug use in general or IDU in particular, was that, while the prevalence of IDU was one useful indicator of the extent of the drug problem in a country, these results were limited in what they revealed about problems relating to drug use because they did not distinguish between dependent use and other types of use, such as experimental, occasional or recreational drug use. In Thailand, as in many other countries, this lack of distinction or misunderstanding, which results in the assumption that any drug use indicated severe dependency, was consistently reflected in the national laws and policies and so could result in misguided policy objectives, for example, requiring that all PWUD be referred to residential treatment centres for drug withdrawal and rehabilitation. Such policies did not appear to be guided by evidence, given the finding by UNODC that only *"…about around 12% of illicit drug users…develop*

drug dependency and become 'problem' drug users" (United Nations Office on Drugs and Crime, 2012d, p. 70).

6.7.3 Harms Related to Injecting Drug Use in Thailand

In Thailand, the mortality rate among PWID was 14 times higher than that of the general Thai population and even the mortality rate among non-injecting drug users was still four times higher than that of the general Thai population. This mortality rate among Thai PWID was also significantly higher than that of PWID in developed countries (3.9% per year as compared with 1.1% per year). A large prospective cohort study which followed 346 injecting and 475 non-injecting drug users over two years in northern Thailand found the mortality among PWIDs was high and even higher among those: from an ethnic minority; who had recently acquired HIV; and/or had a greater number of years of drug injection. The leading causes of death among PWID in Thailand were drug overdose, suicide, and infectious diseases (Quan et al., 2007).

6.7.3.1 Stigma and Discrimination

Throughout the world stigma and discrimination towards PWUD is evident in prejudice, ostracism and human rights violations. This is also the case in Thailand. Stigma and discrimination should be considered as drug-related harms, as well as risk factors which can result in other forms of drug-related harms. In other words, stigma and discrimination can have detrimental impacts on an individual and they can lead to or exacerbate other harms associated with drug use. For example, a study of nursing students in Bangkok using multivariate analyses found attitudes towards PWID were highly stigmatising. Nursing students' stigmatisation score of PWID was much higher than their stigmatisation score for people living with HIV/AIDS. Furthermore, the study found that "*…the stigma score for AIDS in the presence of IDU was more than double that of the stigma score for AIDS with no co-characteristic*" (Chan, Stoove, Sringernyuang, et al., 2008, p. 153); and, "*…the stigma score for CS* [commercial sex] *in the presence of IDU was nearly double that of CS alone*" (Chan, Stoove, Sringernyuang, et al., 2008, p. 154). A similar Thai study involving semi-structured interviews of both qualified and trainee nurses found that the nurses viewed patients living with HIV/AIDS "*…as patients worthy of social support and inclusion,* [but PWUD] *were excluded on the basis that they were perceived as irresponsible 'social cheaters' who pose severe social and economic harm to the community*"(Chan, Stoove, & Reidpath, 2008, p. 1).

One way this stigma manifested was in discrimination in health services against PWUD in the form of restrictive access to effective treatment for HIV. Until 2004, Thai Government policy explicitly permitted the exclusion of PWID from ART programs and even after that policy was rescinded there were still reports of health services refusing ART for PWID. "*Some healthcare providers denied drug users access to ART because of an erroneous conviction that the treatment would be "wasted" on "unreliable" drug users who would fail to adhere to medication, develop resistance to it, or spread drug-resistant HIV strains*" (Kaplan & Schleifer, 2007, p. 3). This is contrary to the arguments advanced for preventing HIV transmission from early effective treatment with anti-retroviral medicines, as was described in detail in the section on "HIV Treatment as Prevention". Yet relatively recently Thailand has recognised the significance of this issue and has begun attempts to address it. For example, in 2008, a partnership agreement was signed between the United Nations Development Programme (UNDP), the Thai Foundation for AIDS Rights, the Thai Department of Rights Protection (Ministry of Justice) and the Royal Thai Police for up to 10,000 junior Thai police officers per year to have education on HIV/AIDS stigma and discrimination (United Nations Development Programme, 2012).

6.7.3.2 Overdose

Drug overdose was among the leading causes of death of PWID in Thailand and a 2007 study reported that overdose accounted for 23% of all the deaths of PWID. Rates of non-fatal overdose among people who injected opioids were similarly high. For instance, in local studies, 30% of heroin injectors in Bangkok reported experiencing at least one overdose. Naloxone is an effective opioid antagonist used to reverse the effects of opiate overdose and five countries in the region (Afghanistan, China, India, Thailand and Vietnam) implement community-based naloxone programs to some extent (Harm Reduction International, 2012).

Conversely, the rate of deaths by overdose in Thailand was actually lower than the rate of overdose deaths seen in Australia (46%) and the United Kingdom (64%) at that time. The lower rate deaths attributable to overdose in Thailand is not because of lower overdose risk factors but mainly due to a much higher proportion of deaths caused by infectious disease among PWID in Thailand. One study found that, apart from mortality due to HIV/AIDS, another 45% of deaths among a sample of PWID were due to septicaemia, pneumonia, tuberculosis and malaria (Quan et al., 2007).

6.7.3.3 HIV Transmission

Evidence indicated that PWID were the first population group in Thailand to experience the spread of HIV and that PWID created the initial transmission bridge to FSW, and thus initiated the subsequent rapid wave of the HIV epidemic into the general population in the early 1990s. The WHO stated that in only 12 months (1987-88) HIV infections among PWID in Bangkok increased from 0% to 49%, the highest HIV burden of people living with HIV and AIDS (PLWHA) in the South-east Asia Region (World Health Organization, 2010b). On the other hand, the Thai Ministry of Health reported that "*From 1985, new infections in this group rapidly increased reaching 33,000 per year in 1987*" (National Committee for HIV and AIDS Prevention and Alleviation, 2007, p. 9) which would put the prevalence rate at approximately 21%, assuming there were around 160,000 Thai PWID at that time. While there is a substantial discrepancy between the two estimates, both are comparatively high figures.

In 2001, a large-scale assessment of drug use in 22 Asian countries was undertaken and involved literature reviews, primary data collection and analysis by three full-time researchers over 20 weeks and claimed to be the largest, most comprehensive collection of information on drug use in Asia in the context of HIV/AIDS compiled to that date. It stated that the 2000 Thailand sentinel surveillance showed the HIV prevalence among PWID to be 54% and with 5-10% of drug users becoming HIV-infected each year (Reid & Costigan, 2002). Thailand's 2008 Country Progress Report to UNGASS (for the period January 2006-December 2007) described HIV prevalence among PWID had remained between 30-50% until 1999 "*…and has only recently declined slowly to 27.8% in 2007. However, limitation in access to IDU* [injecting drug users] *for the sero-surveillance has resulted in getting a small number of sample populations*" (National AIDS Prevention and Alleviation Committee, 2008, p. 28). The subsequent UNGASS Country Progress Report in 2010 (for the period January 2008-December 2009) stated "*The level of HIV among IDU remains high and shows no sign of decline*" (National AIDS Prevention and Alleviation Committee, 2010, p. 26). Using the Asian Epidemic Model (Brown & Peerapatanapokin, 2004) the report projected the number of new HIV infections in 2010 to be 10,853, of which 8.7% were estimated to be among PWID. HIV sentinel surveillance data from the Thai Bureau of Epidemiology report presented that the prevalence of HIV among PWID attending detoxification clinics throughout Thailand had ranged between 30 to 40%. On the other hand, report also highlighted a survey using respondent-driven sampling in the two most populous Thai provinces, which found that the HIV prevalence was 10.8% in Chiang Mai and 23.3% in Bangkok. Among the survey respondents from Chiang Mai, only 13.8% had ever attended a treatment centre (as

compared with 70.2% in the Bangkok sample). It is possible that such a discrepancy occurred because those in the Chiang Mai sample had either not decided to enter treatment or not come to the attention of those who might compel them to treatment. This in turn may have been because they had a shorter and/or less intense duration of drug use and therefore had a lower probability of HIV transmission than those who had already been in treatment. A WHO 2010 estimate based on national surveillance data found a 46% HIV prevalence among PWID in Thailand (World Health Organization, 2012b). As a result of insufficient HIV prevention interventions HIV prevalence among PWID has remained consistently high ever since the HIV and AIDS epidemic started in Thailand and from the early 1990s 5%-10% of all new adult HIV infections have occurred among PWID (World Health Organization, 2010b).

6.7.3.4 Viral Hepatitis

The WHO estimated that in 2010 worldwide there were about 180 million people who were chronic carriers of HCV (World Health Organization, 2010b). The prevalence of viral hepatitis in any population of PWID has often been much higher than HIV prevalence because both HBV and HCV were more easily transmissible than HIV. The Global State of Harm Reduction 2010 report cited the adult HCV prevalence among PWID in Thailand at 90% (Harm Reduction International, 2010). These findings were consistent with earlier reports, for example, a large study of 1,859 drug users in northern Thailand, which reported a HCV prevalence of 86% among drug injectors, found that only injection behaviours among the study sample of PWUD were independently associated with HCV in multivariate analysis (Jittiwutikarn et al., 2008).

A further study conducted through the Mitsampan Harm Reduction Centre, which involved 468 PWID in Bangkok and used data collected over two cycles of surveying from 2008 to 2009, examined access to testing for HCV among PWID living with HIV. Despite HIV and HCV co-infection being highly prevalent among Thai PWID, the study found only half (52.2%) of the HIV-infected PWID enrolled in the study had ever been tested for HCV. Furthermore, the study found that *"Primary reasons given for not having accessed HCV testing included "never heard of HCV" (65.6%) and "not aware of HCV risks" (37.5%)"* (Hayashi, Montaner, et al., 2011, p. 134). HCV is a serious health concern for PWID when it co-occurs with HIV infection. The HIV accelerates HCV disease progression and HCV/HIV co-infection is a leading cause of death among people living with HIV. Overlapping routes of transmission for HCV and HIV result in a high frequency of coinfection. The WHO recommend all people living with HIV also be screened for HCV (2010b).

6.7.3.5 *Sharing Injecting Equipment*

It has long been understood that sharing syringes, needles, and other injecting paraphernalia, is highly correlated with the transmission of HIV, HBV, HCV and other blood-borne pathogens. The Thai Bureau of Epidemiology of the Disease Control Department found that 4.68% of persons infected with HIV, approximately 40,000 people, had been infected through sharing potentially contaminated needles (National AIDS Prevention and Alleviation Committee, 2008). Behavioural data on injecting practices among PWID in Thailand has remained limited or unavailable. Nonetheless, it was reported in 2006 that in Northern Thailand more than 50% of PWID shared injecting equipment (National AIDS Prevention and Alleviation Committee, 2008) and a similar study in the southern provinces showed that as many as 68% of PWID in Thailand shared contaminated needles (Perngmark et al., 2004). There have been some studies assessing risk and harm related to IDU in Thailand but most of those available in English have been relatively small, mainly focussed on PWID in large cities (usually Bangkok or Chiang Mai) and often recruited participants through drug prevention, treatment or harm reduction services. Furthermore, the results of these studies have been largely consistent with global and regional reports on harm reduction. Even so there appeared to be a modest but encouraging trend of a gradual reduction in needle sharing. For example, survey data from 2006 integrated behavioural and sero-surveillance surveys described 55.6% of PWID reported avoiding sharing injecting equipment during last month, *ergo* 44.4% shared equipment (National AIDS Prevention and Alleviation Committee, 2008) and 36% in 2008 (National AIDS Prevention and Alleviation Committee, 2010). The 2010 UNGASS report described a variation in needle sharing across the country from over half to about a quarter of PWID sharing injecting equipment. The report cited survey data from three provinces on needle sharing in the past month. It found the percentage of PWID with a used needle was 53.2% in Songkla, 36.1% in Chiang Mai, and, 26.1% in Samut Prakan. The percentage of those who let someone else use their needle was 38.7% in Songkla, 24.2% in Chiang Mai, and 18.0% in Samut Prakan. Furthermore, those surveyed also often reported unsafe sex, with only 35% reported using a condom during their last sexual encounter, highlighting that there were multiple risks pathways for HIV transmission among and via PWID.

Barriers against safer injecting could be grouped into individual, interpersonal, and environment (or situational) areas of concern. A cross-sectional survey undertaken in 2003, in which 272 PWID were interviewed about needle sharing and drug use patterns at six drug-treatment clinics in southern Thailand indicated that most participants knew

about the routes of HIV transmission, understood their risk of contracting HIV/AIDS, and had tried risk reduction by avoiding unsafe sharing practices (Perngmark et al., 2008). Yet, some still occasionally engaged in high-risk equipment sharing due to craving and withdrawal symptoms, which outweighed their HIV-risk perception. Also, the research indicated that some held the misconception that a person's HIV-seropositivity would be evident by visible symptoms. Other barriers to lower risk injecting behaviours included, inadequate knowledge about how to cleanse needles effectively, fear of being known as 'HIV-positive', and injecting etiquette (e.g. the owner of the needle and the person contributing the largest amount of pooled-money for drugs would have the right to inject first, regardless of one's HIV-serostatus). Barriers at the environmental or societal level included fear of being arrested which led to not carrying new needles, and the need to use drugs quickly to prevent arrest for possession and drug users did not want to waste time purchasing new needles/syringes. Significantly, half of the study participants were HIV-positive, but most had not received post-test voluntary counselling and testing; thus, they were unaware of their HIV-serostatus. The following two tables show firstly, WHOSEARO data on needle and syringe distribution and use in Thailand; and secondly, 2012 WHOSEARO figures on the characteristics of PWID in Thailand (World Health Organization, 2012b).

Table 15: Needle and Syringe Distribution and Use in Thailand, 2012

Estimated number of PWID	No. of NSP sites	No. of PWUD/1000 population	No. of syringes & needles distributed	No. of syringes & needles/PWID/year
68,500	49	0.72	231,458	3

Table 16: Characteristics of PWID in Thailand, 2012

Estimated number of PWID	No. NSP sites	No. of PWID per 1000 population	No. of syringes & needles distributed	No. of syringes & needles per PWID per year	No. of PWID currently enrolled on OST	No. of PWID enrolled on buprenorphine
68 500	49	0.72	231 458	3	2201	NA

6.7.4   Incarceration in Thailand

Incarceration in prisons, or other closed settings, creates a particularly high risk for the transmission of HIV and other BBV for a number of reasons, including high rates of sharing of contaminated injecting equipment. In 2014 Thailand's prison population was 325,000 prisoners, a 30 percent increase from 2001. Most of these people were imprisoned for the sale or possession of drugs, 65% of male and 82% of women (Allen, 2015). Thailand's prisons suffered from overcrowding, exceeding prison capacity by over 50%, a lack of health staff and severe budget constraints (D. Wilson, Ford, Ngammee, Chua, & Kyaw, 2007) and by 2012 the rate of prison overcrowding had nearly doubled (Walmsley, 2015). Most likely as a consequence of these factors, available data indicates that prevalence of HIV among prisoners in Thailand was much higher than in the general population. The 'Monitoring the AIDS Pandemic Network' of epidemiologists and public health professionals used national surveillance data to assess HIV trends in Asia and found:

> *In Thailand, too, studies suggest a link between incarceration and HIV infection. Among drug injectors in northern Thailand who had never been to jail, HIV prevalence was 20%. Among those who had been in jail but did not report injecting drugs while in jail, 38% were HIV-positive after release. Among those who said they injected in jail, HIV prevalence was higher, at 49%. This does not prove that people contracted HIV in jail, but it is strongly suggestive.* (Monitoring the AIDS Pandemic Network, 2004, p. 54)

As was the case for other infectious diseases, such as TB and HIV, the prevalence of hepatitis and especially HCV, was very high among prison populations. For example, studies of incarcerated young methamphetamine users in Thailand found a range of high-risk behaviours associated with HIV and HCV transmission, including injecting and tattooing (Thompson et al., 2009; United Nations Office on Drugs and Crime, 2007b). The risk of co-infection with HIV and HBV and/or HCV was also exceptionally high, on average 23 times higher in prisons than in the general population (World Health Organization, 2010a). Other studies have found similar trends. A cohort study of 689 male inmates in Klong Prem Central Prison, Bangkok, conducted from 2001 to 2002, found that half (50.9 %) were drug injectors, of whom 49% disclosed having injected during incarceration and nearly all (94.9%) had shared injection equipment with others. The HIV prevalence of these Bangkok inmates was found to be 25.4% compared to a general prevalence at that time of 1.5% in the national population. This study recruited a

convenience sample of prisoners who agreed to be tested and it may have been possible that they did so because they thought they were at higher risk than other prisoners of contracting HIV. On the other hand, the researchers also noted that a Thailand Ministry of Public Health Sentinel Sero-prevalence Survey the previous year had reported a 53.4% prevalence rate among inmates in central Thailand (Thaisri et al., 2003). An earlier cohort study of over 1200 Thai PWID who were sero-negative for HIV and who were followed up every four months for up 40 months (mean 29 months) found that the sero-conversion rate for PWID who were incarcerated was 35% per year at risk and was more than double the rate among subjects who reported high injection frequency and sharing of equipment outside of incarceration, which represented 17% per year increase in risk (Choopanya et al., 2002). Other studies have since reiterated that incarceration *"…is an important independent risk for HIV infection among Thai male drug users, especially IDU"* (Beyrer et al., 2003, p. 153).

In summary, HIV has had a substantial impact in Thailand and has been intricately associated with the risks and response to drug use in Thailand. Approximately half of Thai PWID were HIV-positive, and this prevalence rate had remained steady since HIV arrived in Thailand a generation ago (about 30 years). Prevalence rates for Hepatitis B and C also remained extremely high and these viruses have been transmitted by the same vectors, primarily via IDU due to sharing injecting equipment. While there had been a slight decrease in sharing of injecting equipment over the past several years the rates remained seriously high, in terms of BBV transmission. Rates of injecting equipment sharing and subsequent transmission of BBV are dramatically higher among people who had been incarcerated than among those in the community. These factors have resulted in high rates of mortality and morbidity and contribute to the economic burden carried by individuals, families and the state. There was sufficient evidence that HIV was being transmitted among prisoners and it appeared transmission rates were much higher in prison than they would otherwise have been. Furthermore, CCDU have been also high-risk environments for HIV and HCV transmission. There was a dearth of reliable data, however, and it was not always clear whether residents arrived in these centres already infected or whether they became infected in the centres as many do not know their HIV or HCV status before detention. As in prisons, there was anecdotal evidence of unsterile drug use and of unsafe sexual behaviours in these settings (World Health Organization, 2010b, 2010c). Despite this, the Thai Government seemed to have been unwilling or unable to design and implement drug policies which would prevent these health and social harms among PWID, their families and the community.

6.8 Drug Policy in Thailand

The Thai Government established the Central Narcotics Board in 1961 and then restructured it as the ONCB in 1976 under the Narcotics Control Act B.E. 2519 (1976). The ONCB remains the lead drug control agency in Thailand. The mandate of Thailand drug regulations expanded under The Narcotics Act B.E. 2522 (1979) was to increase the entry of drug users into treatment services. The Act stipulated that people found to be drug dependent could be fined between 5,000 and 100,000 Thai baht[18] and could receive a sentence of six months to 10 years' imprisonment. Yet, first-time offenders could be referred to treatment and then put on a two-year probation, or an offence could even be dismissed if the person had applied for treatment before their offence was documented. The Act also introduced compulsory treatment for a third offence (World Health Organization, 2010b). Thailand's subsequent Rehabilitation Act (Royal Government of Thailand, 2002) further expanded the legal framework for treatment and rehabilitation, including the provision for compulsory treatment (Section 19, page 96) for "*Any person who is alleged to consume the narcotics, consume and have in possession the narcotics, consume and have in possession for the propose of disposal or consume and dispose the narcotics…*[sic]" if the alleged offender was not liable for prosecution of any other offences which were punishable by imprisonment. Under the Act, a person could be mandated to rehabilitation for up to six months and be given further six-month extensions of their internment up to a total of three years. Furthermore, if a person who had been committed for rehabilitation:

> "*…violated the rules, conditions or regulations that [were] prescribed*" then the Director of a Rehabilitation Centre or a rehabilitation supervisor "*…shall have the power to inflict upon him any one or more of punishments as the following:*
> *(1) probation;*
> *(2) suspension of permission of being visited or communicated for not longer than three months;*
> *(3) solitary confinement not exceeding fifteen days for each confinement.* (Royal Government of Thailand, 2002, p. 100)

It is significant to note that, according to the exact phrasing of the law, only an *allegation* of drug use was required to enforce compulsory treatment. This has led to criticism by some national organisations that those accused were not permitted due process. They

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[18] In 2014 100 000 Thai baht was approximately $3,200 Australian and the equivalent to more than a year's salary for a skilled worker in most industries e.g. hospitality, sales, or tradespersons.

pointed out that this practice was contrary to the International Covenant on Civil and Political Rights (to which Thailand acceded on 29 Oct 1996) and guaranteed due process in any legal proceedings, prohibited arbitrary detention, and forbad cruel, or degrading treatment (United Nations General Assembly, 2001). Furthermore, there was no differentiation in the text of the Act between occasional or dependent drug use, so it appeared that the authors may have assumed that any illicit drug use identified must have indicated of 'narcotic addiction' and was treated accordingly. This was not consistent with the previous discussion about Goode's research into patterns of drug use which found, *inter alia*, that experimental use is far more common than dependence and "*For all illicit drugs, irregular, episodic, occasional use is more common than heavy, chronic, compulsive abuse*" (Goode, 2006, p. 421). Moreover, there were no science-based treatment guidelines which recommended either a three-month period of separation from family and significant others or two weeks in solitary confinement (United Nations Office on Drugs and Crime & World Health Organization, 2013). On the contrary, it was generally held that in the treatment of drug use disorders:

> *The goal is to place patients in the least restrictive environment that is still safe and effective and then move them along a continuum of care as they demonstrate the capacity and motivation to cooperate with treatment and no longer need a more structured setting or the types of services offered only in that environment.* (Sullivan & Fleming, 2008, p. 60)

Furthermore, one argument might be that the Thai Department of Health would have had the most appropriate expertise to operate drug treatment centres, but in most cases, they were run by the military. At the end of 2008, of the 84 compulsory drug treatment centres in Thailand only 13 were managed by the Ministry of Public Health (through the Department of Mental Health) with the others run by the Royal Thai Army (31 centres), the Royal Thai Air Force (12), the Royal Thai Navy (four), the Royal Thai Armed Forces Supreme Command (three), the Royal Thai Police (two), the Ministry of the Interior (10), the Department of Corrections (two), Department of Probation (one), and the remaining seven centres were run by the Thanyarak Institute (Pearshouse, 2009a).

Probably the most widely known Thai drug policy initiative and one which appeared to impact dramatically, if briefly, on trends in drug use trafficking, indictments and treatment was the highly publicised 2003 Thai *War on Drugs Operation* under then Prime Minister Thaksin Shinawatra. The 'War on Drugs' was the implementation strategy under *The Power of the Land to Win Over Illicit Drugs* policy. This was introduced by the Royal Government of Thailand in response to concerns over increasing use of yaba and was

coordinated and supervised by The National Command Center for Combating Drugs, chaired by the Deputy Prime Minister. Ostensibly the operation,

> …encouraged drug traffickers to report voluntarily to the Administration, which entitled them to an amnesty after a short rehabilitation. [and] health personnel of district health stations and community hospitals were given the responsibility of outreach case-finding in the community. (Poshyachinda et al., 2005, p. 461)

Yet PM Thaksin made his intentions clear in a January 2003 speech announcing the campaign when according to Human Rights Watch:

> …the Prime Minister borrowed a quote from a former police chief known for having orchestrated political assassinations in the 1950s. "There is nothing under the sun which the Thai police cannot do," he said, adding, "Because drug traders are ruthless to our children, so being ruthless back to them is not a bad thing…It may be necessary to have casualties…If there are deaths among traders, it's normal". (Human Rights Watch, 2004, p. 8)

After three months of Thailand's War on Drugs more than 70,000 people were detained without access to due process, an estimated 275,000 (Open Society Institute, 2009) to 320,000 (Windle, 2015) people had entered into rapidly expanded treatment services and an estimated 2,275 to 2,819 (Windle, 2015) people were killed. According to government reports these deaths were all drug dealers shot in battles with police or killed by large-scale dealers who wanted to silence informants. Other commentators said many deaths were simply extrajudicial killings by police using the *"…arbitrary inclusion of drug suspects on poorly prepared government 'blacklists' or 'watchlists;'"* (Human Rights Watch, 2004, p. 1). According to a Beckley Foundation report, *"In November 2007, the Thai Office of the Narcotics Control Board disclosed that some 1,400-people killed had no link to drugs at all"* (D. Barrett, Lines, Schleifer, Elliott, & Bewley-Taylor, 2008, p. 4).

The tremendous fear this campaign generated could have quite understandably resulted in dramatic reductions of both reported and actual ATS use. Evidence from seizure and arrest data suggested ATS use and availability declined substantially immediately following the Thai War on Drugs campaign. In 2004, the year after the War on Drugs yaba indictments fell to about 20% of their pre-War on Drugs levels (38,130 cases in 2004 from 187,676 cases in 2002). ATS seizures also dropped to around 32% of previous quantities (2759.3 kg seized in 2002 down from 8622.0 kg in 2004). Although ATS use may have declined immediately after the operation, the use of other substances increased. In particular, indictment and seizure data suggested rapid increases in the

availability of heroin, ecstasy, marijuana and ketamine (Poshyachinda et al., 2005). Treatment data and other drug user service data indicated substantial increases in alcohol and tranquiliser use during the same period. Some researchers suggested a correlation between these changes in drug use (Daosodsai et al., 2007; Human Rights Watch, 2004). Furthermore, although the number of seizures of yaba decreased in the year following the beginning of the War on Drugs policy they increased significantly each year thereafter, until the number of cases in 2007 was higher than before the operation (Assanangkornchai et al., 2008).

It appeared that this law enforcement approach to drug use continued to intensify. UNDP 2014 Thailand Human Development Report stated that "*Drugs are a growing threat to community life and safety*" (United Nations Development Programme, 2014, p. 4). The report noted that the number of drug-related arrests per 100,000 of population in Thailand had steadily increased from 170 in 2005 to 239 in 2007 and 617 in 2012. Based on a national population of around 65 million this would mean, in approximate figures, that there were about 110,000 arrests in 2005, 160,000 arrests in 2007, and then in 2012 the number of arrests increased enormously to more than 410,000. The UNDP report attributed "*The sharp increase was largely due to the declaration of drug suppression as national agenda*" (United Nations Development Programme, 2014, p. 124)

6.9   Harm Reduction in Thailand

In 2006, the UNAIDS Commission on AIDS in Asia conducted an evaluation of effective responses to HIV in Asia. The evaluation appeared to have been extensive, including a review of over 5,000 papers, commissioning 30 studies, engaging 30 specialists to examine and propose new and innovative ways to address the epidemics in Asian; large-scale survey, sub-regional workshops and five country missions. Among the Commission's conclusions and recommendations were that Asian governments "*…must focus on interventions that have been shown to work*" and recommended that they "*Facilitate and support the introduction of integrated, comprehensive harm-reduction programmes that provide a full range of services to reduce HIV transmission in drug injectors…*" (Commission on AIDS in Asia, 2008, p. 16). In 1988, HIV prevalence rates among PWID in Thailand exceeded 30%. Despite this, no targeted response was formulated or supported despite that fact prevalence continued to climb then plateau, with no significant drop at any time over the following two decades. Since 1992, HIV prevalence rates among PWID have continued to range between 30-50% nationally (Celentano & Beyrer, 2008; UNAIDS, 2011a) with the current rate estimated to be 38.7

percent nationally (Aramrattana, 2013). Given these significant levels of HIV among PWID Thailand's fourth National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011 identified drug users as a major target group. It also acknowledged that more should be done to develop and improve strategies to address HIV transmission among PWID and it set out 'General Measures' for targeting illicit drug use which included:

> *1. Promote campaigning actions within current policies and laws to reduce drug use and associated stigma and discrimination.*
> *2. Study and develop information and lessons learnt related to drugs and drug use.*
> *3. Develop accessible social and health services for drug users.*
> *4. Develop comprehensive treatment and care services and programmes for drug users.* (National Committee for HIV and AIDS Prevention and Alleviation, 2007, p. 36)

Significantly, it even went as far as to state very tactfully, "*…one could argue that the effective implementation of the current 'War on Drugs' policy could have driven many drug users underground, possibly explaining why there were not many IDUs numbers recorded in the official report*" (National Committee for HIV and AIDS Prevention and Alleviation, 2007, p. 9). Nonetheless, it did not take the opportunity to propose or consider harm reduction strategies to address HIV risk and vulnerability among PWID and made no reference to harm reduction at all. Thailand's 2008 UNGASS Country Progress Report highlighted that while the national HIV prevalence had declined overall rates among PWID remained high and unequivocally stated "The prevention work among IDUs is extremely inadequate with limited coverage…" (National AIDS Prevention and Alleviation Committee, 2008, p. 28). It further acknowledged that, "A big challenge to preventing HIV spread among IDU is the lack of a clear harm reduction policy" (National AIDS Prevention and Alleviation Committee, 2008, p. 55).

As mentioned in Chapter Five, in Thai language, harm reduction is การลดอันตรายจากการใช้ยา เสพติด (or in phonetic script: *garnlod andarai jark garnchai yaa septid*) which literally translates as 'the reduction of the danger of the use of addictive drugs'. While it may seem a fine distinction, an important difference between the Thai and the English terminology is the Thai translation puts its focus on addiction rather than a range of different types of drug use. Furthermore, there appeared to be disagreement in Thailand about the merits of harm reduction in the Thai context and there also seemed to be little

clarity about the official status of harm reduction. Global reviews of harm reduction since 2008 have listed Thailand as a country with operational NSP and Opioid Substitution Treatment (OST) programs (Harm Reduction International, 2008) and, from 2010, as a country with explicit supportive reference to harm reduction in national policy documents. Yet, the situation was far more complex than this statement might have suggested. While some saw the mention of harm reduction in national policy documents with cautious optimism, others warned:

> *The existence of national policy on harm reduction does not equate to the provision of the necessary components of a comprehensive harm reduction response. In the majority of countries in the region, drug control policy is in direct conflict with HIV-related policy, which undermines harm reduction in the region. It is imperative that governments harmonise policies to address drug use and its related harms in Asia effectively.* (Harm Reduction International, 2008, p. 30)

For example, in Thailand, as in most Asian countries, the provision of needles and syringes was prohibited by national legislation, and laws still allowed police to arrest people who carried syringes (Aramrattana, 2013). Therefore, such NSP services as were available in Thailand were forced to operate quasi-legally, unregistered and underground. While needles and other injection paraphernalia could be purchased from pharmacies in Thailand the associated costs could be prohibitive to PWID, many of whom were unemployed. In addition, buying injecting equipment from pharmacies posed the risks of recognition, stigma, and discrimination. Furthermore, pharmacists were often reluctant to sell injecting equipment to people they suspected were using illicit drugs. As in the rest of the region, there were no NSPs operating in prisons in Thailand (Harm Reduction International, 2010).

6.9.1 Opioid Substitution Therapy

The Government of Thailand operated approximately 147 sites for the provision of OST (Kongsakon & Pocham, 2006) and, in 2012, the Thai Ministry of Health, Department of Medical Sciences reported that there were 6,085 patients enrolled on Methadone Maintenance Treatment (MMT) during the period of April 2010 to April 2011 (Harm Reduction International, 2012). The Bangkok Metropolitan Administration (BMA) Medical Department alone administered 20 methadone clinics through two hospitals and 18 health centres provided methadone as an out-patient service. Despite this there appeared to be a lack of clarity or perhaps a definitional difference between what was provided as MMT in Thailand and international standards. According to the BMA's

Department of Health new clients underwent 45 days of 'detoxification' on methadone and more recently this was extended to 90 days rather than longer term maintenance. An independent WHO study of methadone treatment in Thailand confirmed that MMT was delivered as *"… serial 90-day detoxification treatments…"* and that the mean methadone dose was 28 mg, well below the recommended dosages in the range 50 to 100 mg which were associated with better outcomes (Ali et al., 2005, p. 7). Similarly, a UNODC review cited patients in Malaysia were better retained in the treatment programs when they received an adequate dose of methadone of around 80 mg and above (Kumar, 2012). European guidelines differentiated between using methadone therapy for detoxification, for which methadone may be prescribed for one month or more, and long-term maintenance, which required stable prescribing over more than six months (Verster & Buning, 2000). Further, Australian national MMT guidelines for example, described effective MMT doses being typically 60-100mg/day and stated that there is a linear relationship between the length of time in treatment and improved treatment outcomes and thus recommended that patients remain in treatment for at least 12 months to achieve a sustained reduction in heroin use and enduring lifestyle changes (Henry-Edwards et al., 2003). Some regional experts and CSO claimed that, as a consequence of Thailand's methadone dispensing practices, patients had to repeatedly undergo periodic detoxification and re-enrolment (Harm Reduction International, 2012).

6.9.2   Harm Reduction for Prisoners

Thailand's Department of Corrections officials and HIV/AIDS clinicians in prisons did not provide methadone in prison stating that *"…it was 'against the law' to provide methadone in prison and that it was not needed as the number of injection drug users in prison was very low"* (Kaplan & Schleifer, 2007, p. 46). Furthermore, prison doctors stated that while injection of drugs in prison "*was a persistent problem…there was no medical reason to provide methadone in prison"* (Kaplan & Schleifer, 2007, p. 46) and they were also concerned methadone might be diverted within prisons. Conversely, government estimates at the time indicated that between 65 to 82% of inmates had a drug use history (Allen, 2015; Kaplan & Schleifer, 2007). As described in the section Incarceration in Thailand in Chapter 8, various national and international researchers found rates of imprisonment for PWID are very high and approximately half of these people reported injecting drugs while in prison. Significantly, nearly all those who injected while incarcerated shared injection equipment. It is highly likely this was a major contributing factor in the very high rates of HIV found among people in Thai prisons, ranging from approximately 25% to approximately 54% depending on the study as compared with a

range of 1-1.5% in the general population during the same periods (Choopanya et al., 2002; Thaisri et al., 2003). There was sufficient evidence to affirm that drugs could be obtained in prison, sharing of injection equipment was widespread, high rates of HIV transmission were common among prisoners and were markedly higher among the prison population than the general community. It is also worth reiterating that regardless of how long a person was incarcerated, eventually they were released and subsequently have presented a high risk for HIV transmission into the general community. These issues have substantiated urgent calls to address HIV transmission via IDU in prisons. Based on their findings researchers recommended urgent measures to prevent HIV transmission among incarcerated PWID, including, the establishment of community diversion strategies as an alternative to prison for drug users and the provision of harm reduction programs in Thai prisons (Beyrer et al., 2003; Hayashi et al., 2009; Thaisri et al., 2003).

6.9.3 *Harm Reduction Policy Position and Implementation*

In January 2009, the ONCB and the Ministry of Public Health agreed to create a working group to prepare policy recommendations and guidelines for implementation of harm reduction. In April 2009, a Senate Health Committee invited representatives from the government, CSO, NGO, and international organisations to make submissions on harm reduction and politicians and high-level managers of relevant organisations travelled to Taiwan and Malaysia to study harm reduction implementation, which culminated in a draft of harm reduction policy guidelines on IDU. By June 2009, the Minister of Health presided over the signing of a memorandum of understanding (MOU) for cooperation on harm reduction for PWID. Among those represented at the signing were the Office of the Permanent Secretary for Health, the Department of Medical Services, Department of Disease Control, National Health Security Office, and the ONCB (National AIDS Prevention and Alleviation Committee, 2010). Later, in November 2010, the Thai Prime Minister, Abhisit Vejjajiva, approved the National HIV Prevention and Care Plan which explicitly referred to harm reduction. A subsequent Prime Ministerial Order No. 306-2553 (2010) on drug control included the deployment of a comprehensive package of services (including NSP and OST) to reduce HIV transmission among PWID in 10 pilot provinces[19] (Tanguay, 2015) (see Appendix Eight for a map of the provinces of Thailand). Nonetheless, in July 2011, following parliamentary approval of the draft policy,

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[19] Bangkok, Samut Prakan, Chiang Rai, Chiang Mai, Tak, Surat Thani, Songkhla, Pattani, Yala and Narathiwat

the Council of State[20] concluded that the distribution of injecting equipment was in contravention of the Narcotics Act (1979) and was 'inciting drug use' which was a crime. This ruling led to a significant loss of support from the government agencies that had developed the policy and the policy was subsequently abandoned.

Later in July 2011, the Pheu Thai Party was elected to government and their leader Yingluck Shinawatra was sworn in as Thailand's first female Prime Minister. The government of Prime Minister Yingluck Shinawatra (sister of former PM Thaksin Shinawatra, who launched the previously described Thai War on Drugs which resulted in 2,275 deaths) indicated a strong reluctance to adopt evidence-based measures to address drug-related issues such as HIV and quickly launched a new war on drugs campaign (Branigan, 2011). Less than two years after the introduction of harm reduction into the Thailand's National HIV Prevention and Care Plan, Yingluck's Deputy Prime Minister (Chalerm Yubamrung) declared he would solve the drug crisis in Thailand within one year. Among his proposals for a solution were a maximum security drug offenders' prison and vocal support for the death penalty for drug offences (Ashayagachat, 2012b). Furthermore, Chalerm called for a legal amendment to speed up the execution process of drug offenders so that condemned drug offenders could be executed within 15 days of an unsuccessful appeal (Ashayagachat, 2012a).

During the same period, Her Royal Highness Princess Soamsawali participated in a study visit to Australia in late 2011 which focused on harm reduction and services to PWUD. Upon her return to Thailand, Princess Soamsawali contacted the Prime Minister's office with a recommendation to implement all necessary services to reduce HIV transmission among PWID, including distribution of sterile injecting equipment. This recommendation was supported by the Thai Red Cross and representatives of many government organisations. This was followed by a series of meetings and in May 2012 documents supporting harm reduction were submitted for consideration by the two Deputy Prime Ministers but no tangible outcomes resulted (Tanguay, 2015).

Thailand's next five-year National HIV/AIDS Plan 2012 to 2016, formulated to align with the UNAIDS Global plan for 'Getting to Zero' (UNAIDS, 2010a). It was developed through extensive consultation and was accompanied by a well-structured and detailed

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[20] The Council of State of Thailand was a department directly under the authority of the Prime Minister of Thailand, and provided legal advice to government agencies and entities on a range of issues, including the preparation of draft laws and issuance of legal opinion on interpretation of legislation.

monitoring plan. It comprised three higher order goals for 2016: Zero new infections; zero aids-related deaths; and, zero stigma and discrimination. Its strategies were structured around Two Strategic Directions: firstly, Innovation and Change; and, secondly Optimization and Consolidation. Acknowledged as ambitious, it focussed on the most at-risk groups (FSW, MSM and PWID) and *"…call[ed] for the removal of legal and political barriers to universal access, and pledges to promote dialogue between health and other sectors, including justice, law enforcement and drug control."* (National AIDS Committee Thailand, 2011, p. 4)

The plan identified that sharing injecting equipment was a leading cause of HIV transmission and explicitly promoted harm reduction programs. It targeted a reduction in new HIV infections among PWID of around 22% every year, 2010 to 2016, through a rapid scaling up of needle/syringe distribution from 230,834 needles/syringes distributed in 2010 to 40,300 PWID to 3,536,727 needles/syringes distributed to 40,300 PWID in 2014 to achieve a target of 82.0% PWID reporting the use of sterile injecting equipment the last time they injected. It also included indicators for the number of PWID on OST for at least three months and the percentage of PWID who reported the use of a condom at last sexual intercourse.

Another significant component of the strategy was its focus on eliminating stigma and discrimination. It proposed to achieve this through: continuous learning and training opportunities for health and other identified key personnel; monitoring stigma and discrimination in critical areas such as the work place, health sector, education and social welfare; strengthening community interventions to change attitudes and behaviour; and, empowering key affected populations to access rights protection services (National AIDS Committee Thailand, 2011). In 2012, an agreement was made between the Royal Thai Police, UNDP, Foundation for AIDS Rights and the Department of Rights and Liberties Protection of the Ministry of Justice to establish a program entitled the *Thai police as key change agents: The innovative learning program on HIV and human rights in the context of law enforcement*. The goal of the program was to provide 10,000 junior Thai police officers per year with education about HIV/AIDS stigma and discrimination towards key affected populations, including PWID. The following year, 40 police trainers were trained, a curriculum was developed, and the program was scaled up to include training of higher-level police officers (United Nations Development Programme, 2012).

In October 2013, following a concerted campaign of demonstrations and delegations from CSO to the Thai parliament, the ONCB formally introduced harm reduction into the

National Drug Control Strategy (October 2013 to October 2015). Specifically, the Order of National Command Centre for Combating Drugs No. 1/2557 and the associated implementation plans provide for a harm reduction package for PWID on a trial basis in 19 provinces with the intention of offering rehabilitation and reintegration services, in line with the UN guidance (Thailand Country Coordinating Mechanism, 2014). On 19 October 2013, Thailand's Deputy Prime Minister announced authorisation of the first national harm reduction policy. Finalised on 7 February 2014, this policy outlined five strategies:

- *To support PWID access health services by strengthening care and support strategies*
- *To reduce the burden of blood borne infections among PWID*
- *To assist PWID access and enter voluntary drug rehabilitation services aimed at reduction and eventual cessation of drug use*
- *To reduce drug-related harms among PWID, their communities and society as a whole*
- *To create an enabling service delivery environment that facilitates access to and delivery of harm reduction services.* (Tanguay, 2015, p. 42)

The policy document recommended aligning the strategy and its implementation with international evidence and best practice, and the WHO/UN comprehensive package services for PWID for the prevention of HIV. The policy was officially launched in Bangkok on 17 March 2014 at a two-day workshop co-hosted by ONCB and Population Services International[21] (the Principal Recipient of the grant from The Global Fund to Fight AIDS, Tuberculosis and Malaria[22], usually simply referred to as the Global Fund)[23]. At the close of the meeting, the National Harm Reduction Committee had been established. Overseen by the Secretary Generals of the Ministry of Health and the Ministry of Interior, a total of 49 people had official seats on the Committee and its members included a wide range of government representatives from the Ministries of Health, Justice, Finance and the Interior. Several CSO were members of the Committee and the following agencies had at least one seat; the ONCB, Department of Corrections, Department of Probation, Royal Thai Police, Department of Mental Health, Department

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[21] Population Services International, is a global health network dedicated to improving the health of people in the developing world. http://www.psi.org/about/at-a-glance/
[22] The Global Fund to Fight AIDS, Tuberculosis and Malaria was one of the largest international financing organisations that attracts and disburses resources to prevent and treat HIV and AIDS, tuberculosis and malaria.
[23] PSI Thailand, ONCB, UNODC. 17 March 2014. *National Harm Reduction Policy Launch* at the Eastin Makkasan Hotel.

of Medical Services, Thanyarak Institute, National AIDS Management Committee, and the Bangkok Metropolitan Administration.

While these recent developments at the policy level may have been encouraging what appeared to be taking place 'on the ground' seemed to have changed little. There were ongoing concerns that implementation of harm reduction has often conflicted with approaches police had undertaken in tackling drug supply and use. For example, there were reports that when peer outreach workers promoted syringe exchange they faced harassment, abuse and arrest for carrying clean needles for distribution or working to assist peers access methadone clinics and were often interrogated to identify active drug users or suppliers (Fairbairn et al., 2009; Kaplan & Schleifer, 2007). These issues were not unique to Thailand and had been reported elsewhere in the region. Thailand's neighbour Malaysia, for example, introduced harm reduction policies and programs in 2005 and had since noted positive impacts, including; better access to ART for HIV-infected PWID, reductions in HIV-risk behaviour, reduced incarceration rates of drug users, and so forth. The most significant barrier to sustaining and scaling up harm reduction services was that the harm reduction policy coexisted with punitive drug policies and "*Despite a standard operating procedure and an understanding with health and law enforcement at senior levels, police raids and arrests of those attending the methadone and needle exchange projects continue*" (Kamarulzaman, 2009, p. 18).

In Thailand, as in the majority of countries in Asia, illicit drug control policy has remained in direct conflict with HIV prevention policies, which has undermined attempts at harm reduction implementation (Harm Reduction International, 2010). This approach to drug use and trafficking echoed the disastrous 2003 Thai War on Drugs and could have serious implications for access to and scale-up of harm reduction programs (Ashayagachat, 2012b). As the 2008 Global Report on Harm Reduction urged, it remained *"It is imperative that governments harmonise policies to address drug use and its related harms in Asia effectively..."* (Harm Reduction International, 2008, p. 30). Even more pragmatically, it appeared that the national government remained unwilling to fund harm reduction services and international sources of the meagre funding available to date seemed unlikely to be replenished.

6.9.4   *Resourcing Harm Reduction in Thailand*
The WHO considered, in general, Asian countries were wealthier than those in other regions heavily affected by HIV, particularly countries in sub-Saharan Africa and

therefore received less support from international donor bodies. "*This situation, combined with the morally, ideologically and politically driven funding strategies of many Asian governments, results in inadequate and unsustainable resource allocation for harm reduction programmes*" (World Health Organization, 2008). Furthermore, a review of grants provided by The Global Fund to countries for HIV prevention and control demonstrated that its funds had significantly declined over recent years (World Health Organization, 2012b). Some analysts claimed unequivocally that Asia could afford universal access to AIDS prevention and treatment. To achieve this, they argued, Asian countries must: firstly, prioritise interventions target MARPs; secondly, they needed to utilise interventions with demonstrably greater effectiveness in averting new HIV infections; and thirdly, such interventions should be low-cost and high impact. By way of example, they cited that the distribution of condoms to FSW or needles/syringes to PWID would have far greater impact in reducing the number of new HIV infections than general awareness campaigns through mass media or sex education in schools. Although they acknowledged the latter were important, by comparison with the former they *"…are likely to avert fewer HIV infections, but when implemented at the expense of programs for at-risk populations, create huge opportunity costs*"(Komatsua et al., 2010, p. 76).

In 2008, the UNAIDS Commission on AIDS in Asia presented the UN Secretary General a report which found that if Asian countries with expanding epidemics invested US$1 in prevention approaches they could save US$8 in treatment costs. Further, it recommended that Asian countries focus their efforts on a prevention package to; raise condom use among FSW and their clients, as well as MSM to over 80%; and halve needle sharing among PWID. They concluded that such a prevention-focussed response was affordable for most countries in Asia and that their analysis indicated that over the period 2008 to 2020 it would result in a reduction in:

- *cumulative infections by five million;*
- *the number of people living with HIV in 2020 by 3.1 million;*
- *the number of AIDS-related deaths by 40%; and*
- *overall HIV prevalence in the region.* (Commission on AIDS in Asia, 2008, p. 10)

Asia regional HIV experts have continued to urge Asian countries to focus on prevention as the priority with a minimum of 60% of national HIV allocations spent on HIV prevention; and have noted that this was not the case in Thailand, where the majority of the HIV budget had been consistently allocated to treatment (Rao, Mboi, Phoolcharoen, Sarkard, & Caraele, 2010). Unlike most countries in the region, Thailand was not reliant on donors for the provision of ART. In fact, most of the country's AIDS prevention and

control program budget (80 to 90%) was domestically generated. This not only reflected the prominence Thailand gave to HIV/AIDS but also allowed it substantial self-reliance in HIV/AIDS policy and implementation. On the other hand, prevention did not appear to have been given a high priority. In 2009 for example, between 69-76% of that budget was allocated to treatment and only 14% for prevention, of which three percent was for condoms procurement and about one-third was for behaviour change communications. Furthermore, most of the prevention component was not from national allocations but was secured from external sources (National AIDS Prevention and Alleviation Committee, 2010). The most important among these has been the Global Fund.

The Global Fund has been strongly supportive of evidence-based HIV prevention, treatment and care interventions for most at-risk populations, including, funding harm reduction initiatives for PWID (Global Fund to Fight AIDS Tuberculosis and Malaria, 2013). A study of the more than 1000 grants the Global Fund had provided, found 120 grants (totalling approximately US$361 million) from 55 countries contained activities for PWID. About two-thirds of that amount was allocated to core harm reduction activities as defined by the United Nations. Nevertheless, the study concluded that "*This funding, while substantial, falls short of the estimated needs [and] Investments in harm reduction must increase if HIV transmission among people who inject drugs is to be halved by 2015*" (Bridge, Hunter, Atun, & Lazarus, 2012, p. 1). Global Fund grants supported harm reduction initiatives in a number of Asian countries, including Thailand (Global Fund to Fight AIDS Tuberculosis and Malaria, 2007). The Global Fund approved funding investments in Thailand for PWID, from Round One (2002) to Round 10 (2010) totalling US$28,000,000 (Harm Reduction International, 2010, 2012). These first grants were driven and coordinated by NGO and peer network organisations including, the Thai Drug Users Network (TDN), the Thai Treatment Action Group (TTAG), Alden House and the Raks Thai Foundation (MacDonald & Nacapew, 2013).

A funding crisis in 2011 forced the Global Fund to audit existing funds, cancel their planned Round 11 funding disbursement and introduce tougher funding criteria for countries seeking grant renewals or new grants for HIV prevention and control programs (Bosely, 2011). Under the new approach for funding grants countries were grouped in to bands, determined by the highest disease burden and the level of their economic development, among other factors. Under these new rules countries classified as 'Upper Middle Income', when applying for grant renewals, were expected to meet a minimum threshold for counterpart financing of 60% of the required budget (Global Fund to Fight AIDS Tuberculosis and Malaria, 2011b, 2012). Under the new Global Fund criteria

Thailand was classified as an upper-middle-income country and as it was no longer listed on the OECD's Development Assistance Committee list of overseas development assistance recipients it would not be eligible for donor funding. Conversely, because Thailand had a high burden of disease with respect to HIV they could receive a pre-defined maximum amount of funding, if the Thailand government was not a direct recipient of that funding, and the application was submitted by, and the program was managed by, an NGO within the country (Global Fund to Fight AIDS Tuberculosis and Malaria, 2014).

Nevertheless, this had significant implications for an already under-resourced small-scale harm reduction response in Thailand which was struggling against an unfavourable policy environment and reliant on internal funding sources. At the time of writing, NSPs operating in Thailand were funded by the Global Fund under the CHAMPION-IDU project. This project supported 13 drop-in centres and 10 satellite outreach networks in 19 out of Thailand's 77 provinces (MacDonald & Nacapew, 2013). Population Services International (Thailand Foundation) was contracted under the Global Fund grant to implement the harm reduction components for PWID and was believed to be the only provider of NSP in the country. Still there were increasing concerns that, since international sources were the major contributors to Thailand's HIV prevention activities in general and harm reduction activities in particular (the Global Fund provided 70-80% of those funds), any further reduction in the Global Fund's fiscal capacity or restrictions in Thailand's eligibility as a fund recipient would place Thailand in a vulnerable position with respect to resourcing its already very modest harm reduction efforts (Patcharanarumol et al., 2013).

6.10 Recent Developments in the Thai Drug Policy Debate

In July 2015, the Thai Minister of Justice, General Paiboon Khumchaya, told a drugs seminar audience, including judges, prosecutors, senior police commissioners, and public health officials *"…that the eradication of illegal drugs was a counterproductive policy goal, and one that should no longer be pursued"* (Fawthrop, 2015, para. 11). He further stated that *"Such heavy-handed law enforcement strategies have led only to systemic police corruption, and prison cells overcrowded with non-violent offenders – mostly drawn from the ranks of the impoverished"* (Fawthrop, 2015, para. 12). Shortly thereafter, the Ministry of Justice began a consultation process for the first review of drug laws in 40 years. This window of opportunity could have an important impact not only on Thailand domestic drug policy but also on Thailand's influence within ASEAN and her

aspirations as a centre of excellence on drug responses among the countries of the Greater Mekong Sub-region.

The review of Thai drug legislation included a number of public forums during which the Minister of Justice, General Paiboon, made public statements stating that the War on Drugs was not solving Thailand's drug problems and, especially in regards to methamphetamine, new approaches were required (Tibke, 2015). At the time of writing the new drugs legislation had not yet been tabled in parliament and it was not clear what changes would occur. Some media reported that Paiboon had recommended ATS should be decriminalised (Calvo, 2016) or even legalised (Laohong, 2016b). Some suggested that many within the government did not share his views and in an interview close to the time of writing he was quoted as saying unequivocally "*There's no way Yaba (methamphetamine) will be made legal. It will remain as an illicit drug. We're not ready to legalise the drug.*", that "*Traffickers and major dealers will face drastic measures...*" and that Thailand was not ready to abolish the death sentence for drugs offences (Laohong, 2016a, para. 2). According to the interview, he did state however, that those dependent on methamphetamines should be sent to treatment not prisons but it was not clear at that time how the distinction would be made between those who would receive prison or those who would receive treatment (Laohong, 2016a). At the Opening Ceremony of a Bangkok public forum on the Draft Narcotics Code in August 2016 Paiboon also stated that if he did not get support of Thai Government departments and the public then he will use section 44 of the new constitution, which allowed for a prime ministerial decree to make the necessary changes (specifically to reschedule of methamphetamine from a schedule one to a Schedule Two drug, meaning lesser penalties would apply and making medical prescription possible) (Koomchaya, 2016).

Representatives of the revered Thai monarchy have also been noted in this policy space. HRH Princess Bajrakitiyabha (appointed UN Women Goodwill Ambassador in September 2008) had an interest in the quality of life of women in prison, alternatives to incarceration for women and more broadly justice system reform for women. She patronised the Kamlangjai Project, the purpose of which was to decrease the number of female inmates in Thai prisons. The project called attention to the increasing number of female inmates in the Thai prison system and subsequent problem of overcrowding in prisons. The Kamlangjai Project was set up for female prisoners to have an opportunity to attend life's skills activities, such as alternative medicine, beauty vocation, massage, yoga and dharma (United Nations Office on Drugs and Crime, 2008b). During that time, the Princess was a Goodwill Ambassador she led Thailand on the 2015 CND and the

United Nations Congress on Crime Prevention and Criminal Justice Crime Congress. That year the Thailand delegation had the second biggest delegation after only the host, Qatar. The princess was there for the entire week of the congress and Thailand was represented by high-level officials from all relevant portfolios, e.g. Prisons, Department of Justice and the ONCB (United Nations, 2014).

6.11 Chapter Summary

Thailand's illicit drug policies have been strongly influenced by that country's interpretations of the prohibitionist approaches of the international drug control treaties, to which Thailand is signatory, and the CND, on which Thailand has permanent representation. These treaty obligations and their interpretation by the Thai Government clearly remain critical influences in the formulation of national policy in Thailand. Thailand has been a producer of opium in the past but even then, was a net importer of the drug. Throughout the 20th century to the present it has been an important transit country for manufacturers and traffickers of illicit drugs (opium, heroin, ATS, and others). This has focused Thai law enforcement on interdiction efforts as well as those of destination countries for shipments of those drugs.

Thailand's high rates of IDU, first with heroin and increasingly with ATS, has led to extremely high prevalence rates of HIV and other BBV among PWID, primarily driven by injecting drug use and sharing injecting equipment. Prevalence rates of HIV among PWID have remained at close to 50% since the beginning of the HIV epidemic in Thailand. International and national evidence indicates the resultant mortality and morbidity among PWID, their families and the community could be substantially reduced or prevented through harm reduction measures such as those recommended in the United Nations Comprehensive Package of Interventions for the Prevention, Treatment and Care of HIV among PWID (World Health Organization et al., 2012). Despite this the Thai Government appeared so far to have been unable implement drug policies which would prevent these health and social harms. On the other hand, the relatively successful historical example of government legislation and regulation of the opium trade in Thailand for a hundred years from the 1850s to the 1950s is evidence of Thailand's ability to respond innovatively to social problems and respond pragmatically to reduce the social economic and health-related harms of drug use, as was also seen in the previously cited example of extremely successful response to HIV among FSW with the 100% Condom Campaign.

A brief examination of funding allocations showed that Thailand has had a strong focus, some critics have said a disproportionate focus, on the treatment of HIV with little national finance allocated to prevention work in general, or harm reduction specifically. These activities have been reliant solely on international funding, which was announced to be withdrawn by 2017. Some Thai and international experts have raised concerns that this funding approach was unsustainable and allocations either from national government budgets or new international donors must be found to finance strategies to prevent further transmission of HIV and other BBV.

While the Thai monarchy has been a respected institution and has had some engagement in drug policy. The King patronised a long-term and successful opium crop eradication alternative development project which has been the centrepiece of international presentations of Thai drug policy and more recently his granddaughter, Princess Bajrakitiyabha, has promoted justice system reform for women, many of whom have been incarcerated for minor drugs offences. Despite this the official monarchical influence has been limited in the arena of drug policy.

There have been concerns expressed nationally and internationally about the democratic implications of a military coup and a military government in Thailand. Conversely, it may be there was a person (a policy entrepreneur) within the military government, General Paiboon, Minister of Justice, who would champion the cause of drug policy reform. Paiboon stated he had been subject to a lot of criticism over his proposal to liberalise Thai drug policy including criticism from ONCB but said that he was not concerned with this and would continue to pursue drug policy reform. There appeared to be potential for some change in drug policy. For example, there appeared to be shared support for changes that would address, for example, the high numbers of women in Thai prison, more proportional sentences for drug-related crimes, alternatives to imprisonment for people who had committed minor drug-related offences and who had drug dependencies and so forth. At the time of writing, however, a radical shift in Thai drug policy did not seem imminent.

Chapter 7: Analysis and Interpretation

The following chapter is in four parts: the first section presents the analysis of the survey data; the next presents the analysis of the interview data; the third and fourth sections present a thematic analysis and interpretation of the data from both the survey and the interviews. These last two sections are divided into national and international themes respectively. Therefore, there is limited discussion of the findings initially in first section because it is only after the analysis of both sets of data (from survey and interviews) are presented that their interpretation can be compared and contrasted. Discussion of the findings is then further expanded and more extensively crossed referenced with the literature reviews in the final chapter. To assist the reader in following the discussion of data from the survey and from the expert interviews those who participated in the survey are referred to as survey respondents, or respondents, and those who participated in the interviews are referred to as expert interviewees, or simply experts.

7.1   Analysis and Interpretation of Survey Data

Survey respondents were attending the International Harm Reduction Conference, in October 2015 in Malaysia. There were 51 survey responses returned, of which 43 were complete, fully legible and usable. Data were only collated and analysed from those surveys. Full details of the survey methodology were provided in the methodology section, Chapter Two.

The conference attracted participants from around the world and survey respondents came from a broad spectrum of 19 countries, which included, low-income developing countries, middle-income countries and developed high-income countries[24]. The respondents came from the following countries: Afghanistan; Australia; India; Kazakhstan; Kenya; Kyrgyzstan; Malaysia; Myanmar; Nepal; Philippines; Romania; Russia; Scotland; Sweden; Tajikistan; Thailand; Ukraine; United Kingdom; and, USA. A full listing of countries by income classification is provided in Appendix Nine. These conference participants also met all criteria planned for the survey in the methodology. That is: they were engaged in harm reduction policy dialogue, advocacy, development or services provision; they were drawn from provincial, national, regional and international

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[24] The World Bank classifies 189 member countries into income groups according to 2015 Gross National Income per capita. The groups are: low-income, $1,025 or less; lower middle-income, $1,026–4,035; upper middle-income, $4,036–12,475; and high-income, $12,476 or more. The effective eligibility threshold for International Development Assistance is $1,185 or less (World Bank, 2016).

levels of policy formulation and implementation; and they included personnel working in national government departments, multilateral or United Nations agencies, and civil society or non-government organisations. Survey respondents described the organisations they worked for as: Civil Society Organisation[25]; Harm Reduction Service; Hospital; International Non-Government Organisation; Ministry of Public Health; Private Company; Public Health Service; PWUD Network; Research Organisation; Technical Support Agency; Treatment and Rehabilitation Service; and University. The respondents' roles within these organisations fitted broadly within the following categories: communications; health worker; management; medical practitioner; monitoring and evaluation; nurse; outreach worker; researcher; and technical advisor. Full details are provided in Appendix 10. The following is an analysis synthesised from the completed surveys using thematic coding and analysis undertaken both manually and assisted by NVivo software version 10. The following responses with very brief explanatory notes have been structured around the four research questions (asking what were the major factors which hindered or helped drug policy formulation or implementation). A more thorough discussion is provided in the 'Discussion of Findings' section in which analysis of the survey data was incorporated into and compared with the analysis of the interview data.

7.1.1   Question 1: Factors That Hinder Formulation

In response to the question which asked survey respondents to identify factors that hindered policy formulation, the greatest number of answers were about politics and the next greatest number of replies were issues related to government and government administration. Comments about public attitudes also featured frequently in responses, along with concerns about legislation and policy focus on criminality rather than health of PWUD. Also mentioned were issues related to the role of CSO, resource and funding issues, and a few made comments about the negative role the media played in the formulation of drug policy.

Respondents identified a range of political challenges which they considered hindered effective policy formulation which they described variously to be perceived as apathy, close-mindedness, intolerance, and/or discrimination/stigma. Nonetheless, the most frequent descriptions used were a lack of political will and lack of political commitment to

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[25] 'Civil Society Organisation' is used to include all similar types of organisation listed i.e. Community-based Organisation, Non-Government Organisation, Not-for-Profit Community organisation.

change political positions on drugs, described neatly by a Swedish survey respondent as *"A tradition of zero tolerance to drugs". S*everal comments also suggested there was some broad agreement that politicians in many countries had demonstrated a failure to understand or acknowledge the unintended consequences of current policies. A few comments suggested that respondents thought politicians were concerned about voter responses if they were to attempt drug policy reforms, and a Thai respondent mentioned unpredictable political change as a hindrance to policy reform. The issues of political will and the relationship between policy and public opinion recurred in the survey responses.

Respondents from several countries (Afghanistan, Kazakhstan, Kyrgyzstan Tajikistan, Ukraine) stated corruption was a significant problem which prevented drug policy reform, with one respondent stating, "*Harm reduction advocates cannot bribe parliament members, unlike drug lords*". A respondent from Kazakhstan also mentioned regional geopolitical issues as influencing national drug policy, i.e. "*The growing influence of the Russian Federation government*". At the administrative government level, a few comments were made about bureaucratic regulation as a hindrance, particularly in Malaysia, but unfortunately there was little explanation about which regulations or how they hindered formulation. Thai respondents also mentioned fragmentation and inconsistencies between the approaches of different government departments as creating difficulties in drug policy formulation and implementation.

Further related to issues of politics in policy debate and policy formulation were matters related to insufficient access or input into these processes by people affected by drug use[26] or civil society and community-based organisations (CBO). This was raised by many respondents from diverse country contexts (Australia, India, Scotland and Thailand). Many of the same respondents also described concerns that the effectiveness of advocacy efforts and contributions to policy formulation by organisations representing people affected by drug use and other CSO in their countries was hampered by insufficient coordination, cooperation and alignment of aims among themselves.

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[26] Although the researcher acknowledges the term 'people affected by drug use' may have slightly different definitions for some people in some circumstance, it is generally understood to mean, those who have been personally and directly affected by the ongoing use of drugs. Specifically, that is, people who currently use drugs, people who have recovered from problematic drug use, their intimate partners and family members. That is the sense in which the term has been used in this research.

The attitudes of the public towards drug use and drug users featured frequently in comments, and appeared to be a common theme among most respondents. The issues here encompassed social stigma, discrimination, conservative religious beliefs, described in the words of the respondents as, "*Cultural barriers and taboos*", and public opinion, characterised as "*The moralistic public outcry against drug use and people who use drugs*". One UK respondent coined the term "*Intoxiphobia*" which they defined as public attitudes which discriminated against PWUD. A Filipino respondent said, of public attitudes in their country, *"Drug use is considered as an evil thing that needs to be purged, people included".* This statement was made even more significant when several months later the highly-publicised extrajudicial killings of PWUD began in the Philippines[27][28].

Under the theme about "Law", the common concern cited by many respondents (from Asia, Africa and Europe) was that policies and legislation which focused on the criminalisation of drugs and PWUD did not support, or conflicted with, public health approaches.

The role of the media in generally hindering drug policy reform was raised by several respondents. Interestingly, these concerns were only mentioned by respondents from high-income developed countries (Australia, UK, Scotland). The comment suggested sentiments were strong on this topic and specific media outlets, media personalities and owners were named. Media influence was described as promoting a powerful negative bias against drug use and PWUD and as being irresponsible in promoting what one respondent summarised as "*The moral panic, misinformation and attitudes which lead to the stigmatisation and discrimination which dominate the PWUD".* They also suggested that such reporting unduly influenced politicians and the policies they supported.

Only respondents from three of the 19 countries raised issues related to insufficient evidence or technical assistance as hindering drug policy formulation and these came from respondents working in low-income countries with limited capacity (Afghanistan,

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[27] Philippines President Duterte ordered police to carry out summary executions and also urged citizens to kill drug users and dealers. 'My order is shoot to kill you. I don't care about human rights, you better believe me,' said Duterte. A month after his inauguration over 400 people had already been killed and 565,806 had turned themselves in to Police (Dean, 2016).
[28] "*Duterte said:* 'There are three million drug addicts (in the Philippines). I'd be happy to slaughter them. If Germany had Hitler, the Philippines would have...,' *he said, pausing and pointing to himself…. He took office on June 30 and over 3,100 people have been killed since then, mostly drug users and peddlers, in police operations and in vigilante killings*"(Lema & Mogato, 2016).

Kazakhstan and Kyrgyzstan). This may suggest that middle-and higher-income countries had sufficient access to evidence and technical expertise for drug policy formulation, or it was not considered as important to them as other factors in moving drug policy agenda forward, such as political support and commitment. Resources and funding concerns were mentioned by respondents from only a few countries and, on analysis, it was apparent these comments related to drug policy implementation and not of drug policy or strategy formulation, thus they will be discussed in a later section.

7.1.2 Question 2: Factors That Hinder Implementation

In identifying the major influencing factors that hindered national harm reduction policy implementation, the respondents provided much more commentary than on the factors that hindered formulation. The areas that received the greatest number of comments, and approximately similar volumes of commentary, were discussions of public attitudes, politics and government administration, law enforcement, and issues related to resources and funding as constraints on effective policy implementation.

Common themes about the difficulties created by public opinion during implementation were similar to those cited for drug policy formulation, that is, cultural, moral and religious beliefs which created or exacerbated stigma and discrimination against PWUD. Many respondents suggested these social attitudes resulted from lack of public awareness, understanding or education, coupled with a lack of informed community and political leadership. The responses suggested these concerns were common to nearly all respondents. Respondents from Afghanistan and Tajikistan appeared to face uniquely difficult challenges due to war and violence, for example by "*religious vigilante groups acting against people with drug dependence*".

The concerns raised about politics, politicians and the administration of government in constraining the implementation of drug policy reform and harm reduction were very similar to responses about factors that hindered policy formulation. Primarily the difference being that a greater number and volume of remarks were made on the issue of implementation. Some suggested that the topic of PWUD was a political liability for politicians seeking to maintain office and populist so-called 'tough on drugs' or 'war on drugs' policies were thought to receive better responses from voting constituents than health-focused policy approaches, such as harm reduction, which may have required more explanation and education for the public.

Insufficient funding for implementing drug services in general, and harm reduction service delivery in particular, was mentioned in a substantial volume of comments by many individuals from 13 out of the19 countries in the sample. The three main areas of concern appeared to be: firstly, insufficient national government funding to implement effective programs with adequate coverage; secondly, the need for international donor funding for low-income countries with insufficient national budgets; and thirdly, issues around reliability and sustainability of a budget for service provision. One respondent from India described the latter issue in the following statement "*Timely release of budget for implementing activities is one of the biggest factors as it creates a lot of problems for those on the ground in terms of service delivery and access to service",* and Kyrgyzstan also noted government administrative issues in ensuring reliable procurement and supply management of goods for service provision. Respondents from Afghanistan, India, Thailand and Malaysia indicated that drug services, especially harm reduction services such as OST, were largely or solely dependent on international donor funding and that was "*drying up*". In addition, a US drug treatment provider expressed concern about what they described as "*Price gauging by big Pharma for hepatitis C treatment and naloxone*". In other words, effective treatments were readily available in that country but the high prices demanded left them out of reach of many who needed them. This was in stark contrast to the situation in some other countries, such as India and Thailand which, under the Doha Declaration[29], had ensured drugs for treating serious diseases (e.g. antiretrovirals) were available, accessible and affordable for their citizens.

One respondent from Thailand remarked that having drug use as an integral part of, what they described as the HIV dialogue had become an impediment to drug policy reform. This was contrary to interpretations from other respondents. This may have been related to competition for funding. For example, a respondent from India said that because harm reduction was part of the overall HIV prevention and management program this reduced funding available to these types of responses for PWUD, but the available evidence did not enable more detailed analysis of this issue.

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[29] The 2001 Doha Declaration allowed compulsory licenses to be issued in developed countries for the manufacture of patented drugs, provided they were exported to countries on the UN's list of least-developed countries. This was not limited to only least-developed countries and every member of the WTO had the right under the TRIPs agreement to issue a compulsory license if there was a public health need.
https://www.wto.org/english/tratop_e/dda_e/dohaexplained_e.htm

In regard to law enforcement, many respondents appeared to think criminalisation of drug use and drug users created difficulties in implementing harm reduction policies and resulted in unintended consequences, such as police harassment of service providers and service consumers. Many respondents expressed concern about harsh laws and harsh implementation of those laws. For example, an Australian expressed concern about what they described as the "*the militarisation of law enforcement*". A couple of respondents also expressed concern about what they called police and vigilante action against PWUD.

Respondents from the Philippines, Thailand and USA cited problems with laws that prevented harm reduction implementation policy, such as those which allowed for arrests of persons in possession of injecting equipment even when other laws in the same jurisdiction allowed for the legal purchase or distribution of such equipment. Respondents also described jurisdictions which endorsed OST in policy and law and yet hampered its implementation due to restrictions on the number of patients, type or dose of opioid or the circumstances in which medical practitioners could prescribe.

People working in Indonesia, Romania and Thailand were the only ones to identify problems in implementation processes related to the engagement of CSO and PWUD and it appeared this was for differing reasons. Comments suggested that in Romania and Indonesia the main issue was that CSO and PWUD had not been consulted or included sufficiently in the process, whereas in Thailand respondents spoke of difficulties with coordination and cooperation between CSO and PWUD CBO which prevented more effective advocacy and participation. The lack of, or insufficient, evidence and technical expertise for implementation was mentioned only briefly by respondents from two countries, Myanmar and Nepal, both low-income countries and countries which had been experiencing recent armed conflict. Possibly these characteristics had prevented the development of national capacities available within other countries. The concerns about media creating difficulties for implementation of drug policy appeared to be of much less concern when it came to implementation and were mentioned only by two Australian respondents, who remarked on the negative media impact of "*Fear, moral panic and tabloid journalism*". It is not clear from the information in the surveys why negative media coverage of drug use and drug policy appeared to be of so little concern to most other respondents.

7.1.3   *Question 3: Factors That Help Formulation*

In response to the question which asked what the main factors were that helped formulation of effective national harm reduction policy, the overwhelming majority of comments by survey respondents were related to the role of CSO and engagement of PWUD. In general, the replies indicated that respondents considered the active participation of CSO in raising awareness and educating their communities and politicians about evidence-based responses, such as harm reduction, to drug users and drug use was extremely important in drug policy formulation. The majority also stressed that it was critical that PWUD were engaged in those processes. They also described the importance of formal and informal partnerships between CSO, local communities, health service providers and politicians or other policymakers. For example, an Indonesian respondent described this as creating "*A platform for dialogue between communities and policy makers*". To some extent it might be expected that these factors (the role of CSO and engagement of PWUD) would be a strong feature of responses because there was high representation of CSO among the respondents (i.e. 13 of 43 respondents identified themselves as working with CSO). Comments on this theme appeared to be of common interest among respondents, in that they were made by people from 13 of the 19 countries which responded to the survey. Many also described the personal attributes required to successfully advocate, lobby and educate. For example, a respondent from Kyrgyzstan summarised those attributes as "*Strong, skilled, smart and creative harm reduction Civil Society Organizations and leaders from the community*". Patience and persistence were also repeatedly cited and a worker from the Philippines mentioned the importance of "*Engaging government officials in non-adversarial ways and ways which make them interested*".

There were also many comments about the importance of evidence, guidelines and technical assistance to support the formulation of harm reduction policy. These were generally about the critical relevance of being able to provide findings from monitoring, evaluation, and research on the effectiveness of harm reduction strategies, and in particular the resultant changes in prevalence and incidence rates of HIV. Respondents from Myanmar, Kyrgyzstan, Tajikistan and Kazakhstan also mentioned the importance to them of in-country technical assistance from harm reduction experts. It may be that in countries with lower technical capacity this was much more important than in places where such expertise was more readily available. On the other hand, some Australian respondents mentioned that "*good academic institutions*", "*collegiate bodies: RACP,*

CLAM, AMA, ADLRF[30], etc." and scientific drug research institutes had been helpful in drug policy formulation reflecting the important role of established institutional capacity in more developed countries.

Several respondents from five different countries mentioned the importance of political leadership and "*political will*" as being important in drug policy formulation. One person working in the USA stated, *"Working with law enforcement has been the biggest help to allowing us to open up dialogue with conservative politicians and change policy*". A respondent from Myanmar represented a common perception by writing "*Government is seeing the 'war on drugs' policies are failing and so is willing to rethink its approach*". Another from Nepal suggested political receptivity to harm reduction was simply motivated by "*Government greed for money from donors".* Several other respondents from four other countries (Afghanistan, Philippines, Romania and Ukraine) also noted the importance of available international funding for the formulation and implementation of harm reduction. Two respondents from the USA spoke positively of current legal reforms around cannabis had assisted more generally in harm reduction policy formulation but, in this survey, these were the only respondents who mentioned this.

7.1.4 Question 4: Factors That Helped Implementation

Similar factors that helped policy formulation were also identified as having facilitated policy implementation and the greatest emphasis again was on advocacy efforts of CSO and the engagement of PWUD in those processes. Thus, raising awareness and educating the public, community leaders and policy makers was important and, as a survey respondent from Romania put it, "*The genuine passion of people who were designing and implementing harm reduction policies and services – the human factor*". The cultivation of partnerships and collaborations to facilitate the process appeared to be critical regardless of whether that was in highly-developed countries such as Sweden and USA or low-income developing countries such as Afghanistan and Kyrgyzstan. Respondents from several countries mentioned the importance of taking a long-term view and one Australian described a common sentiment that harm reduction policy implementation required "*Harm reduction warriors who never give up*". Malaysian respondents also emphasised the importance of engaging religious leaders in implementation.

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[30] Royal Australasian College of Physicians, Australian Medical Association, Australian Drug Law Reform Foundation. Unable to determine full title for the abbreviation CLAM in the respondent's answer.

The main differences to emerge in the analysis between the formulation and implementation of harm reduction policy were that closely following CSO and PWUD activity, respondents considered political issues and government administrative factors to be of major importance in implementation. The importance of political will and leadership to drive harm reduction policy implementation was mentioned by respondents from several countries. The importance of having advocates within government was also considered extremely important. For example, Australian and Kyrgyzstani respondents mentioned the huge difference having a supportive Minister of Health made in facilitating harm reduction policy implementation in their respective countries. Respondents in Thailand also quoted the important role of public servants within the Ministry of Public Health and their National AIDS Commission. The importance of a supportive and coherent government administration was also noted by many. This was described in several ways, such as: coherent planning; enabling regulatory frameworks; transparent funding; and, reliable budgeting processes which enabled the development of a coherent effective drug services sector. For example, respondents from Sweden and Romania mentioned that national guidelines and regulatory frameworks had helped in implementation of harm reduction strategies, and respondents working in Nepal stated that national budget allocations through public health systems were important for public accountability and ownership.

The role of evidence was given much less emphasis by respondents in the policy implementation phase than for policy formulation but it was still considered important. The two main areas where evidence was considered particularly important during implementation were: firstly, in monitoring and evaluating the effectiveness of the implementation of services; and secondly, measuring the impact of harm reduction strategies on HIV incidence and prevalence. In comments about monitoring and evaluation, respondents from developed countries, such as Australia and Sweden, emphasised the role of national institutions, while respondents from developing countries and those experiencing conflict (such as Ukraine) discussed monitoring and evaluation in terms of provision by external or international institutions. A few respondents discussed the importance of contextualising drug use as a health, rather than criminal, issue during implementation. Moreover, an Indonesian respondent suggested this could be assisted with well-developed monitoring and evaluation systems using indicators focussed on health outcomes, such as "*The number of people saved as opposed to the number of drugs seized*". Australian, Romanian and US respondents mentioned the importance of having agreements with law enforcement which supported the implementation of harm

reduction strategies or regulations. Several respondents from the Philippines, Thailand and Ukraine mentioned the importance of funding to successful implementation. In these cases, they mentioned how external or international funding had been important both for implementation and the monitoring and evaluation of implementation.

There were only two examples in the survey which portrayed the media as a positive influence on drug policy reform in general, or harm reduction policy implementation specifically. One example was from a respondent from Kenya who stated that "*Media that characterise drug users as people not "The Other" leading to the increasing acceptance that drug use is a medical issue, not a moral or legal problem*" had assisted in implementation. The other comment was from a respondent from the USA, who said "*The media is open to the message*". Considering the context of other comments this respondent made, this comment may have related to the changes which were occurring in some states of the USA at the time in which marijuana laws and the subsequence debates and stories in the US media about drug laws more generally were open for public discussion.

7.1.5 Other Comments

Finally, the survey provided an opportunity for respondents to offer other comments and most respondents provided these. Many reiterated or amplified comments respondents had made under the previous questions and so already have been included in those relevant sections of the analysis. Others related to respondents' statements about the need for drug policy reforms including health-focused drug policies and policies that enabled efficient effective coverage of evidence-based services for PWUD, including the most marginalised and those in rural remote areas. Many also discussed perceived need for decriminalisation of minor offences, such as possession for personal use. Their comments about drug policy reform were frequently expressed with passion and urgency. There were many comments about the perceived ineffectiveness and unintended negative consequences of prohibitionist and abstinence-based policies and related to this were quite a number of concerns written about CCDU which they described as being ineffective and inhumane when compared with community-based treatment and care options. These remarks were generally, but not exclusively, provided by respondents from South-east Asian countries. Another common theme from a wide range of the respondents within this "Other Comments" section was concerns about treatment and prevention for HBV and HCV, including education, testing, vaccination and treatment delivered in such a way as to provide broad and effective coverage. Some

respondents, especially those in countries dependent on international funding, stated that there was a "*funding crisis*" and a sense that donors might be "*walking away*" from drug use prevention and treatment policies and programs. Some respondents working in countries where services were available also expressed concern that there was an urgent need to scale up and achieve adequate coverage to prevent drug-related harms on a population basis.

7.1.6   Summary

Survey respondents from 19 countries identified that major factors hindering the formulation of harm reduction policies were the lack of political will and commitment to change political positions on drugs, and a failure to acknowledge the unintended consequences of current policies. This appeared to be connected to politicians' apprehension about voter responses should they attempt to reform drug policies. Also, linked to this was politicians' sensitivity to public attitudes including: social stigma and discrimination; conservative religious beliefs; cultural barriers; and, "*moral panic*" in relation to PWUD. It was suggested that this political populism was in turn fuelled by public belief that politicians could and should provide rapid and simple solutions to these drug problems. In addition, respondents from several countries described that fragmentation, poor communication or inconsistencies between the approaches of different government departments made community participation in policy debate difficult and, at times, even gaining a clear understanding of government positions on specific issues had been problematic. Respondents commented that was exacerbated when governments did not adequately consult and engage PWUD and communities in policy consultation processes. Insufficient evidence was only mentioned by respondents from three low-income countries with very limited capacity and no survey respondents said evidence to inform policy formulation had to be locally generated.

Factors that survey respondents identified as hindering the implementation of harm reduction were very similar to those which hindered policy formulation, but the emphasis was greater on operational factors, that were, for example, factors which directly hampered the operation of service provision. For example, issues of governance were more important during implementation and so unresponsive or ineffective government bureaucracy, inter-department jurisdictional gaps or conflict, and corruption were issues which received more attention. Funding also became more important during policy implementation, and the three areas where this was said to be most significant were: national government funding that was insufficient to achieve adequate coverage with

effective programs; reliability and sustainability of government budgets that were not adequate to ensure continuity of procurement and supply management or service provision; and for low-income countries with sparse national budgets, the need for international donor funding. The other area of implementation which received a great deal of attention was on issues associated with law enforcement, including: harsh laws and harsh implementation of those laws; inconsistent understanding or application of laws; and, perceived police harassment of service providers and service consumers.

Conversely, most of the factors identified as helping drug policy formulation and implementation were the reverse of those which hindered. For example, the active participation of CSO and engagement of people who had been affected by drug use in educating their communities and politicians about evidence-based responses, was considered extremely important in drug policy formulation. Related to this issue, developing non-adversarial formal and informal partnerships between CSO, local communities, health service providers and politicians or other policymakers was emphasised and working with law enforcement in cooperative ways was also described as very helpful. The importance of political will and political leadership to drive health-based drug policy, including harm reduction, was repeatedly emphasised and some respondents mentioned how helpful it had been to have had advocates within government. Respondents from many countries also mentioned the crucial role played by community policy champions, described variously as passionate, patient and persistent. Adequate, reliable and sustainable funding was also noted as critical and it was further stated that such funding should be managed through transparent and reliable budgeting processes, which enabled the development of a coherent effective drug services sector, and were part of articulated government planning and enabling regulatory frameworks. The role of evidence in facilitating drug policy implementation was highlighted but this was in relation to the monitoring and evaluation of services implementation and their impact e.g. impact of harm reduction strategies on HIV incidence and prevalence among PWUD.

The majority of the key factors influencing drug policy formulation and implementation which were revealed though the analysis of the survey appeared to be broadly consistent across most responses although there were some differences. For example, the need for international donor finance and technical assistance expressed with a sense of urgency by respondents in low-income developing countries but did not emerge in responses from middle-or high-income countries. The identified factors were also broadly consistent with many of the issues which emerged through the analysis of the interview data

focussed exclusively on the Thai drug policy environment. There was also some variance between the Thai respondents and the other responses.

While challenges of government bureaucracy were also highlighted as a significant obstacle in Thailand, this was not described as being a result of indifferent, corrupt or ineffective government departments but appeared to be much more related to mismatches in jurisdictional responsibilities or objectives. Further, Thai CSO also expressed concern about insufficient participation in policy process but described that this was not simply due to the government being insufficiently receptive to input. They described that a substantial issue was also the result of insufficient coordination, cooperation and alignment among CSO or CBO. This suggested that there may have been issues at play other than just country income rating. These and other matters will be explored further in the following sections which will provide a more detailed examination of the similarities and differences which emerged between the data in the survey and interview methodologies.

7.2   Analysis and Interpretation of Interview Data

7.2.1 Introduction to Interview Data Analysis

The sampling and interviewing processes were described in detail in Chapter Two. Twenty-four interviews were completed with 23 individuals[31] .Ten of the 23 individuals (just under half) were Thai nationals and the non-Thais were made up of three Australian, one British, one Canadian, one French, three Indian, one Japanese and three US citizens working in Thailand at the time of the interviews.

Those interviewed worked for one of the following types of organisations: Thai Government; Thai Non-Government Organisation; Thai Academia and/or Research; International Non-Government Organisation; Regional Non-Government Organisation, Foreign Academic, International Financial Organisation, United Nations Agency or Foreign Government. Most had worked in a number of different capacities during their career and had thus crossed between non-government and government sectors, or between national and regional or international organisations. In fact, only four experts had never transferred between sectors or between national and international areas of work - two people who had been working long-term in the Thai non-government sector

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[31] One interview took longer than anticipated and, at the request of the interviewee, was conducted in two separate parts, morning and afternoon.

and two who had been working long-term in the Thai Government sector. See Appendix 11 for full details. This resulted in rich information and often enabled experts to discuss complexities of issues in detail and they frequently demonstrated the ability to consider issues from more than one perspective.

7.2.2   Identifying Information on Interview Participants

There was a relatively limited field of potential interviewees, making it important to ensure that confidentiality or anonymity were not inadvertently breached. To ensure the confidentiality and anonymity of the drug policy experts who volunteered as interviewees, caution had to be taken to avoid identifying the speakers, including not using unique identifiers (such as numbers) which would allow readers to identify and piece together multiple separate statements of an individual and, by that means, potentially identify the speaker. On the other hand, being able to make some distinctions about the respondents, for example whether the speaker was a Thai national or worked in an international agency, added to the descriptive power of the analysis and improved understanding. Therefore, some very broad approaches to differentiate speakers, or to provide context have been used. For example, statements have been labelled as made by an international, regional or Thai respondent. Also, at times, the speakers' work backgrounds have been described, such as government or non-government. The latter have generally been applied where more than one speaker is being described or where the expert's background is already evident from the content of comment. Experts identified as regional were not Thai but were from the Asian or South-east Asian regions, and active in one or more aspects of Thai drug policy. Experts identified as international were active in one or more aspects of Thai drug policy and not Thai nor Asian by nationality (e.g. Australian, European, US, etc.) and may have been based abroad, posted to Thailand (commonly for three to four years), or may have been a long-term resident in Thailand, in some cases for 10 to 20 years. Experts identified as Thai were Thai nationals who were expert, or had experience in national drug policy, and may have worked in either government or non-government sectors, or sometimes both at separate times. In addition, to assist the reader in distinguishing interview transcript material from all other quoted sources (i.e. quotations from the reviewed literature and the survey responses) these have been formatted distinctively in quotation marks, indented, italicised and in a slightly different font from the main text or other quotes.

A further minor issue for clarification in the analysis was that experts not working in government organisations identified themselves variously as being with 'civil society

organisations', 'non-government organisations' and 'community-based organisations'. While by definition a civil society organisation is a community-based non-government organisation, not all NGO necessarily identified as CSO or CBO. For ease of analysis the researcher has simply used the nomenclature of the experts' own statements/self-descriptions.

7.2.3 Analytical Models Used

PEA was the primary model for analysis of the data, but at times this was supplemented with other models (e.g. Kingdon's multiple streams approach) to add greater explanatory power. In addition, other social science theories were used to support the examination of specific thematic areas, for example, the use of theory of cultural dimensions and face-work theory to probe emergent cultural themes, or social construction theory to scrutinise the role of political and public opinion in the development of stigma and discrimination.

The key factors which were identified during the thematic analysis varied by which query they related to (facilitated drug policy formulation, facilitated drug policy implementation, hindered drug policy formulation, and hindered drug policy implementation) and, in the opinion of some experts, they might relate to more than one depending on the situation. To further assist with clarification, a visual representation has been provided in Table 17. Some factors were identified as affecting only one quadrant. For example, 'Politics' was only identified by expert interviewees as a factor that hindered the formulation of drug policy. Some factors were considered to have impact in two quadrants. For example, CSO were identified as both facilitating the formulation of drug policy reforms and facilitating implementation of drug policy reforms. On the other hand, 'International Funding' was considered an important assisting factor in implementation, whereas its absence created an obstacle to implementation. Some factors were identified as being active in three quadrants, depending on the circumstances, and the role they played. One thematic area (or influencing factor) the ONCB, was considered variously by experts as important in all four quadrants depending on the role it played, that is, it could hinder or facilitate the formulation or implementation of drug policy reforms. This complexity will be dissected and explained in the following discussion of the analysis and findings. Also, in the discussion that follows, each section will comprise a distinct theme along with related subthemes (parent and child nodes). In some cases, distinct themes which emerged through coding were intrinsically related to another and were thus considered together in the discussion, for example, 'Public Opinion of PWUD' and the 'Role of the

Thai Media' were so interconnected that it seemed appropriate to treat them in the same discussion section.

To assist the reader in following these data, the next table has consolidated some items (e.g. some Parent and Child Nodes have been integrated and duplicate items removed). The following table provides a schematic representation of the major themes from the analysis of the expert interviews and how the factors they described interacted with either drug policy formulation or implementation.

Table 17: Major Thematic Factors from Interview Analysis their interaction with Drug Policy Formulation and Implementation

Theme	Hindered Formulation	Hindered Implementation	Facilitated Formulation	Facilitated Implementation
National – ONCB	red	red	green	green
National - Royal Thai Police	red	red		green
National - Gov't Admin & Politics	red	red		green
National - Law & Law Reform	red	red		
National - Ministry Health	red	red		
National - Culture & Social Values	red	red		
National - Messages & Education	red	red		
National - Ministry Justice	red			
National – Military	red			
National - Public Opinion	red			
National - Thai Media	red			
National – Treatment (CCDU)	red			
National – Harm Reduction/NSP		red		
National – Monarchy			green	green
National - CSO/NGO			green	green
National - Research & Evidence			green	
National - Human Rights			green	
International – USA	red	grey	grey	grey
International – UN: INCB/CND	red	grey	grey	grey
International – Funding/Resources	grey	red	grey	green
International – Donors/Global Fund	grey	red	green	green
International – UN: UNODC	grey	grey	green	green
International - CSO/NGO	grey	grey	green	grey
International – ASEAN	grey	grey	green	grey

Colour coding was used to provide a visual contrast to assist the reader in more rapidly and easily identifying and interpreting this information. Factors that hindered and factors that facilitated were coded red and green respectively, and the prefixes 'National' and 'International' added along with the grey shading to easily differentiate between these types of factors. Note also that, for ease of reference in this table the themes 'Legislation' and 'Drug law reform' have been integrated as "Law and Law reform" in this table only.

7.3. Thematic Analysis - The National Policy Environment

The national policy environment not only comprised the formal and informal institutional structures, such as the organisations, political and economic policies, legislative and regulatory frameworks, physical infrastructure and so forth, it also included the historical, social, religious and cultural context. The following discussion described the findings from analysis on the political and economic and ideological positions or roles of the key institutions involved in Thailand's drug policy. All the same, before that a description will

be provided on some of the less tangible influencing factors which emerged from the data, in particular the cultural and social dimensions which are integral to an in-depth and comprehensive understanding of the structural aspects of the political economy. Closely following the social-cultural discussion will be a related examination of the data on public opinion, stigma and related topics.

7.3.1   Thai Culture and Society

The theme which accounted for the greatest number of comments by the greatest number of experts was 'Thai Culture and Society'. Under this theme, experts discussed a variety of issues, both those that hindered and those that assisted the formulation and implementation of drug policy, including issues about: Thai public attitudes; culture; stigma; discrimination; religion; and, hierarchy. Comments also included cultural attitudes towards issues perceived to be linked to drug use e.g. gender, sexuality, and commercial sex as impediments to pragmatic drug policy. Considerations of culture linked very closely with the other categories, for example, tying in directly with discussions of Thai public attitudes, particularly in relation to morality, the idea of sin, emphasis of self-discipline and responsibility to the family.

One respondent, for example, discussed how politics and cultural influences both interact to create harsh prohibitionist drug policy in Thailand:

> *"I think this is both political and cultural. It is political because in Thailand when you take a really harsh prohibitionist approach to drug problems then you get public support. So, in political campaigns Thai politicians always say they will take a hard-line approach to drug problems and so they get support from the public. But it may also have a cultural aspect to it too, for example, having really strong self-discipline is highly valued in the Thai culture. "You should be able to just stop drugs using your strong will." (Regional expert)*

Stigma and discrimination were most frequently cited by experts as being outcomes of Thai cultural and social values and as obstacles to evidence-based and effective drug policy formulation and implementation, as well as issues that profoundly affected quality of life for PWUD. Survey respondents and expert interviewees also often explained stigma and discrimination as resulting from poor understanding of drugs, drug use, and drug users (as has been previously noted). One interview discussed the contrast between Thai attitudes towards FSW in contrast to PWUD and the differences in policy responses towards these groups. They then linked these ideas with the centrality of the family in Thai culture and society:

*"But if we don't confront that really underlying factor, the stigma, it will be difficult. The attitude is "*Okay, the female sex workers are doing this for their family but those drug users are really just sinners and they don't deserve to be treated well*." The kind of attitude is everywhere here and if we don't deal with that perception then it is very difficult to change anything for people who use drugs. The family dimension is very important in Thai culture" (International expert)*

Interviewed experts also often mentioned stigma and discrimination in the context of other themes, for example: stigmatising public attitudes; the role of the media in stigmatisation of PWUD; discrimination against services for PWUD by law enforcement; or, the exacerbation of stigma and discrimination caused by incarceration in CCDU. Therefore, stigma and discrimination will be discussed further under the relevant themes.

7.3.1.1 Culture and Human rights

Several references by experts involved discussion of the perceived conflict between the concept of individual human rights versus a cultural preference for unity, conformity and interdependence. This silence of dissenting or minority views is likely to be even more important in a culture, such as Thailand, described in Chapter Six as highly collectivist, and wherein maintenance of harmony within the group, and preservation of relationships is valued far greater than procedural outcomes. Silence of dissent is also likely to feature more in cultures, such as Thailand, which were characterised as very hierarchical societies with highly structured stratified social roles.

In addition, it has been suggested that a cultural preference for unity, conformity and interdependence seemed to outweigh concerns of individual human rights. Many experts appeared to perceive that Thai public or political opinion often expressed the idea that individual human rights were not compatible with Thai cultural emphasis of the priority of duty to family and society. Most of expert interviewees and many of the survey respondents expressed concern that human rights of PWUD should be respected in order to achieve effective and sustainable drug policy outcomes and many felt this had not been the case to date. Furthermore, many references involved discussion of the perceived conflict between the concept of individual human rights versus a cultural preference for unity, conformity and interdependence. This silence of dissenting or minority views is likely to be even more important in a collectivist culture, such as Thailand, wherein the maintenance of harmony within the group and preservation of relationships is valued far greater than procedural outcomes and where social roles were

structured stratified. One of the experts interviewed responded directly to this issue of human rights being framed as a Western invention:

> *"It seems to me that the old argument that Asian values and culture are incompatible with Western human rights principles is rearing its head again, particularly in relation to compulsory treatment verses community-based treatment and harm reduction approaches. Human rights based arguments are not gaining much traction with those that are clinging to the Asian values argument. I think this is so politically manipulated. That is fallacious and needs to be challenged. It is a pretence that human rights discourse is alien to Asia, when in fact it is not." (International expert)*

The topic of human rights also occurred throughout other themes, such as the Thai 'War on drugs' campaign, the importance of using health-based approaches, in relation to concerns about CCDU and so on. Therefore, human rights will be covered as it arose in those themes.

7.3.1.2 Face

The term 'face' originated in China centuries ago but today it is an internationally understood and widely known concept that can be seen to influence interpersonal relations. It is primarily related to the establishment and maintenance of harmonious relations between the interlocutors. According to an extensive body of research, '*face*' can be lost, saved, given and gained (Gudykunst & Ting-Toomey, 1988; Oetzel, Ting-Toomey, Yokochi, Masumoto, & Takai, 2000). Moreover, face is not just a Chinese or Asian concern. Oetzel's (2008) study of 768 participants from four cultures (China, Japan, Germany, and the USA) found that:

> *Overall, the patterns of associations for other-face are consistent across the four cultures. These findings primarily indicate that the manner in which we demonstrate concern for other are similar and demonstrate the validity of making cross-cultural comparisons and assuming that explanations are relevant across the cultures (i.e. an ethic perspective). One important stipulation must be made. Even if patterns of association are similar, the magnitude of the associations differs by national culture.* (Oetzel et al., 2008, p. 379)

The issue of 'face' was raised as another important factor that can mediate influence on Thailand's domestic drug policy. The concept of 'face' recurs throughout the analysis of the interview data and this, for example, was also associated with the issue of Thailand's regional and international roles and aspirations.

 "Thailand, more than any other country in Asia, would want to do things that make it look like a good international citizen." (International expert)

"I hope ASEAN might help to push for good drugs policies in Thailand because Thailand is very concerned with their image in the region and how they compare been thing side policy responses to other ASEAN countries. So maybe ASEAN will help to pressure the government of Thailand to change some policies." (Thai expert)

The cultural imperative to 'save face' was also seen as an obstacle to frank and open debate and change in policy positions but it could also be leveraged in some circumstances, for example in the need to appear a good global citizen and trading partner.

> *"While working there I had interactions with the United Nations agencies, the Royal Thai government and law enforcement agencies and what we kept seeing was that well-meaning people, such as Michel Sidibé and the U.S. ambassador, every time they came to Thailand and they met and spoke with the Thai government the next day there would be a police crackdown and an increase in arrests of people who use drugs along with newspaper articles saying this is how we are responding to drugs in Thailand. I'm not sure exactly what the connection is but I think it might be about saving face."*

The magnitude of face concerns within Thai culture was considerable. The protection and maintenance of face was widely recognised as crucial within the Thai culture and constantly attending to the face of others an essential process in maintaining relationships and harmony within the Thai social collective. "*Thailand is best described as a collectivist society, it was important that one should not criticise collectivists in public making them lose face*" (Corbitt, Peszynski, & Thanasankit, 2003, p. 1022). Face, therefore, should be considered an important cultural and negotiating consideration in policy processes in Thailand. Several experts mentioned the importance of face, for example, in respect to Thailand's international and regional relations, as well as interactions with various government departments and officials. Therefore, it may be that this could be a factor in why approaches using public shaming of government agencies about a lack of drug policy reform did not result in long-term gains. It certainly cautions against such an approach. A further example of the importance of maintaining face in policy advocacy is provided in the thematic analysis subsection about the ONCB.

7.3.1.3 Religion

The role of religion was closely related to culture, the social construction of individual or groups within society and the consequent attitudes and responses to those people. In

the interviews however, few people spoke about religion. to culture One international expert stated that Thai public attitudes to drug use and PWUD were heavily influenced by religious attitudes of morality, sin, karma and a fatalism resulting in a minimalist or non-interventionist approach to changing the social conditions of drug use. An example they gave to explained this perspective was:

> *"Buddhism is interpreted by many in Thailand with a fatalism, that is, they believe a person's present situation is a result of their karma from a previous life and therefore it's deserved and there is a sense of non-intervention in another's karma, that is, 'Who are we to intervene?'"*
> *(International expert)*

There were some comments about morality and one international expert mentioned that they believed that religion played a part in the public and political attitudes to drug use and PWUD. Thai cultural researcher Pimpa (2012a) also described the importance to Thai people of the Buddhist concept of karma in the maintenance of social hierarchy and the character of relationships between different strata within Thai society. She stated that Thai people believed karma determined:

> *…their position in family, workplace and society. They are destined to be in the position to accept those who were born in the rich and powerful family. That is destiny and they simply cannot change it. Their position (Ti) is fixed by their familial and social status. The boss represents people at the top of organization or social hierarchy. This is their position and you tend to accept them because of their position, not what they did for the organization.* (Pimpa, 2012, p. 37)

Although many of the Thais interviewed discussed Thai culture and social values, none of the Thai experts mentioned Buddhism in these discussions. Conversely, according to census data 93.6% of Thais were Buddhist (Central Intelligence Agency, 2016) and Buddhism generally played an integral role in the lives and conversations of Thai people. Furthermore, in the survey response data the significance of the role of religion and religious leaders was noted by respondents. Most frequently this was in the context of moralising and stigmatising public responses to PWUD, but in some responses (notably from those working in Malaysia) this was also in relation to support provided for community service implementation by religious leaders.

There may be a variety of potential reasons for the complete absence of comment on religion as an influence in Thailand. One possible reason is that Thai experts might have simply thought that it was not relevant to the topic. Yet this seems unlikely since, as previously mentioned, Buddhism and its philosophical tenets were commonly integral to

most conversations with Thai people, especially those about social issues. Furthermore, in the researcher's 'lived experience' of 10 years in residence in Thailand, Buddhism, and concepts like reincarnation and บุญ (*boon*) and กรรม (*gam*), good and bad karma respectively, have been a part of everyday conversations with Thai people and were often used in political rhetoric too. Another plausible explanation may simply be the widely-recognised phenomena that sometimes an outside observer can more readily identify and analyse a culture milieu than a person immersed it and enculturated from birth. Avruch, a researcher who specialised in cultural conflict resolution, stated "*Any one of the major assumptions of realist thinking can render culture invisible*" (Avruch, 1998, p. 28) and puts it even more simply when he stated, that for most of us "*...culture is invisible because it is simply the way the world is*" (Avruch, 1998, p. 59).

One other possibility is that some experts were reluctant to speak up on this issue due to concerns that unpopular and minority opinions might leave them socially vulnerable to criticism, and this issue will be considered in more detail later in the discussion section. Noelle-Neumann's spiral of silence theory (1984, 1991) asserted that individuals will refrain from expressing opinions perceived to be in the minority due to the fear that they will be socially isolated. Noelle-Neumann used the term 'spiral' to describe how people experience a continually increasing pressure to conceal their views when they think they were in the minority. Noelle-Neumann's theory concerns itself primarily with what she called "*opinion climates*" (Moy, Domke, & Stamm, 2001, p. 8) in society at large. Later researchers confirmed this, and further noted that perceived consonance with one's with family and friends (what they termed microclimates or reference groups) was an even greater predictor of the expression of opinion than consonance with society at large. "*Pressure to conform therefore seems more likely to exist within the 'microclimates' of reference groups*" (Moy et al., 2001, p. 9). A cross-cultural study measuring levels of expression inhibition across three different cultures (American, Israeli Jews and Arabs) produced similar findings for all groups, suggesting that this phenomenon was generalizable across cultures. This cross-cultural study also found "*… in all three cultures, issues of sociability and the fear of offending or harming others proved more important in inhibiting conversation than fear of disapproval, marginalization, punishment, surveillance-or of being in a minority*" (Wyatt, Kim, & Katz, 2000, p. 101).

7.3.2   *Public Opinions on People Who Use Drugs and the Role of the Thai Media*

The two themes "Public Opinions of PWUD" and the "Role of the Thai Media" emerged distinctly in the analysis, but a closer examination of the overlap in the content of the

commentaries showed they were intimately linked and, therefore, will be treated together in this section. Furthermore, although during the coding process these themes emerged separately from Thai Culture and Society, they were so closely related that it was appropriate for description of these comments to follow on immediately from the previous topic. Generally, the interviewed experts did not appear to consider that the media were particularly influential on the Thai drug policy debates, despite several describing negative news stories about PWUD in Thailand. For example,

> *"I think that the voice of Thai media is not recognised by the government officials."*
> *(International expert)*

This was also similar in the analysis of the survey data, which indicated that the influence of the media in influencing public opinion and politicians on drug policy only appeared to be a significant concern for respondents from developed countries (e.g. Australia and the USA), and not so evident from countries in Asia, or lower income countries elsewhere. The reasons for this were not obvious from the available data, especially given the extensive body of evidence and academic argument that media reporting does influence both public opinion and public policies, for example, the findings of media researchers such as Benjamin Page (1996, p. 23):

> *The days of belief in "minimal effects" by the media are over. A large body of evidence now indicates that what appears in print or on the air has a substantial impact upon how citizens think and what they think about. … Further, what the media say often has direct effects upon what policymakers do.*

It is possible that interviewed experts underestimated the influence of the media.

It is also possible that this perception may have been due to larger issues associated with the amount of autonomy and impact a free press might have had on individuals or parties within a relatively open democratic system versus a greater sense of impunity a more authoritarian government might have when a press faced greater censorship and censure. Certainly, since the 2014 coup, the Royal Thai Military Government had issued warnings that they would not tolerate criticism of the government or their policies, had censored print and electronic media, and reprimanded and incarcerated journalists (Rueters, 2016; Ruvic, 2016; Sami, 2015). In their 2015 Annual Country Assessment for Thailand of press freedom, the independent international institute Freedom House rated Thailand as 'Not Free', which was lower than its rating of 'Partly Free' during the 10 years prior to the coup (Freedom House, 2015). Further investigation of the issue would be required to confirm the plausibility of this proposition and determine the strength of the relationship.

"I think the media in Thailand has been passive and submissive; the Bangkok Post for instance, is read by people like you and me [expatriates] and is at the fringe. If you look at the domestic media in Thailand for years, all you would ever have seen on the pages of these newspapers have been pictures of the consequences of drug use, including shootings and other "horror" images. I think they have been manipulated to give a partisan line, I don't think they are an independent press." (International expert)

Conversely, most experts interviewed seemed to think that what limited influence the media did have on public opinion was negative, reinforcing portrayals of PWUD as socially undesirable and a danger to society, promoting tough law enforcement responses and not necessarily supporting health responses:

"…the Thai Media is influential to a certain extent; I don't know exactly how influential the media has been, but what they do report is overly promoting a harsh prohibitionist approach rather than promoting other approaches like harm reduction." (International expert)

Many of the experts spoke both Thai and English and talked about the differences they saw between the Thai language and the English language news coverage:

"The Thai language newspapers only focus on stories about drug supply reduction or about the drug treatment centres. The international media in Thailand, the Nation and the Bangkok Post for example, do more reporting around policy change." (International expert)

Research (B. Page & Shapiro, 1983) has found that the relationship between policy and public opinion was generally congruent, that is, policy generally reflected the same concerns in the same way as public opinion and when they did not then the two would generally align over time (greater than one year). In addition, they found that the course of influence between policy and public opinion was bi-directional, each could influence the other. In the case of the US, the research found that policy followed public opinion in more than 50% of cases. It is likely that, if the percentage points were represented as a scale, then the balance between direction of influence for each country would fall on a different point on that scale. Furthermore, if policy tended to influence public opinion more often than *vice versa* in a specific country then that could explain a perception that the media was not so influential on a policy issue. So, it is possible that in Thailand, either public opinion more often followed policy than *vice versa*, or drug policy was one of the minority of policies in which policy tended to follow public opinion.

Another theme in the discussions about media was experts' thoughts about how people might work better with the media to achieve advocacy outcomes and a more balanced reporting:

"We need new methods to talk with the media people when there has been some incident with a drug user, they do something that, the press only think about the problem was that guy. They don't think about the broader issues of drug use and all of the other drug users. We need to have more discussions with the media people so they are aware of all of the issues when they write the news about people who use drugs." (Thai expert)

More often, the experts' discussions on messaging about drugs and drug users was about information communicated via other means, such as through government communications strategies and through schools. As previously described, Social Constructionists (Schneider & Ingram, 1993) advanced arguments that social constructions can be identified based on the two dimensions of political power and social construction. That is, a specific group may have weak or strong political power and a positive or negative social construction. In this schema, PWUD would be categorised as 'Deviants' with negative social constructions and weak political power and, therefore, subject to policies designed to change behaviour through coercion, punishment, incarceration or, at their most severe, through execution:

The government messaging was always around "We will take you back but you have got stop using drugs.", "What's wrong with you!", "You are morally weak.", "You are a blight on society." There was no medical understanding of addiction; it was all from a social perspective of needing to be a part of the group and to not detract from society or family. You must be a functioning member of your family and your society. The internalised stigma was enormous for people who use drugs and people who inject drugs in Thailand. People who inject drugs, even those within the harm reduction movement had a terrible image of themselves. That is why the human rights approach was so important to restore the dignity of these people. The government had so undermined the value of these people. It was unintentional but that was the impact of these media and messaging campaigns." (International expert and fluent Thai speaker)

Stigma and discrimination were most frequently cited as obstacles to evidence-based and effective drug policy formulation and implementation, as well as issues that profoundly affected the quality of life for PWUD. Experts described how discrimination against PWUD could be subtle yet have profound consequences:

"…many health workers think that 'These are drug users and they may not be good [patients]*, I will not put them on ARV* [antiretroviral treatment]*. If you ask me I would put them on ARV. If they are IDU and they are infected I will put them on ARV and try to talk to them about having good adherence to treatment and so on. So, this is another contributing factor. A lot of health workers think that drug users have to stop using drugs before they can put them on HIV treatment. But this is impossible, they might stop for a while but then start using again." (Thai expert)*

Experts also often explained stigma and discrimination as resulting from poor understanding by politicians and the public about drugs, drug use, and drug users. As previously noted, many of the experts' observations about public attitudes in general seem to centre around concerns about low levels of understanding about types of drug use, and dichotomous thinking, i.e. all drug users were a threat to society, all drug use results in addiction, all drug users only respond effectively to punitive measures, and so on. As a result, they reasoned, Thai politicians and the voting public were likely to favour 'tough on drugs' law enforcement policies. Many experts discussed shortcomings of the Thai public and politicians' awareness of drug issues and stressed the need to improve messages and education about drug use and people affected by drug use. Some interviewed experts emphasised the need for engagement of PWUD and CSO in the process of raising awareness and increasing public understanding of these issues to better inform community participation in drug policy debate and to reduce stigma.

"I think if we want policy change we need to...find ways to explain and make the public understand about the life of a drug user. They must show PWUD are people too and they are people with problems and sometimes when people can't find solutions to their problems they will use drugs these problems might be caused by their social circumstances and that when people used drugs. It's not only a problem for the drug user but for the community as well. For example, if you have a history as a drug user and then you go to apply for a job at a factory or anywhere there are policies that you will not be employed if you have used drugs before and that creates more problems. Drug users and the Drug User Networks need to help the public to understand about these problems." (Thai expert)

"I think now we try to work at the community level to help them to understand about drug users. We have done this under the Global Fund as much as we can but this is only small scale. We need the public to understand about drug users more. So, the Thai Government needs to pay attention to this….we still have stigma and discrimination about HIV and drug users in Thailand. If the government can't look after these people, then they should provide some budget for organisations that can do that. At the moment, we have little funding for the public media campaigns because it is costly to make these. If the government can't do this, then they should have some budget for the professionals who can change public attitudes and we need to do this continuously not just 'flash mob'." (Thai expert)

In response to questions about whether there had been health information campaigns that raised awareness around drug use, such as information about HIV transmission, one expert explained:

"Yes and no. Well, you can see the posters that say, 'You should not use drugs', or that 'Drug use or injecting drug use is illegal', and so on and so forth. But if you ask, 'Do you see the campaign or poster on condom use [for IDU]?' the answer is 'No'. As compared to alcohol use, you can see a big campaign on alcohol use, but not on condom use. Not on drug use. You know, you can see 'This village is drug free' or 'This town is drug free', 'This school is drug free', 'Drug use is criminal'. That is all the awareness campaign there is on drug use. But whether or not it will scare off people from drug use or reduce the number of new HIV infections or hepatitis infections, I don't know. I think in terms of preventing HIV from drug use or from sex I think it is the same. There is no campaign any more now days. It is not a priority." (Thai expert)

Several experts also talked about the need to educate governments and government departments about drug use and drug users. The education of members of the ONCB and Ministry of Public Health received distinct mention as they were considered the leaders in drug policy formulation and implementation. One expert with a health background explained how the military were not trained or qualified to run drug treatment centres and so relied on doctors from district hospitals or provincial hospitals (when available) to provide them with knowledge about drug issues and then commented:

"But these kids know more about drugs than any of these professionals." (Thai expert)

Many expert interviewees and survey respondents suggested that populist so-called 'Tough on Drugs' policies were thought to receive better responses from voting constituents than health-focused policy approaches which required more explanation by politicians and education for the public. Other interviewed experts also described the need to raise awareness within government and to educate the policy makers about drug use and people affected by drug use using evidence-based approaches. This opinion was also expressed in many survey responses. These comments suggested a bi-directional process of drug policy and drug knowledge, that is, a better-informed community resulted in better drug policies and better drug policy responses resulted in a better-informed community. This was consistent with the findings of Page and Shapiro's study (1983) which used data from several hundred national surveys examining 357 instances of significant US policy changes over a 40-year period and found:

There has been a great deal of congruence between changes in policy and changes in opinion… [and that] …congruence appears more frequent when the policymaking process is allowed time to react to change in opinion, and a one-year lag is a reasonable time interval. (B. Page & Shapiro, 1983, p. 177)

They stated that, generally, policy moves in directions congruent with public opinion, even though it may not move as far or change as radically as a change or move in public opinion on a specific issue. For example, as strong reaction in public opinion on an issue, such as a demand for decriminalisation or "moral panic" about increasing methamphetamine use, may result in congruent but only incremental reforms in drug policy. On the other hand, they also stated that such influence could be bi-directional, that is, public opinion could be influenced by politicians and other opinion leaders through education and persuasion or, less benignly when, "*interest groups or politicians' manage to manipulate opinion through lies or deception, and policy subsequently responds*" (B. Page & Shapiro, 1983, p. 189).

This observation, that prosecution of law enforcement approaches was a result of populist political strategies, also appeared in the survey data from several other countries. As mentioned previously, in Schneider and Ingram's social construction schema, PWUD would be categorised as 'Deviants' who have negative social constructions and weak political power Schneider and Ingram (1993) contended that:

> *…public officials commonly inflict punishment on negatively constructed groups who have little or no political power, because they fear no electoral retaliation from the group itself and the general public approves punishment groups that it has constructed negatively.* (p. 336)

Moreover, they stated that negatively constructed politically powerless groups would be the targets of policies based on punishment, especially during election campaigns, even though evidence or previous experience demonstrated such punishment policies may not have achieved effective results. This certainly appeared to be the case for PWUD in Thailand.

Experts discussed concerns that morality-based messages often resulted in creating more stigma and discrimination against drug users and gave a false impression that all drug users were hopeless and dangerous:

> *"At the moment, we have the Thai health promotion that uses the budget from the 'sin tax.' Those organisations need to change public attitudes about the drug users as well. Because, if you understand people who use drugs, you will not simply ask them to stop using the drugs. We have to do more in terms of harm reduction before they can stop using the drug. But if you just say from the beginning "stop using drugs", they cannot stop using by themselves. When you start with 'quit it', i.e. abstinence right from the beginning, this attitude needs to be changed at the beginning and you need to understand the drug user's life more.*

Also, they need to understand this is a chronic disease, and relapsing can happen at any time. So, these kinds of things people need to understand in general first." (Thai expert)

Some experts expressed the view that most people in Thai society who used drugs lived, what they described as "*normal lives*", meeting their occupational and family responsibilities. Several experts expressed concern that government and media messages that portrayed PWUD as dangerous, immoral and/or weak also encouraged the use of harsh law enforcement responses and CCDU which removed PWUD from community:

"… it is easier to write the simple story that 'He was a bad guy and thank God he is no longer on the street.' (International expert)

Conversely two experts mentioned that encouraging information about good treatment outcomes might promote different policy responses:

"…good stories about people getting back to work and supporting their family… This kind of information might convince people that opioid substitution therapy is better and cheaper than a rehabilitation centre." (International expert)

"People can see that these methadone clinics can help reduce the problems associated with drug use for the drug use them for their family and community. And people can see that even though the person might be using one drug (methadone) their situation has improved and it is not necessary to be totally abstinent to reduce drug-related harm, for example they have stopped using multiple drugs or stopped injecting or so on. You must explain this to the public so they understand about reducing drug-related harm." (Thai expert)

While a few were primarily concerned about communicating the harm that could result from drug use, most experts who spoke on this theme were concerned that the information be science-based or evidence-based rather than based on morality. As summarised in the following quote:

"Thailand needs education for young people which is more sophisticated than just saying what drugs are bad, and they need education that will enable young people to make informed choices about their lifestyles." (International expert)

Two experts, both of whom worked in NGO, expressed concern that a lot of government employees at the implementation level (e.g. police, health workers) did not understand or could not operationalise the macro-level drug policy. They said that, because of this lack of understanding on the ground there was little support for services or projects:

"It is almost like you are starting from point zero in every community; developing relationships and trying to create local policies. In some cases, this is successful and some it is not successful." (International expert)

Finally, an interesting discussion emerged in an interview about the role of social media in shaping policy debates, particularly emerging debates around changes to drug laws including decriminalisation. A Thai expert discussed changes in policy influence due to advances in technology and social media:

"I think that changes in the drug laws in the United States would influence drug policy in Thailand, there are some countries that have influence on Thailand and USA is one of them. Obviously, the USA has had a long relationship with Thailand and things have occurred in the United States that appear on social media in seconds." (Thai expert)

The same Thai expert went on to explain further:

"For example, marijuana legislation occurred in Holland 20 years ago, but it never appeared in social media in Thailand at that time, but once Colorado announced marijuana decriminalisation it suddenly appeared in the social media in Thailand. So, people in Thailand are talking about that and one of the influential tools has been social media. You just can't underestimate the power of social media. And then marijuana users have used social media to get together and pressure about "If the U.S. will legalise marijuana then why won't Thailand do that?" We know that with social media that sometimes the information is inaccurate or the quality of the information is not so good but it is very effective in raising the issues and people's concerns." (Thai expert)

Social media, as a rapid and open vehicle for communication, has begun changing the way information is disseminated and debated in Thailand, as in much of the rest of the world, and may have significant impact on drug policy deliberations in the future. These social media have frequently played an important role where censorship or other practical limitations on communication, has restricted information and debate in other media, for example, during the so-called 'Arab Spring'.

7.3.3   Criminal or Health Paradigm

How a problem is framed influences what solutions are identified and then utilised. Central to the conversations about the factors which influenced drug policy formulation and implementation were, whether drug use (and associated problems) were framed as a criminal or health issue. Experts also maintained, directly or indirectly, that it then followed that policy responses would also be framed within the same paradigm, either criminal or health. The need for a health-based policy approach to drug use and drug

users rather than a criminal justice approach was raised repeatedly during the expert interviews by Thai, regional and international experts, and perhaps the most eloquent and succinct description of this idea was:

> *"…a 'paradigm shift' in policy away from a 'War on Drugs' towards a more humane public health and human rights approach to drug policy." (International expert)*

Feminist scholar Carol Bacchi's (2012, p. 4) WPR or "*What's the problem represented to be*?" approach (which she acknowledged drew heavily on the work of Foucault) has argued that not only does the way a problem is defined determine subsequent policy responses, but also it is possible to deconstruct or reverse engineer a policy proposal to understand how it produced the 'problem'. In other words, how policy makers' terms of reference and hidden assumptions characterised the problem. Furthermore, Bacchi's work discussed how contemporary industrialised liberalist and neoliberalist governments emphasised individual responsibility and, consequently, have been predisposed to define individual behaviours as the problem in policy. For example, drug policy framed as criminal responses would therefore focus on individual accountability for deviant behaviour. While there were some differences of opinion among the experts about whether a health-focussed alternative problem construction of drug use was complete or inclusive enough (e.g. some argued that drug use could not be reduced to just a health issue but it was a valid lifestyle choice, which may or may not impact a person's health in any significant way) there appeared to be consensus among experts interviewed that health-based approaches were preferred over the current approach. In the experts' opinions, heath-based drug policy resulted in far less political economic, social or individual harm consequences than criminal justice based drug policy.

A common concern about the then current criminal justice approach was its focus on arrest and imprisonment of drug users rather than effective health interventions. Many experts interviewed and survey respondents seem to correlate human rights-based approaches very closely with health-based approaches to drug use. One expert expressed concern that Thai Government health services were not provided to drug users because they were seen as criminals:

> *"Does the Ministry of Public Health have the voice to speak out about drug issues? I am surprised that doctors who have studied for many years and really understand about the health issues of drug use do not come and talk about drug policy and Thailand. That is a problem. They are not concerned about relating drug policy to health issues. Healthcare providers still think drug issues are only criminal issues. They never see the place of health in responding to drugs. They say "No, this is not my responsibility because drug use is a*

crime.*" People who use drugs are high health risk for HIV, hepatitis B and hepatitis C and I am surprised that they are not concerned about the human rights of the situation." (Thai expert)*

Experts also reported what they thought may have been confusion or reluctance among government ministries or departments over who ought to lead such health-based approaches:

"When we talk with ONCB they always say harm reduction is good but in practice when we try to implement harm reduction in the field we do not get their support. If ONCB was more open to support harm reduction in practice that would be good and also if we could get the Ministry of Health to take the lead, with the Ministry of Health in front of the non-government organisations instead of the non-government organisations in front of the Ministry of Health." (Thai expert)

Many experts mentioned that even though the Thai Government had made a "…pledge to treat drug users "as patients, not criminals" (Werb et al., 2009, p. 1) in official documents (Royal Government of Thailand, 2002) and government messages, it seemed interpretations of what this actually meant varied. One of the key factors in these differences of interpretation seemed to be whether or not a distinction was made between drug dependence and other types of drug use. For example, this was related to comments about the inappropriateness of all PWUD being sent to long-term residential treatment centres, when most did not have severe drug use problems or were not drug dependent. As described in the discussion on treatment and rehabilitation, some experts expressed concern that CCDU were promoted as a health-based approach to drug use, yet they still resembled a law enforcement measure utilising incarceration. For example, in practice this approach resulted in police randomly urine testing people for drugs use, and then incarcerating them in CCDU or other custodial settings which were stigmatising, breached human rights and lacked evidence-based treatment interventions. This issue of criminal versus health policy paradigm seemed central to the drug policy debate and its lack of resolution was a critical factor in drug policy formulation in Thailand. A comprehensive and shared understanding of this issue also appeared to be important for effective implementation of Thai drug policy.

"Law enforcement are not clear about what harm reduction is and that is why they still do not agree with [harm reduction] *in general. But once we have a close dialogue with them and they understand then I think they would support it. What they said to me was, 'If the doctors say that needle and syringe are prevention tools then we would not arrest you'. Some high-level police officers said this. But we have rarely heard this from the Ministry of Public Health, doctors making statements, that needle and syringe programs are prevention tools for drug*

users. Now police officers arrest drug users because the law says they are criminals but it doesn't mean the police officers want to arrest them but it is stated in the law that if you find the drug user you have to send them to the compulsory treatment centres for drug users, or if they don't go to the compulsory treatment centres then they have to go to jail." (Thai expert)

Furthermore, Bacchi (2010) described the processes of policy-making and policy analysis as commonly conceptualised around problem-solving. Nonetheless, the way such problems were defined were bound by positivist assumptions that 'problems' were readily identifiable and objective in nature and that participants in the policy process may not even be aware of their own assumptions. If this was so, then one logical conclusion would be that more inclusive and collaborative consultative approaches which incorporated a broad range of stakeholder views to examine policy issues should lead to more comprehensive and effective policies and strategies. This concept of policy problem formulation also interconnected with issues over departmental jurisdiction (between Ministry of Justice and Ministry of Health), which were frequently discussed by experts as a hindrance to agreement, coordination and leadership in progressing health-based and rights focused approaches to drug policy. This will be examined further in the discussion of government departments and their jurisdiction.

7.3.4 Drug Treatment and Rehabilitation

Closely linked to discussions about progressing health-based and rights-focused approaches to drug policy, were discussions about treatment and rehabilitation, and the role of CCDU in Thailand's drug policy implementation. This was a particularly intense topic in which most of the experts (around 80%) had a considerable amount to say. Both Thai and non-Thai nationals stated that provision of a range of quality drug treatment interventions was important to reduce both the supply and demand for drugs in Thailand and enhance the quality of current treatment services for PWUD:

"… the government should really focus on drug treatment if we are going reduce drug supply to reduce demand for drugs. If drug users have been treated effectively it tends to reduce a large amount of drugs in the market." (Thai expert)

Within the Treatment and Rehabilitation Node, CCDU were the most frequent topic or subcategory, and accounting for more than half of the total references made by most of those experts who discussed treatment and rehabilitation:

"In the policy documents about drugs they always use the language that first they want to promote voluntary drug treatment but in reality, they are using a compulsory drug detention centre system as the main means to address drug use epidemics in Thailand." (Thai expert)

In the opinions of nearly all the experts interviewed, CCDU were not appropriate health services and were doing more harm than good. The concerns about the capacity and quality of care in the CCDU, as well as the high rates of recidivism and human rights abuses have been discussed in detail in the literature review. Furthermore, they seemed to think that CCDU were also an obstacle to implementation of evidence-based drug policy because the CCDU were using scarce resources which could have been used for community-based treatment and care for PWUD. Several experts (both Thai and Non-Thai) stated that it was inappropriate for the military to administrate these centres because it was outside their scope and skills to undertake such medical and psychological assessment, treatment and rehabilitation. Some of these also questioned the budget allocations for the centres going to the military rather than the Ministry of Health. Two experts also pointed out the close links between the Royal Thai Military and ONCB as an influence on the direction of drug policy. These issues were again raised by those interviewed and the overwhelming majority of these experts expressed a sense of urgency that CCDU should be replaced with models of community-based treatment and care, which were evidence-based and human rights respectful and that these services should be run by the Ministry of Health supported by CBO, not by the military. Some indicated that this might require additional technical guidance and assistance initially and that such assistance could come from both international (United Nations) and national organisations. Experts repeatedly mentioned the importance of treatment needing to be evidence-based, integrated into the community and involving the participation of PWUD:

> *"Thailand has to realise and accept that we do not have a high enough quality of drug treatment programs." (Thai expert)*

The great majority of experts shared the opinion that the use of CCDU was an outcome of harsh prohibitionist policies and most experts expressed concern that these centres were ineffective, providing little or no evidence-based treatment, and diverted much-needed resources away from viable alternatives such as community-based treatment options:

> *"…the United Nations Office on Drugs and Crime learnt a long time ago that these boot camps are not effective… So, the UNODC has come in and said to the Thai Government to stop this approach. But when you have the idea that it is just the problem of discipline, a moral problem and if you ask us to stop using these boot camps what is the choice, what else can we do." (Thai expert)*

"United Nations agencies… have tried to encourage Thailand and other countries in the region to reconsider their approach, UNESCAP, UNAIDS, UNODC, UNDP, WHO, in fact 12 of the United Nations agencies have said, in relation to compulsory treatment, "What you are doing is not a smart thing to do and there is a better way of doing it." (International expert)

Later in the interview the same international expert went on to emphasise:

"The problems are that they waste money doing things that don't work. They should not be doing Compulsory Treatment of Drug Users. They should be transitioning to voluntary community-based treatment..." (International expert)

On the other hand, some felt that the United Nations and other international agencies should be more assertive and provide more guidance than simply making statements critical of CCDU:

"International agencies make statements to the international community about the broader issues like closing the compulsory drug detention centres but they do not directly challenge the government of Thailand or talk about the details of how these things should be done." (Thai expert)

Most of these experts talked about how the CCDU were neither evidence-based nor effective and many also cited concerns about well documented human rights abuses in the centres:

"And some people take the position that surely these CCDU are better than people being criminalised. It may be better than being locked up for 20 years in prison but let's look at the alternative that is being offered, it is certainly, not for the most part, rights respectful or protective. I certainly have not seen it reduces stigma. I certainly have not seen that it enables people who use drugs ability to get along in society improved. So, the discourse that results is odious, especially in states that are inherently repressive. Not least of all because it's predicated on the assumption that people don't know what's good for them, therefore the treatment that people are going to get is going to be mandatory and that is a real problem because it will be debasing and rights violating treatment." (International expert)

These concerns were reaffirmed by others, for example another expert stated:

"Going forward I think abolishing that compulsory drug detention system is really a priority for Thailand because our research found they were responsible for really gross human rights violations." (Regional expert)

Some also expressed concern about what they thought were insufficient quality standards or limited availability of skilled professionals to adequately undertake targeted assessment and treatment services in the CCDU:

"So, for example when their prisons fill up with drug users they organise military camps for them. These camps pass as military boot camps; they have 10 days of basic training and then the soldiers come in and discipline them and soldiers are very good at discipline [laughs]. *The soldiers worked closely with the Ministry of Interior because the Ministry of Interior is responsible for searching for drug users in the community and when they find them* [PWUD] *they put them in military camps. However, the soldiers asked ministers and doctors from the Ministry of Health, from district hospitals or provincial hospitals to come and provide knowledge about drug issues."* (Thai expert)

Quite many of both Thai and international experts indicated that there were fundamental structural problems with drug treatment and rehabilitation in Thailand. These were associated with the way that drug treatment and rehabilitation was offered through CCDU which were funded through and managed by the military and the Ministry of Justice rather than the Ministry of Health or CBO:

"I think it's an issue of direction, I don't know who has been advising the Prime Minister but it seems that the idea of investing in treatment has never been the priority. You can look at the budget for treatment, when they allocate the budget for drug users their way of allocating is through the ONCB which is under the Ministry of Justice which is under the Ministry of Interior. This is because they see it as a moral or criminal issue not a health issue. It is the Ministry of Interior that needs to fix this not the Ministry of Health, that is my interpretation because if you look at the way they channel the budget down you can see that the military is receiving the money, the budget, for setting up treatment camps organised by the Ministry of Interior and the soldiers. And the people from the Ministry of Public Health only come in as assistants to the military." (Thai expert)

Some experts advised that if drug treatment services were offered through general community health centres then this would make them less stigmatising and ensure low threshold for access to services. It was also suggested that:

"Services for people who use drugs should be peer-led interventions and education." (Thai expert)

One expert thought the infrastructure necessary for providing the services was already available in Thailand in the health service system used for testing and treatment of HIV. The expert suggested this same service system could be expanded to meet the needs of PWUD efficiently:

"Actually, service provision for PWUD in Thailand could be really simple because their service provision for HIV is already in place, and these services set up for HIV are already really good. All you have to do is add one more component for people who use drugs. You already have people coming to these clinics for HIV testing and medications, for hepatitis

testing and treatment, Thailand has great health service infrastructure. Instead of having another agency or organisations setting up parallel services for people who use drugs, services for them could be provided within existing settings. Thailand has these great smartcards that they use for HIV testing and treatment." (International expert)

Others raised the importance of matching the different needs of the diversity of PWUD to a variety of appropriate responses, including an active role for peer led interventions:

"A critical question that is not being asked enough is, 'What are the service needs of people who use drugs but are not dependent on those drugs?'" (International expert)

"In Thailand, it is not that simple; there are some PWUD who are a little bit better off than others and the way to reach them might be little bit different to the way to reach others who are less well off…The community of PWUD in Thailand is not homogeneous and there is a need understand the differences." (Regional expert)

Some suggested that the establishment of CCDU was a logical outcome of the moral model of addiction and the disease model of addiction being used to socially construct both PWUD and the government services available to them, as is evidenced by the following statements, one by a Thai and one by a non-Thai expert:

"…the United Nations Office of Drugs and Crime learnt a long time ago that these boot camps are not effective, and recommend that you don't do supply reduction as the number one strategy but focus on demand reduction. So, the UNODC has come in and said to the Thai Government to stop this approach. But when you have the idea that it is just the problem of discipline, a moral problem and if you ask us to stop using these boot camps what is the choice, what else can we do." (Thai expert)

"…Thailand's Narcotics Act, [is] framing people who use drugs as sick people who are mentally ill. They assert that people who use drugs are not criminals but they are sick, they're mentally ill. And it is a mental illness that undermines the person's agency and autonomy and these people don't know what's best for them when they are using drugs and that justifies mandatory treatment. It justifies removing people from the social body because they are contaminants. That is why I think we have seen the growth of these detention centres in South-east Asia. And it is also why I think we see of all sorts of other so-called social undesirables swept up into these centres." (International expert)

According to Schneider and Ingram "*…the social construction of target populations has a powerful influence on public officials and shapes the policy agenda and the actual design of policy."* (1993, p. 334). They further argue it is critical in the rationale that legitimates policy choices and the selection of policy tools. Their theory of social construction could

help to explain the support for CCDU in Thailand, and other parts of South-east Asia, when they stated:

> *When beneficial policies are directed to deviant groups, such as rehabilitation programs, they ordinarily attempt to change the person through authoritarian means, rather than attack the structural problems that are the basis of the problem itself. Drug diversion programs, for example, will usually require attendance and drug testing, and threaten participants with heavy penalties for failure to comply with the rules* (Schneider & Ingram, 1993, p. 339).

The implication here may be the key to transition from CCDU to community-based, evidence-based and rights-based treatment options is in reconstructing social perceptions of PWUD. The much-quoted Thai Government rhetoric "*Drug users are patients not criminals*" may be the beginning of a transition from a moral model to a disease model of understanding drug use and reframing drug users from 'social deviants' to 'social dependents'. Although, promoting more sophisticated models, such as the bio-psycho-social model, diathesis–stress model, or the strengths and vulnerabilities model, may more effectively transform Thai understandings of drug use and better assist in formulating more nuanced and effective interventions.

There were many comments about the role of the United Nations, especially the UNODC, regarding drug user compulsory treatment centres. While there was general agreement that UNODC had tried to promote a move away from CCDU and towards community treatment, there appeared to be a great variance in opinion as to how influential UNODC had been on this issue, with some experts saying that they had been quite influential and a similar proportion saying they had very little influence because in the end policy was determined through the lens of national sovereignty. In addition, one interviewee raised concerns over their perception that UNODC had changed its strategy on this issue:

> *"… the United Nations Office on Drugs and Crime has retreated from its unequivocal statement against Compulsory Treatment Centres for Drug Users in South-east Asia; that there is no evidence the centres are effective, there is evidence they are harmful, and they should be closed immediately. Whereas, now the position that UNODC seems to be taking is that these Compulsory Centres for Drug Users are inefficient, they are a bad use of resources in resource constrained environments. 'You would use your money better if you invested it elsewhere rather than in these places.' To me that is a really weak arguing position. It is also fatally compromised because it is leaving it open for them say, 'Well we can demonstrate that they are cost-effective and they do meet our aims.' I don't think this is*

sufficient I think you have to take the position that this is odious and this is wrong. This is an
affront to human rights." (International expert)

A few experts also mentioned that PWUD but were not dependent (e.g. recreational drug users) were still sent to compulsory centres, when apprehended, even though they did not need drug withdrawal treatment or residential rehabilitation. This issue, combined with the observation that people who did do not use drugs but had other social issues (e.g. homelessness or mental illness) were also sometimes found to be in CCDU, lead some experts to suggest CCDU were used not just to treat drug dependence but to simply "*take people out of the public eye*". An international expert who was a long-term resident in Thailand said:

"Also, kids would say "I want to get off drugs, I will do anything." But the options available to them were so extreme...None of this was evidence based but there was desperation for people not to be plagued by these addictions and there was nothing available." (International expert)

Only three experts, all in very senior positions with key Thai Government agencies, appeared to be in favour of the CCDU. An example of this view was represented in the following statement by one of those Thai national experts:

"Treatment and rehabilitation is also government policy. Now if you look at treatment options in Thailand, now they have a system of inducement for treatment of drug addicts. So, drug addicts did not pay anything they just go to the government hospital and everything is done by the Ministry of Public Health free of charge; whereas in other countries you have to pay for treatment." (Thai expert)

The node 'Guidance and Technical Assistance' was closely linked to the theme 'Drug Treatment and Rehabilitation' through discussions of prevention and treatment policy and services provision. When experts discussed drug treatment and rehabilitation, many mentioned that Thailand, and particularly Thai CSO which implemented services, would benefit from the provision of guidance and technical assistance for the delivery of services to PWUD:

"We still have the OZONE organisation, the Thai Drug User Network and Raks Thai who work on issues related to drug users but those are not big organisations and not big enough. They also need technical assistance and need their capacity built to support work on this kind of issue." (Thai expert)

Several experts, both Thai and non-Thai nationals, said the implementation of more effective drug policy, including the delivery of community-based treatment services would

be assisted through the development and dissemination of national and international guidance. They mentioned examples of United Nations recommendations and guidance documents. They also described that there were examples of good practice in Thailand, which they thought should be evaluated and documented to provide locally generated evidence and technical guidance to assist setting up and expanding services for PWUD in Thailand:

"If they don't understand they don't see why it is important and why they need to implement it. It is just a policy on paper and it lacks the detail necessary for them to implement it. For example, I think harm reduction policy was endorsed for 19 provinces. But where is the guidance that tells government offices why this is important and why they need to do it? What is the goal? What are the indicators that measure performance? How should the policy be implemented?" (International expert)

A few experts also highlighted the importance of guidance to assist service providers in working with law enforcement. Experts also felt that it was important that such guidance should be practical, unambiguous and locally relevant:

"We need to flush out the compromising wording in the WHO guidance and recommendations on harm reduction." (International expert)

Despite this, not all experts thought the United Nations agencies had had the impact they could and perhaps should have had:

"I think the international agencies such as UNODC, UNAIDS are scared to talk to the Thai Government about these issues because they know the government does not want to hear them and they have to work smoothly with the government. Sometimes the government offers just lies about what is happening and these international agencies know that the government is lying but they decide to keep quiet about it." (Thai expert)

In summary, it appeared from the preceding opinions expressed by the experts interviewed that, the theme of treatment and rehabilitation was related to policy formulation and implementation in three main ways. Firstly, experts made statements to the effect that the current treatment and rehabilitation service provision through CCDU hindered drug policy reform because the centres were presented as a credible effective response to an identified need in drug policy implementation, whereas most experts assessed these centres as neither evidence-based nor effective. They indicated that the centres were ineffective, were associated with high recidivism rates and were not consistent with the application of international human rights. Secondly, they seemed to suggest that government endorsement of CCDU as an efficient (cost-effective) and therapeutically effective system prevented the careful consideration of other models of

treatment and care. Thirdly, in the experts' view, the establishment of a system of treatment and care services for PWUD that were voluntary, evidence informed, and community-based was an urgent need which was largely absent from current policy dialogue, formulation or implementation.

Also, linked to this discussion, was the sub-theme of the need for international guidance and technical assistance as well as the identification, documentation and dissemination of national good practice examples. Experts discussed capacity gaps of Thai CBO and CSO and their need for training, legal support and other technical assistance to effectively implement drug policy. The United Nations and International NGO were identified as expected sources of such technical assistance.

7.3.5   Harm Reduction

The issue of harm reduction was of particular concern to most of the experts and of concern to all experts who worked with international and national CSO and CBO.

> *"…if you understand people who use drugs, you will not simply ask them to stop using the drugs. We have to do more in terms of harm reduction before they can stop using the drug." (Thai expert)*

The majority of the experts appeared to hold the following three opinions: firstly, adequate harm reduction service coverage was essential to preventing HIV in Thailand; secondly, not enough had been done in terms of harm reduction service provision; and, thirdly, there were serious impediments to harm reduction in policy and practice in Thailand:

> *"The progress of harm reduction in Thailand has been very slow." (Thai expert)*

A Thai expert suggested that while there was some overt verbal support there appeared to be unspoken opposition:

> *"When we talk with ONCB they always say harm reduction is good but in practice when we try to implement harm reduction in the field we do not get their support." (Thai expert)*

> *"I really believe that there is a strong opposition to harm reduction from within and Thailand has never been really convinced about harm reduction." (Thai expert)*

And perhaps, most simply expressed by one Thai expert as:

> *"I think Thailand is not convinced about harm reduction full stop." (Thai expert)*

International experts seemed much franker in their statements with one who had been working in Thailand for many years put it most emphatically saying:

> "*Thailand is the black sheep of South-east Asia when it comes to harm reduction. It has done so little and so late, it only approved harm reduction in any government policy last year, it is so far behind all of the other countries.*" (International expert)

The literature review confirmed that harm reduction services in Thailand were a long way from achieving the minimum coverage necessary to impact substantially on the transmission of BBV. Various reasons were put forward for the lack of significant progress in harm reduction service provision in Thailand. Most of the international and Thai experts working with or in NGOs seemed to consider that harm reduction was one of the most salient issues in Thai drug policy reform and much of the discussion about harm reduction centred on the provision of MMT and NSP. Consistent with the previous discussion in the literature review, experts described MMT, as it was dispensed in Thailand, as being more like a medically supervised opioid withdrawal regime with very low doses of methadone than as long-term maintenance therapy:

> "*So, we are balancing on that; trying to do some supply reduction, try to improve the drug treatment facilities, with limited resources or budget. For example, you will see more methadone detox than methadone maintenance treatment. At that time, we only had methadone maintenance treatment in Bangkok... This is primarily due to limitations of personnel and resources. Also, the clients have to pay all costs 'out of pocket'. Universal health care system for Thailand only started in 2000. So, the poor people cannot afford it and service accessibility is poor. If they have to go daily [to collect their methadone], they are living high up in the hills and they have to come down daily for the treatment it is impossible for them. So, that is the way things have been.*" (Thai expert)

Several other Thai experts working in health and community services expressed similar opinions:

> "*Thailand has been implementing Methadone treatment for 30 years and so that is often mistakenly understood to mean that Thailand has been implementing methadone maintenance treatment and therefore harm reduction but this is not so.*" (Thai expert)

Another international expert stated he was generally pessimistic about the future of drug policy reform in Thailand:

> "*The fact that Thailand is now ruled by a military junta does not help drug policy or harm reduction in Thailand. Discussions on rights based approaches are now unlikely, especially on the topic of drugs.*" (International expert)

A key issue mentioned was that the harm reduction agenda was an ideology driven by international donors and not national agents. Among other issues this meant it was entirely dependent on finance and other resources outside the national policy environment. The provision of harm reduction services appeared to attract both strong advocacy and strong resistance:

> *"… most of the harm reduction programs have been a result of money being available outside of the national budget and pressure from some of the donors." (Thai expert)*

Experts discussed their concerns about the lack of adequate coverage of harm reduction service provision in Thailand and in the following quotes describe what they considered being other key factors limiting the implementation of these services:

> *"But if they believe the only approach to the problems of drug use is that the drug user must stop using themselves; I think if someone still holds this believe then it is difficult to step beyond this belief and support harm reduction." (Thai expert)*

> *"… when I have talked with the Thai Department of Drug Control they have said, "Handing out clean needles and syringes seems like a good idea because it will help reduce the transmission of HIV but we cannot do it." They say that is because the legislation does not allow people to carry syringes but I don't think that is the real reason. If they really wanted to distribute clean needles and syringes now they could do it, they could introduce the policies necessary or the guidelines whatever they needed to do it." (Thai expert)*

> *"In response to a question that civil society recently had a win with the ONCB endorsement of harm reduction policy. It is difficult to call that a win because I believe that they are only endorsed harm reduction because they were under pressure from civil society and the community and felt that they had no choice. There was also pressure on them from international agencies and that is not good for Thai civil society. I think that if ONCB were not under pressure then they would not have supported harm reduction by themselves. I also think that endorsing a policy but not truly understanding it could be a problem later." (Thai expert)*

During the period the interviews were being undertaken, the Thai Government National AIDS Committee released a national report that estimated there were 75,000 Thai injecting drug users, a figure nearly doubled the previous estimate of 40,000. A very senior government official interviewed said:

> *"…in the present situation in Thailand we do not have many people who use drugs by injection. Most of them take drugs as pills or they drink or smoke them. Very few people inject drugs. In my opinion on this point I think in Thailand we should educate people about the sexual transmission because when people get drugs like amphetamine-type substances*

and they have a party they and they lose their control and forget to protect themselves. But

they don't inject, not many people use syringes." (Thai Senior government official)

This could suggest there were some different interpretations of available evidence, which might need to be considered and, where appropriate, addressed in future policy development.

As described in the discussion about 'Thai CSO and NGO' and the section on 'Economics and Resources', harm reduction services were provided through the non-government sector which was reliant on funding from international donors for service provision. With the impending withdrawal of the primary financier of these services, the Global Fund, it appeared harm reduction services would cease before they achieved sufficient coverage to impact on national transmission rates of HIV or other BBV. Analysis of CSO in Thailand suggested that they were the least powerful and least resourced institutions directly involved in Thai drug policy and they were the sole drug policy entrepreneurs attempting to ensure these strategies were incorporated into drug policy and implemented.

7.3.6   *Royal Government of Thailand Administration and Strategy*

Many of the experts indicated that they considered the Prime Minister to be the most important determinant of drug policy in Thailand. Prime Minister Thaksin Shinawatra[32] was most often discussed as an example of this use of prime ministerial power in implementing drug policy, and particularly his internationally reported War on Drugs Campaign[33], as typified in the following statement:

"When I think about drug policy at the national level I often think about the War on Drugs

which occurred during the Thaksin period." (Thai expert)

According to Thai experts, when Prime Minister Thaksin came to power he reorganised the government processes and structures for determining and administrating drug policy. Until that time, the National Committee on Drug Policy and the ONCB had both reported directly to the Prime Minister. In the opinion of the experts this direct reporting

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[32] Prime Minister Thaksin Shinawatra was and remains arguably the most internationally recognised political figure Thailand has produced. He made frequent appearances in the international media (including the covers of Time, Newsweek, BusinessWeek and the Economist magazines on multiple occasions). He also received an enormous amount of publicity, often negative, and international criticism over implementation of his 'War on Drugs' campaign.

[33] As has been previously described, in February 2003, the Thaksin government instructed police and local officials that persons charged with drug offenses should be considered "security threats" and dealt with in a "ruthless" and "severe" manner. The result of the initial three-month phase of this campaign was estimated at some 2,275 extra-judicial killings (Human Rights Watch, 2004)

relationship prioritised drug policy responses and instilled in those bodies substantial authority and, according to some, offered opportunities for all relevant government departments to have a voice and some influence. PM Thaksin changed this arrangement so that these key drug policy bodies reported through and were directly accountable to the Ministry of Justice. Some experts, including senior government officials and senior figures in research and academia were of the opinion that this inevitably led to a greater emphasis on 'law and order' approaches and a stronger role in responses to drugs and drug use by Ministry of Justice, and agencies under the authority of the Ministry of Justice.

"Prime Minister Thaksin is the one who moved ONCB from the Prime Minister's Office to the Minister of Justice. That meant that from then on Thailand was going to be 'Tough on Drugs': suppression, eradication, seizures, arrests and so on. That is clear." (Thai expert)

There was a difference in opinion as to how positive experts thought these changed arrangements were. Those who were within or more closely associated with the Ministry of Justice considered the arrangements more favourably than those who were within or more closely associated with the Ministry of Health. But all indicated they thought the loss of a reporting line directly to the Prime Minister was undesirable.

"In Thailand ONCB was under the Prime Minister. Later (about 10 years ago) ONCB was transferred to the Ministry of Justice because the government at that time thought that we were just an implementation body and were something more like the US DEA [USA Drug Enforcement Agency]. *But we are not only an implementation body; we have a very complex function." (Thai Government official)*

Despite the discussions about the changes in reporting structures and so forth most experts appeared to take the view that drug policy in Thailand had changed little for many years. They reflected that Thailand had consistently taken a 'Tough on Drugs Approach', and Prime Ministers Thaksin's 'War on Drugs' campaign had just been the most extreme manifestation in recent times. Both Thai and international experts made comments like the following:

"I think the policy towards drugs and Thailand over the last 10 years has been fairly consistent though regardless of which government has been in power." (Thai expert)

"So, the Prime Minister consults the relevant agencies but no one has said 'Go this way!' because no one is sure which way is effective…So after failing with the war on drugs in Thailand for 10 years, people don't feel confident about standing up and saying, 'Go this way!'. Except the civil society who has been affected by the war on drugs policy. They say, 'Please stop this and work with us. We know because we have experienced this.' You can

see that Thaksin was never interested in sitting down with civil society and discussing the
drug issues. He would say, 'You follow my policies or you go and that's it.' You can see with
the harm reduction conference held in Bangkok in 2006 civil society were treated badly by
the prime minister." (Thai expert)

It is important to note the distinction that, even though there was wide international
criticism of the War on Drugs campaign, experts' assessments were that it had been
successful in domestic politics and received strong Thai voter support. There seemed to
be general agreement among experts that a key reason for this approach was that public
security focused drug policy was politically popular with voters:

"So, that became a political ploy. Whenever you want to get votes you do something like the
war on drugs and the public seem to think the war on drugs is good and we will vote for the
war on drugs." (Thai expert)

"There was a rising of international concern, voices expressing concern about the
implications of the 'War on Drugs', and that included the United Nations agencies… Every
government would like to say it maintains its own sovereignty but international opinion would
have had an influence and I am confident that was the case." (International expert)

"I think that Thai politicians believe that the public want to hear messages about being
'Tough on Drugs', 'our community is clean and there are no drug users', and that the
politicians and have achieved this by supporting law enforcement activities and putting drug
users in jail. I think this type of policy has been very successful for the Thai Rak Thai[34]
politicians." (Thai expert)

Another Thai expert added:

"We did research to ask the public views and 3 months after the War on Drugs they said, 'Oh
we have a quiet village now.' and so on, because the drug users have all been arrested and
sent to internment, some fled to Myanmar and some were shot dead. And because of the
fearful atmosphere people said good things and things go underground. The general public
were satisfied. It was like you when you sweep things under the carpet then things look good
and clean." (Thai expert)

A common theme in discussions was that, despite frequent changes in Prime Minister
and Cabinet Ministers over the past decade or more, successive governments had

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[34] The Thai Rak Thai (Thais Love Thais) Party was the political party lead by Thaksin Shinawatra from 2001
until it was banned in 2007 following a military coup. It was outlawed for violating electoral laws and 111 of
its party members were banned from participating in politics for five years.

continued to implement policy instruments focussed on strict prohibition through law enforcement (see Appendix 13 for further details on Ministers of the Government of Thailand). Furthermore, nearly all the experts stated they saw this approach had repeatedly failed. There seemed to be a shared view that these policies continued to be used for party political reasons (i.e. they were popular with voters) rather than due to evidence of effective outcomes.

> *"The political turmoil in Thailand obviously has a big impact on drug policy because they want to use in drug issues politically. That means when a new government comes in they have to issue a new drug policy, saying they have a new approach to drug policy. But it seems after that things have never been under control. And the political turmoil in Thailand has been good for those that market drugs and helps them black market to grow." (Thai expert)*

> *"It has been 10 years already since the war on drugs policy started in Thailand. Why are there still so many drugs in the community? Why has the number of drug users continued to increase? Why is the prevalence of HIV among drug users continue to increase? We need to keep asking questions like these. To some questions like these the government departments say, 'Well, that's not my responsibility'. But when you ask a question like 'How come you've spent so much government money and the problem has not been solved? What happened?' then you make them more accountable." (Thai expert)*

A shared concern was the continued implementation and failure of policy instruments focussed on law enforcement of a policy of strict prohibition. This also appeared to be related to the common perception that there were limited opportunities for those outside government to contribute to discussions framing drug policy problems and solutions. This may have been because, to some degree at least, for a long period the Government of Thailand, through successive administrations, was perceived to have acted as a relatively closed system in relation to drug policy, and without substantial input from CSO, CBO and PWUD. In the past, this may in turn have made it more difficult for government to develop more innovative and successful responses. A great deal has been written about how closed political systems and authoritarian regimes can lead to harsh social repression, political stagnation and sometimes even catastrophic policy failures. This concept has been covered extensively in the works of many intellectuals, for example, Noam Chomsky (Chomsky, 1987, 1999, 2003) and Asian academic Amartya Sen (Amartya Sen, 1988; Amartya Sen, 1997) and in the numerous critiques of some of the most extreme examples, such as Stalin's USSR, Mugabe's Zimbabwe, and the Democratic People's Republic of Korea. This should not be misunderstood for a moment to suggest that Thailand is an authoritarian state like those mentioned, but

simply to make the point that closed political systems were less likely to access input from outside government, particularly CSO and CBO, and less likely to then produce liberal and innovative policy reforms. This limited consultation with outside parties and CBO may also be related to cultural characteristics of power distance, collectivism and preservation of face. On the other hand, this was not an issue unique to Thailand, and survey respondents from several other countries raised concerns that there was insufficient access or input into policy debate and formulation processes by PWUD and CSO.

7.3.6.1 The Need for Leadership

Several interviewed experts discussed the need for leadership in driving Thai drug policy reform. This appeared to be in the context of political leadership and linked to discussions about political commitment and political will. But each of the comments seemed to involve perspectives of a different type of leadership. For example: four experts spoke of the need for greater government leadership on drug policy by the Prime Minister, Deputy Prime Minister, Ministers and Cabinet respectively; a fifth called for government leadership in terms of service provision; and, the sixth spoke of the need for government implementing agencies to provide leadership in harm reduction. One expert who had worked both in an international non-government organisation as well as in the United Nations system on drug and other health policy initiatives commented that:

> *"Advocacy has had limited impact because Government participants have not had sufficient seniority to influence policy or make decisions. Ministers and Cabinet members are needed for policy decisions. These decision makers need to be engaged in the workshops and study tours, etc." (International expert)*

Another expert who had been deeply involved in policy negotiation and dialogue gave a very specific example about the authority they thought was needed for drug policy decisions:

> *"…when we were discussing about the compulsory centres for drug users with government delegations from this region, including Thailand, they would say "Okay, we have this committee in our country and the committee is headed by a Deputy Prime Minister so he makes all the calls." Now law enforcement representatives and public health representatives might agree that this particular approach, strategy or policy is the best for the community from a public health perspective but the decision has to come from the Deputy Prime Minister and we do not have access to him." (Regional expert)*

Leadership was often spoken of in conjunction with 'political will' and sometimes these terms were used interchangeably:

"But the most important factor is the political will of the government. That is the most important thing; if the government has the political will to see the problem, understand the problem and solve the problem." (Thai Expert)

The term political will was also often used the in literature reviewed, survey responses and in interviews. The lack of political will and lack of political commitment to change political positions and to acknowledge the unintended consequences of zero tolerance policies was the most frequently cited of political problems thought to hinder effective policy formulation. Even though it might not be possible to say exactly how every survey respondent or expert interviewee defined the term political will in every occurrence within the data, the analysis suggests that there was a general enough understanding that it required direct and sustained attention by high-level government with sufficient decision making authority. A most pragmatic definition was offered by one expert who, when pressed to define political will in respect to Thai drug policy, said it meant:

"The prime minister has good intentions, will really look at and monitor what is going on, and will put what is necessary into the budget for the country to deal with the drug issues." (Thai expert)

This definition is in alignment with research by Post, Raile and Raile (2010), who undertook a critical review of the literature in an attempt to produce a definition of the term political will, which they characterised as "*the slipperiest concept in the policy lexicon*" (Post et al., 2010, p. 654). Their critical analysis concluded that political will was a dynamic interactive process which required four key components:

1. A sufficient set of decision makers,

2. with a common understanding of a particular problem on the formal agenda,

3. [who were] committed to supporting,

4. a commonly perceived, potentially effective policy solution. (Post et al., 2010, p. 671)

The frequent changes in Thai political leadership has been discussed in the critical review of the literature on Thailand in Chapter Six, and this issue was also raised as a substantial concern by several experts, especially those engaged in CSO and NGO sectors. Some considered that the continued use of the same or similar drug policy may have even been related to the frequent changes in government and so a lack of continuity of leadership to champion and see through sustainable policy development on drugs. Thailand has experienced turbulent change and instability in its national politics. For example, in the 10 years between 2004 and 2014 Thailand had a total of 11 Heads

of Government, two successful military coups and 4 constitutions (see Appendix 14 for details). It is possible that this may have contributed to challenges in advancing and implementing drug policy in the country during this period. Certainly, some experts identified the ongoing turbulent political change as a barrier to progressing advocacy, design and implementation of effective drug policy in Thailand:

"*Governments in Thailand change frequently and that is a huge problem for our advocacy work. We would do a lot of work with some people and then the government changes and everything gets put on hold or has to start all over again. I think is a major factor in why Thailand has not advanced in respect to its drug policy and harm reduction.*" *(Thai expert)*

Political analysts have also noted this political instability and its negative impact on democratic processes in Thailand, for example, Kuhonta and Sinpeng's (2014) investigation of political institutions and democracy in Thailand found:

A general image has now emerged of Thailand in the past eight years (2006–14): one characterized by a spiral of political instability, street mobilization and violence, and clear democratic regression. All of this is somewhat surprising given the fourteen years of democratic progress that occurred between 1992 and 2006 (Kuhonta & Sinpeng, 2014, p. 334).

It may be that Thai Government politicians or public servants were not as sensitive to the impact that frequent changes in government had on policy formulation and implementation as were those people providing advocacy, information, or health and social services 'on the ground':

"*It is almost like you are starting from point zero in every community; developing relationships and trying to create local policies. In some cases, this is successful and some it is not successful. For example, establishing methadone maintenance treatment in prisons, work started but it just faded away without continuing support.*" *(International expert)*

In situations where there were frequent changes in government leadership, either episodic or continual, the bureaucracy may provide stability and continuity in policy although perhaps not policy innovation. Peters (2009) discussed how increasingly the roles of modern bureaucrats or public servants have become those of managers, policy makers, negotiators (with a wide range of social actors) and democrats (as networks of social actors interact with all levels of the public bureaucracy in order to influence policy design or implementation). These roles, he reported, may predominate more in traditional forms of democracy with declining efficacy or stability. Furthermore, Kane and Patapan (2006) described how, traditionally, public administrators have been conservative in policy matters due to the trade-off between policy innovation and their

need to represent the public values of stability, continuity, predictability, trust, and prudence.

It is possible that these frequent and continuing changes in Thai political leadership have impacted on drug policy in two ways. Firstly, as has been stated by experts interviewed, it has been difficult for policy ideas to progress and evolve and so governments have stuck with a simple law enforcement approach popular with voters. Secondly, it may be that in the absence of the sustained government management of a long-term political plan for drug policy, that the ONCB has provided de facto policy stability in its role as policy adviser and ensured continuity in the policy approach presented over the past 40 years, since the agency's establishment. It is possible that one outcome of the most recent military government, its subsequent redrafting of the constitution and restructure of the political processes, may be to provide the stability necessary for long-term drug policy reform. The impact of turbulent change in government appeared to have been an issue identified mainly by Thai experts who worked in CSO and CBO and was also corroborated in responses from the survey methodology, by survey respondents who were working in Thailand.

In the survey responses, there were also many comments about the importance of leadership in helping policy formulation and implementation but the type of leadership described was different. In the survey responses, the descriptions suggested community advocates variously described, for example as 'champions' or 'policy warriors' who were passionate and tenacious. Kingdon stressed the importance of such advocates in the process of identifying policy problems, formulating policy solutions and achieving policy implementation. He called them policy entrepreneurs:

> *Policy entrepreneurs, people who are willing to invest their resources in pushing their pet proposals or problems, are responsible not only for prompting important people to pay attention, but also for coupling solutions to problems and for coupling both problems and solutions to politics.* (Kingdon, 2010, p. 20)

Kingdon claimed that for a policy entrepreneur to be successful they must have three qualities: firstly, a claim to be heard through expertise or authority (e.g. as representative of an interest group); secondly, they must have political connections or negotiating skills; and, thirdly, they must have patience and tenacity. The survey response emphasised the role of the policy entrepreneur but this was absent in the interview data. This may reflect differences in Thailand around community-based participation in policy process or perhaps cultural differences to do with social stratification, hierarchy and power distance

relationships discussed previously. It is also interesting to compare this identified lack of policy leadership in Thailand, with Thailand's successful '100% Condom Campaign' which was famously championed by Meechai Viravaidya. Affectionately called 'Mr Condom', Viravaidya was described as 'a master showman', and a 'social entrepreneur' and was instrumental in the highly successful and internationally acclaimed response to HIV among FSW (Rosebery, 2013). Furthermore, being a senator Viravaidya met Kingdon's criteria of having the authority to be heard and the access to political connections. It is likely, given Thailand's political and cultural characteristics, as previously described, that a policy entrepreneur in Thailand would be far more liable to be successful if they from within government rather than from a community organisation outside of the formal political institutions.

7.3.6.2 Government Departmental Jurisdiction

Several experts mentioned problems of policy formulation and implementation related to a lack of coordination or agreement over jurisdictional issues between governmental departments. This issue of differences of opinion or interpretation over which agency or ministry had jurisdiction and responsibility for formulating and implementing drug policy was a recurring theme throughout many of the interviews and emerged through many of the coding categories. In the comments by participants in this research, this seemed to be confined to the relationship between Ministry of Health and Ministry of Justice. There were, for example, no references of jurisdictional issues between the Ministry of Justice and other Ministries or departments. Furthermore, there was a common perception expressed that the Ministry of Health took the view that drug use was primarily a public health issue whereas the Ministry of Justice, and the agencies like the ONCB which reported to the Justice Minister, considered drug use was primarily criminal issue. Many Thai and international experts suggested that one of the reasons criminal policy responses prevailed in Thailand was because the Ministry of Health had less authority and influence in government budgetary and policy decision making processes than the Ministry of Justice:

> *"I don't think that the Thai Ministry of Public Health has any influence over the Thai Ministry of Justice. If you are a criminal here, you will get basic Health Care but you have to be criminalised first. So, the Ministry of Health can run programs and they have initiated healthcare base programs. But when it comes to a confrontation the Ministry of Health will always back off." (Regional expert)*

At a forum in United Nations Regional Headquarters, Bangkok, one senior Thai Government Official[35] commented that Thailand's Government Ministries could be perceived as A, B, C or D ministries depending on their budget and authority. He further stated that the Ministry of Justice might be perceived as an example of an 'A' grade ministry and the Ministry of Health perceived as an example of a 'C' rated ministry (2016). This issue of differences of opinion or interpretation over which agency or ministry had jurisdiction and responsibility for formulating and implementing drug policy was a recurring theme throughout many of the interviews. One expert described similar issues not only between ministries but also between departments within ministries. While similar situations could be found in many other countries it nonetheless created considerable challenges in Thailand, particularly during the implementation stage of drug policy:

> *"But that* [harm reduction] *is a rather specific sector under the Disease Control Department under the Ministry of Public Health and the view from the Disease Control Department and the Department of Medical Services who look after the treatment of drug users never actually get along very well. So, they said harm reduction is your job so the disease control department should do harm reduction among drug users. But the Disease Control Department says, '*How can we reach drug users when we're not the people that treat them? We do not have the treatment centres*.' They say to the Medical Services Department, 'You are the people that see them every day, when you have given treatment you should integrate harm reduction into your service*.' *So, you can see that the same office says, '*It is not my job. It's not my job*.' So, you can see the Ministry of Justice, Ministry of Public Health, the ONCB, the Disease Control Department, the Medical Services Department, they actually don't quite coordinate." (Thai expert)*

While jurisdiction and responsibility for supply reduction approaches seemed widely understood, when it came to demand reduction and harm reduction policy interventions, differences in interpretation and gaps in implementation were frequently discussed:

> *"Some people in the Thai Government sit back and say that the drug use is a health problem but it seems deep down they do not really believe that. I have heard people and the Ministry of Public Health for example said that they think harm reduction is useful but I have not heard them making strong statements in support of harm reduction or bringing out strong policies in support of harm reduction or implementing activities that support harm reduction." (Another Thai expert)*

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[35] To respect confidentiality, the official's name and positon details have not been included in the reference.

"I always thought that it was strange that when people said ONCB should do more on harm reduction they would respond that harm reduction is a health issue and therefore harm reduction advocates should approach the Ministry of Health. The advocates would respond that one of the main barriers to harm reduction implementation was the actions of law enforcement and that ONCB was responsible for that." (Regional expert)

"One of the problems is that the Thai Ministry of Public Health does not have much influence on drug policy compared to agencies like the ONCB…I think they have done many study tours and travelled everywhere because so many donors have paid for study tours. And I'm not sure they have been particularly helpful." (International expert)

"10 years has been long enough to have many structural interactions. So, when the harsh policy was initiated the Ministry of Justice needed to haul a lot of work to the police, to the courts, to the department of probation, to department of corrections and the prisons. They needed to spend a lot of time on this problem and it never stopped. It just kept increasing an increasing. So, you can imagine the quality of the implementation of this policy had just kept getting poorer and poorer. Then the Ministry of Justice had to initiate anything they could think of to help this problem for example, they might say we will add demand reduction techniques and skills to our probation officers. So, they tried to do that; they tried to train officers but it was ineffective. Then they said, 'The Ministry of Health needs to come and help. It is their area of expertise not our area of expertise. But after negotiating with the Ministry of Justice the Ministry of Health said, 'There is just too many people we can't handle that.' So, the problem went back to the Ministry of Justice. So, the two departments are playing a blame game now, the Ministry of Health's says to the Ministry of Justice 'You cannot treat them properly.' and the Ministry of Justice says to the Ministry of Health 'Why don't you take them then.'" (Another Thai expert)

Another Thai interviewee conveyed how a government departmental budget was both an indicator of relative department policy authority and a means to exercise that authority i.e. enabled them to provide services and gave them greater political clout when negotiating drug policy:

"The Thailand Ministry of Public Health is not strong enough; it doesn't have enough power or have a big enough budget to be very influential in national drug policy. It appears that most of the money comes from the Global Fund so possibly they don't need a lot of money but probably they do not have enough negotiating power at the level of cabinet for the Ministry of Public Health to get a bigger budget." (International expert)

Competition between government agencies for authority, budget, and other resources; a lack of clarity over jurisdiction or responsibility for the implementation of policy

instruments; differences in the relative influence of different ministries in policy formulation and Cabinet decision-making; and, the prioritisation of national security issues and law and order policies over health policies, were issues that were common in many democratic governments throughout world. Weiss described that negotiating and creating policies, and the programs that implement them, was subject to:

> …*interagency and intraagency jockeying for advantage and influence. The politics of program survival is an ancient and important art. Much of the literature on bureaucracy stresses the investment that individuals within an organization have in maintaining the organization's existence, influence, and empire.* (Weiss, 1993, p. 95)

Halperin (1971) described how departmental interests were often an overriding determinant of the interpretation and position taken on a policy issue "*Organizations with missions strive to maintain or to improve their (1) autonomy, (2) organizational morale, (3) organizational 'essence,' and (4) roles and missions. Organizations with high-cost capabilities are also concerned with maintaining or increasing (5) budgets*" (Halperin, 1971, p. 95).

In addition to the disparities and gaps between government departments, experts described gaps in knowledge and practice between national and local level implementation:

> "*A lot of the people on the ground level don't know about these policies and won't implement them. One of the successes of Thailand has been at the community level where people who inject drugs and their allies and NGOs are working very hard to make something happen at the micro level. But in spite of these macro level policies that may be emerging e.g. statements like "*Drug users are patients not criminals*", because it is not being translated in to anything tangible, there are no budgets or national programs or even a multi-sectoral taskforce that is headed by the government you don't see anything happening. This makes it very hard at the local level to implement harm reduction services. It is almost like you are starting from point zero in every community; developing relationships and trying to create local policies. In some cases, this is successful and some it is not successful.*" (International expert)

These concerns were not unique to Thailand, nonetheless international, regional and national experts interviewed, still considered them significant issues which hindered effective policy formulation and implementation. Many of the experts, predominantly those working outside government, were concerned and even expressed frustration at what appeared to be an impasse due to a lack of jurisdictional clarity between

departments over drug policy. This was especially evident with respect to harm reduction services and most particularly regarding NSP. It was not evident that this was resolvable in the current policy environment within the foreseeable future.

7.6.3   National Legislation and Law Reform

The interviews were undertaken in the months leading up to the 2016 UNGASS[36] and while Thailand was going through a lengthy process of reviewing and redrafting drugs legislation. This meant that drug law reform internationally and nationally was very topical and many explored issues related to law reform in their interview responses. Views were divided on whether the UNGASS would influence Thai drug policy:

> *"I do not see the 2016 UNGASS on drugs as being a particularly strong influence at the international level on national drug policies." (International expert)*

> "*I think that the UNGASS and the changes in other countries will have an important effect on us because some European and American countries are talking lot about legalising drug. In some countries, they are even selling marijuana through automatic vending machines. But in Asia we do not agree with this. They have tried to push for us to legalise and have tried to show that it is better if you legalise marijuana. They say for example; you can earn money for the people through taxation and you can reduce street crime and so on but I think they do not have the studies to show this is effective in the long-term." (Senior Thai Government official)*

The Thai emphasis on arrest and imprisonment of PWUD rather than health interventions was commonly expressed concern. This was also discussed under the theme of 'Criminal or Health Paradigm'. There were two areas of law reform experts were primarily concerned with: laws directly addressing drugs and drug use; and, laws affecting harm reduction services, most specifically NSP. Examples of specific law reform that experts said were needed included: changes to administration of random urine testing; proportional penalties for relatively minor offences e.g. for position of small amounts of drugs; and, the abolition of the death penalty. There appeared to be unanimous agreement among those who mentioned drug law reform that current laws resulted in disproportionate numbers of people arrested and imprisoned for small amounts of illegal substances for personal use. This was perhaps summed up most concisely by a senior Thai law enforcement official who said:

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[36] The UN General Assembly Special Session (UNGASS) on drugs was held from 19 to 21 April 2016. At its 59th session in March 2016 the Commission on Narcotic Drugs transmitted the outcome document, entitled "*Our joint commitment to effectively addressing and countering the world drug problem*" to the General Assembly and recommended its adoption at the plenary of the special session on the world drug problem.

"…we need to deal with or arrest the drug mafia not the small carriers but at present a lot of the jails are full of small time drug couriers, which has effects on the prison system also." (Senior Thai Government official)

There were multiple references to the problems in harm reduction service provision resulting from the Thai national law on needles and syringes. There were also multiple interpretations and understanding of the law indicating a lack of clarity in its application. For example, some experts stated needle and syringe possession was illegal, while others said that it was the distribution of injecting equipment and establishment of NSP which was illegal under Thai law. Two experts explained that it was legal in Thailand to purchase needles or syringes from pharmacies and indeed the international health organisation, Population Services International, ran a pilot program in Thailand using a voucher system for PWID to collect needle and syringes from pharmacies in Bangkok for a brief period:

"Most people in Thailand, I can't say all, can afford to buy needles and syringes from a pharmacy and a pharmacy will sell them to you. People of low middle class backgrounds are not going to go to hospital and say, "Please give me 10 needles and syringes." they would rather buy them from a pharmacy." (Regional expert)

Another respondent also the importance of recognising differences in the situations of PWUD when formulating appropriate responses:

"In Thailand, there is not that simple; there are some people who use drugs who are a little bit better off than others and the way to reach them might be little bit different to the way to reach others who are less well off. That may also be why sometimes we feel there has been some rejection by Thailand, of what might be called the 'gold standard' of harm reduction service provision. The community of people who use drugs in Thailand is not a homogeneous and there is a need understand the differences." (International expert)

Others pointed out that although it was not illegal in Thailand to have a needle or syringe, in practice when making arrests, police used possession of such equipment as evidence of drug use. Experts working in service provision pointed out that, while strictly speaking drug use paraphernalia could only be used as evidence if they had been used and had detectable drug traces, in practice, possession led to police interrogation, harassment and obstructed safe disposal of used equipment, such as contaminated syringes. Experts from national and international NGO and CSO reported the uncertain legal status of NSP was often cited by Thai Government Departments as the reason they could offer little or no support for harm reduction activities:

> *"… when I have talked with the Thai Department of Drug Control they have said handing out clean needles and syringes seems like a good idea because it will help reduce the transmission of HIV but we cannot do it. They say that is because the legislation does not allow people to carry syringes but I don't think that is the real reason. If they really wanted to distribute clean needles and syringes now they could do it, they could introduce the policies necessary or the guidelines whatever they needed to do it." (Thai expert)*

Nevertheless, some commented that they believed an apparent lack of clarity about the legal status of needle or syringe possession was merely used as an excuse when the reality was that personnel in these departments opposed harm reduction in both principle and practice:

> *"… if they believe that the only approach to the problems of drug use is that the drug user must stop using themselves; I think if someone still holds this believe then it is difficult to step beyond this belief and support harm reduction." (Thai expert)*

One expert explained that the Ministry of Health had disagreed with a Ministry of Justice agency over whether NSP could be implemented under Thai law. Consequently, they appealed to the Office of the Council of State of Thailand expecting an opinion. The opinion received was that NSP promoted drug consumption and drug use is illegal. Subsequently, police arrests of NSP workers and clients for carrying needles and syringes appeared to increase. Harm reduction activities including NSP did continue, but limited in scale and only through NGOs using international funding; not through Thai Government funding or departments:

> *"…in Thailand, there is a problem with the law that prohibits the distribution of needles and the establishment of needle and syringe programs. According to UNAIDS needle and syringes are important in the transmission of HIV so the Thai Government has tried to turn a blind eye to Non-Government Organisations which have been engaged in this activity, distributing clean needle and syringes." (Thai expert)*

Most experts who discussed this topic expressed the need for law reform to allow NSP to operate with Thai Government support and without interference from law enforcement. Only one expert expressed the opinion that any changes to the law should strengthen government opposition to implementation of harm reduction activities, especially NSP:

> *"Harm reduction is not being implemented through Global Fund now but there seems to be a hidden program of people teaching drug users how to clean their syringes and things like that and we have some small groups in the north of Thailand with needle and syringe programs. The NGOs to experiment with the free needle or syringe. But we cannot declare this for a*

national policy because the law is very strong on this that it is illegal." (A senior Thai Government official)

There appeared to be evidence of significant differences in the interpretations of drug policy implementation objectives and instruments between the Ministry of Health and the Ministry of Justice. This could be due to confusions over definitions and jurisdictional authority, or it could be evidence of ideological conflict between the departments, or perhaps both. Due to the sensitive nature of the issues, it may be difficult to categorically state which is the case, but quite clearly this would hinder the efficient and effective implementation of drug policy. In the meantime, as a result it would appear from the interview responses that NSP and other harm reduction services operated in Thailand on the basis that the national government would not overtly support them, but higher levels of government would not prevent them, and lower level government personnel were often uncertain about the status of policy implementation instruments or services and so and acted on their own discretion.

7.3.7   Thai Monarchy

In Thailand, the monarchy was esteemed and it would be difficult to overstate the reverence with which most Thais held King Bhumibol Adulyadej. The key role of the monarchy in the formulation or implementation of drug policy in Thailand was mentioned by approximately equal numbers of Thais and non-Thais and, as a potentially sensitive topic, all experts handled the subject with respect. The King's patronage of the opium crop substitution and alternative development program of Thailand has been lauded domestically and internationally as arguably the most successful opium crop substitution program in the world. A senior Thai official explained:

> *"…the King, you see that he has long ago tried to find a positive way out of the drug problems. Actually, his attempt was not to rapidly curb the problem down but attempt to find alternatives which were sustainable for Thai people. And that needed a lot of effort and financial support and because of him we got very good donations from the internal community, from the United Nations, and from western countries like Australia." (Thai expert)*

Furthermore, his granddaughter, Princess Bajrakitiyabha Mahidol, has been active nationally and with the United Nations in working for improved quality of life of women in prison, alternatives to incarceration for women and, more broadly, justice system reform for women. Since the majority of women in prison in Thailand were there for drug-related offences, she seemed to have also taken more of an interest in drugs policies as they related to women.

"The work of the Thai princess is always connecting the work of Thailand to the international stage. She has an interest more broadly in the criminal justice system and was ambassador to Vienna until last year and during that time she led Thailand on the Commission on Narcotic Drugs and the UNCCPJ [United Nations Commission on Crime Prevention and Criminal Justice]*. The crime congress happens every five years and in April the Thailand delegation was the biggest after only the host delegation* [Qatar]*. This was due to the princess being there. The princess was there for the entire week of the congress and because she was there Thailand was represented by high-level officials from all relevant portfolios, e.g. Prisons, Department of Justice and the ONCB." (International expert)*

As noted in previous chapters Her Royal Highness Soamsawali, mother of Princess Bajrakitiyabha, following an Australian study tour in 2011, recommended to the Prime Minister's office the provision of all necessary services to reduce HIV transmission among PWID, including harm reduction services, but these recommendations were not implemented (Tanguay, 2015). Furthermore, there were some who expressed concerns that there have been occasions where the King's policy concerns have been misinterpreted, for example:

"If you go back to 2002 and you look at the king's speech, he mentioned methamphetamines and a few weeks after that PM Thaksin Shinawatra announced the first war on drugs. So, when you ask what influences drug policy in Thailand you can say the king but the king never initiated the war on drugs. He never said anything about a war on drugs. The king always addressed problems by helping Thai people, to give them alternatives not involved with drugs." (Thai expert)

An international expert said of the monarchy that:

"…in the 1990s there was a high-level quasi U.N. meeting held with Thai officials and a member of the royal family. In the process of translation among other things, the Thais concluded that needles and syringes promoted drug use and as a result needle and syringe distribution was banned by royal Decree. …Time will not change laws that have been put down as royal decrees, these will never change, it would take a royal to undo them." (Regional expert)

Another international expert, in speaking of similarities between the prohibitionist drug policies of both Thailand and the USA, suggested some influence in this situation had occurred through members of the Thai monarchy:

"Members of the Thai royal family had been educated in the United States and if you think that will have no influence on deliberative decision-making, then you don't know Thailand. So, there are a variety of ways that the U.S. Government has directly and indirectly influenced policy in Thailand." (International expert)

Although the Thai monarchy was a revered formal institution, it was a constitutional monarchy and, like constitutional monarchies elsewhere (e.g. those in Britain, Japan or Norway), its powers were restricted by the national constitution and the members of the Royal family exercised careful restraint with regards to direct participation in politics, legislation or policy. While their cultural leadership and influence was significant, their more obvious and public direct contribution to drug policy has generally been through patronage of charitable projects and indirect advice on specific issues of interest.

7.3.8   Royal Thai Military

While the analysis of the interviews found that responses under the theme 'Royal Thai Military' were smaller in number than for example, 'Thai Culture and Society', they were generally quantitatively larger responses and qualitatively more detailed and informative. It was clear that Thai and international experts attributed substantial importance and impact to the Thai military on policy and politics. In the analysis of Thai drug policy, the role of the Thai military appeared central. The experts who discussed the Thai Military considered them to be very influential on the formulation and implementation of national drug policy. Among the reasons mentioned for this influence were:

i.   Close-knit relationships between the military and the government;

   "… when the issue of drugs has been raised as a national issue it is the Prime Minister and their ministers, for example Minister of justice, those in charge of the military or the police. It is these people who can speak out about this issue and who will influence and shape the policies". (Thai expert)

ii.   The military sat on the National Committee on Drug Policy along with the ONCB, Royal Thai Police, and Ministry of Justice;

iii.   The military's close relationship with the ONCB;

   "…people in the ONCB often get promoted up into military posts and so the military must have a lot of influence on the people within the ONCB…" (International expert)

iv.   The government budget allocations that the military received for their role in undertaking supply reduction and demand reduction strategies, including the military's management of the drug treatment and rehabilitation centres, or "*military boot camps for drug users*" as many experts referred to them;

   "…if you look at the way they channel the budget down you can see that the military is receiving the money, the budget, for setting up treatment camps organised by the ministry of interior and the soldiers. And the people from the Ministry of Public Health only come in as assistants to the military." (Thai expert); and

v. The important role of drug policy in providing government departmental authority and opportunities for career advancement for the military and police.

"The Royal Thai Military and the Royal Thai Police get a lot of power from the current drug laws. Along with the power, they receive extra budget, opportunities for promotion and also opportunities for corruption. Because drugs are at the top of the national agenda, if you can show your performance on drug control is very good, then it is easy for your boss to promote you." (Thai expert)

One expert suggested that a primary reason for the implementation of the highly successful 100% Condom Campaign was not concern about HIV prevalence among FSW but concern about prevalence of HIV among the young military conscripts who frequented them and the impact of HIV on the Thai military:

"A high percentage of military conscripts had HIV. The young men in the military were considered differently than people who use drugs and valued more by Thailand society. This led to the program of HIV prevention among female sex workers. This was driven by concern for the fine young men in the military not the female sex workers. And it was presumed that the young men of the military were heterosexual. Whereas men who have sex with men and people who inject drugs were expendable" (International expert)

While it is difficult to determine now whether this was a key influence, it is interesting to note that military conscripts were a key population examined in sentinel surveys and other research prior to and during the campaign, although this itself may have influenced the initial interpretation.

Nearly all the people who discussed military's influence on drug policy expressed views about the impact of the recent military coup and the installation of a military dictatorship in Thailand. Some Thai and international experts stated, for example, that they believed this could increase the national emphasis on harsh prohibitionist drug policies and that consultation and discussions had become:

"…more difficult and more restricted since the change of government to a military government." (Thai expert)

Yet as will be discussed later, this was not quite how things appeared to have subsequently begun to evolve.

One expert gave the example that just prior to the coup the Minister of Justice stated kratom use should be decriminalised and the Ministry of Health was conducting consultations but progress on the issue ceased when the coup occurred. Others said the military government appeared to support a return to a War on Drugs approach:

> *"The fact that Thailand is now ruled by a military junta does not help drug policy or harm reduction in Thailand. Discussions on rights based approaches are now unlikely, especially on the topic of drugs." (International expert)*

After becoming a constitutional monarchy in 1932 Thailand was ruled by military-led governments for almost five decades and since then to the present a number of prime minister's, both elected and appointed, have also been military leaders (Prasirtsuk, 2007; Rakson, 2010). The current military government was the outcome of the 21st coup d'état Thailand has experienced since 1916 (BBC News, 2015; Harlan & Samuels, 2014; Tsang, 2014). The historical and contemporary role of the Royal Thai Military in politics and government underscored the critical importance, often overlooked by many researchers, of engaging with the military in matters of national policy, including drug policy responses.

The Thai military were far more active in the drug policy domain, and politics in general, than was common in many other countries. Rakson's (2010) examination of the Thai military's influence in politics made the distinction that western militaries considered themselves as a tool of government, serving the state as a professional institution rather than becoming involved in politics, whereas the Thai military, he argued, perceived their role as preserving the security of the state against external or internal threats, including from what they considered to be weak or corrupt governments. In addition, the Thai military "*… maintain a high degree of influence in political and economic affairs due to pursuing its own interests rather than those of the general public*" (Rakson, 2010, p. 4). The role of the Thai military in drug policy responses including eradication, interdiction, prevention and treatment has grown even further since the military coup of 2014 and all cabinet and other ministerial positions were filled with serving high-ranking military officers[37]. This included the key position in drug policy, the Minister of Justice, held by General Paiboon Koomchaya, who was widely held to be the foremost candidate to succeed General Prayuth Chan-ocha as the head of the Army immediately prior to the coup (The Nation, 2014).

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[37] In 2015 army Generals or their equivalent naval and air force counterparts i.e. Admirals and Air Chief Marshals occupied the following ministerial offices in the Royal Thai government: Prime Minister, the four Deputy Prime Minister offices, Minister of Interior, Minister of Defence, Deputy Minister of Defence, Ministry of Social Development and Human Security, Minister of Transport, Minister of Natural Resource and Environment, Minister of Energy, Minister of Agriculture, Minister of Commerce, Minister of Labour, Minister of Education, and Deputy Minister of Education. The ministerial positions not filled by currently serving military officers were incumbents appointed by the military government and usually because they had close links with the military(Asia Group Advisors, 2015; Editorial, 2014).

In the parlance of PEA, the Thai Military were an institution with extensive formal political power, substantial informal political influence, and they enjoyed vast financial and other tangible and non-tangible national resources, as well as resource contributions from international sources, most notably the USA. Just to give a general sense and context of the Thai military's power and resources, the 2015 Thai military budget was US$5,390,000,000 or 1.5% of GDP, this excluded their banking, resource and industrial investments and was based on figures prior to their installation and consolidation as the current national government. The Thai military was also ranked as the 20th most powerful military force out of the top 126 world powers in 2016 (Central Intelligence Agency, 2016; Global Firepower, 2016). Within PEA terms, they would be described as 'winners' under the current policy context. Furthermore, the narrative, to date, of the prosecution of the prohibitionist war on drugs approach has been also confluent with the military's ideology of protecting the state from internal and external security threats.

Unlike some other countries in which the debates on drug policy have been primarily driven by or considered the domain of public health and civil society, in Thailand the military has historically played a key role, (Prasirtsuk, 2007) and this thesis argues it still did at the time of this research. Despite this, it appeared that the military have been often overlooked in negotiations on drug policy which have taken place with the Ministry of Public Health and CSO, which by comparison were institutions relatively weak in influence, relatively poor in resources, and more distant from the central core of political power. Nevertheless, it became evident at the time of completing this research that some people in Thai Government departments, including the Ministry of Justice, were reassessing the relevance and effectiveness of existing Thai drug policy and considering other approaches.

7.3.9   Office of Narcotics Control Board (ONCB)

Nearly all the experts described the ONCB[38] as extremely influential in drug policy, and some described it as the most powerful formal institution nationally:

> *"At the national level the Thailand ONCB is a key player, they have a major role to play in drug control and drug suppression. When they create a proposal to the Royal Government of Thailand it normally has been implemented at the operational level. Every government*

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[38] The Royal Thai Narcotics Control Act B.E. 2519 (1976) (1) made provision for the creation of the Office of Narcotics Control Board (ONCB). The ONCB was described as having three functions: information (surveillance and police intelligence); policy formulation, policy implementation.

department knows that this organisation has the responsibility to deal with drugs in Thailand; including establishing mechanisms, strategic plans, education, training programs and so on. This organisation gets lots of money from the Royal Government of Thailand because one of the top priorities of government is drug policy." (Thai expert)

A critical part of that influence came from their formal legislated role of providing information, advice and guidance to the Prime Minister on drug policy. Experts explained the Office of Drug Control Policy was an important mechanism through which the ONCB influenced drug policy. The Thai Government set up the Office of Drug Control Policy, chaired by the Prime Minister (although in practice the Prime Minister delegated his authority to the Minister of the Office of the Prime Minister), as a high-level national body on which every ministry concerned with drug-related problems had a representative and through which they made recommendations and decisions on Thai drug policy. Officially the Office of Drug Control Policy was independent of the ONCB but the secretary of the ONCB served as the secretary of the Office of Drug Control Policy and the Office of Drug Control Policy meetings took place at the ONCB offices. As has been described, the ONCB enjoyed close working relationships with the Thai military, including working together on opium eradication, drug surveillance and interdiction, and both have enjoyed substantial funding from national and international sources for these activities. There also appeared to be informal career pathways between these institutions. PEA describes how actor networks form coalitions around shared values, common incentives and cooperative access to resources. This seems to be the case between the Thai military, the ONCB, and the Ministry of Justice more generally. In addition, these formal institutions comprised the majority membership of the National Committee on Drug Policy.

"The National Committee on drug policy, of which there ONCB is the Secretary, is comprised of Police Military Justice Corrections and so on these are all people on the supply reductions side and they dominate the ideas." (Thai expert)

A few experts (both from government and non-government sectors) discussed that ONCB staff often received promotions into key military, police and other senior government positions (e.g. high-level positions in the Anti-Corruption Agency, Anti-Money Laundering Office and Human Rights Commission) thereby cementing close relationships between the ONCB and these other departments. This suggested a close relationship between these organisations and, therefore, likely support for, and convergence of, perspectives on drug policy approaches, unlike, for example, the

reported differences between the Ministry of Justice and the Ministry of Health discussed earlier:

> *"[ONCB] train the good officers so they become the chiefs, for example…the chief of the Anticorruption Agency and the former secretary general as the member of the board of the Anticorruption Agency and… officers even sit in the office of the Human Rights Commission, so all these high positions are from ONCB." (Senior Thai Government Official)*

Many experts seemed to be of the opinion that the ONCB support was critical to any drug policy reform as it was the agency which determined whether drug policy change would occur or not. They described it as having the power to obstruct or facilitate harm reduction implementation in Thailand. Many indicated they believed that the ONCB had been either unwilling or at least reluctant to support harm reduction. Some thought that this was a philosophical position and others suggested it was a jurisdictional issue, i.e. that harm reduction was a Ministry of Health responsibility not a Ministry of Justice responsibility. Conversely, they described that the Ministry of Health could not initiate and drive the policy and legislative changes necessary to support harm reduction implementation because this was the responsibility of the ONCB as the lead agency on drugs. One interviewee summarised the common perception of the ONCB in the following statement:

> ***"I think ONCB is the most powerful organisation on drug policy in Thailand, they are very powerful*** *[emphasis added]. The ONCB mandate is on drug control and supply reduction. I don't think they are going to do anything on harm reduction at all. It is only the Ministry of Health that we can hope will implement harm reduction. And they have to convince ONCB and the Ministry of Justice first." (Thai expert)*

Not only was ONCB perceived to be the most powerful key stakeholder in Thai drug policy, it was also considered to be one of the most stable in a political environment characterised by turbulent change:

> *"…the previous government tried to arrest the drug users and show the number of arrests to the public and we have 400,000 people who use drugs this year and last year we had 450,000 so that means this has been successful. But that is not correct, we know that. So how about the next government? The current government is quite keen on the idea of drug treatment so they don't focus on drug arrests and drug treatment has been put in place. If a new government is interested in drug arrests, then the drug policy will be changed again. So back to my point about ONCB; ONCB is a key player to propose ideas and to talk to government leaders and to explain that it is not good policy simply focussing on arresting drug users but we need to treat them and help them. (Thai expert)*

"We [ONCB] actually have three functions: information, policy formulation, policy
implementation. We formulate drug policy and then propose that to the government of
Thailand. Every government when they are deciding their policy positions they will ask our
agency to propose a draft of the policy and they select which one is the most important for
them and then they declare it to the parliament and the public which one they have chosen."
(Senior Thai Government Official)

In PEA terms, the ONCB is unquestionably the political institution invested with the most
formal and explicit authority over drug policy. The Thai Government established the
Central Narcotics Board in 1961 and then restructured it as the ONCB in 1976 under the
Narcotics Control Act B.E. 2519 (1976). The ONCB appeared to have been modelled on
the Drug Enforcement Agency, under the U.S. Department of Justice. Even so, its
mandate and influence is much broader than simply enforcement and interdiction. It is
the leading agency for formulating drug policy advice and guidance for government and
has been a constant in this regard throughout many changes of government and periods
of political instability. As described in the preceding quotes, the ONCB remained the lead
agency for drug policy formulation and implementation in Thailand. Using PEA
shorthand, the ONCB is a 'winner' in terms of the departmental authority, political power
and access to budget and other resources under the current policy environment.
Informally it did not have as much power and resources in pursuit of current drug policy
aims, however, as was available to the Thai military.

7.3.10 Royal Thai Police

The Royal Thai Police Force was identified as an important formal institution at policy
implementation level rather than policy design or formulation level, and engagement of
law enforcement was considered critical for successful implementation of drug policy
strategies, such as outreach or harm reduction services within the community. Several of
the experts discussed the importance of the role of the Royal Thai Police in facilitating or
obstructing community services, such as outreach services for PWUD. Some said
implementation of services to PWUD were confronted with serious challenges 'on the
ground' if effort wasn't invested in ensuring local law enforcement officers had an
operational understanding of drug policy or strategies which had been endorsed by
higher levels of government:

"Engagement of law enforcement in harm reduction is important but implementation of harm
reduction policy needs to be tackled at many levels. But for this to have greater impact and
more sustainable impact it needs to be incorporated into the curricular of police academies.

But if we don't confront that really underlying factor, the stigma, it will be difficult." (Thai expert)

Some experts appeared to hold the opinion that, in some instances at least, there could have been deliberate attempts to obstruct service provision:

"They faced a lot of challenges, in terms of their workers being harassed, drug tested and arrested. There were a lot of issues and we do not know if they were deliberately targeted toward those problems were just a result of police confusion, thinking "this is wrong and you should not be doing it". (Thai expert)

Generally, though, the discussions seemed to centre on the importance of engaging police in the early stages of design and implementation of drug policy and services for PWUD:

"There is a harm reduction strategy officially endorsed by ONCB but still it's not implemented. The ONCB's harm reduction policy was launched in March last year [2014] *but when you talk to police at the decentralised level they seem to have very little knowledge of it. This is not unique to Thailand many countries have this situation where police on the street they have very limited knowledge of the national drug policies or harm reduction policies. The challenge is to really be able to design a model that will reach to the decentralised level because drug users are not only in Bangkok but all over the country and we should not try to apply a 'one size fits all' model for harm reduction in Thailand." (International expert)*

Reponses suggested ongoing work was required to improve cooperation and collaboration between law enforcement and the CBO and NGO delivering services in the community. Experts interviewed considered communication and education between high-levels of government and local law enforcement officers would be required. The importance of communication and coordination with law enforcement was also mentioned in some survey responses from other countries, either as a problem due to its absence or a supportive factor when managed successfully. In relation to this, some experts made positive references about the work UNODC had begun undertaking with the Thai Police on these types of issues and this will be discussed later under the 'United Nations' theme.

Based on 2012 figures, the Royal Thai Police had 250,000 personnel nationally. An entry level salary for a Thai police officer who did not hold a bachelor's degree was 6,800 baht (US$212) per month and a police officer holding a bachelor's degree or better would start with a monthly salary of only 8,340 baht (US$260) (Trimek, 2014). Furthermore, each police officer was expected to purchase their own uniform, equipment (e.g. hand

gun, torch, stationary, etc.), vehicle (usually a motorcycle), and ongoing supplies (e.g. petrol, batteries and bullets). It was for these reasons that earning extra cash through 'fines', bounties, rewards and other incentive payments might have been seen by some as an essential part of the job (Samabuddhi 2012; The Economist, 2008). Police officers in Thailand were paid cash bounties or incentives for arrests of drug users and for seizures of illegal drugs (Cheesman, 2003; Chouvy, 2013; Phongpaichit & Baker, 2009). "*The Prime Minister said of the cash incentives that "at three Baht [U.S.$0.07] per methamphetamine tablet seized, a government official can become a millionaire by upholding the law, instead of begging for kickbacks from the scum of society*" (Human Rights Watch, 2004, p. 7). There appeared to be some recent reconsiderations about the effectiveness of this approach. In August 2016, Minister of Justice General Paiboon Koomchaya stated that the incentives paid to police for arrests of PWUD exacerbated the problems of poorly thought out or implemented drug policy responses and resulted in enormous numbers people being arrested and imprisoned for minor drug possession charges. He further stated that these incentive payments should be abolished (Koomchaya, 2016). In terms of PEA, there might appear to be very significant incentives for the Royal Thai Police to support the current law enforcement approach to drug policy in which they are resource 'winners' and they would be potential 'losers' if a change of drug policy was implemented in which most PWUD were referred to treatment and or education instead of arrested and prosecuted. Resistance by the Royal Thai Police to substantial changes to drug policy should be considered possible or even likely, unless careful consideration was given to strategic provision of incentives for police officers to support more health-focussed responses to drug use.

7.3.11 Research and Evidence

Respondents frequently stated further evidence of the effectiveness interventions, such as development of community-based treatment models and harm reduction services was crucial in advocating for better of drug policy solutions. Furthermore, the perception seemed to be that such evidence must be locally generated to be both valid and convincing to policymakers:

> *"We can learn from harm reduction activities in other countries outside of Thailand but we also need activities in Thailand that have outcomes we can learn from. I think we can learn a lot from other Asian countries and it would be good to have cooperation agreements about developing good Drug policy or activities with other countries it would be helpful." (Thai expert)*

Some explained that for Thai ministries to make a case to the Thai Government they needed Thai evidence:

> *"…the ministry of health needs to push very hard in their efforts to influence the Ministry of Justice. I think they've tried their best but we do not have the evidence from Thailand that they need to make their case." (Thai expert)*

It is not certain of the extent to which this was a universally accepted issue. For example, while statements about the need for more evidence for health-based approaches appeared frequently in the interview data, this was not apparent to any great extent within the critical review of the literature or the analysis of the survey data. On the contrary, in the survey responses the only respondents who discussed insufficient evidence or technical assistance were from low-income countries with very limited capacity (Afghanistan, Kazakhstan and Kyrgyzstan). Moreover, none of the survey respondents who mentioned that need for evidence said that the data must be locally generated. This may suggest that middle and higher income countries had sufficient access to evidence and technical expertise for drug policy formulation and other factors such as political support and commitment were much more important for them in moving drug policy agendas forward. On the other hand, it is possible that there were particular situations during political negotiations when policy makers felt they needed locally generated data to win their case and that this varied greatly with policy context and timing.

In addition to research undertaken by academics and government departments, experts discussed examples of the important contribution made by Thai CSO and international NGO, as well as United Nations agencies in gathering evidence to inform policy debate:

> *"PSI* [Population Services International] *did the advocacy, the service provision, the research, the data collection, the evaluation, the involvement of peer reviewers." (International expert)*

> *"The Thai AIDS Action Group…set up a drop-in centre, piloted methadone treatment overdose prevention, led on community-based research inviting academic research groups to come in to their organisation to undertake research and in the process, build capacity of their workers to collect and analyse data and to jointly publish and always with involvement of the people who use drugs. That was the first time that such community-based research had been done in Thailand." (International expert)*

> *"UNAIDS has also been influential since the HIV epidemic, for example through studies on HIV transmission by needle sharing. The working group of UNAIDS worked in close*

collaboration with Chulalongkorn University to do research in this area and found out that injecting drug users have been very important in terms of HIV transmission." (Regional expert)

Areas highlighted where the generation of research evidence would be valuable included: Thai community-based treatment and care models which engaged the local community; public health outcomes as a result of harm reduction; prevention of HIV and other BBV through provision of clean injecting equipment; good practice models for service delivery; identification of obstacles to efficient services; the health and social outcomes of non-abstinence based interventions such as MMT; and, matching appropriate interventions with different types of drug use:

"A critical question that is not being asked enough is 'What are the service needs of people who use drugs but are not dependent on those drugs?' This is an area that is not being addressed and responses are underdeveloped." (International expert)

"You have disparities in the way harm reduction has worked in Thailand. In the south, it has worked reasonably well for two major reasons: first, the good role of the religious leaders; and second, there have been other major security issues and so law enforcement has shown a very collaborative approach in implementing harm reduction compared to the other provinces and Thailand. So, I think there will be the lessons that can be used from there." (International expert)

It could be easily inferred from some of the previous statements that Thailand had not been developing research and evidence but this was not the case. Thai researchers and academics had been building networks and contributing research findings to drug policy discussions for many years:

"There are key individuals in Thailand, [name removed] *has been doing a lot of research and is very engaged with the community. We need to identify more individuals like this at the country level and we also need some kind of breakthrough with the Thai politicians. National Networks may be an effective way of doing this." (International expert)*

The formal institutions of government department staff, academics and NGO researchers have, for many years, been patiently building network coalitions for the development of evidence in drug policy and services:

"…ONCB has a primary role in directing drug policy in the kingdom. They have through generosity and wisdom created a network of connections with academics and intellectuals and researchers to get soundings from them and advice from them. They don't always act on that advice but they have access to the advice." (International expert)

It may have been that some key stakeholders believed that simply tabling the right type, quality or quantity of evidence would be a primary factor in triggering policy reform. That is, that the presentation of compelling evidence would produce a radical change in support for health-based drug policy approaches which had not yet been achieved. At least one piece of evidence suggests the reverse might be possible, as was described by one Thai expert. When 2001 Thai population-based research showed use of methamphetamine was vastly greater than had hitherto been believed, the government embarked on an even more vigorous law enforcement campaign.

> "The number of people who reported (Methamphetamine] use in the last year was about a million, which compared to just 100,000 from the previous estimate; so, that may be the data that triggered serious responses to the drug situation." (Thai expert)

Whether or not it was a contributing factor cannot be determined from the interview data alone. It is possible there were other factors at play than simply the production of evidence when, immediately following the national survey report, a greater concentration of law enforcement measures was brought to bear on drug use, stigmatisation of drug users increased (which included renaming ATS to *yaba*, literally 'crazy drug') and soon thereafter the War on Drugs campaign was implemented leading to thousands of deaths. Research and other evidence have contributed to policy debate and formulation in Thailand, but the nature and weight of their contribution was uncertain, as it has been in other countries. As many political and policy analysts have observed, it is difficult to determine what evidence will be used, in which way and when, if at all. For example, Weiss (1979, p. 428) observed:

> *Research becomes ammunition for the side that finds its conclusions congenial and supportive. Partisans flourish the evidence…to neutralize opponents, convince waverers, and bolster supporters. Even if conclusions have to be ripped out of context, research becomes grist to the mill.*

The frequently heard statement that Thai policy deliberations could only be made with Thai generated evidence is a familiar argument used in other countries throughout the world and may be simply the conclusion drawn from observing the limited impact that *any* evidence has had in the negotiating and bargaining processes which characterise politics and law making. It may also reflect the importance given to information that is locally or personally relevant in influencing health-based decisions. Some experts said they thought evidence had little impact in policy debate:

"Evidence of what is effective does not result in much influence in policy." (International expert)

Alternatively, some experts appeared to believe (perhaps more cynically) that the requirement for local research (where they believed it was well understood that little or none was available) could have been a tactic employed to obstruct policy proposals that power elites did not support. Besides which, not all interviewed experts held the view that local evidence was essential before policy decisions could be made. Some spoke about it as an unnecessary obstacle or false assumption. One Thai expert reasoned:

"… a lot of people say, 'That might work in your country but we are different here we have a different situation and different culture.' I do not believe that. I believe the nature of drug users is similar throughout the world, for example, and an injecting drug user is going to find a needle no matter what. So, my personal opinion is that we can use evidence from another country to support our responses in Thailand. But the authorities here only want evidence from Thailand and we just can't find it." (Thai expert)

As has been previously described, Thailand was classified an upper-middle-income country and had good health and social service infrastructure compared with most other countries in the region. Furthermore, as was shown in the literature review there was already an abundance of evidence about the effectiveness and cost efficiency of health-based approaches to drug use in a great number of countries. Therefore, it is plausible that meeting demands for more and different kinds of evidence about health-based approaches may not be as much of a deciding factor in policy reform as many in Thailand seemed to hope. This situation was not unique to Thailand. Weiss, said of her experience advising successive US Governments, that policies and programs:

This of course does not mean that policy-makers venerate outcome data or regard it as the decisive input for decision. They are members of a policy-making system that has its own values and its own rules. Their model of the system, its boundaries and pivotal components, goes far beyond concern with program effectiveness. Their decisions are rooted in all the complexities of the democratic decision-making process: the allocation of power and authority, the development of coalitions, and the trade-offs with interest groups, professional guilds, and salient publics. How well a program is doing may be less important than the position of the congressional committee chairman, the political clout of its supporters, or other demands on the budget. A considerable amount of ineffectiveness may be tolerated if a program fits well with prevailing values, if it satisfies voters, or if it pays off political debts. (Weiss, 1993, p. 98)

Yet she does not say that evidence is unimportant; just that it is often not the primary factor, or often even a major factor, that wins a policy debate. She also explains that one must take a long-term view with the accumulation of evidence over years, sometimes a decade or more, before it has a significant impact on policy decisions. Moreover, as Kingdon elucidated, such evidence needs a champion or policy entrepreneur and a policy window of opportunity for it to be utilised (Kingdon, 2010). In other words, simply accumulating or presenting evidence is not sufficient to have significant policy influence, it required the right person, with the right evidence, at the right time, addressing an agreed construction of a policy problem.

7.3.12 Thai Non-Government Organisations and Civil Society Organisations

Both Thai and international experts working in government health services or non-government sectors said that CSO and NGO played an important role in policy advocacy and implementation. One capacity they seemed to offer was as the only vehicle through which PWUD could have a direct input into these processes. Nevertheless, the experts commonly assessed that overall CSO were not particularly powerful or influential. As discussed in the earlier sections on policy, Schneider and Ingram (1993) argued governments would actively try to exclude 'Deviants' from conventional forms of political participation such as setting up interest groups, and voting or running for office, therefore, they were either unlikely to participate at all or, when they did, were more likely to resort to disruptive strategies such as protests, strikes or even riots. This certainly seemed to be the case in Thailand and appeared to be conveyed in reports from experts:

> *"Firstly, it is very hard to legally set up a network of people who use drugs in Thailand. You cannot register it, incorporate the organisation or list it as a charity. You cannot have the words 'drug user' in its name. You could call it a 'Welfare Trust for People Afflicted with Social Evil' or something like that but not, for example, a Positive Network for People Who Use Drugs. And the laws in Thailand that cover the structure of Non-Government Organisations, charities and community membership networks require that you all on your board are Thai nationals, and they have to be of high standing in society. So basically, you cannot set up an organisation that can be self-governed by people who use drugs in Thailand. So, this is a structural factor which limits the amount of influence that people who use drugs can have on drug policy." (International expert)*

Interviewed experts indicated that CSO had some influence on drug policy in Thailand but that influence was very limited. Experts seemed to assess the strength of CSO influence by the outcomes they had achieved, which were generally acknowledged as

modest. The reasons put forward for their limited influence included: there were few organisations which worked with drug users; disagreement in and between these organisations about goals and strategies; and, the organisations described themselves as weak, particularly since the 2003 Thai war on drugs campaign. One Thai expert described the situation as:

> "Thai Drug User Network was very strong several years back until the War on Drugs happened and now they're only based in Chiang Mai and their focus has been reduced." (Thai expert)

> "Non-Government Organisations like PSI [Population Services International] made an extraordinary effort to influence the government and they managed to set up the first national harm reduction policy and that, it has unfortunately expired. But the fact that the harm reduction policy has expired and no longer exists suggests that civil society is not powerful enough may be." (Regional expert)

Experts working for Thai civil society, by their own assessment, described national CSO as weak in influence and divided in their strategies and aims. Kuhonta and Sinpeng's (2014) political analysis of Thailand examined the role of CSO and NGO and concluded they were divided, divisive, and driven by partisan interests. Their analysis did not focus specifically on CSO engaged in drug policy but focused more generally on the role and impact of these non-government actors in advocacy, accountability, and empowerment for democratic goals and political rights more broadly. Nonetheless, their analysis resonated very much with interviewed experts' comments about CSO, CBO and NGO engaged in advocacy, accountability, and empowerment towards drug policy reform, formulation and implementation. Similar opinions were also mentioned in the survey data from respondent from several other countries. These respondents stated that, in their countries the effectiveness of advocacy efforts and contributions to policy debate and formulation by organisations representing PWUD and other civil society was hampered by insufficient coordination, cooperation and alignment of aims among these organisations:

> "Now I feel that Thai civil society and community networks are weak. I don't think they're not interested, but I feel like they're sleepy now so the priority is to wake them all up. I don't think they're a clear about what they want to see in the end. Some want methadone, some want needle and syringe programs, hepatitis C treatment but they do not have a common vision. We need a common understanding and come together and agree on a common civil society strategy." (Thai expert)

There were also several comments that CSO and NGO representing drug users also suffered stigma by association and therefore some loss of credibility with formal government institutions. Some discussed the difference in attitudes and responses between representing PWUD ('Social Deviants') compared to CSO which represented people living with HIV, often considered by the public and politicians as more 'Deserving'. Schneider and Ingram (1993) labelled people living with HIV as 'Dependents' i.e. those with weak political power but a relatively positive social construction. Weiss described how advocating for marginalised populations and negotiating for unpopular policy can weaken CSO and other interest groups:

> *If the organisation is dealing with marginal clienteles, it can fall heir to the marginal repute of its clients, and it is likely to have relatively low public acceptance. Organisational vulnerability can become the dominant factor in determining what actions to take, and the need to build and maintain support can overwhelm the imperatives to achieve program goals. (Weiss, 1993, p. 95)*

This was also consistent with social construction theory (as previously discussed) and suggested this 'spill-over effect' also constructs CSO representatives as social deviants. In doing so, it reduced their perceived social value, as well as their social and political negotiating power:

> *"Also, the drug user groups such as the 12D Network gives drug users a voice but it is not strong enough and it needs other organisational support. For example, legal support because people who use drugs are still considered criminals, which makes it hard for them to voice their concerns. There are many organisations that work for HIV/AIDS and the right of People Living with HIV/AIDS but a lot of organisations are scared or not confident to work on issues about drug use." (Thai expert)*

Again, this was not unique to Thailand but nevertheless an important observation of how CSO and NGO effectiveness could be weakened through reflected stigma. Therefore, it would be logical to assume that addressing the social construction of CSO, NGO and CBO could have a positive impact on their influence contributing to drug policy dialogue, formulation and implementation. Many experts mentioned CSO experienced problems with accessing and engaging government officials at levels senior enough to directly shape policy decisions:

> *"… it is difficult for civil society organisations to influence these policies. It is not difficult for civil society to raise the issue, it is easy enough to talk about the problems of drug use or drug current drug policy, this part is easy. But it is also easy for civil society just to look like complaining people when they raise these issues. The influence to shape policy comes from higher." (Thai expert)*

Related to this point, several survey respondents stated that one of the factors that helped in drug policy formulation, but was not mentioned in the interviews, was the importance of establishing and maintaining formal and informal partnerships between CSO, local communities, health service providers, and politicians or other policymakers to create "*A platform for dialogue between communities and policy makers*" and "*Engaging government officials in non-adversarial ways and ways which make them interested.*" It is possible this issue may not have been mentioned in the interviews because the interviewees assumed it did not need to be made explicit. On the other hand, it may have been that they perceived their advocacy efforts and relationships (between Thai communities and Thai policy makers) as more hierarchical than collaborative. Furthermore, in general it appeared that experts who worked with government agencies associated with Ministry of Justice did not seem to view CSO or CBO as having, at best, more than a minor significance in policy debate, formulation or implementation.

Although Thai NGO and CSO were considered important, and occasionally successful, in achieving policy advocacy outcomes, by comparison to the other formal institutions discussed they were thought to be relatively weak politically and economically. In PEA, Thai CSO and NGO could be considered 'losers' in access to funding and other resources, having to rely predominantly on grants from international donors for their work. The withdrawal of financial assistance from the Global Fund did not bode well for Thai CSO or NGO, and experts expressed concern that the proposed New Thai Funding Mechanism based on philanthropy would not provide the support needed for highly stigmatised people in the most at-risk groups, such as PWUD. Given this situation, it was probably not surprising that most also described frustration at limited progress achieved by the efforts of CSO in trying to work with the Ministry of Health.

> "*Some people in the Thai Government sit back and say that the drug use is a health problem but it seems deep down they do not really believe that. I have heard people and the Ministry of Public Health for example said that they think harm reduction is useful but I have not heard them making strong statements in support of harm reduction or bringing out strong policies in support of harm reduction or implementing activities that support harm reduction.*" (Thai expert)

This was particularly significant in light of many other comments made in the expert interviews about the Ministry of Health's relatively weak position in directing drug policy compared with the Ministry of Justice and even more so compared with ONCB,

described by nearly all experts as the single most powerful organisation (nationally or internationally) in regard to Thai drug policy.

7.3.13 Economics and Resources

Economic factors did not feature as extensively in discussions about influences on drug policy in Thailand compared to other considerations, such as politics or departmental authority. Under this theme, the two main (and intertwined) issues were: firstly, the Global Fund financing, and anticipated withdrawal from Thailand; and secondly, the Thai Government budget focus on drug supply reduction and HIV treatment in preference over HIV prevention interventions and harm reduction activities. These two issues were entangled:

> "This is not just an issue about jurisdiction but also about resources. Actually, Thailand has no resources for HIV prevention; 80% of Thailand's funding is spent on HIV treatment and 80% of the money spent on prevention of HIV in Thailand comes from the Global Fund and that is ending next year. So, when we say who is influential at the national level we must say that if Thailand did not have the Global Fund then we could not start harm reduction in this country because no one has put effort in to this issue to then have a budget for harm reduction." (International expert)

Yet there seemed to be general agreement that external resources were still required to improve and change drug policy in Thailand:

> "There needs to be a real investment by some of the international organisations to focus on Thailand because it could potentially be a big influence in the region. It really could do better in terms of implementation of a comprehensive harm reduction policy and get rid of some on the really bad policies, like the death penalty. It still requires funding from key donors like Australia, UK and United States and the Global Fund." (International expert)

Prevention, outreach and harm reduction activities were funded outside the national budget by the Global Fund. In the view of experts, the lack of national budget allocation was clearly a significant impediment to drug policy implementation of these types of services. It was also a concrete indication that those types of services did not have the support of the Thai Government. By comparison, the Thai Government provided extensive public finance for HIV treatment for example, as well as CCDU. As was suggested by some experts, it may have been the case that the Thai Government simply did not see the areas being financed through the Global Fund as priority policy areas at that time. This seemed to be supported by the analysis of the survey data in which only respondents of a few low-income countries with insufficient national budgets claimed a

need for international donor funding to implement effective programs with adequate coverage for PWUD.

Experts explained how the Global Fund had been very influential in Thailand since their Round 8 grants in 2009, especially regarding prevention and harm reduction work. In 2015, Thailand announced that it would no longer be a global fund recipient and negotiations commenced between the Global Fund in the Thai Government to plan Thailand's transition away from global fund financing:

> *"The Global Fund has been supporting countries and bringing down the HIV rates and so they have been influential with national governments and they can point to the support they have provided and the benefits that countries have received as a result of the support for example the health outcomes increase in GDP and so on, and when governments graduate to take over funding of their own services the global fund provides advice on how they can continue to achieve these outcomes or benefits. On the other hand, it would be unfair on the part of the global fund, or for that matter any other bilateral or multilateral donor… to just arbitrarily stop their funding because a country has achieved a certain level on an economic indicator, like the national income level, without a medium term or longer term phasing out transition plan." (International expert)*

> *"Thailand decided to graduate from being a fund recipient of the Global Fund before they actually had to do it. They plan to stop receiving funding from the Global Fund by 2017 and this will cause problems for currently funded programs and we can see programs for people who use drugs are already being affected." (International expert)*

The experts also discussed what they thought may have been the reasons for the decision and the new philanthropic Thai New Funding Model for prevention activities proposed by Thai government:

> *"Thailand's decision to stop being a recipient of Global Fund funding probably had two purposes. The first being to profile Thailand as a country that does not need external help; but probably also the [Global Fund Agreement on] funding does not provide Thailand with as much freedom as it would like. Most of the funding at the moment is going towards harm reduction, and a few key at-risk populations. The global fund is not supporting HIV treatment in Thailand." (International expert)*

Another international expert explained:

> *"And one of the problems with the transition from the Global Fund is that there is no mechanism to provide government funding directly to NGO so what they are considering is what they call the Thai New Funding Model to establish some form of social contracting and have a pool of resources, relying also on private philanthropists, rich people, and then add*

some sort of system where they will receive applications, evaluate the applications and then give money to some of them. This would include all HIV prevention activities not only harm reduction. That is the idea but it does not look very sustainable to rely on philanthropists unless they will fund goals beyond 'one off' pledge." (International expert)

The other less significant, but nonetheless relevant, issue raised related to being more pragmatic in advocacy activities by using economic rather than human rights arguments. Associated with this issue of advocacy, were comparisons made between the response to HIV among FSW and among PWID, and suggesting that the differences, in part at least, related to economics:

"We need to make the case for harm reduction based on economic development or Thailand's international reputation, or something that would really resonate with the people in power. So far, the whole thing has been about providing services to people who use drugs or drug users' right to health and there are a lot of people who think that drug users have no rights at all. So, that argument is not winning. What would win is talking about bringing people back to being productive; or the family, which is a big value in Thailand. International reputation; because of course if you want to be recognised as a developed country, somewhere people want to do business with…" (International expert)

"Female Sex Work is an enormous industry for Thailand they make billions of dollars around travel and tourism, and the hotel infrastructure and they cared about HIV because of it effected the sex work industry. But with drug use there is nothing about it that means anything to Thailand's economy. That is one of the major reasons that Thailand did not move to respond to HIV among people who use drugs." (International expert)

While it would be difficult to substantiate the supposition of the expert interviewed, the sex industry in Thailand was substantial and a significant economic sector. In 2003 the Thai Government estimated the annual revenue from commercial sex at US$4.3 billion (Australian Associated Press, 2003). Earlier research (Simpkins, 1998, p. 1) estimated that the Thai commercial sex industry employed approximately 300,000 and concluded that in Thailand "…*at least one of every 100 working women is a sex worker*". According to a 2016 report FSW in Bangkok could earn 5,000 Thai Baht (approx. $145) per night compared with the minimum wage of 300 Baht (approx. $8.50) per day (The Financial Express, 2016). As a result, FSW:

...impact on both urban and rural economic life far exceeds their numbers because they often send most of their money back to their families in the countryside. Thus, both sex workers and their relatives depend on these relatively high wages to ward

off poverty and to participate in the consumer economy, buying houses, cars, and land they otherwise could not afford. (Simpkins, 1998, p. 1)

Furthermore, according to Simpkins a large section of the Thai economy was directly dependent on the sex industry and an even larger section was indirectly economically connected for example, hotels, restaurants, bars and many other businesses. Some experts, mainly those from Thai CSO and NGO, were of the opinion that service provision for PWUD and the funding for that service provision would be managed more efficiently and effectively by civil society or NGO:

"If the government can't look after these people, then they should provide some budget for organisations that can do that." (Thai expert)

"One additional issue for Thailand is that it is in a situation of transition away from donor funding to rely exclusively on domestic funding for harm reduction. The challenge there is how will it be possible to push resources to civil society organisations at the decentralised level when there are legal issues which prevent that, or at least that is what we are being told. So, this needs to be worked on very soon. Even if you have the political will to implement harm reduction policy but you do not have the mechanism to mobilize resources." (International expert)

Prior to the Global Fund's new (2014) funding restrictions, Thailand received financial support from the Global Fund Grant Round 8 for a package of HIV/AIDS prevention activities under the "Comprehensive HIV Prevention among the most at-risk groups FSW, MSM, PWID and Migrant Workers). Yet, by the Global Fund's own assessment in its 2011 Grant Assessment Report, the amount of existing funding for IDU and HIV prevention was low, only accounting for less than US$1million of the US$77.6 million necessary to implement the program in 30 provinces over three years (Global Fund to Fight AIDS Tuberculosis and Malaria, 2011a). International and Thai experts working with the non-government sectors expressed deep concerns over the World Bank reclassification of Thailand as an upper-middle-income country for two reasons: firstly, they believed the aggregate GNI figure used for the classification concealed great disparities between wealth and poverty in the country[39]; and secondly, the

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[39] On the World Bank rating of income disparity Thailand raked 24 with a GINI of 48.4. For comparison Australia ranked 119 with a GINI of 30.3 and Denmark ranked 143 with a GINI of 24.8. The GINI index measures the degree of inequality in the distribution of family income in a country. The more nearly equal a country's income distribution, the lower its Gini index and the more unequal a country's income distribution, the higher its Gini index. If income were distributed with perfect equality the index would be zero; if income were distributed with perfect inequality, the index would be 100 (Central Intelligence Agency, 2016).

reclassification meant the Global Fund would apply restrictions on funds to Thailand and a planned withdrawal from the country. This was clearly a significant impediment to drug policy implementation through services provided by Thai CSO and CBO. At the time of this research, there was no indication that national sources of funding would be forthcoming for these activities and so it appeared that outreach services on harm reduction services provided by these organisations would be forced to cease.

7.4   Thematic Analysis - International Institutions and Issues

Outside of the Thai national political economy, the most influential formal institution comprised a combination of United Nations treaties and agencies, i.e. the various international agreements on drugs to which Thailand was a signatory. ASEAN was another much-discussed formal institution external to the national context. Despite a multiplicity of committees, instruments, policy documents and agreements the consensus seemed to be that ASEAN was a useful forum for sharing ideas but was constrained by consensus-based decision-making which often resulted in the most conservative positions prevailing. Probably the next most significant formal institutions outside the national system were those which comprised a very loose coalition of International NGO. While these were mostly viewed positively for contributions in providing evidence and advocacy for policy dialogue and even some service provision, their influence was usually indirect and did not appear particularly strong. Conversely, the USA government was considered to be the most informally politically powerful and economically resourced institution outside of the national context, influencing drug policy formulation and the policy tools used in implementation.

7.4.1   USA Government

Most of the experts said they believed the USA Government had been very influential in the direction and implementation of Thai drug policy. Most seemed to consider that the history of US influence on Thai drug policy had been achieved through active US foreign policy interventions or tools being purposefully employed rather than from incidental contact or Thailand's passive observation of policy abroad. They explained that this influence had been achieved through the provision of practical support and advice to the Thai government, especially to the Thai Military and agencies of the Thai Ministry of Justice, such as the ONCB. Examples of practical support given included: financial support; air and satellite surveillance; other intelligence; vehicles, such as helicopters, other military and police equipment; technical assistance; and, education and training. The policy direction the US promoted and pursued with Thailand was supply reduction

through such policy instruments or measures as crop eradication, supply disruption, interdiction and prosecution of drug suppliers and users:

> *"USA Government - the US Government drug policies are mirrored almost directly in Thailand but not just for Thailand I would say that the USA Government is probably the most influential globally so **I would put them at the top in terms of the most influential** [emphasis added]. And it is not necessarily in terms of what we want in terms of harm reduction. The USA Government positon is very hard core, prohibitionist drug control and punishment not about public health responses." (International expert)*

> *"A major determinant is the source of funding for policy implementation so this means that USA has been a major influencer of Thai drug policy, particularly via DEA [USA Drug Enforcement Agency] and through the Thai ONCB. And that is why for a long period most of the drug policy in Thai has been nearly the same as USA drug policy which has emphasised law enforcement rather than alternatives or treatment or prevention because the USA policy has been focussed on supply reduction." (International expert)*

Experts spoke a great deal of military aid they believed had been provided by the USA to Thailand, which included general cooperation building, education and training but also described how the US Ministry of Justice and US military provided the Royal Thai Military, Royal Thai Police and the ONCB with technical assistance, training, facilities and technologies for dealing with drugs in Thailand. This included equipping drug surveillance and interdiction programs and programs for the monitoring and eradication of opium crops e.g. with provision of helicopters and satellite access:

> *"The U.S. government has invested a lot of money in Thailand to support a crackdown on drugs. They have sent trainers for the Royal Thai Police; they had sent helicopters for surveillance and other financial support like that." (Thai Senior government official)*

> *"Then when his majesty the King started the Royal Project in about 1969 the United Nations Fund for Drug Abuse Control, called the UNFDAC, gave Thailand about two million U.S. dollars to try to replace the opium production in the hills of Thailand. The funding came through UNFDAC but I understand that the money came directly from the United States." (Thai Senior government official)*

The US government was also described as influencing Thai drug policy through the provision of funding for education and training of the military and law enforcement, for example:

> *"[Thailand] received a lot of technical assistance e.g. the John Jay College of Criminal Justice in New York. They provide courses in and they sent people to Thailand for education and training in policing and criminal justice." (Thai Senior government official)*

Experts also reported that the US government influenced Thai treatment responses, including for example, clinical research, medical treatment, drug rehabilitation programs and attitudes to harm reduction. The US, they said, had provided substantial funding for clinical research, such as the HIV vaccination trials:

> *"There has been a large amount of research in Thailand that has been funded by the U.S., such as clinical trials on vaccines or treatments and so on under ethical guidelines that would never have been passed in the U.S. We had the HIV vaccine trials, the PREP study, clinical drug studies that are being conducted on methadone clients, etc. Methadone clients are convenient targets for this kind of research simply because if you use methadone patients then you have a very high retention rate for your study. That has an influence on health policy and health provision in Thailand. The National Institute on Health in the U.S. has been putting millions of dollars into funded research like this in Thailand." (Regional expert)*

Abstinence-based disease model treatment approaches commonly endorsed in the US, were also supported in Thailand (and other parts of South-east Asia) either directly through US Government agencies or indirectly through US private sector organisations supported by the US government. The discussants described how they considered these disease model and/or abstinence-based treatment approaches were limited in scope and efficacy and how this excluded other effective approaches e.g. brief interventions, out-patient counselling, pharmacotherapy long-term maintenance, harm reduction or many others. Some examples given of the promotion of these abstinence-based disease model treatment approaches included drug treatment technical assistance, education and training through National Institute on Drug Abuse (NIDA), the Matrix Model programs, the Colombo Plan Drug Advisory Programme, and the Day Top Rehabilitation model.

NIDA, for example, is a federally funded institute under the U.S. Department of Health and Human Services which also has a high profile in South-east Asia, teaching that addiction is a chronic brain disease addressed through abstinence-based models (Becoña, 2016). NIDA has funded and actively promoted the Matrix Model programs, including those in South-east Asia. In another example, even though the Day Top Therapeutic Community model for drug rehabilitation is not a US government initiative, at least as far back as 1994 US government public health officials established a Day Top rehabilitation centre called Day Top Village in Kunming, China funded by the US State Department (Bureau for International Narcotics and Law, 1995). The Day Top Therapeutic Community rehabilitation model has been actively promoted and was well

known throughout South-east Asia. In addition, the United States Government is the largest contributor of aid to the Colombo Plan and actively promotes its Drug Advisory Programme in which people from south-east Asian countries were funded to train and become certified in their disease model abstinence-based drug treatment programs. For example, first Colombo plan Drug Advisory Programme training event in Indonesia in 2016 was branded "*Colombo Plan Assists with the Implementation of the Inaugural Indonesia – U.S. Drug Demand Reduction Workshop*" (Colombo Plan Secretariat, 2016,para. 1). This added to the perception in South-east Asia approaches to treatment were often seen to be "*…dominated by abstinence-based behavioural interventions, which, in the main, have been developed in the USA without cultural translation for the Asian region...*" (Khabir, 2003, p. 1879).

> *"The US Government has been a great influence on Thailand in relation to drug control policy and drug treatment e.g. the Thailand Matrix program." (International expert)*

> *"…part of the battle that we face in the region is that there are well funded organisations like NIDA that do not promote harm reduction but promote abstinence-based drug treatment." (International expert)*

> *"There are counsellors in the region that want education and training and qualifications so that they are qualified to practice and the only qualification that they could find was the Colombo Plan. The Colombo Plan has a certification process but the Colombo Plan primarily promotes therapeutic communities and abstinence based approaches to treatment and that is a huge problem. That is an important influence." (International expert)*

This was significant because, *inter alia*, it illustrated the difference between stated US foreign policy on drug prevention and treatment (and HIV prevention) through its international aid program USAID, as opposed to the perceived and actual impact of US Government supported models for treatment, either actively sought by countries in South-east Asia or assertively promoted to countries in South-east Asia by the US organisations. Many experts discussed their perception that the US Federal government had a long-standing opposition to harm reduction in general, and NSP as a specific example of US influence in Thai drug policy:

> *"The US government has been clear about the fact that they do not want to talk about needles and syringes distribution. …Federal money cannot be used to buy needles and syringes although they can do anything else around drug harm prevention and treatment." (International expert)*

> *"…around 2007-2008 all of the funding for injecting drug uses in Thailand was essentially provided by USAID at the time the USA Government policy changed about funding for needle and syringe programs then that was cut out overnight." (International expert)*

On the international stage the US had, until relatively recently, actively opposed harm reduction in international policy or agreements and had not provided support for harm reduction through international aid or other foreign policy support. For example, while the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) fund was "…*the largest contribution to the HIV response from any single nation.*", committing US$52 billion since 2003, only 0.6% of that had been allocated to PWUD and a congressional ban imposed on the fund prevented it from supporting NSP overseas (Cook, Bridge, McLean, Phelan, & Barrett, 2014)[40]. It may be that this long history of highly visible US opposition to harm reduction, its continued contestation domestically, coupled with the active promotion of abstinence-based drug prevention and treatment in South-east Asia by the programs already mentioned, has left Thailand (and neighbouring countries) with the impression that the USA does not support harm reduction or other non-abstinence-based approaches to drug use.

Nonetheless, it was also noted that Government of USA was not homogeneous, in the sense that US policy implementers abroad might not always share the same views as policy makers in Washington:

> *"USAID has a different perspective than the Washington policy makers because USAID has HIV experts based in Bangkok and they know that HIV is transmitted by injecting drug use but their hands are tied by their government's policy. They would assist where they could e.g. by negotiating with GFATM or the Government of Thailand or UN on behalf of PSI* [Population Services International] *and providing support for PSI program evaluations, etc. I wouldn't call it advocacy so much as quiet diplomacy, not in public. However, their focus remains primarily on Men who have Sex with Men." (International expert)*

While some spoke of the US influence as primarily through the generous provision of technical advice, large funding grants, advanced technology and expensive equipment,

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[40] "*In 2009, the ban was lifted, and in July 2010, PEPFAR released Comprehensive HIV prevention for people who inject drugs, revised guidance, which includes a summary of the evidence for the effectiveness of NSPs and states that 'PEPFAR-supported NSPs can include the distribution of injection equipment… However, in 2011, the ban was returned by Congress, and to date, PEPFAR investment has not included funds for the purchase of needles and syringes.*"(Cook et al., 2014, p. 23)

others were more forthright in the way they described what they believed were the methods and motives of this US influence:

> "*The U.S. government has invested a lot of money in Thailand to support a crackdown on drugs. They have sent trainers for the Royal Thai Police; they had sent helicopters for surveillance and other financial support like that." (Thai expert)*

> "*Of course, for the U.S. government the primary role of their embassies is to promote international trade and they're very good at linking trade with any other foreign policy. …And while it is unlikely to be explicit it seems the underlying message is that, "If you want to trade with the U.S. your other policies such as drug policy should be an alignment with ours also." (International expert)*

> "*… the USA Government uses bully intimidation and threats to get countries to formulate policies that the US holds dear. It is not so much about negotiation as saying, 'Thailand, we pay enormous sums of money for you have our military installations in your country if you pursue policies we do not agree with such as harm reduction then we will move our bases to somewhere else like Malaysia. And we are going to cut your subsidies.' That is how the USA Government operates to get other countries to model their drug policies." (International expert)*

This is congruent with Robison's (2010) review of using PEA in which he stated donor countries (e.g. USA) often required that development policy enhances recipient government strategies that are supportive of the donor's economic or geo-strategic interests. He argued, however, that this could operate as a significant constraint, not only on the actions of recipient governments but also, on development practitioners from those donor countries who must acquiesce to, what he described as, "…*their political and economic paymasters*" (Robison, 2010, p. 39).

Others thought that the US government simply served as a role model on drug policy which countries like Thailand tried to emulate:

> "*On the other hand, there is probably a really large segment of the Thailand population that likes the approach of the USA Government on drugs policy and thinks the USA is doing extremely well with their drug policy…" (International expert)*

> "*The U.S. has influenced Thai drug policy. If you look at the mechanisms that we use for monitoring the opium crops these were heavily subsidized by the USA government and when we use that information to track down the opium crops and do the proper eradication operations, and we were able to use it effectively." (Thai expert)*

Some suggested that US influence of Thai drug policy was simply a consequence of broader foreign policy interests:

> *"The United States government would probably be the most influential player on domestic Thai drug policy. There has been quite a lot of work done to understand and unpick why. McCoy's…view about this was that the Americans were only interested in war and trade. They weren't interested in drug policy per se; they were more interested in domestic security and in trade supply and the economic benefits to the USA. This included ensuring that Thailand had a drug policy consistent with the United States but this was not a primary driver of their foreign policy in the region. So, that has meant that the U.S. has had an interest in Thai domestic policy and that has been political stability in the Kingdom of Thailand." (International expert)*

The changes some of the states in the USA were undertaking in cannabis legislation was of interest among experts but in general they seemed to have low expectations of Thai drug policy changing in a similar direction:

> *"…if Thailand wanted to change its policy, for example, to decriminalisation, it would face a lot of pressure through neighbouring countries." (Thai senior government official)*

In terms of PEA, the US Government was a powerful institution with huge resources and considerable informal authority through its execution of its foreign policy in the region. This influence was positioned outside of, and was one step removed from, the Thai national political and social systems, working through support provided to intermediaries within the national system, most notably the military, the ONCB and the Royal Thai Police. These intermediaries were the national system 'winners' in access to additional finance, resources and other international support provided by the USA. Equally, it was noted that the USA Government was not homogeneous in its foreign policy approach to drugs and drug use, and furthermore US foreign policy interests in Thailand were considerably broader than just drugs. Finally, some discussed the changes that were occurring at the time in US domestic drug policy and speculated whether that would also impact on Thailand. There appeared to be diverse views among the experts as to whether those changes might have positive or negative flow-on effects for Thailand.

7.4.2   Association of South-east Asian Nations (ASEAN)

There were a wide range of opinions about the relative influence of ASEAN on Thailand and although two thirds of experts indicated that they thought ASEAN had some influence on Thai drug policy, they each described the strength and quality of that influence quite differently and overall it appeared that, according to the experts

interviewed, ASEAN was not as influential as many other institutions, formal or informal. They discussed how ASEAN had several relevant committees and instruments, such as: the ASEAN Senior Officials Meeting on Transnational Crime (SOMTC); the ASEAN Senior Officials on Drug Matters; the ASEAN Task force on HIV/AIDS, which connected with or informed drug policy in South-east Asia and beyond (some of these examples included China). In addition, there were the ASEAN 'pluses' e.g. ASEAN +3 which included China, Japan and Korea; and ASEAN+6 (the East Asia Summit) which comprises ASEAN+3, Australia, New Zealand, and India. Some characterised ASEAN as ineffective and hamstrung by consensus:

> *"They produce excellent glossy brochures and booklets with all of the right words and right discourse but nothing else. They produce nice plans but there is no effort to actually mobilise resources to implement the plans they have develop d or to change national policy in anyway. So, they are impotent and purely decorative. They kind of have an influence. They hold lots of meeting and are an extravagantly expensive organisation." (International expert)*

Other experts described ASEAN as a group of friends working together to solve problems they had in common. Generally, the more positive interpretations of ASEAN were held by Thai nationals, particularly those working in the Thai Government:

> *"It depends on the leadership. When you have a group of friends you probably know someone who will devote their time and energy to satisfy their friends or to solve the main problem." (Thai Government official)*

> *"So, people when they are friends at the same table, and when your friend says please take this issue then you have to take on something. That is the ASEAN relationship." (Thai Government official)*

Nonetheless, overall it appeared they thought ASEAN was not perceived as being as influential as many other organisations or factors:

> *"I think many people overestimate what ASEAN is. Apart from the issues of common interest, trade and economic roles for example, ASEAN is just a gathering of a number of countries. Many donors and many countries approach ASEAN for some kind of very high-level political commitment on this or that issue but that is not the way that as ASEAN. So, I am not saying that, for example, the Drug Free ASEAN by 2015 policy had no impact but I think that it just reflected the existing national policies of the ASEAN members. When you get the situation where all countries need to agree then it's difficult to make any progress with policies, in the way that for at you might for example if you just needed a majority vote." (International expert)*

There also appeared to be some concern that the consensus-based decision-making which is a feature of ASEAN resulted in policies in which the most conservative positions prevailed:

> *"ASEAN is relevant, for example, they have the policy of 'A Drug Free ASEAN by 2015'… But they are incredibly old fashioned and conservative, even more than the Royal Thai Government… We would have recommendations to make for ASEAN, especially during the war on drugs, but it really fell on deaf ears…. They were not willing do anything at all during the Thai war on drugs. No one in ASEAN was willing to push back on Prime Minister Thaksin, to stand up to him or influence him." (International expert)*

> *"It is a very conservative organisation. I think it is very far from endorsing policies on drug law reform. I do not expect them to change things." (Thai expert)*

A few experts also mentioned Thailand's aspirations of positioning itself as a South-east Asia regional leader in both drug supply reduction and demand reduction responses. They stated they thought this was another important factor which influenced how Thailand framed its domestic drug policy. This was also associated with the issue of the 'regional/international image or 'face' of the country. This was linked to the concept of 'face' discussed previously in detail. In this context experts were referring to the perception about how favourably Thailand was perceived by the world in general and by international organisations such as the United Nations or ASEAN, in particular:

> *"…I think it would matter a lot for Thailand how it would look to other ASEAN countries and when I have spoken to people from ONCB they have said that they want Thailand to become a regional centre of excellence, when it comes to drug rehabilitation. And they give education and training e.g. last year Thailand provided education and training to Cambodia on drug treatment, not through the ONCB but the Ministry of Health through Thanyarak." (International expert)*

> *"Thailand cannot accept it if other countries say that they're not good, compared to other countries in the region, like Laos for example." (Thai expert)*

> *"Agreements like that* [the ACCORD[41]] *would be pressures for Thailand because its international image matters a lot to Thailand." (International expert)*

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[41]The Association of South East Asian Nations and China Cooperative Operations in Response to Dangerous Drugs (ACCORD) was endorsed in October 2000 and included the development of a regional framework to supress and eradicate illegal drugs.

There appeared to be quite different viewpoints between international and Thai experts about the influence of ASEAN. The international and regional experts were more likely to characterise it as lacking enough capacity or credibility to be relevant or effective in national drug policy formulation or implementation, slow to make decisions and agreements and its consensus-based processes tended to reflect the positions of the most conservative members. On the other hand, Thai experts (especially Thai Government experts) appeared to value ASEAN for its informal processes, implicit understandings of shared problems and the cooperative working relationships that it promoted between member countries.

7.4.3   United Nations

The influence of various United Nations agencies (as previously mentioned a full list of United Nations Programs and Funds is provided in Appendix Two) on Thai drug policy was considered important by most of the experts interviewed. There was a great deal of descriptive discussion about the different ways these agencies influenced Thai drug policy, the issues they responded to and the relative strength of their influence. Experts spoke a great deal about the roles of various United Nations agencies on Thai drug policy and the relative type and strength of their influence. The agencies mentioned included UNAIDS, the WHO, the CND, the INCB, but the agency which generated the most discussion and was considered the most influential United Nations body was the UNODC:

> *"UNAIDS, United Nations Office on Drugs and Crime and the whole United Nations body as such are influential but not as influential as they could be. We would love to see them being more influential than they have been in the past and to achieve their mandate. We would love to see them getting more vigorously involved in policy and dialogue and engagement." (Thai expert)*

The UNODC was mentioned frequently by nearly all the experts who, to varying degrees, considered it had some influence and was generally seen by most key stakeholders in drug policy as 'an honest broker'. They discussed its international credibility as a convening power, and its ability to access high-level Thai Government officials and ministers for dialogue on various drug issues, such as CCDU. They also discussed what they perceived as the constraints UNODC worked within:

> *"UNODC has traditionally had a tense relationship with Thailand. I think Government of Thailand sees UNODC as very much outsiders, that they are not sensitive to Thailand cultural context so they don't really work very well with UNODC and that has limited their influence." (International expert)*

"… in the case of the Compulsory Centres for Drug Users, UNODC is one of the lead agencies that is driving that process and encouraging governments in the region to change their policies, to switch from compulsory centres for people who use drugs to a Community-based Model with a menu of options. So, they are very influential and they have huge convening power but in terms of influencing decisions they are bit more restricted because UN agencies typically work by consensus not by majority, so internally there are challenges. Externally, they have to cater for all of their member states and the UNODC office here is not a Thailand office it is a regional office. So, when they come out with products or outputs these have to fit and appeal to all of the countries in the region not just Thailand. So, in that respect UNODC has a lot influence but due to its own internal limitations it restricts its influence in Thailand." (Regional expert)

Some experts expressed frustrations that these restraints (consensus driven decisions making and overriding deference for national sovereignty) limited UNODC's effectiveness. Nonetheless, nearly all experts seemed to consider UNODC's role as critical in monitoring, guiding and advising on drug policy in Thailand, and throughout the region. This was particularly so regarding law enforcement. Experts highlighted UNODC's role in law enforcement; promoting supply reduction strategies, brokering international agreements e.g. on border control, and building the capacity of the Royal Thai Police through education and training, and data collection and reporting mechanisms and so forth:

"UNODC in Thailand has been pretty effective with the police; UNODC has an access point through the Ministry of Justice. They started out a lot of police training and support like that. I do not know what happened but then for some reason they seemed to shift their focus on to stimulants and then they started doing a whole lot of projects on amphetamine type stimulants and basically on trafficking. But while we have been in meetings, we have been in meetings together on Compulsory Drug Treatment Centres and drug policy and rights-based Health Care and so on, with Thai law enforcement agencies and UNODC have been very helpful in facilitating those meetings. Within South-east Asia UNODC has a lot more influence with law enforcement agencies and Ministries of Justice than, for example, UNAIDS or other United Nations agencies." (Regional expert)

Experts also described the relationship between Thai national laws, the United Nations drug treaties, the INCD as custodian of those treaties, and UNODC's oversight of the treaty implementation:

"The Royal Thai Police Force and the ONCB have to listen to what the UNODC advises because Thailand is a signatory to the UN agreements on drugs and so Thailand has agreed to follow these UN policies at the international level." (Thai expert)

"For Thailand two major external international influences have been the UNGASS and the UNODC because the ONCB, as the representative, must coordinate with UNODC on international drug policy agreements and must report to Vienna every year in March and observe the directions of world policy trends and then come back and adjust the policy in Thailand. So, this is an annual mechanism to interact with international drug policy." (Thai expert)

"There is a country representative of the World Health Organization in Thailand who is attached to the Thai Ministry of Health. So, there is a close collaboration between the Ministry of Public Health and the World Health Organization in the field of treatment of drug addicts and in the classification of drugs. They provide technical assistance, expert opinion on treatment and scheduling of drugs." (International expert)

Some also discussed that they perceived a distinct change recently in UNODC's strategy from administration of what they saw as stringent prohibitionist international treaties to mediating health-based approaches including harm reduction.

"Way back when UNODC did their massive propaganda efforts to push their agenda of the United Nations drug conventions, and that is what they did in South and South-east Asia. That was an amazingly ambitious strategic plan to make all countries lay down strict drug laws. UNODC achieved that and today they still retain that kind of power. And then people get very confused when now the UNODC has taken on a different role, they say 'But you told us to do this and now you are telling us not to do it. Make up your mind'. So, they lost a little bit of credibility there." (Regional expert)

This was also noted in the published literature, for example, Bewley-Taylor stated "…*the UNODC remains unable to find a coherent position on harm reduction.*" (2005, p. 427) and raised concerns about what he described as "…*the mixed messages concerning harm reduction interventions coming from the UNODC.*"(Bewley-Taylor, 2005, p. 425).

Most experts appeared to welcome the analysis, guidance, technical assistance and the credibility the United Nations lent to regional and national policy processes They indicated that they perceived it as an enabler of drug policy formulation and to some degree, for drug policy implementation as well, perhaps primarily in monitoring and acting as 'honest broker' in dialogue processes. Yet overall, it appeared that most experts considered these organisations to have, at best a very minor impact on drug policy in Thailand:

"I think the international agencies such as UNODC, UNAIDS are scared to talk to the Thai Government about these issues because they know the government does not want to hear

them and they have to work smoothly with the government. Sometimes the government offers just lies about what is happening and these international agencies know that the government is lying but they decide to keep quiet about it. International agencies make statements to the international community about the broader issues like closing the Compulsory Centres for Drug Users but they do not directly challenge the government of Thailand or talk about the details of how these things should be done." (Thai expert)

In terms of constraints on drug policy reform and health and human rights based approaches the principal custodians of the international drug control treaties, the INCB and the CND appeared to be viewed as more conservative institutions maintaining the status quo of international drug prohibition. The role of the INCB as described by one expert interviewee:

"The INCB mandate and influence comes from the three international drug control conventions that regulate the entire drug control apparatus. They are the custodians for these treaties and they supposed to monitoring and evaluating whether countries are upholding them. This mandate gives them a disproportionate influence on the drug policies of countries. The first treaty of 1961 states in the preamble of that the purpose of the treaty is to improve public health." (Thai expert)

Thailand had permanent representation on the CND and this permanent delegation from Thailand to the CND provided a close connection between Thailand and the CND and the United Nations more generally. The structure and function of the Commission on Narcotic Drugs as explained by a Thai expert interviewee:

The Commission on Narcotic Drugs (CND) is the forum for a regular session in the United Nations every March…The CND is only a channel for discussion of problems and then annually there are recommendations in the form of a resolution that comes out of the CND, as international law that is binding to every member state. The Thai Government respects the resolutions of the CND. Before the finalisation of a resolution there is a lot of discussion among the permanent representatives of other member states as well as the Thai permanent mission. There are approximately 53 members who can vote and 90 observers who, while they cannot vote, can influence the discussion and the direction of the resolutions.

Experts suggested a close alignment between those international policies and treaties with Thai foreign policy and domestic policy related to drugs:

"In forums like Commission on Narcotic Drugs Thailand, more than any other country in Asia, would want to do things that make it look like a good international citizen. Thailand is more susceptible to international influence than some of the other countries in the region. I think Thailand wants to look good to the UNODC." (International expert)

On the other hand, some assessed there were differences between the espoused and operational views of member states on CND:

> *"The U.S. government has been influential because they have a significant presence here in Thailand. Recently the position of the U.S. government on drugs has changed but that does not necessarily mean that people in key positions in the region have also changed their positions. So, if you go to the Commission on Narcotic Drugs now the statement of the U.S. government would be very different from the statements they have made in the past. But at the same time, you may find that some of the statements of people in the country offices, or the diplomatic attaches, however pushing for the same approaches. That is, there may be different applications of the formal government positions by different country offices."*
> *(International expert)*

Thailand is also a member of the INCB and at various times Thailand's representative has been Chair of the INCB Standing Committee on Estimates, Chair of the Committee on Finance and Administration and Vice-President of the Board. Experts considered that this relationship would also influence Thailand's domestic drug policy strongly in alignment INCB:

> *"On the international stage, I think Thailand has been influenced by having membership on the International Narcotics Control Board." (Thai expert)*

> *"The International Narcotics Control Board is very influential in Thailand because they say things the Government of Thailand wants to hear so it is like a self-reinforcing triangle between the Government of Thailand, the USA Government and the INCB. They are all mutually reinforcing each other's positions despite the lack of scientific evidence for these positions." (Thai expert)*

While opinion was divided, it appeared that most the experts were concerned about the influence of the CND and the INCB on Thailand because they considered these relationships pushed Thailand towards more conservative and harsher responses towards PWUD:

> *"Thailand actually gets praise from INCB for their tough approach to drugs, their 'War on Drugs" and for their alternative development projects." (International expert)*

> *"They* [INCB] *publicly name and criticise countries that adopt harm reduction as countries that are promoting drug use." (International expert)*

> *"Ironically if you get criticised by INCB it is because you are doing something about public health, because you are addressing HIV, Hep C, overdose and police harassment and*

corruption. So, in that context it means you are doing good things if you are a country that is criticised by INCB." (International expert)

Other United Nations agencies specifically mentioned as having had some influence were the UNAIDS and the WHO:

"The UNAIDS has also tried to do some work here through the regional office in Bangkok, on the 'opposite side' with mixed results." (Regional expert)

"I think the most important influence, for a while at least, was the UNAIDS convened taskforce. This really was an opportunity to develop a plan together, define tasks, there was funding and each group was talking to each other and was sharing information and there were projects that emerged." (International expert)

Overall, it appeared from the analysis that generally guidance and assistance was welcome from the United Nations. It was perceived as an enabler of drug policy formulation and, to some degree, an enabler of implementation as well. The perceived strength of that enabling capacity varied between UN agencies. For example, on the one hand WHO was seen as principally providing technical information, whereas UNODC was perceived to have a much more active role in convening coordinating and providing technical assistance through programmatic interventions. On the other hand, the principal custodians of the international drug control treaties, INCB and the CND appeared to be viewed as more conservative institutions maintaining the status quo of international drug prohibition. Whether these roles were perceived as favourable or not depended on the position of the expert. That is, those in favour of some kind of drug law reform (the majority of experts) perceived these two institutions as a hindrance, whereas those experts who were most concerned with maintaining current approaches drug use and PWUD viewed them much more positively.

7.4.4 *International Non-Government Organisations*

Several International NGO had close involvement with Thai drug policy processes. Organisations, such as the Canadian HIV/AIDS Legal Network, International Drug Policy Consortium, Harm Reduction International, and the Transnational Institute: convened conferences and meetings in Bangkok and other South-east Asian cities to which they invited government agencies and NGO for informal dialogue on drug policy issues; they engaged in advocacy and lobbying activities; conducted situational analyses and other research activities; published and presented findings, policy briefings and practice guidelines; and, in a few cases, as with Population Services International, they partnered

with local CBO in the implementation of services for PWUD. Other International NGO, such as Human Rights Watch, Open Society Foundation and Amnesty International focussed on identifying, monitoring and reporting on human rights e.g. human rights violations in CCDU and during the Thai War on Drugs. These organisations were apparently viewed positively by nearly all the experts, especially by experts working with or for Thai CSO or CBO:

> *"The last* [International Harm Reduction] *conference held in Bangkok was held in 2012 and that was at a time the Government of Thailand was restating its commitment to a war on drugs approach and after the conference the war on drugs did not really happen. So, while you could not claim a direct influence in targeting a specific individual decision maker or in targeting a specific decision making body in Thailand but through the attention it brings and the media hype it generates it forces governments to play it a bit safer, to be more temperate or take more balance positions on drug control issues. So, their influence is very indirect." (International expert)*

Only a few Thai Government officials appeared to have viewed the involvement of International NGO in the Thai policy space not quite so positively:

> *"There are a lot of international organisations and regional organisations that have their offices in Bangkok and some of these organisations have been active in discussions with the Government of Thailand about how drug problems should be dealt with, including the introduction of harm reduction programs for example. But to my knowledge the Thai Government always seems to have an opposition to the influence of those international organisations because they think Thailand is unique, and programs and practices that worked internationally in other country settings may not work in Thailand because they have their own situation and culture." (Regional expert)*

Organisations, such as International Drug Policy Consortium (IDPC), Harm Reduction International, Population Services International, and the Transnational Institute (TNI) were described as having; lobbied the ONCB, presented lessons learnt on drug policy from other countries, convened meetings in South-east Asia to which they had invited government agencies and CSO for informal dialogue, engaged in advocacy, undertaking research, data collection, evaluation, and service implementation:

> *"So IDPC and TNI would hold multi- stakeholder meetings and bring in expert speakers and they would try to cultivate relationships with key Thai policy makers, e.g. they would take them on study tours." (International expert)*

While organisations such as Human Rights Watch, Open Society Foundation and Amnesty International focussed on identifying, monitoring and reporting on human rights e.g. human rights violations in CCDU:

"I know Amnesty International was also advocating around the 'War on Drugs', we worked to bring the Canadian HIV/AIDS Legal Network which also worked closely with us to develop policy briefs and research into Compulsory Centres for Drug Users." (International expert)

"More recently established international organisations, policy 'Think Tanks', such as, IDPC, TNI, Human Rights Watch, Open Society and so on, influence the people who influence decision-making. But I do not think they have a direct influence on policy. They do this by providing evidence and information and helping people to understand the issues in a way they may not have understood them before. I think they are excellent examples of transforming evidence into meaningful sound bites and I think they do it extremely well. But I have never seen their audience as being policy, rather those who influence policy. They are a medium and I think they have been incredibly affective at doing that." (International expert)

"And now we also have other international organisations like the International Drug Policy Consortium, and the United Nations family such as the UNODC, UNAIDS, and so on who are all speaking with the same tone and try to see how they can intervene in drug policy. And they have some influence on the Thai Disease Control Department because the HIV epidemic in Thailand needs to be brought under control and to do that they need to work effectively on HIV transmission among drug users. And that may be some mechanism that will drive harm reduction [policy in Thailand]. So, it is the international agencies like the Global Fund or UNAIDS can have a voice on that." (Thai expert)

Nonetheless, two examples of direct influence stood out in the discussions. One example was the direct provision of harm reduction services in 10 provinces by Population Services International with finance from the Global Fund; and, the other was direct advocacy action by a collaboration international and national NGO for the endorsement of harm reduction policy in Thailand:

"In 2012, in Thailand IDPC, in partnership with Harm Reduction International and the International HIVAIDS Alliance, initiated an advocacy campaign called 'Support Don't Punish'. They provided materials to in country partners like PSI [Population Services International] and we held activities on 26 June, which is International Day Against Drug Trafficking and Abuse. We held some activities in front of the government house with banners of 'Support Don't Punish'. We protested against the 'War on Drugs' that the Government of Thailand was proposing. The secretary general of the Office the Narcotics Control Board of Thailand came out to meet with us and promised a meeting in two weeks in front of media and we met with him and negotiated and eventually that whole process of

several meetings which started with the IDPC campaign of 'Support Don't Punish' led to the ratification and approval of the harm reduction policy in Thailand." (International expert)

This advocacy victory appeared to be short lived however, as the harm reduction policy which was initially endorsed by ONCB was rescinded soon afterwards. This may be a case which illustrates the earlier discussion about the importance of face in Thailand. It may have been a situation where concerns about public loss of face forced agency representatives to publicly support a position but only temporarily, until the public attention diminished sufficiently for them to feel comfortable in retracting that position.

International NGO appeared to play an important role in highlighting drug policy issues, and informing policy advocacy activities and policy debate. They also appeared to enhance the transparency of policy processes, for example, organizing meetings or other events and by drawing media attention to them. Most experts seemed to value the contributions International NGO made, within the limits of the policy space in which they worked. Be that as it may, being positioned outside the national system their influence was quite indirect, working by trying to influence people or organisations who in turn influenced policy processes, and their power to shape or guide national Thai drug policy processes was considered weak.

7.5 Chapter Summary

This chapter described how the data analysis demonstrated that there were a wide range of influences on the Thai policy environment in general and on drug policy in particular. The results showed the important role of key institutions and the influence of central paradigms, ideologies and cultural values. National level institutions, such as the Royal Thai Military, the Ministry of Justice, and the ONCB have been particularly influential. The analysis also described the important, though distal and thus less substantial, influence of international institutions such as donors and the custodians of international treaties and agreements. The influence of values and ideas, including public opinion and cultural beliefs, and in particular how these impacted on drug policy process was examined in accordance with the PEA framework (DfID, 2009). Furthermore, PEA was also able to accommodate and be enhanced by other relevant theories and models. For example, social construction theory elucidated how national perceptions of PWUD affected public opinion and thus stigma and discrimination (Schneider & Ingram, 1993). The next chapter aims to synthesise the analysis of information from all sources, the literature review, the interviews and survey, into a summary of the findings, to discuss

some of the main strengths and weaknesses of the study, and finally to offer suggestions, based on the analysis, for possible future activities to support drug policy reform, including further potential research.

Chapter 8: Findings

8.1 Research Aims and Methods

This research aimed to identify the key factors which constrained or facilitated the formulation and implementation of drug policy for the prevention of the transmission of HIV (and other BBV) among PWUD in the Thai drug policy environment. To achieve this, relevant policy analysis models were identified, adapted and utilised in a comprehensive approach to systematically identify and understand these key factors. This included a historical and geographical analysis of Thai drug use and policies. Importantly, this illustrated that Thai drug policy has not been static but has experienced significant changes in response to social, economic and geo-political imperatives. The preceding section introduced the analytical models and processes used in the critical examination of the themes and subthemes which emerged from the data. Primary among the models used for analysis was PEA, supported by other previously described models or theories, such as Kingdon's multiple streams approach, Schneider and Ingram's social construction theory, and Hofstede's theory of cultural dimensions, which were described in detail in previous chapters. The research involved multiple methods including literature reviews, interviews and a survey. One of the strengths of this approach was that it allowed for the triangulation of data, and their comparison and contrast, during the thematic analysis.

The discussion of the thematic analysis, in the experts' own words, was structured into approximately 20 subsections highlighting the tangible institutions (national, regional and global) which were active in the Thai drug policy space. The analysis also presented the major intangible influences in the national policy environment, such as Thai cultural and social values, as well as the contested paradigms used to define the policy problems and target policy responses. It elucidated the roles these tangible and intangible factors played including, who were the winners and losers, in terms of political power and economic resources. The examination and interpretation of the analysis showed the factors in the national policy environment that had the most direct and evident effects on domestic drug policy. These included the institutions, cultural and ideological forces that competed and collaborated in shaping policy. That was then followed by an examination of the more distal but still significant factors in the regional and international policy environments. These exerted some influence on the formulation or implementation of Thai drug policy sometimes through the provision of material aid but most often by supporting national key stakeholders to strengthen or transform ideas, ideologies and agendas.

8.2   Summary of Main Findings, Interpretations and Implications

The summary of findings, interpretations and implications is a commentary on the mix of institutional and ideological influences. The critical institutions were: The Royal Thai Military; Ministry of Justice (and especially the ONCB); Royal Thai Police; Ministry of Health; and the key ideologies were the contested paradigms of criminal versus health policy approaches, Thai culture and society, and the social construction of PWUD.

8.2.1   *Royal Thai Military*

Summary of Findings and Interpretation on the Royal Thai Military Theme

According to the experts interviewed, the most significant formal institutions at the national level were, in order from greatest to least influence on drug policy: The Royal Thai Military; ONCB; the Ministry of Justice; the Royal Thai Police; the Ministry of Health; and, finally, among key stakeholders, the national CSO and NGO were considered to have the least political power or access to resources. The ONCB was acknowledged by all as officially and ostensibly the most powerful national organisation on drug policy in Thailand. Conversely, when examining institutions with informal power, the Thai military was perceived to be the most powerful institution in Thailand politically and in relation to drug policy. Since it established itself as the national government, the military should also be cast as the most powerful formal political institution and was an institution which historically has had a significant role in responding to drug problems. In terms of resources, again the Thai military was seen as having greater access to resources (financial, technological, equipment, facilities and personnel) than any other national institution dealing with drug policy. Following the military, the ONCB was considered to be the most well-funded and resourced agency that worked in drug policy. The role of Royal Thai Police was identified as most significant during drug policy implementation rather than at the policy design or formulation level, and communication and coordination with law enforcement were considered critical for successful implementation drug policy strategies and services. Conversely, survey respondents and experts interviewed generally considered the Ministry of Health as a relatively low-ranking ministry, lacking the political authority or budget of, for example, the Ministry of Justice. Lastly, the Thai CSO and CBO appeared to have the least resources or policy weight of any of the national institutions analysed.

Implications on the Royal Thai Military Theme

There appeared to be a powerful coalition between the Thai military, the ONCB, and the Ministry of Justice more generally, with these formal institutions sharing the major proportion of resources and authority related to drug policy, for example, they comprised the majority membership of the National Committee on Drug Policy. The implications of this suggest a nexus where targeted dialogue, advocacy and evidence might maximise political leverage for progression of drug policy reform. As discussed in Chapter Six, recent developments in the Thai drug policy debate have included emphatic statements by Justice Minister of Paiboon that the Thai prohibitionist drug policy had failed and must change. Furthermore, he stated that he believed that ONCB was responsible for perpetuating that drug policy status quo (Koomchaya, 2016). The PEA suggested any significant change in a political economy would create 'winners' and 'losers' (DfID, 2009). It may be that in this case, were there to be a radical change in drug policy (for example, from criminal towards health and human rights-based approaches and instruments) it would necessarily result in a redistribution of departmental budgets, authority and policy influence related to drugs. This may shift resources and political power away from the current powerful coalition and towards a coalition of proponents of health and rights-based approaches, such as the Ministry of Health and community organisations engaged in health service provision for PWUD, their families and other community members. Oftentimes such shifts are resisted by those who stand to lose political and economic resources. Therefore, it may be a pragmatic strategy for key stakeholders consider how substantive losses to budgets, authority and face which could occur during shifts in policy objectives, might be mitigated or otherwise offset. This type of negotiation might be considered undesirable by some observers but has always been a necessary part of the routine political machinations well known in high-level politics.

8.2.2 Contested Paradigms

Summary of Findings and Interpretation on the Contested Paradigms Theme

Those interviewed repeatedly identified the need for a shift from a law enforcement to a public health paradigm in response to drug use as one of the most salient issues in Thai drug policy, as it is in a significant number of other countries of the world. All experts articulated that an increased emphasis on health-based approaches in drug policy implementation was desirable, whether that was simply the provision of treatment for people arrested on minor drugs charges, such as personal use, or policy reforms that involved more comprehensive changes, which could, for example, include harm reduction services with national coverage.

Implications of the Contested Paradigms Theme

In Thailand progress with government ministries and departments of public health and social welfare to rebalance drug policy towards health and rights-based approaches has been modest at best. Policy outcomes might be achieved more effectively by working with coalition members closer to the centre of political power and economic resources, as identified earlier, and for example, priority should be given to acknowledging the key role the Royal Thai Military has played and continues to play in drug policy formulation and implementation. On the other hand, encouraging greater engagement of CSO and PWUD in these policy processes may lead to more innovative and comprehensive solutions by reframing policy problems. During 2016, the Ministry of Justice had undertaken a series of public consultations as part of a review of Thai drug legislation. These consultations included attendance by national and international research and policy experts, as well as Thai CSO and CBO.

8.2.3 *Political Will, Leadership and Stability*

Summary of Findings and Interpretation on the Political Will, Leadership and Stability Themes

Political will, leadership and stability were repeatedly identified as crucial requirements for progress in drug policy reform. Frequent change in government and political turbulence may have increased the difficulty of governments to take more sustained or innovative approaches to policy. It may have also produced 'winners' and 'losers' in the political economy.

Implications on the Political Will, Leadership and Stability Themes

The relative instability of the Thai political system, most especially over the past 10-15 years, appeared to have enhanced the importance of agencies like the ONCB, probably because it had been able to provide much need stability and continuity in drug policy advice over the past 40 years. Conversely, frequent change in government may have made it more difficult for CSO to develop strong and enduring partnerships with government stakeholders. Furthermore, despite concerns by some experts about the impact of the current governing body, it is possible that the military government, its restructure of the national political architecture, and its revision of the constitution may provide the stability necessary for long-term drug policy reform.

8.2.4   Thai Civil Society and Community-based Organisations

Summary of Findings and Interpretation on the Thai Civil Society and Community-based Organisations Theme

CSO and CBO played an important role in advocacy and service implementation and appeared to have offered the only vehicle for PWUD to have an input into advocacy and other policy processes. Conversely, they were reported to be weak in influence and hampered by insufficient coordination, cooperation and alignment of aims. They also appeared to lack established partnerships with government and other interested parties to act as platforms for collaborative dialogue. Although most experts and respondents spoke of the important roles of national CSO and CBO they conceded that these organisations were not particularly powerful or influential, for example, compared with government agencies. Those working within CSO and CBO assessed their own organisations and those of their colleagues as being divided and weakened by those divisions. To date, a wide range of international and NGO groups have been active in Thai drug policy advocacy and implementation. Chief among these was 12D, a coalition of 12 different South-east Asian CSO and CBO. These included organisations focussed on the needs of people living with HIV/AIDS as well as organisations advocating for and assisting PWUD.

Implications on the Thai Civil Society and Community-Based Organisations Theme

The CSO identified the need for more leadership and from the analysis there emerged two related areas where this appeared particularly relevant: firstly, the need to improve coordination, strategy and outcomes among their organisations; and secondly, the need for a policy entrepreneur with the expertise, political access and tenacity to achieve significant influence in drug policy formulation and implementation. One of the issues raised in the interviews and surveys was confusion and conflict of different agendas and objectives of CSO, for example, the conflation of the needs of PWUD and those of People living with HIV. While these groups do overlap, and have come together in the 12D collation of CSO organisations over the issue of harm reduction, the interests of people affected by drugs are much broader than harm reduction and many of the issues of PWUD are not necessarily always the same as those experienced by people living with HIV. This issue may be assisted through the establishment of a Thai national peak body focussed purely on issues of drugs and drug use. As regards the need for policy entrepreneurial leadership, given the political and cultural milieu in Thailand as previously discussed, it is likely that the identification and support for a policy entrepreneur from within the government would have greater efficacy than one from a

CBO representing those who might be perceived by some as 'social deviants' and from one of the lowest strata of the Thai social hierarchy.

While Thai CSO and CBO did seem to have developed good working relationships with the Ministry of Health and its agencies, it seemed unlikely that they would be able to achieve their desired outcomes without similar well-developed collaborative relationships and support from the Ministry of Justice and the ONCB, who appeared to view Thai CSO as at best minor participants in the policy process, and the reflected stigma of the deviants (in the terminology of social construction theory) that they represented probably hampered their access and dialogue in policy process. Therefore, it may be strategic to address the social construction of CSO, NGO and CBO to enhance their influence. One way of doing so would be to focus on advocacy strategies which refashion political and public images of PWUD from deviants existing outside the community to typical community insiders. For example, disseminating media portrayals of (the approximately 90% of) PWUD who were not dependent and continued meet their vocational, family or social responsibilities regardless of their drug use, may help to reconstruct the social perceptions of PWUD. Of course, this example is just one illustration in a complex process of social deconstruction and reconstruction, and it is recognised that a comprehensive and enduring approach would be required to addressed ingrained and widespread perceptions. Nonetheless, it appeared that the national CSO and CBO provided one of the few, perhaps the only, opportunities through which PWUD could directly participate in policy advocacy and service delivery processes and for that reason, they remained a critical institution in the Thai drug policy enabling environment.

8.2.5   Demand Reduction

Summary of Findings and Interpretation on the Demand Reduction Theme

Most experts indicated that they thought that CCDU in Thailand impeded the formulation of evidence-based treatment. There appeared to be four major contentions for this point of view. The first of these was that these centres for drug users could be used politically to make the argument that the government supported the stated positon that drug users are patients not criminals (Royal Government of Thailand, 2002). The second contention was that they could be used further to make the case that the government already provided appropriate health services for these '*patients*'; Thirdly, the first two arguments could then be used to repudiate the need for alternatives, such as evidenced-based community treatment and care services or PWUD. Whereas, the literature review and interview data analysis revealed significant issues with the capacity and quality of care in

the CCDU, as well as the reported high rates of recidivism and human rights abuses which indicated these facilities were not adequate service responses. The fourth contention, in the opinion of experts interviewed, was that the CCDU constituted an obstacle to the implementation of evidence-based drug policy because they were allocated resources which could (and in the opinions of many experts, should) have been used for voluntary community-based treatment and care for PWUD.

Implications on the Demand Reduction Theme

All but a few interviewed experts emphasised that drug use treatment in Thailand needed to be of high enough quality to meet international standards of good practice to ensure: good therapeutic outcomes; low rates of recidivism; cost-effectiveness; and, the involvement of families and the community. CCDU were not perceived to meet those standards. It was believed that Thailand needed to invest in the capacity to deliver large-scale high-quality community-based treatment and care for PWUD. Experts also advised drug treatment centres would probably produce better outcomes for PWUD if they were under the administration of Ministry of Health rather than the Thai Military although of course, this remains untested.

8.2.6   Thai Culture and Society

Summary of Findings and Interpretation on the Thai Culture and Society Theme

Thai Culture and Society was a frequently raised theme and integral to many other themes which emerged in the analysis. It was most often cited as hindering drug policy reform due to negative public attitudes, stigma and discrimination, and the challenges of public participation within a very hierarchical social system. Issues of the Thai cultural veneration of hierarchy and social status, its preference for unity, conformity and conflict avoidance, and, the significant attention to maintaining and saving face, have created a complex context within which multifaceted forces interacted with drug policy and have added cultural challenges to the political processes of negotiating drug policy reform.

Implications on the Thai Culture and Society Theme

Consistent with the some of the themes raised in the chapter examining Thai history and culture in relation to drug policy, a regional expert providing technical assistance on drug policy in Thailand suggested one possible approach for international observers:

> *"Thailand is a complex country that can only be explained by Thais. Sometimes I think we should you stay out of it and let the Thais handle it. We can give advice, offer money, run training programs but let the Thais handle it."*

On the other hand, a less conservative view from the analysis suggested that one implication was that there is a role for the generation of Thai evidence to guide the integration of appropriate elements of the Thai socio-cultural context into tailored national responses to drug use. This will be considered further in the following section. Furthermore, experts and respondents repeatedly mentioned the importance of material, technical and other assistance provided by international and multilateral agencies for monitoring drug policy, supporting advocacy drug policy and legislative reform and even in direct service provision.

8.2.7   Evidence

Summary of Findings and Interpretation on the Evidence Theme

Many interviewed experts argued that locally generated scientific evidence was essential for convincing policy makers to accept and implement health-based approaches to drug use including harm reduction. Yet this was not supported by either the data in the survey from other countries or the literature review. Unlike the data from the face-to-face interviews, none of the survey respondents mentioned that the data must be locally generated. It is possible that this may have been an implicit assumption in some of the comments, but it was never stated explicitly.

From the interview analysis, it appeared that there were more compelling political and policy processes at play which would weigh more heavily on policy formulation decisions and implementation outcomes. This did not mean that evidence was not important but perhaps not as critical in the political process of policy debate as some perceived. Weiss, who worked as an adviser and evaluator of US Government policies and programs for 30 years, was well aware of both the importance and limitations of evidence when she stated, *"…policies and programs with which evaluation deals are the creatures of political decisions"* and explained that while evidence did at times play an important role it was generally a modest one at best (Weiss, 1993, p. 94). In addition, survey responses indicated that evidence generation in the form of monitoring and evaluation of implementation may be just as important or more, for ensuring political support to scale up and sustain drug policies and programs rather than to win arguments of the effectiveness of health-based approaches during policy formulation.

Implications on the Evidence Theme

There was general agreement among respondents and experts that there was a need to generate, disseminate and promote credible and generalisable evidence to inform Thai

drug policy. Significantly, this was not simply to prove that health-based approaches worked (e.g. to prove harm reduction interventions decreased transmission of BBV), for which there is already ample scientific evidence, but to demonstrate successful adaptations of intervention models to the cultural and socio-economic context of Thailand. Various experts discussed this extensively and the following three examples elucidated this point:

i. *"In the south* [of Thailand] *it* [harm reduction] *has worked reasonably well for two major reasons: first, the good role of the religious leaders; and second, there have been other major security issues and so law enforcement has shown a very collaborative approach in implementing harm reduction compared to the other provinces and Thailand. So, I think there will be the lessons that can be used from there."*

ii. *"A critical question that is not being asked enough is 'What are the service needs of people who use drugs but are not dependent on those drugs?"*

iii. *"There are key individuals in Thailand…doing a lot of research and very engaged with the community. We need to identify more individuals like this at the country level ... National Networks may be an effective way of doing this."*

It is most likely this could best be achieved through monitoring and evaluation of policy implementation using OCED Development Assistance Committee (2010) criteria to improve policy and program relevance, effectiveness, efficiency, impact and sustainability (see Appendix 15 for a detailed description of the evaluation criteria), rather than experimental designs, such as randomised control trials to repeat studies which have proven that harm reduction is a safe and effectual health strategy in general. This may be especially salient in resource-constrained contexts.

8.2.8   Public Opinion and Thai Media

Summary of Findings and Interpretation on the Public Opinion and Thai Media Themes

In general, the experts did not seem to believe that the Thai media had much impact on drug policy decisions or design. On the other hand, experts and survey respondents expressed concern about stigma and discrimination perpetuated through poorly informed public opinion. Notwithstanding, they seemed to be more concerned with government messaging and school education about drugs and PWUD than with media messaging. Concerns were expressed about the need for the government to raise awareness and educate the public about drug use and drug users in ways that were evidence-based and non-stigmatising. These statements were consistent with reframing the social

construction of deviant groups (Schneider & Ingram, 1993) to be perceived by the public as more deserving and thus more empowered to participate in social and political processes.

Implications on the Public Opinion and Thai Media Themes

The previously mentioned work of Page and Shapiro (1983) discussed congruence and directionality of influence between policy and public opinion, especially through the influence of the media. This type of assessment indicated that Thai drug policy was reasonably congruent with popular public opinion and the influence appeared to be bi-directional and self-reinforcing. The previous examination of the literature on this topic suggested that a change in Thai drug policy would necessitate either: public opinion changing in congruence with the new policy; or, any drug policy change would need to lead public opinion. Either way, the general voting public would need awareness raising and education, as well as opportunities for dialogue on drug-related issues to increase political support for any drug policy change. Furthermore, it would be, in all likelihood, harder for a government to implement and sustain drug policy reform in the long-term without the support of public opinion. In addition, survey respondents and experts discussed the need to educate members of the government in the same way so that they might be better informed in making policy decisions and implementing those policies. In other words, a better-educated government could help to inform and lead public opinion on drug policy and a more informed public could better participate in democratic processes around government drug policy formulation.

8.2.9   *US Foreign Policy*

Summary of Findings and Interpretation on the US Foreign Policy Theme

Outside of the national policy environment, the experts assessed that by far the most powerful informal external (international) influencing agent on Thai drug policy was the USA. An important caveat or distinction on this point is that the experts' discussions of US foreign policy influence were primarily through military and law enforcement programs rather than via US international development aid. Historically long-standing collaborative relationships between the militaries of the two countries, law enforcement and criminal justice agencies, and these close working relationships were central to this perceived influence. A key example cited by experts was the close and influential relationship between the US Drug Enforcement Agency and the Thai ONCB. The US has worked through national intermediaries, such as the Thai military and Royal Thai Police, in a way that was perceived to achieve its foreign policy objectives and in the process

these intermediaries have been the beneficiaries or 'winners' of foreign material and non-material support.

Implications on the US Foreign Policy Theme

These findings were also supported in the review in Chapter Six of the historical geo-political dynamics which developed during the cold war period and continued thereafter. Notwithstanding this important context, US domestic drug policy and its international role in South-east Asian has been changing. It remains to be seen, for example, if after a century of pursuing drug prohibition and supply reduction policies, the US tentative experiments with harm reduction and recent liberalisation of drug laws in many US states will significantly change the dynamics and focus of US drug policy domestically and abroad in the longer term. It will be of interest, not only to Thailand but many other countries, to follow further developments in US domestic drug policy and examine how subsequently impact upon or shape future US foreign policy, especially in South-east Asia.

8.2.10 United Nations

Summary of Findings and Interpretation on the United Nations Theme

Internationally, the most influential agency with an official or formally endorsed role in advising or influencing Thai drug policy appeared to be perceived to be the UNODC. The UNODC seemed to be generally respected for its convening power and technical expertise, as well as its close relationship with the custodians of the international drug treaties, the INCB and the CND (both perceived to be formal institutions of significant influence on Thai drug policy).

Implications on the United Nations Theme

In its role in regional drug policy dialogue UNODC has demonstrated all three of Kingdon's (2010) policy entrepreneur criteria:

1. A claim to be heard through expertise or representative authority;
2. Political connections or negotiating skills; and,
3. Patience and tenacity.

Nevertheless, their policy influence was indirect and attenuated as a result of being an institution which is not a part of the national policy environment. In addition, perceptions that UNODC had historically strongly promoted stringent prohibitionist international treaties and then more recently changed strategy to encourage health promotion and HIV prevention approaches to drug use appeared to have left some people a little unsure

as yet of UNODC's long-term intentions or objectives. It follows then, that the UNODC may need to continue to articulate its strategic relationship with these two quite different policy positions and how it reconciles them in its drug policy work within the region. Furthermore, it would need to do so in ways that are perceived as unambiguous and ensure they were clearly communicated to and understood by a broad range of stakeholders.

8.2.11 International Non-Government Organisations

Summary of Findings and Interpretation on the International Non-Government Organisations Theme

In the international environment, the International NGO and policy 'Think Tanks', formal institutions with indirect influence at particular times on specific issues were also considered to be significant influencers of Thai drug policy. This was reported by interviewees as being achieved mainly through knowledge management strategies to inform and promote transparency in policy debate and policy implementation. In addition, various donors over time had achieved some influence on particular programming matters, usually, commensurate with the level of finance provided to such programs.

Implications on the International Non-Government Organisations Theme

The most compelling issue of resources was the sustainability of finance provided by the Global Fund for HIV prevention work and harm reduction and the Fund's planned withdrawal from Thailand. National CSO were wholly reliant on Global Fund finance for outreach and harm reduction services and, since it appeared the Thai Government was not willing to fund these from national budgets, it was unlikely that harm reduction services would continue in Thailand. The donor operations in Thailand related to drug policy and services for PWUD, as discussed in the interview data, lacked sustainability and could have done more to align with aid effectiveness best practice by working through existing government financial and government service infrastructure as described under international agreements: the Paris Declaration of Aid Effectiveness; the Accra Agenda for Action; and, the Busan Partnership for Effective Development Cooperation (Meyer & Schulz, 2008; OECD, 2008, 2011, 2012). At the conclusion of this research, advocacy and dialogue in Thailand with the Global Fund, PEPFAR and other potential donors continued with some indications that there might be potential for an extension of funding to continue the harm reduction work begun in Thailand might yet be possible (Thailand Country Coordinating Mechanism, 2016). Even so, there were no

agreements or guarantees and the future of harm reduction services in Thailand remained uncertain at that time.

8.2.12 ASEAN

Summary of Findings and Interpretation on the ASEAN Theme

ASEAN was seen as a formal institution with little official influence in the national drug policy environment. One of the reasons given for this perception was its consensus-based decision making which tended to anchor policy decisions with those of the most conservative members. Some reported that its strength was in offering channels for informal support and influence between members. Furthermore, experts' observations about Thailand's aspirations within ASEAN as a leader in drug supply and demand reduction suggested opportunities for Thailand to achieve such leadership through redress in the balance of their drug policies and services from a criminal to a health-based paradigm. On the other hand, at the conclusion of this research ASEAN, under the chairmanship of Philippines president Duterte, appeared to have begun pursuing an aggressive law enforcement campaign against PWUD.

Implications on the ASEAN Theme

Respondents and experts expressed that they considered official channels for negotiating within ASEAN were unlikely to support any significant movement of policy focus away from continuing rigorous supply reduction, policing and interdiction. While it may be possible that informal networks and relationships between ASEAN members (sometimes referred to as 'diplomatic back channels') might provide some opportunities for unofficial discussion and support other possible approaches, it appeared unlikely that drug policy reform initiatives or support would arise from ASEAN in the foreseeable future. It may also be possible that the formal ASEAN agreements (as described in Chapter Five), the current chairmanship of ASEAN by Philippine President Rodrigo Duterte and the informal 'peer pressure' exerted by the association may have been underestimated some respondents and experts. At the completion of this research for example, the 5th ASEAN Ministerial Meeting on Drug Matters held in Singapore adopted The ASEAN Work Plan on Securing Communities Against Illicit Drugs 2016-2025 (ASEAN Secretariat, 2016) and shortly after Cambodia announced the launch of its first national campaign against illicit drugs (Sophavy, 2016).

8.2.13 Harm Reduction

Summary of Findings and Interpretation on the Harm Reduction Theme

Lastly, in the summary of the discussion, interpretation and implications of the analysis, the focus returns to harm reduction. Harm reduction was a topic which concentrated a great deal of attention, both negatively and positively, on PWUD and drug policy reform, and it seemed that NSP were considered the most contentious of harm reduction approaches. Harm reduction appeared to have been parked before a political impasse waiting either, for the accumulation of evidence to reach critical mass or the opening of a policy window of opportunity and the arrival of a policy champion.

Implications of the Harm Reduction Theme

At this point, the national government appeared unwilling to support harm reduction politically or economically and, with the withdrawal of finance by the global fund and other donors, there was little to indicate that anticipated reforms in drug legislation and strategy would include support for harm reduction policy initiatives. This highly contentious approach has gained little traction in Thailand despite nearly two decades of dialogue and advocacy from national and international groups. It seemed that, as well as very real concerns about the importance of these types of interventions to reduce mortality and morbidity, a government endorsement of harm reduction approaches may have also become a kind of policy touchstone, or perhaps the 'canary in a coal mine', which would signal a seismic shift in the Thai policy landscape for drug policy reform. Therefore, it could be said to be a major factor in drug policy formulation and implementation, whether or not harm reduction services themselves (such as NSP) were successfully implemented and sustained. Regardless, the data from the review of the literature, survey responses and the interviews concurred that harm reduction had gained little traction in Thailand and significant further gains appeared unlikely in the immediate future.

8.2.14 Summary and conclusions

An examination of the data from an interrogation of the published and grey literature, a historical and geographical analysis of Thai drug use and related policy, expert interviews and survey respondents through the lens of PEA has revealed the key institutions, values and paradigms which have shaped Thai drug policy. PEA has also assisted in the interpretation of the dynamic interplay between the various national and international actors and the values and ideologies which are both their driving rationales and the milieu within which they must operate.

Historically drug policy in Thailand has been intermeshed with issues of national security from both foreign and domestic threats, and the military has played a key role in those threat assessments and responses. The role of the military in drug policy has remained central and pervasive, including intelligence, surveillance, crop eradication, interdiction, and even provision of civilian rehabilitation centres. An influential coalition of national institutions, the Royal Thai Military, ONCB, Ministry of Justice, and the Royal Thai Police were given the formal policy mandates, the political and administrative structures, and the economic resources necessary to achieve their mandates of drug prohibition through supply reduction, interdiction and apprehension.

Conversely, the evidence suggested that the Ministry of Health in Thailand has played a relatively junior role and has had to acquiesce to the authority of the Ministry of Justice and the ONCB as the lead agency in drug policy in the country. It appeared that the Ministry of Health along with a loosely associated grouping of national institutions (primarily CSO and NGO) with international support have sought to alter the status quo of Thai drug policy in the direction of evidence-based health interventions for PWUD. They have struggled, however, with significantly less political support or resources and so their achievements to date have been modest. The analysis also described the important, though distal and thus less substantial, influence of international institutions such as donors and the custodians of international treaties and agreements. Nevertheless, in the opinion of experts, 40 years after the establishment of the current Thai drug criminal code and the establishment of the ONCB they were no closer to achieving their stated aims (e.g. A Drug-Free World - We Can Do It, A Drug-Free ASEAN by 2015, or victory in the War on Drugs in Thailand).

Historically the Thai monarchy was able to initiate bold drug policy responses which were largely successful, for example, in terms of reducing social harms and the proceeds of organised crime through the legalisation and regulation of opium. While the role and authority of the current constitutional monarchy has changed has maintained some engagement in drug policy. On the one hand the King had patronised a long-term and successful opium crop eradication alternative development project. On the other hand, attempts in 2011 by HRH Princess Soamsawali to promote the implementation of services to reduce HIV transmission among PWID, including distribution of sterile injecting equipment had not, to date, resulted in tangible outcomes but policy change can be slow and it may be that such efforts will have influence in the future. In addition, over the past decade HRH Princess Bajrakitiyabha has been able to use her position to draw

attention to the quality of life of women in prison and advocate for alternatives to incarceration for women, many of whom were in prison for drug offences. This may help to influence policy and legislative reform in the future but as yet there have been no tangible outcomes from her dedicated efforts. It is also possible that the King's Royal Project received national and international support and became a centrepiece of Thai drug policy because it was consistent with the pre-existing dominant paradigm of Thai drug policy. That is, it was primarily an issue of national security which required a stringent supply reduction response backed by the military.

History has shown that Thailand could mount rapid and successful HIV prevention campaigns. Thailand was justifiably praised internationally for its harm reduction response to the rising rates of HIV among FSW during the late 1980's and early 1990's. Its '100% Condom Campaign' (supported by public health behaviour change communication strategies, testing and treatment) focussed political commitment, high public spending, and a multi-sectorial approach which resulted in dramatic reductions in the prevalence of HIV and other sexually transmitted infections among FSW in less than 12 months from the start of the initiative. Yet, this was in stark contrast to the response to HIV among PWID. Thailand's high rates of injecting drug use, first with heroin and increasingly with ATS, has led to extremely high prevalence rates of HIV and other BBV among PWID, primarily driven by injecting drug use and sharing injecting equipment. Prevalence rates of HIV among PWID have remained at close to 50% since the beginning of the HIV epidemic in Thailand. International and national evidence indicates the resultant mortality and morbidity among PWID, their families and the community could be substantially reduced or prevented through harm reduction measures such as those recommended in the United Nations Comprehensive Package of Interventions for the Prevention, Treatment and Care of HIV among PWID (World Health Organization et al., 2012). Despite this the Thai Government appeared to have been unwilling or unable to design and implement drug policies which would prevent these health and social harms. While certainly not the only reason, and perhaps not even the primary driver, it appears that historically and contemporarily economic factors have been a consideration in drug policy responses. For example, there was a correlation between changes to the royal commodity monopolies, foreign trade agreements, and the establishment of the Royal Opium Franchise. Some interviewees suggested that the economic importance to Thailand of tourism and the commercial sex industry played a part in the harm reduction response to sexually-transmitted HIV. However, it must be noted that this claim has been difficult to validate through published research. It is more likely that the willingness to invest in prevention of HIV among FSW rather than the predominantly male injecting

drug users was related to the different social constructions of these two groups, and the way social stigma and discrimination subsequently manifested differently towards these two groups.

Many experts and respondents expressed concern that the establishment of a military government in Thailand might constrain drug policy reform. Alternatively, it may be the case that precisely because a military government was not subject to the electoral process, need not be concerned about election campaigns or promoting populist policies, nor deal with formalised opposition and debate, that they may have been able to enact policy and legislation changes that a democratically Thai Government might not have been able to achieve. Such may have been the case for significant changes to drug policy and legislation which might not have been easily understood or supported by many voters. In this way, major policy reform might be more rather than less feasible under a military government, if there was a person (a policy entrepreneur) within the military government who would be willing to champion such a course of action. It appeared that General Paiboon, Minister of Justice, may have been that policy entrepreneur. At public drug policy consultations events, he stated that the War on Drugs had not solved Thailand's drug problems but had created further negative consequences. He argued therefore that new approaches were required, especially regarding methamphetamines.

The impact of values, ideas and ideologies (including as manifested in public opinion and cultural beliefs) on drug policy processes was examined in accordance with the PEA framework (DfID, 2009). Furthermore, the PEA was also able to accommodate and be enhanced by other relevant theories and models. Social construction theory elucidated the mutually reinforcing roles played by Thai culture, social values, public opinion in defining drug use, PWUD and the policy responses pursued within the dominant criminal paradigm. Kingdon's three streams model augmented the insights provided by the previously mentioned frameworks pointing to the emergence of a potential policy entrepreneur in Justice Minister Paiboon and the opening of a policy window with the review of national drug policy and legislation currently underway. This is consistent with the description in Chapter Five of Kingdon's proposition that a confluence of at least two of the three policy streams (problem, policy or political) provided the precondition for policy agenda setting during a policy window (Kingdon, 2010). Table 18 summarises some of the main factors in each of Kingdon's three streams which have contributed to a policy window or brief period of opportunity for moving drug policy reform forward in Thailand.

Table 18: Kingdon's Three Streams Applied Drug Policy Reform in Thailand

Problem Stream	Policy Stream	Political Stream
Advocacy of Citizens and Interest Groups *(Thai civil society & community-based organisations)*	A Policy Entrepreneur *(General Paiboon)*	Changes of Administration *(The coup and establishment of a military government)*
External Events and International Agreements *(Recent drug policy reform in an increasing number of countries stimulating international debate)*	Debate by Leading Experts Outside Government *(Dialogues with & publications by Thai CSO, International Think Tanks & United Nations)*	Jurisdiction & Competition Amongst Government Agencies *(Contested paradigms between Ministry of Justice, Ministry of Health and other key stakeholders)*

In regard to drug policy and law reform, there appeared to be shared support for changes that would address, for example, the high numbers of women in Thai prison, more proportional sentences for drug-related crimes, alternatives to imprisonment for people who had committed minor drug-related offences and who had drug dependencies and so forth. At the time of writing an imminent seismic shift in Thai drug policy seemed unlikely but, after decades of harsh enforcement of strict prohibitionist drug policy, any move towards a more health and human rights based approaches would be viewed by many as a positive step. In any country, radical change in a major policy is usually a rare and notable exception to the more gradual or incremental reform. Weiss, US policy advisor and evaluator, said of her experience in US policy work that*:*

> *... evaluators are generally dealing with programs that are only incrementally different from the programs that came before. Not often are they called in to study radically new programmatic efforts, because not many radically new programs see the light of day. So, we tend to study incremental changes, and incremental changes often have modest effects at best.* (Weiss, 1993, p. 108)

While the review of drugs legislation may have been a window of opportunity to shift the balance of drug policy further from criminal sanction towards health-based approaches, PEA explained a change in the policy balance may also meant a change in the balance of political power and access to resources for key stakeholders. In PEA terms, a change in policy would most likely result in the construction of a different set of 'winners' and 'losers'. Nonetheless, it appeared that for most Thai drug policy experts, that regardless of what future policy or legislative developments occurred, their hope was that the PWUD, their families and their local communities would be the ultimate winners.

8.3   Strengths and Limitations

The research encompassed a mixed methods approach, and predominantly a qualitative inductive theoretical approach. This enabled the researcher to draw on a variety of primary and secondary information sources and provided a great deal of rich data for analysis. It also meant that the research used an inductive approach to identify, develop and synthesise new understandings. It allowed for the combination and adaptation of existing theories and models (such as the application of PEA, along with Kingdon's three streams model, social construction theory and other frameworks) in innovative ways during the analysis and interpretation of the primary and secondary data.

The researcher had been resident in Bangkok for 10 years and so had a good understanding of the key issues and many of the nuances of Thai culture, society and politics. Furthermore, although the researcher did not speak Thai at a level fluent enough for a sophisticated discussion of the political economy, he did speak well enough to be able to observe social courtesies and to assist with clarification of discussion points or terminology and it appeared to help to the Thai experts feel a little more comfortable in interview discussions. Furthermore, while living in Bangkok the researcher had worked for several years on international development programs which included working on health, HIV and drugs programs and policies. This not only provided important contextual and content knowledge but also meant the researcher had developed important networks which enabled access to people who may not have otherwise participated, including senior level government officials. In addition, the research benefitted from the Thai perspective brought through the approval process of a Thai ethics committee.

The methodology itself was a strength and an important enabling vehicle for the study. These methods were purposefully sequenced: first, the interrogation of the literature, (which included and extensive review of the grey literature because there is limited systematic peer-reviewed analysis available to inform analysis of policy development in Thailand); followed then by conducting the expert interviews; and, finally the distribution of the survey. This was to allow for each method to inform and strengthen the next. For example, the series of literature reviews assisted in informing the interview protocol and question guide, then interview results help to inform the development of the survey instrument. Data from each method was also compared with the others which further enriched the analysis.

Conversely, when interpreting the discussion, it is important to keep in mind that there were limitations to the data and its analysis due to contextual and methodological restrictions. Firstly, it is worth very briefly discussing the context of this research. During the period of this research the political situation in Thailand was unstable and at times tumultuous. This, at times, consisted of large-scale and long-term street protests, the occupation of streets and government buildings, street violence and armed conflict between the military and civilian groups. While the military coup in 2014 signalled an end to the protests and brought political and civil stability, it also increased perceived intolerance for and (what would be considered in many other countries) censorship of even fairly moderate political critique. Journalists, opposition politicians and ordinary citizens who expressed criticism of the military government were reportedly sent to what the government called "*attitude adjustment camps*" (Rojanaphruk, 2015, para. 1) or simply imprisoned. This impacted on this research in many ways, for example, over time access was blocked to an increasing number of websites that were proving useful to this research. It was in this context that requests for interviews were made and so it may have impacted on the willingness of people to participate in the interviews or the survey and may have also made people more cautious than they otherwise may have been when they did participate. It also created some practical challenges to the conducting research during such a politically tumultuous background, for example, making and keeping appointments with key stakeholders or simply trying to travel through the city was difficult or sometimes not possible at times of protests, curfews or street violence.

There were also language considerations. The research was limited to the English language published and grey literature and Thai literature which had already been translated. No translation of documents was undertaken except to translate into Thai the information on the interview protocol and the interview questions for interview participants. While some Thai research articles and government reports are routinely translated, and published in English not all such material is available in English. To mitigate against this, the research consulted with Thai researchers and academics in the field about whether there was key information in Thai language but not already available in English.

All participants in the interviews were fluent in the English language. This may have excluded potentially different information which might have been supplied by non-English speakers. This may have been more of an issue if the target group for interviews had been service consumers or the Thai public but the target audience for interview participants were people who had extensive involvement in policy advocacy, dialogue,

design or implementation. Most of these people were in middle or senior organisational positions which either attracted or equipped people with strong English language skills. Although the researcher's Thai language skill level was not high enough to conduct a technical discussion with confidence it was sufficient to facilitate the interviews, to assist with clarification of points of discussion where required and to appreciate the cultural context and nuance. Even so, the researcher was a foreigner and this had both advantages and disadvantages. For example, at times it appeared that Thai interview participants were more frank and forthcoming with a well-informed *outsider* or *farang*[42] than they might have been with a Thai colleague. At other times, it was possible that some implicit or culturally embedded understandings which may have been shared by Thai discussants may have been missed by the researcher.

Although there were roughly equal numbers of men and women on the list of potential interview candidates, most women appeared to be more reluctant to respond to an interview request or to agree to interview if they did respond thus, only four of those who agreed to be interviewed were women. One of the reasons for this appeared to be that senior positions in government and NGO were more likely to be held by men and when contacted women were more likely to insist that the interviewer speak with the more senior person rather than them. This type of referral upwards occurred more often with women than men, i.e. a man in a less senior position might be more willing to talk with the researcher, while a woman appeared more likely to insist the researcher contact another person in a more senior position (who was often male). This was a limitation of the research in that it under-represented the voices of women and this might be addressed in future research by, for example, engaging a female researcher to also participate in contacting potential interviewees and engage in the subsequent interview processes.

Interview and survey respondents were sought from a broad range of organisations, including national, international, government, non-government, service provision, policy, administration and so forth. Even so, there was a high representation of respondents who were working for CSO, CBO, or NGO (e.g. approximately 30% of the survey respondents). This was likely to influence the responses, for example, adding emphasis in the data to the issues and perspectives which affected these types of organisations and their activities. Furthermore, the survey was distributed at the International Harm

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[42] The Thai language vernacular for 'white' or Caucasian foreigners.

Reduction Conference. This was intentional because the conference participants reflected the targeted group, people active in the field of drug policy and harm reduction. However, it could have skewed the responses to reflect a greater concern with harm reduction than other issues in drug policy and the responses did appear to reflect this. In addition, because the conference was held in Malaysia it is likely that there would have been a high proportion of people attending from neighbouring countries in South-east Asia. Again, this did appear to be reflected to some degree in the survey data.

In some instances, the responses from the survey provide some information on a matter but not enough to analyse or interpret it further, or sometimes the responses provided raised further questions. This illustrates one of the limitations of an anonymous survey, i.e. further probing of responses was not possible.

The survey was designed with open-ended questions to maximise the scope people had to respond. But in retrospect, the interviews had already produced an abundance of rich data and it may have been more useful to design the survey with more closed-ended questions, and rated responses, such as Likert-type scales so that the rich qualitative information from the interviews could have been supplemented and supported with more quantitative data to produce a more balanced mixed methods approach.

Another limitation was that the researcher was working alone and so was unable to implement a process of inter-rater reliability to develop a degree of concordance among different rates during the analysis.

The interviews provided an enormous amount of information and the interview participants were consistently generous with their time and knowledge. Even so it might have strengthened the research if it had been possible to go back to ask further questions to clarify or augment these following the initial analysis. On the other hand, since the interviewed experts had already been so generous, requesting a second round of interviews may have been stepping beyond the boundaries of professional courtesy and may have resulted in refusals.

In addition, the research analysis and interpretation could have been strengthened if there were more robust, credible and comparable population size estimates of PWUD and PWID available for Thailand over the past few decades. Further, research in this area would be of substantial support for many endeavours related to Thai drug policy

formulation and implementation, including planning and delivery of programs and services for PWUD, their families and the community.

Finally, the thematic analysis identified and examined the major factors and relationships (as described by the experts interviewed and survey respondents and the literature review) in the Thai drug policy environment. This analysis was not exhaustive however, and the Thai policy environment (indeed any major policy environment) is a complex and chaotic system. Of course, as described in the literature review under complexity theory and chaos theory the real world is non-linear and far more complex and chaotic than the analysis of the major factors presented in this and previous chapters.

As described in the earlier discussion of complexity the multidimensional stratification of policy actors each embedded in their own contexts makes causal attribution in complex environments tenuous. Political leaders and policy makers may demand evidence of direct causal attribution and managerial systems may seek or assume it, but in the complexity of the real world, this is often simply not possible (Stame, 2004). This is further explained using the schematic presented in Figure Two which shows the PEA as a map of key stakeholders. The concentric circles indicate the national policy environment and international environment. The tangible institutions (orange) and intangible factors, such as ideologies, values, ideas, etc. (violet). Resources (green) in the form of funding, equipment, technical assistance, research and evidence are shown as crossing the boundaries of the concentric circles because some of these resources are internationally sourced and some sourced from within the national policy environment. Examples are given to show international influence, such as US influence through the provision of resources (funding, equipment, intelligence, training, etc.) to the Thai military and ONCB. The fine dotted lines indicate lines of influence from international key stakeholders which were indirect and relatively weak compared with the thick purple lines of the direct influence the military or ONCB could exert within the national environment. Also, note that the figure suggests that the influence of all institutions must go through, be filtered by and mediated through the nontangible components of the milieu such as culture, public opinion, paradigms use to define policy problems and responses.

Figure 2: Political Economy Analysis Illustrated as a Key Stakeholder Map.
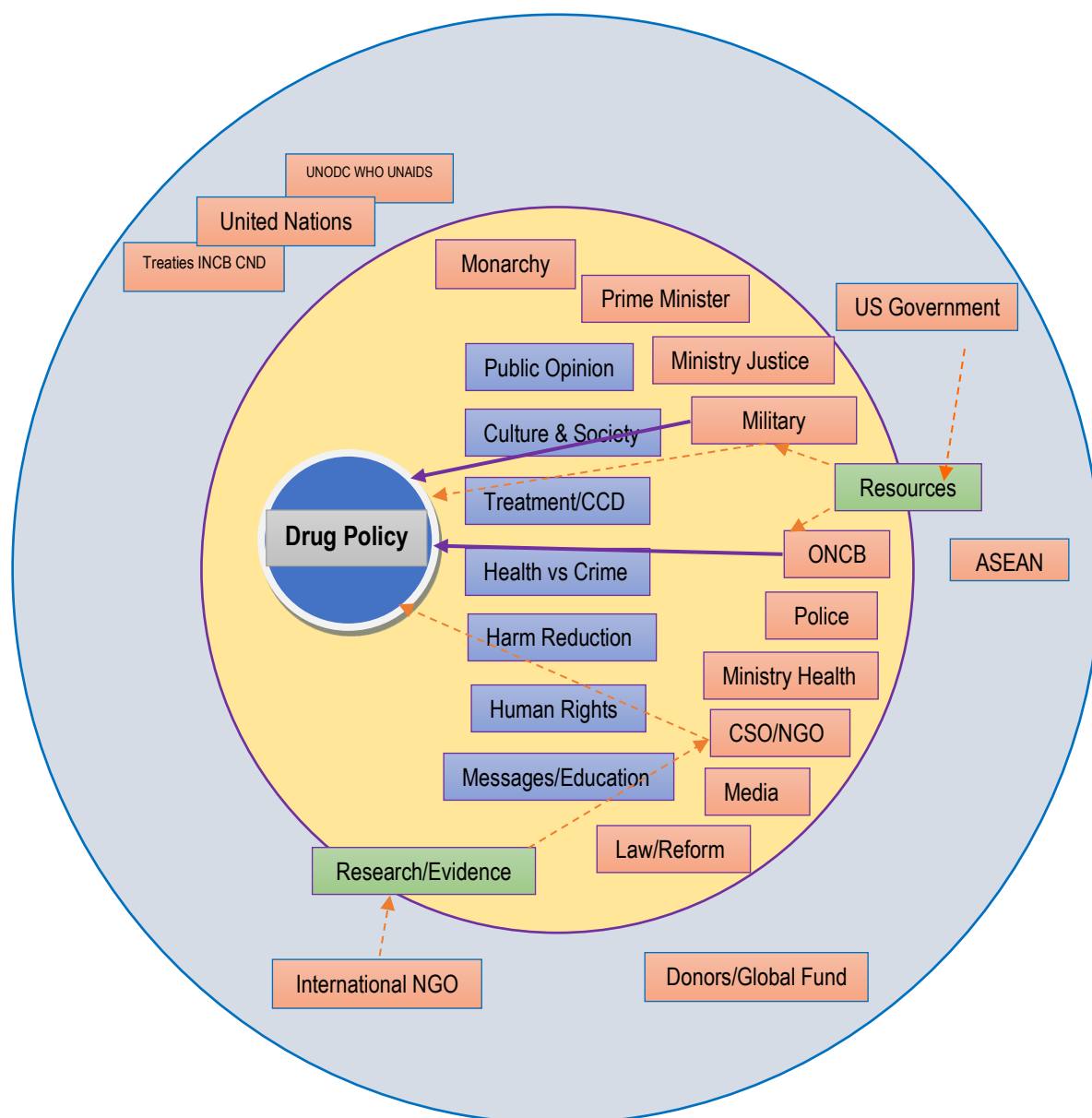
In this schema, there are only the 19 major institutions listed from the thematic analysis and of course there may be others not identified in this analysis. For example, the Thai Department of Corrections would have had some interest in drug policy reform, primarily due to concerns about prison overcrowding. However, it was not included as a theme here because the relatively low frequency with which it was mentioned did not indicate it was a priority, at least in this instance. In addition, the reality of the relationships between various factors would be much more complex than just those major relationships described in the analysis. The 19 items listed here produce 197 dyadic relationships, that is, the sum of each item interacting with each of the others listed in distinct and exclusive

pairs. These relationships alone would produce more phenomena of interest than could be adequately examined within this study.

In reality, all of the items would, however, interact with all the other items in multiple combinations which would produce an almost inestimable number of relationships. These relationships would also be bi-directional interactions between institutions and ideologies. For example, the military influence on drug policy would not just be mediated by public opinion, but the military would also be a mediator of public opinion and so forth. Characteristic of complexity and chaotic environments, this would also produce virtuous or vicious cycles which would be self-reinforcing. For example, when the Ministry of Justice invests in criminal paradigm approaches to drug use, it results in increased arrests and seizures. This, in turn, creates an accumulated evidence of crimes, which then reinforces the apparent veracity of the criminal paradigm of responses to drug use motivating and justifying further investment in criminal responses. Furthermore, the manifold interactions in a multiplicity of directions within the policy environment inevitably obscure 'unknown unknowns' and produce emergent phenomena, both of which, by their nature, contribute to the unpredictability of systems.

8.4   Future Activity and Research

Even as this research was concluding it appeared that leadership on drug policy reform had emerged from within the current Thai Military Government with the Minister of Justice, General Paiboon in the role of policy champion or policy entrepreneur. The advent of such a 'policy window' may be a once in a half-century opportunity for drug policy reform and an opportunity for all key stakeholders to utilise this opening to inform, support and guide the reform process. Conversely, the minister had stated that if he did not get constructive advice on drug policy reform and the active support of key stakeholders (government and non-government) to formulate better drug policy then he would invoke section 44 of the new constitution (Koomchaya, 2016). This would mean policy reform through prime ministerial decree. Such a precedent could result in unintended negative political consequences for drug policy including the exclusion of key stakeholders from further meaningful participation in the policy process. This suggested that it would be critical for key stakeholders to maximise their leverage of this policy opportunity through participating as actively as possible.

In responding to drug use in the new millennium Thailand was being pressed by many key stakeholders to adjust its policy balance along the continuum between the contested

paradigms of criminality and health policy approaches, in favour of the latter. What was not apparent though was agreement about which point on this notional continuum at which Thailand would or should strike a better balance. This is presented visually here in figure three as a notional continuum of policy responses between health-based and crime-based approaches.

Figure 3: Health and Crime-Based Policy Responses as a Continuum

The consultations on drug policy that the researcher attended appeared to achieve vigorous agreement among the various key stakeholders that the current approach to drug policy was not as effective as intended and had created unintended negative consequences (e.g. high rates of BBV transmission, disproportional punishments and prison overcrowding to name a few). However, policy solutions were much less forthcoming at these consultations. An unequivocally clear statement from each of the major stakeholder groups on where they believed Thailand should position itself on the health/criminality policy paradigm continuum and how this would manifest (perhaps, for example, in the form of carefully considered detailed policy or position statements) might assist the debate in moving forward to an eventual negotiated agreement.

Thailand would benefit from a broad and sustained evidence-based public education campaigned about drugs, drug use and PWUD. The research analysis determined that this would be important to: address stigma and discrimination; facilitate community engagement in the policy process; and therefore, assist in Thai society's acceptance, ownership and longer term support for policy change. Such a communications and education strategy should necessarily involve a substantial role for the national media.

The meaningful engagement of PWUD, their families and members of their local communities would be imperative for well-informed inclusive public education as well as the formulation of innovative, effective, cost-efficient and sustainable drug policies and services. This type of community engagement would also be vital for better educating the public and policy makers about the complexities of drug policy issues. Nationally-generated evidence would also be needed to develop culturally and socio-economically relevant health promotion strategies on drug use and to reduce the stigma and discrimination experienced by PWUD.

CSO and CBO would continue to provide a key conduit through which PWUD, their families and communities could have direct input to policy problem identification and the formulation of evidence and rights-based policy responses. Thai CSO may improve their precision of focus, cohesion of purpose and policy impact if they were to form a national peak body dedicated solely to educate and advise on drug issues. In addition, Thai stakeholders, particularly civil society, might consider lessons learnt in other countries (such as their neighbour Malaysia) on the importance of greater engagement and prominence of religious leaders as advocates in policy discussions and community services implementation.

Evidence generated by Thai research was needed. Yet it would have been redundant to set up experimental studies in Thailand just to prove that health-based approaches to drug use reduced mortality or morbidity. This is already well established and a literature review covering the past few decades could provide more than sufficient evidence for that purpose. Nevertheless, it was consistently observed by key stakeholders that Thailand did need to undertake further research to identify local service needs and guidance on how to tailor locally relevant service interventions. This could include for example: national studies which would provide accurate information not only drugs used but on contemporary patterns and emerging trends of how those drugs are used; up to date population estimates of at-risk groups (such as PWID); impacts on and needs of families of PWUD; and monitoring, evaluation and the dissemination of findings on relevant existing Thai programs to support ongoing program improvement, expansion and replication.

The transition from CCDU to evidence-based community treatment and care warranted continued promotion and support. This was another area where it was perceived that a Thai evidence-base should be generated and disseminated to assist the adoption and adaptation of international standards for drug treatment services models to Thailand's cultural and socio-economic milieu.

There were some indications that continued advocacy and negotiation with international donors may yet lead to a funding extension of Thailand's nascent harm reduction services. In addition, and notwithstanding the difficulties, advocacy and negotiation with the Royal Thai Government should continue in parallel with international negotiations to attempt to ensure more enduring budgetary support for the continuation and expansion of these services nationally. This would require political will, for to paraphrase one Thai

expert, a key indicator of political will is the allocation of adequate budget to implement and sustain such policy. The UNODC, International NGO and other relevant multilateral partners (e.g. UNAIDS and WHO) continued to play a significant role in Thai drug policy reform. However, as some experts have pointed out, these institutions needed to be unequivocal and unambiguous in the language they use to describe their policy positions.

Finally, this research utilised a PEA framework (and supplementary models) to critique and better understand the historical and current Thai drug policy enabling environment. If the scope or scale of this research had been greater then, using similar methods of analysis, it might also have been able to do the reverse. That is, use the analysis of the Thai drug policy enabling environment as a case study to critique and contribute improvements or adaptations to the PEA framework (and supplementary models, such as Kingdon's three streams model) appropriate for this context and application. In this way, the research could also have contributed to testing and improving the utility and breadth of models for the analysis of policy environments more generally. This suggests itself as an area deserving of further research.

Appendix 1 - Definitions of Commonly Used Terms

Abstinence	Refraining from alcohol or other drug use, whether for health, personal, social, religious, moral, legal or other reasons. Someone who is currently abstinent may be called an "abstainer", or a "total abstainer". The term "current abstainer" is sometimes used for research purposes and is usually defined as a person who has not used drugs for a specified period, for example, 3, 6 or 12 months.
Abuse	A term in wide use but of varying meaning. In international drug control conventions "abuse" refers to any consumption of a controlled substance no matter how infrequent. In Psychiatry, it has a very specific and clearly defined meaning as provided for example in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), American Psychiatric Association, 2013. However, the term "abuse" is often used pejoratively and imprecisely and so many experts discourage its use.
Addiction	One of the oldest and most commonly used terms to describe long-standing drug use. Increasingly the term has been replaced by the term "dependence". The WHO Lexicon of Alcohol and Drug Terms defines "addiction" as: the repeated use of a psychoactive substance(s), to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance(s), has difficulty in voluntarily ceasing or modifying use, and exhibits determination to obtain the substances by almost any means. In the 1960s, WHO recommended that the term "addiction" be replaced by "dependence", which can exist in various degrees of severity. The ICD-10 does not use the term addiction, but continues to be widely used by professionals and the public.
AIDS	AIDS is a condition in humans in which progressive failure of the immune system allows life-threatening opportunistic infections and cancers to thrive. Without treatment, average survival time after HIV infection is estimated to be approximately 10 years, depending on the HIV subtype.
Analgesic	A substance that reduces pain and may or may not have psychoactive properties. Opioids are analgesics.
Antagonist	A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. For example, naloxone and naltrexone are both antagonists for opioid receptors.
ASEAN	The Association of Southeast Asian Nations is a regional organisation comprising ten Southeast Asian states which promotes intergovernmental cooperation and facilitates economic integration amongst its members. Since its formation on August 8, 1967 by Indonesia, Malaysia, the Philippines, Singapore, and Thailand, the organisation's membership has expanded to include Brunei, Cambodia, Laos, Myanmar (Burma), and Vietnam. Its principal aims include economic growth, social progress, and sociocultural development, protection of regional stability and provision of a mechanism for member countries to resolve differences peacefully.
Benzodiazepines	A group of chemically related drugs used mainly as sedatives, hypnotics, muscle relaxants, and anti-epileptics. Benzodiazepines were introduced as safer alternatives to barbiturates but they have a significant potential for physical and psychological dependence and misuse.
Bioavailability	The fraction of an administered dose of unchanged drug that reaches the blood circulation so when a drug is administered intravenously its bioavailability is 100%. However, when a medication is administered via other routes (such as orally, or via inhalation), its bioavailability generally decreases due to incomplete absorption and first-pass metabolism.
Brief Intervention	A treatment in which structured therapy of a limited number of sessions (usually one to four) of short duration (typically five to 30 minutes) is offered to assist an individual to cease or reduce the use of a psychoactive substance or (less commonly) to deal with other life issues. It is designed for general practitioners and other primary health care workers.
Buprenorphine	Buprenorphine is a mixed agonist/antagonist which can be used in substitution treatment. It has been used extensively in many countries for the short-term treatment of moderate to severe pain. The mixed opioid-action/blocking-action appears to make buprenorphine safe in overdose and possibly less likely to be diverted than pure opioids. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate day dosing.
CD4	CD4 cells, sometimes called T-helper cells, are a type of white blood cell that fight infection.
Co-Morbidity	See: Dual diagnosis.
Compulsory or Mandated Treatment	A characterization of treatment, sometimes called coercive treatment that is organised by the criminal justice system. Typically, a court (or other criminal justice body) orders that an individual enters a therapeutic program (sometimes as an alternative to a custodial sentence). Treatment is mandated in the sense that failure to enter the program or comply

	with its rules may result in the individual receiving the criminal justice penalty that would normally be invoked.
Correctional System	The organization of police, judiciary and penal structures that operate in a state or jurisdiction. The terms "correctional system" and "criminal justice system" are synonymous.
Craving	A strong desire or urge to use drugs, most apparent during withdrawal and may persist long after cessation of drug use. Symptoms are both psychological and physiological. Cravings may be triggered by many different cues, e.g., drug paraphernalia, seeing a dealer, walking past a place where drug use occurred in the past.
Decriminalisation	Essentially substitutes civil penalties for criminal penalties for possession and use of relatively small amounts of illicit the drugs. However, from a legal point of view the drugs are still considered harmful substances and full formal prohibition remains in place
Demand Reduction	A general term used to describe policies or programs directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly in reference to educational, treatment, and rehabilitation strategies, as opposed to law enforcement strategies that aim to interdict the production and distribution of drugs (supply reduction).
Depenalisation	Sometimes used in the context of drug decriminalisation discussions, usually indicates that drug violations (for possession and consumption) remain criminal offences but punishment by means of incarceration was eliminated or sentences were substantially reduced.
Dependence, Dependence Syndrome	According to the WHO Lexicon of Alcohol and Drug Terms, "dependence, dependence syndrome" is defined as follows: as applied to alcohol and other drugs, a need for repeated doses of the drug to feel good or to avoid feeling bad. The terms "dependence" and "dependence syndrome" have gained favour with WHO and in other circles as alternatives to addiction since the 1960s. In the DSM-IV, dependence is defined as "a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems". See also: Addiction
Detoxification	The term "detoxification" literally implies a removal of toxic substances and their metabolites from the body, overtime it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal and any associated physical and mental health problems. See also: Withdrawal, Dependence syndrome.
Diacetylmorphine, Diamorphine	Alternative generic chemical names for heroin.
Drug Abuse	Current international drug control treaties do not define drug abuse but use various terms, including abuse, misuse and illicit use. In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive dose levels, or over an unjustified period.
Drug Substitution	Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The goals of drug substitution are to eliminate or reduce use of a specific substance, especially if it is illegal, or to reduce harm from a method of administration, the attendant dangers to health (for example, from needle sharing), and the social consequences. Drug substitution is often accompanied by psychological and other treatment.
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders is the standard classification of mental disorders used by mental health professionals in the United States and used widely throughout the world. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of different disciplines e.g. medical, psychodynamic, cognitive, behavioural, interpersonal, etc.). DSM-5 (fifth edition), published by the American Psychiatric Association in 2013, was designed for use across settings. It is also a tool for collecting and communicating accurate public health statistics. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets and the descriptive text.
Dual Diagnosis	Also, known as comorbidity. A general term referring to comorbidity or the co-occurrence in the same individual of a substance use disorder and another psychiatric disorder. Making differential diagnoses is often complicated by overlapping signs and symptoms of dependence and diagnostic entries; for example, anxiety is a prominent feature of drug withdrawal. A further complication is with shared casual processes, e.g. a mild mood disorder leading to some drug use which eventually leads to an exacerbation of the mood disturbance, to further drug use, dependence and severe mood disturbance.
Early Intervention	A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided before such time as clients might present of their own volition and in many cases before they are aware that their substance use might cause problems. It is directed in particular at individuals who have not developed physical dependence or major psychosocial complications.

Greater Mekong Region	The sub-region with East Asia which includes those countries which share the Mekong River, i.e. Cambodia, China, Loa PDR, Myanmar, Thailand, and Viet Nam. It is also sometimes referred to as the Greater Mekong Sub-region or GMS.
Hallucinogen	A chemical agent that induces alterations in perception, thinking, and feeling. Examples include LSD, mescaline, and phencyclidine (PCP).
Harm Reduction	In the context of alcohol or other drugs, harm reduction refers to policies or programs that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used for policies or programs that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve lower risk drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce the transmission of blood borne viruses via needle sharing among people who inject drugs .
Harmful Use	According to the WHO Lexicon of Alcohol and Drug Terms, "harmful use" is defined as follows: a pattern of psychoactive substance use that is causing damage to the health of the drug user. The damage may be physical (for example, hepatitis following injection of drugs) or mental (for example, depressive episodes secondary to heavy alcohol intake). Harmful use generally has adverse social consequences as well. The term was introduced in the ICD-10 and supplanted "nondependent use" as a diagnostic term.
Incidence	The rate at which conditions or illnesses occur, often expressed in terms of the number of cases per 10,000 people per year. For example, the incidence of HIV infection is the number of people contracting the virus in a year.
Intoxication	According to the WHO Lexicon of Alcohol and Drug Terms, "intoxication" is defined as follows: a condition that follows the administration of an amount of a psychoactive substance which results in disturbances in the level of consciousness, cognition, perception, judgement, affect, behaviour, or other psychophysiological functions and responses. The disturbances are related to the acute pharmacological effects of, and learned responses to, the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. The term is most commonly used regarding alcohol use.
Legalisation	The complete removal all drug-related offences (use, possession, cultivation, production, trading, and so on) from the sphere of criminal law with no legal sanctions applying.
Maintenance Therapy	Prescription of medication on a long-term basis to support behavioural change. Opioid agonists (methadone, buprenorphine) and antagonists (naltrexone) can both be used in maintenance therapy.
Medication Assisted Treatment	Combination of pharmacological intervention with counselling and behavioural therapies to provide clients with a comprehensive approach to treatment of substance misuse disorders.
Methadone	A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. When given in an adequate dose to opioid dependent individuals, methadone reduces the desire to use heroin and other opiates, eliminates opioid withdrawal, and blocks the euphoric effects of the other opioid drugs. It is the most widely used treatment for opioid dependence in the developed world.
Methadone Maintenance Therapy	Usually abbreviated as MMT. As above: using Methadone to treat Opioid dependence
Naloxone	Naloxone is a narcotic antagonist, blocking opioid receptors in the central nervous system. It is short-acting and primarily used for the reversal of opioid overdose. It reverses the respiratory, sedative and hypotensive effects of heroin overdose. It can be injected intramuscularly, intravenously or subcutaneously. A nasal spray preparation is now also available in some countries. Its trade name is Narcan.
Naltrexone	A drug that antagonizes the effects of opioid drugs. Its effects are similar to those of naloxone, but it is more potent and has longer duration of action. It is used in various ways in the treatment of opioid dependence and alcohol dependence. The most widely adopted use is to prescribe it at a dose that will block the psychoactive effects of all opioid drugs. While the drug needs to be taken daily to maintain that blockade, it can minimize the chance of impulsive decisions to relapse.
Narcotic	A chemical agent that induces stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. However, it is often used loosely to mean any illicit drug, irrespective of their pharmacology.
Needle and syringe programs	Also, sometimes called Needle Exchange Programs. These services reduce the transmission of infectious diseases which occur via sharing of contaminated injecting equipment. They provide sterile injecting equipment (hypodermic needles, syringes, cleaning swabs, water for injection, etc.) in exchange for used needles which are then safely disposed. In practice, an "exchange" is not always required and clean injecting equipment is provided on demand. Usually the service is free but some programs require a small payment.

Non-Government Organization	Usually abbreviated to NGO. A service agency which is independent of government and operates in a broad social field. As most of them are non-profit, non-governmental organisations (NGOs) can be funded by Governments, public institutions and/or private donations. Often, such agencies have a mix of paid staff and voluntary workers and they often provide services in sectors where it would not be possible to provide funding for fully-paid staff.
OECD	The Organisation for Economic Co-operation and Development was established in 1961 to promote policies that will improve the economic and social well-being of people around the world. Originally focussed on the reconstruction of post-war Europe it now has 34 member countries and a global mandate.
OECD-DAC	The OECD Development Assistance Committee promotes development co-operation and other policies to contribute to sustainable development, including pro-poor economic growth, poverty reduction, improvement of living standards in developing countries, and a future in which no country will depend on aid.
Opiate	According to the WHO Lexicon of Alcohol and Drug Terms, "opiate" is defined as: one of a group of alkaloids derived from the opium poppy (Papaver somniferum) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma and respiratory depression. The term opiate excludes synthetic opioids such as methadone.
Opioid	According to the WHO Lexicon of Alcohol and Drug Terms, "opioid" is: the generic term applied to alkaloids from the opium poppy (Papaver somniferum), their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses.
Opioid Substitution Treatment	Usually abbreviated as OST. See Maintenance Therapy
Outreach	A community-based activity with the aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Outreach can be "detached", "peripatetic", or "domiciliary" or "peer". Detached outreach takes place outside of an agency or organizational setting in public places such as the streets, public transport stations, nightclubs, hotels and cafes. Peripatetic outreach focuses on organisations (for example, half-way houses, needle exchanges, youth clubs, schools and prisons) rather than individuals. Domiciliary outreach takes place in people's homes. Peer (or indigenous) outreach projects use current and former members of the target group (e.g. people who use drugs) as volunteers and paid staff.
Overdose	The use of any drug in such an amount that acute adverse physical or mental effects are produced. Overdose may produce transient or lasting impairment or death. The lethal dose of a specific drug varies with the individual and with circumstances. Many overdoses are the result of inadvertently or deliberately combining drugs (polydrug use). Deliberate overdose is a common means of suicide and attempted suicide.
Peer Support	The peer support or outreach worker provides some form of assistance to a peer. The assistance is usually ongoing rather than a single discrete episode. Examples include support provided by peer carers of people living with AIDS who may be unwell. The term "peer support group" is used to describe collectives or self-organisations of members of a community for representing their shared interests at a community level.
Polydrug Use	The simultaneous or sequential non-medical use of more than one drug.
Prevalence	A population measure of the extent of a condition or illness usually expressed in terms of the number of cases per 10,000 people in a given population. For example, the prevalence of HIV infection is the number of people in a population infected with the virus at a point in time.
Prevention	An intervention designed to avoid or substantially reduce risk for the acquisition or further development of adverse health and interpersonal problems.
Psychoactive Drug or Substance	Substances which act upon the central nervous system, affect brain function, and can cause temporary changes in perception, mood, consciousness and behaviour. That term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit, of interest to drug policy. "Psychoactive" does not necessarily imply dependence-producing.
Regulation	Refers to the administration a controlled legitimate market for the production, distribution and sale. Such regulations would determine parameters for quality control, availability, access, and pricing (by taxation); as has been used variously for pharmaceutical drugs, caffeine, alcohol, tobacco and so forth.

Rehabilitation	The process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation typically follows an initial phase of treatment in which withdrawal and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training, and work experience. There is an expectation of social reintegration into the wider community.
Relapse	A return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse ("slip"), with the latter denoting an isolated occasion of alcohol or drug use. The rapidity with which signs of dependence return is thought to be an indicator of the severity of the drug dependence.
Residential Treatment	Treatment and rehabilitation services are provided in residential setting, i.e. the client resides at the facility for an agreed period. The programs generally strive to provide an environment free of substance abuse, with an expectation for compliance in various activities such as withdrawal, assessment, information/education, counselling, group work, and the development or recovery of social and life skills.
Risk Reduction	Risk reduction describes policies or programs that focus on reducing the risk of harm from alcohol or other drug use. Risk reduction strategies have some practical advantages because risky behaviours are usually more immediate and easier to objectively measure than harms, especially those harms which have a low prevalence. For example, it may be more practical to measure reduced sharing of needles and other injecting equipment than harm such as the incidence of HIV. See also: Harm reduction, Safer use.
RNA	RNA stands for ribonucleic acid. HIV RNA tests detect the virus directly (instead of the antibodies to HIV) and thus can detect HIV at about 10 days after infection, as soon as it appears in the bloodstream, before antibodies develop. These tests are costlier than antibody tests and therefore are not generally used for an initial screening test.
Safer Use or Lower Risk Use	Although some people refer to 'Safe use' most consider this to be inappropriately optimistic and 'Lower Risk Use' more accurate. Most drugs may be used in a way in which risk of adverse consequences is reduced by means of a combination of safer preparation, low dose, safer route of administration and in safer settings. In most cases, it is possible to identify drug-using practices which reduce, though usually not eliminate, the risk of serious adverse consequences.
Screening	A rapid procedure designed to detect individuals who have a substance abuse problem.
Stimulant	Any agent that activates, enhances, or increases central nervous system activity. Examples are amphetamines, cocaine and caffeine.
Substance Abuse	DSM-IV-R Criteria: A maladaptive pattern of substance use, leading to clinically significant impairment and distress, as manifested by 1 or more of the following, occurring at any time in the same 12-month period: 1) Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home substance is often taken in larger amounts or over a longer period than was intended 2) Recurrent substance use in situations in which it is physically hazardous 3) Recurrent substance use – related legal problems 4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance use
Substance Dependence	DSM-IV-R Criteria: A maladaptive pattern of substance use, leading to clinically significant impairment and distress, as manifested by 3 or more of the following, occurring at any time in the same 12-month period: 1)Tolerance, as defined by either of the following: a) a need for increased amounts of the substance to achieve intoxication or desired effect b) markedly diminished effect with continued use of the same amount of substance 2) Withdrawal, as manifested by either of the following: a) the characteristic withdrawal syndrome for the substance b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms 3) The substance is often taken in larger amounts or over a longer period than was intended 4) There is a persistent desire or unsuccessful efforts to cut down or control substance use 5) A great deal of time is spent in activities necessary to obtain the substance 6) Important social, occupational, or recreational activities are given up or reduced because of substance use 7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance use

Substance Use Disorder	DSM-5 Criteria 1. Substance is taken in larger amounts or over a longer period than was intended 2. There is a persistent desire or unsuccessful efforts to cut down or control use 3. A great deal of time is spent in activities necessary to obtain, use, or recover from use 4. Craving, or a strong desire or urge to use their substance of choice 5. Failure to fulfill major role obligations at work, school, or home 6. Continued use despite persistent or recurrent social or interpersonal problems 7. Important social, occupational, or recreational activities are given up or reduced 8. Recurrent substance use in situations in which it is physically hazardous 9. Continued use despite having persistent or recurrent physical or psychological problems likely to have been caused or exacerbated by the substance
Supply Reduction	Refers to policies or programs which aim to interdict the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.
Tolerance	A state in which continued use of a drug results in a decreased response to the drug. Increased doses are needed to achieve the same level of effect previously produced by a lower dose. Tolerance develops fastest with more frequent episodes of use and with larger amounts per occasion. Tolerance may be metabolic or functional. Metabolic tolerance usually arises because of an induction of liver enzymes which acelerate metabolism of a drug dose, thereby reducing the level and duration of blood-drug levels. Functional tolerance refers to diminished effects of a given blood-drug level and thought to occur both by neuroadaptation and by the user learning to anticipate and accommodate intoxicating effects.
Treatment	The WHO Expert Committee on Drug Dependence 30th Report described the term treatment as referring to "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and wellbeing is reached". More specifically, treatment may be defined as a comprehensive approach to the identification, assistance and health care for a person's presenting problems caused by using a psychoactive substance. Treatment services aim to maximize clients' physical, mental and social abilities to help them to attain social and psychological outcomes, including to reduce, control or completely abstain from drug use. Treatment services and opportunities can include supervised withdrawal, substitution/maintenance therapy, counselling and psychosocial therapies.
Urine testing or Urinalysis	Analysis of urine samples to detect the presence of substances a person has ingested, or for other medical or diagnostic purposes. Different drugs can be detected in the urine for different time periods. Heroin and amphetamines can only be detected in the urine within a few days of last use, while cannabis may be detected up to several weeks after last ingestion in persons who have been long-term heavy users.
Withdrawal or Withdrawal Syndrome	According to the WHO Lexicon of Alcohol and Drug Terms a withdrawal syndrome is: a group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psycho-pharmacological meaning of dependence.

Appendix 2 – List of United Nations Programs and Funds

The following definitions and descriptions were taken from the United Nations Website: http://www.un.org/en/sections/about-un/funds-programmes-specialized-agencies-and-others/index.html

1. UNDP - The United Nations Development Programme works in nearly 170 countries and territories, helping to eradicate poverty, reduce inequalities and build resilience so countries can sustain progress. As the UN's development agency, UNDP plays a critical role in helping countries achieve the Sustainable Development Goals.

2. UNICEF - The United Nations Children's Fund provides long-term humanitarian and development assistance to children and mothers.

3. UNHCR - The United Nations High Commissioner for Refugees protects refugees worldwide and facilitates their return home or resettlement.

4. WFP - The World Food Programme aims to eradicate hunger and malnutrition. It is the world's largest humanitarian agency. Every year, the program feeds almost 80 million people in around 75 countries.

5. UNODC - The United Nations Office on Drugs and Crime helps Member States fight drugs, crime, and terrorism.

6. UNFPA - The United Nations Population Fund is the lead UN agency for delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled.

7. UNCTAD - The United Nations Conference on Trade and Development is the United Nations body responsible for dealing with development issues, particularly international trade – the main driver of development.

8. UNEP - The United Nations Environment Programme established in 1972, is the voice for the environment within the United Nations system. UNEP acts as a catalyst, advocate, educator and facilitator to promote the wise use and sustainable development of the global environment.

9. UNRWA - The United Nations Relief and Works Agency for Palestine Refugees has contributed to the welfare and human development of four generations of Palestine refugees. Its services encompass education, health care, relief and social services, camp infrastructure and improvement, microfinance and emergency assistance, including in times of armed conflict. It reports only to the UN General Assembly.

10. UN Women - UN Women merges and builds on the important work of four previously distinct parts of the UN system, which focus exclusively on gender equality and women's empowerment.

11. UN-Habitat - The mission of the United Nations Human Settlements Programme is to promote socially and environmentally sustainable human settlements development and the achievement of adequate shelter for all.

UN Specialized Agencies

12. The UN specialized agencies are autonomous organisations working with the United Nations. All were brought into relationship with the UN through negotiated agreements. Some existed before the First World War. Some were associated with the League of Nations. Others were created almost simultaneously with the UN. Others were created by the UN to meet emerging needs.

13. The World Bank - focuses on poverty reduction and the improvement of living standards worldwide by providing low-interest loans, interest-free credit, and grants to developing countries for education, health, infrastructure, and communications, among other things. The World Bank works in over 100 countries. The World Bank Group:
    a. International Bank for Reconstruction and Development (IBRD)
    b. International Centre for Settlement of Investment Disputes (ICSID)
    c. International Development Association (IDA)
    d. International Finance Corporation (IFC)
    e. Multilateral Investment Guarantee Agency (MIGA)

14. IMF - The International Monetary Fund fosters economic growth and employment by providing temporary financial assistance to countries to help ease balance of payments adjustment and technical assistance. The IMF currently has $28 billion in outstanding loans to 74 nations.

15. WHO - The World Health Organization is responsible for global vaccination campaigns, responding to public health emergencies, defending against pandemic influenza, and leading the way for eradication campaigns against life-threatening diseases like polio and malaria.

16. UNESCO - The United Nations Educational, Scientific and Cultural Organization focuses on everything from teacher training to helping improve education worldwide to protecting important historical and cultural sites around the world. UNESCO added 28 new World Heritage Sites this year to the list of irreplaceable treasures that will be protected for today's travellers and future generations.

17. ILO - [The International Labor Organization](#) promotes international labour rights by formulating international standards on the freedom to associate, collective bargaining, the abolition of forced labour, and equality of opportunity and treatment.

18. FAO - The [Food and Agriculture Organization](#) leads international efforts to fight hunger. It is both a forum for negotiating agreements between developing and developed countries and a source of technical knowledge and information to aid development.

19. IFAD - The [International Fund for Agricultural Development](#), since it was created in 1977, has focused exclusively on rural poverty reduction, working with poor rural populations in developing countries to eliminate poverty, hunger and malnutrition; raise their productivity and incomes; and improve the quality of their lives.

20. IMO - The [International Maritime Organization](#) has created a comprehensive shipping regulatory framework, addressing safety and environmental concerns, legal matters, technical cooperation, security, and efficiency.

21. WMO - The [World Meteorological Organization](#) facilitates the free international exchange of meteorological data and information and the furtherance of its use in aviation, shipping, security, and agriculture, among other things.

22. WIPO - The [World Intellectual Property Organization](#) protects intellectual property throughout the world through 23 international treaties.

23. ICAO - The [International Civilian Aviation Organization](#) sets international rules on air navigation, the investigation of air accidents, and aerial border-crossing procedures

24. ITU - The [International Telecommunication Union](#) is the United Nations specialized agency for information and communication technologies. It is committed to connecting all the world's people – wherever they live and whatever their means. Through our work, we protect and support everyone's fundamental right to communicate

25. UNIDO - The [United Nations Industrial Development Organization](#) is the specialized agency of the United Nations that promotes industrial development for poverty reduction, inclusive globalization and environmental sustainability.

26. UPU - The [Universal Postal Union](#) is the primary forum for cooperation between postal sector players. It helps to ensure a truly universal network of up-to-date products and services.

27. UNWTO - The [World Tourism Organization](#) is the United Nations agency responsible for the promotion of responsible, sustainable and universally accessible tourism.

Other Entities

28. UNAIDS - The [Joint United Nations Programme on HIV/AIDS](#) is co-sponsored by 10 UN system agencies: UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, the ILO, UNESCO,

WHO and the World Bank and has ten goals related to stopping and reversing the spread of HIV/AIDS.

29. UNISDR - The United Nations Office for Disaster Reduction serves as the focal point in the United Nations system for the coordination of disaster reduction.

30. UNOPS - The United Nations Office for Project Services is an operational arm of the United Nations, supporting the successful implementation of its partners' peacebuilding, humanitarian and development projects world-wide.

Related Organisations

31. IAEA - The International Atomic Energy Agency, is the world's centre for cooperation in the nuclear field. The Agency works with its Member States and multiple partners worldwide to promote the safe, secure and peaceful use of nuclear technologies.

32. WTO - The World Trade Organization is a forum for governments to negotiate trade agreements, and a place where member governments try to sort out the trade problems they face with each other.

33. CTBTO - The Preparatory Commission for the Comprehensive Nuclear-Test-Ban Treaty Organization promotes the Comprehensive Nuclear-Test-Ban Treaty (which is not yet in force) and the build-up of the verification regime so that it is operational when the Treaty enters into force.

34. OPCW - The Organisation for the Prohibition of Chemical Weapons is the implementing body of the Chemical Weapons Convention (CWC), which entered into force in 1997. OPCW Member States work together to achieve a world free of chemical weapons.

Appendix 3 - Information for Interview Participants

Interview about Drug Policy in Thailand

What is the purpose of this interview?

The interview aims to gather information to help understand the things that influence drug policy in Thailand.

Who is conducting the interview?

My name is Michael Cole and the research is part of my PhD studies with Curtin University, Perth, Australia. For the past 8 years, I have been based in Thailand working in the field of international development. My email address is michael.cole@student.curtin.edu.au and my phone number is 0815 736 822.

Who funded this research project?

This research is fully funded and supervised by Curtin University.

Why have I been asked to participate?

You have been identified as someone who has expertise with drug use, harm reduction and/or HIV and who can provide us with special insights regarding these issues. Interview participants were selected to include a broad range of perspectives; government and non-government sectors, and service providers and non-service providers.

How long will the interview take?

This interview should take around 20-30 minutes to complete (depending on the depth of your responses).

Will my answers be confidential?

Your responses will be completely confidential. Interview responses will not include names, positions or other personal identifying information and the identity of the participants will not be known by anyone other than the researcher. No completed interviews will be published or distributed in anyway and no individual's name will be associated with any of the results. Only grouped data will be discussed.

Who sees my answers?

I am the only person responsible for collecting the information. Completed interviews will not be seen by anyone else. Any demographic information you provide (such as where you work) will <u>NOT</u> enable your responses to be linked back to you. Responses from the interview will be presented as being from groups of people not individuals. In this way, anonymity will be safeguarded. You can decline to answer any question and to withdraw from the study at any time.

What happens to the information I take part in the interview?
The information will be stored in a non-identifiable form, identified by code only, will be stored on a password protected hard drive which can only be accessed by the researcher.

How do I consent to participate?
You can simply consent to participate in the interview verbally. If you do not to give your consent, then you do not need to do anything more after reading this. Your involvement is purely voluntary, and at any stage you may withdraw your consent and any information you have provided will be destroyed unless you give permission to retain it. No compensation will be paid to interviewees for participating in the interview.

Recording the interview
If you consent, then I will use a voice recorder during the interview so that I can make certain I get an accurate record of your responses. As soon as the study is completed the recording will be erased and/or destroyed. If you do not consent to the use of a voice recorder, then I will only rely on hand-written notes of the interview.

Supervision and Ethics Approval

My supervisors are Professor Steve Allsop (s.allsop@curtin.edu.au) and Dr Susan Carruthers (s.carruthers@curtin.edu.au). If you have any questions you can contact me or my supervisors. I also receive advice from an Associate Supervisor at Chulalongkorn University.

This study has been approved by both:
1. The Curtin University Human Research Ethics Committee (Approval Number 4856). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au

2. The Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU). Institute Building 2, 4th flr, Soi Chulalongkorn 62, Phyathai Rd., Bangkok 10330, Thailand, Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th.

When the study is completed a summary report will be put on NDRI's website so you can review the outcomes. If you would like to receive notification and an internet link to the report please indicate below.

☐ I want to receive notification when the study is completed and available on the NDRI website.

Thank you for consenting to participate in the interview. Your contribution is very important to gain an accurate understanding of the influences on drug policy in Thailand.

Appendix 4 – Interview Question Guide

Interview Questions about Policy Responses to Prevent HIV transmission from Illicit Drug Use in Thailand

1. Which most closely describes the type of **organisation you work** with?
   [   ] Government Health Agency, [   ] Government Law enforcement, [   ] Academic Institute, [   ] Research Organisation, [   ] International Development Agency, [   ] United Nations Agency, [   ] International Finance organisation, [   ] Non-Government Organisation, [   ] other (please specify)………………………………………………….

At the International and Regional Level

2. In your opinion, at the international level who are the major organisations/people which influence drug policy in Thailand?

Prompts: Only individuals, agencies or departments you think have a <u>major</u> or <u>significant</u> impact on drug policy in Thailand

3. How influential do you think each of these major influencers is?

Prompts: 1 – Not at All Influential   2 – Slightly Influential 3 – Somewhat Influential   4 – Very Influential,   5 – Extremely Influential

4. What type of influence you believe they have?

Prompts: consider types of influence like Political, economic, social, information, technological, or some other kind of influence e.g. powerful allies or spiritual authority?

5. How did they achieve this influence?

Prompts: What type of actions, behaviours or strategy did they use?

6. What is has been the effect of their influence on Thai Drug policy?

Prompts: Did their influence slow/accelerate/ stop/start/changed direction etc. of drug policy debate or implementation?

At the National Level   *(same questions and same prompts but focussed on national level stakeholders)*

7. In your opinion at the national level who are the major organisations/people which influence drug policy in Thailand?

8. How influential do you think each of these major influencers is?

9. What type of influence you believe they have?

10. How did they achieve this influence?

11. What is has been the effect of their influence on Thai Drug policy?

At the International and Regional Level and National levels

12. How would you describe the way each of these various major influencers (of Drug Policy in Thailand) they interacted with each other?

Prompts: What types of interactions did they have with each other? Did they support, obstruct, harmonize with, ignore, or work independently of other major players? Do not need to mention every combination of stakeholder previously mentioned but the relationships that seem most important to you.

13. Do you have any other comments you would like to add about how Thai illicit drug policy is influenced?

Priority Responses to Drug Use for Thailand

14. Do you think there are there are more services, or different types of services, needed in Thailand for the prevention and treatment of drug use? If yes, then what do you think are the most important priorities for Thailand over the next few years?

Prompt: Some possible examples of services/interventions for implementation of Thailand's response to illicit drug use are listed below for your consideration. There also may be other services or interventions not listed that you might want to add. Please give your opinion about which services/interventions Thailand should give priority over the next few years.

   i.   Change in legislation to increase legal penalties against drug production and distribution

   ii. Change in legislation to increase legal penalties against drug use and drug possession

   iii. Community Treatment Services for people who sometimes use drugs but are not dependent on or addicted to those drugs

   iv. Compulsory Treatment centres for people who are dependent on/ addicted to drugs

   v.   Condom programs for people who inject drugs

   vi. HIV medications (Antiretroviral therapy) for drug users who are living with HIV

   vii. Needle and syringe programs

   viii. Opioid substitution therapy (e.g. methadone or buprenorphine)

   ix. Prevention and treatment of sexually transmitted infections (e.g. gonorrhoea, chlamydia, etc.)

   x.   Prevention, diagnosis and treatment of tuberculosis (TB)

   xi. Prevention, vaccination, diagnosis and treatment for viral hepatitis (Hep B and C)

   xii. Targeted information, education and communication for people who inject drugs

xiii.   Treatment Centres in prisons for people who are dependent on/ addicted to drugs

xiv.   Voluntary HIV testing and counselling for high-risk groups (Female Sex Workers, Men who have Sex with Men, People Who Inject Drugs)

xv.   Voluntary Treatment Centres for people who are dependent on/ addicted to drugs

15. Is there anything else that you think needs to be done to make prevention of HIV transmission from Illicit Drug Use even more effective in Thailand?

…………………………….…………………………….…………………………….………

Your feedback will be extremely helpful for this research. Thank you for your cooperation

Appendix 5 – Information about the Survey for Participants

Survey about Harm Reduction

What is the purpose of this survey? The survey aims to help us understand the factors that influence drug policy at the country level. This research is part of a PhD program of study and the researcher's scholarship is fully funded by Curtin University.

Who is conducting the survey? My name is Michael Cole, I have been living and working in Thailand for the past ten years and this research is part of my PhD with Curtin University, Perth, Australia. My email address is michael.cole@student.curtin.edu.au and my phone number is +66 (0) 815 736 822.

Why have I been asked to participate? Participants attending of the International Harm Reduction Conference have been identified as people with an interest, knowledge and experience in various aspects of harm reduction and therefore an ideal group of people to ask about their perceptions of harm reduction policy decisions, design or implementation in their countries.

How long will the survey take? The survey should take around 10 minutes to complete (depending on the number of comments you make). Information gathered from a large number of surveys will be helpful in building a better understanding of what influences drug policy, particularly that relating to harm reduction, at the national level.

Will my answers be confidential? Your responses will be completely confidential. Survey responses will not include names, positions or other personal identifying information and the identity of the participants will not even be known to the researcher. No completed questionnaire will be published or distributed and no individual's name will be associated with any of the results. Only grouped data will be discussed.

Who sees my answers? Your anonymity will be safeguarded. You can put your completed questionnaire in a sealed envelope and then simply place it directly into the box marked "Survey" at the ANPUD stand (18). At the end of the conference I will collect the box and I will not know who answered the questionnaires. Completed surveys

will not be seen by anyone else. Information you provide will <u>NOT</u> enable your responses to be linked back to you. Responses from the survey will be presented as being from groups of people not individuals. You can decline to answer any question if you wish.

What happens to the information I take part in the survey? The information will be stored in a coded non-identifiable form on a password protected hard drive which can only be accessed by the researcher.

Who can I ask for further information? You will have the opportunity to ask me questions at any time by using my contact details provided. If you want to, you are welcome to discuss the information about this survey and your responses with friends and colleagues before completing the questionnaire.

How do I consent to participate? You consent to participate in the survey simply by returning your survey form. If you do not to give your consent to take part then you do not need to do anything more after reading this. Your involvement is purely voluntary.

My research supervisors are Professor Steve Allsop (s.allsop@curtin.edu.au) and Dr Susan Carruthers (s.carruthers@curtin.edu.au). If you have any queries you can contact me or contact my supervisors directly.

This PhD is fully funded by Curtin University and has been approved by the Curtin University Human Research Ethics Committee (Approval Number 4856). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Your responses will help to better understand how drug policy is designed and implemented. Thank you.

Appendix 6 – Drug Policy Survey

Survey about Drug Policy

Your answers will be anonymous. The following questions about the person responding will *NOT* enable your responses to be linked back to you. If you do not wish to answer any questions leave the space blank. By completing and submitting this anonymous survey you are consenting to take part.

What country are you currently working/studying in? _____

What country are you from?   _____

What best describes your occupational status at the moment (Please tick 1 or more as relevant):

[   ] Employed, [   ] Volunteer, [   ] Student, [   ] Consultant, Other (please specify):

_____

How would you describe your organisation? _____
(e.g. civil society organisation, university, hospital, drug treatment centre, police force, donor, etc.)

How would you describe your role in your organisation/sector? _____
(e.g. outreach worker, nurse, social worker, community advocate, policy maker, peer support worker, psychologist, fund manager, program evaluator, health researcher, police officer, etc.)

The following 6 Questions are about harm reduction in the country in which you now work/study

1. In the country in which you work/study now, what do you think have been the most effective harm reduction strategies that have been implemented in the past 5 years?

_____

_____

_____

2. In what ways have these harm reduction strategies demonstrated to you that they have been effective?

_____

_____

_____

_____

When answering the following questions, you might consider particular organisations (international, regional or national) that you think play a very important role for/against harm reduction; and/or you might consider specific political, economic, social, cultural infrastructural, technological factors that you think play a very important role. It will be helpful if you are quite specific in your answers. For example, if you think that resources are important please mention the type of resources, where they should come from and where they need to be used.

As a guide I have set out the answer space for the top 3 factors you think are very important but if you think there are more (or less) factors that are very important then please answer in your own way.

3. In your country what do you think are the main influencing factors that hinder the formulation of effective national harm reduction policy?

i) _____

ii) _____

iii) _____

_____

_____

4. In your country what do you think are the main influencing factors that hinder the *implementation* of effective national harm reduction policy?

i) _____

ii) _____

iii) _____

_____

_____

5. In your country what do you think are the main influencing factors that help the *formulation* of effective national harm reduction policy?

i) _____

ii) _____

iii) _____

6. In your country what do you think are the main influencing factors that have helped the *implementation* of effective national harm reduction policy?

i)

ii)

iii)

If you would like to, you are welcome to add any other comments about harm reduction policy in your country in the space below.

When you have finished the survey please put it in the envelope provided and then 'post' the envelope into the box labelled '**Deposit Surveys Here'** at the **ANPUD** conference booth number 18.

Your responses are a valued contribution towards this research and will help to better understand the challenges and opportunities for harm reduction policy design and implementation in different country contexts.

Thank you.

Appendix 7 – Ethics Committee Approval

AF 02-12

The Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University
Jamjuree 1 Building, 2nd Floor, Phyathai Rd., Patumwan district, Bangkok 10330, Thailand, Tel/Fax: 0-2218-3202 E-mail: eccu@chula.ac.th

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COA No. 102/2015

Certificate of Approval

Study Title No.198.1/57 : AN EXAMINATION OF THE FACTORS IN THE POLICY ENABLING ENVIRONMENT THAT INFLUENCE THE FORMULATION AND IMPLEMENTATION OF HARM REDUCTION POLICY IN THAILAND

Principal Investigator : MR. MICHAEL COLE

Place of Proposed Study/Institution : National Drug Research Institute,

Curtin University, Australia

The Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University, Thailand, has approved constituted in accordance with the International Conference on Harmonization – Good Clinical Practice (ICH-GCP) and/or Code of Conduct in Animal Use of NRCT version 2000.

Signature: ...Prida Tasanapradit, MD... Signature: ...Nuntaree Chaichanawongsaroj...

(Associate Professor Prida Tasanapradit, M.D.)   (Assistant Professor Nuntaree Chaichanawongsaroj, Ph.D.)

Chairman   Secretary

Date of Approval : 28 April 2015   Approval Expire date : 27 April 2016

The approval documents including

1) Research proposal
2) Patient/Participant Information Sheet
3) Researcher
4) Questionnaire

Protocol No. ....198.1/57......
Date of Approval....... 28 MAY 2015
Approval Expire Date....... 27 MAY 2016

The approved investigator must comply with the following conditions:

1. The research/project activities must end on the approval expired date of the Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group, Chulalongkorn University (ECCU). In case the research/project is unable to complete within that date, the project extension can be applied one month prior to the ECCU approval expired date.
2. Strictly conduct the research/project activities as written in the proposal.
3. Using only the documents that bearing the ECCU's seal of approval with the subjects/volunteers (including subject information sheet, consent form, invitation letter for project/research participation (if available).
4. Report to the ECCU for any serious adverse events within 5 working days
5. Report to the ECCU for any change of the research/project activities prior to conduct the activities.
6. Final report (AF 03-12) and abstract is required for a one year (or less) research/project and report within 30 days after the completion of the research/project. For thesis, abstract is required and report within 30 days after the completion of the research/project.
7. Annual progress report is needed for a two- year (or more) research/project and submit the progress report before the expire date of certificate. After the completion of the research/project processes as No. 6.

Appendix 8 - A Map of the Provinces of Thailand

https://en.wikipedia.org/wiki/Provinces_of_Thailand, accessed 04/09/2016

Appendix 9 - Drug Policy Survey World Bank Country National Income Classification

The following table lists the World Bank National Income Classification for each of the countries represented in the survey. The World Bank classifies 189 member countries into income groups according to 2015 Gross National Income per capita. The groups are: low-income, $1,025 or less; lower middle-income, $1,026–4,035; upper middle-income, $4,036–12,475; and high-income, $12,476 or more. The effective eligibility threshold for International Development Assistance is $1,185 or less (World Bank, 2016).

Table 19: World Bank Income Classification by Country

Country	World Bank Income Classification
Afghanistan	Low
Australia	High
India	Lower middle
Indonesia	Lower middle
Kazakhstan	Lower middle
Kenya	Lower middle
Kyrgyzstan	Lower middle
Malaysia	Upper middle
Myanmar	Lower middle
Nepal	Low
Philippines	Lower middle
Romania	Upper middle
Russia	Upper middle
Scotland	High
Sweden	High
Tajikistan	Lower middle
Tajikistan	Lower middle
Thailand	Upper middle
UK	High
Ukraine	Lower middle
USA	High

Appendix 10 - Survey Respondents Countries, Organisations and Roles

Table 20: Countries, Organisations and Roles of Survey Respondents

Country	Organisation	Role
Afghanistan	Technical Support Agency	Technical Advisor
Australia	Civil Society Organisation	Outreach Worker, Community Advocate, Peer Support Worker
Australia	Hospital	Medical Practitioner - Doctor
Australia	Private Company	Management - Director
Australia	Public Health Service	Nurse
Australia	Public Hospital	Medical Practitioner - Doctor
Australia	Treatment & Rehabilitation Services	Health Worker
Australia	University	Researcher
India	Hospital	Monitoring and evaluation manager
India	Harm Reduction Services	Community Advocate, Program Evaluator, Health Researcher
India	Non-Government Organisation	Management - Program Manager
India	PWUD Network	Management - Board Member
Kenya	Civil Society Organisation	Researcher
Malaysia	Civil Society Organisation	Management - Audit Executive
Malaysia	Civil Society Organisation	Management - Program Manager
Malaysia	Civil Society Organisation	Monitoring and Evaluation Manager
Malaysia	Ministry of Public Health	Medical Practitioner, Management - Program Coordinator
Myanmar	Hospital - Drug Treatment	Management - Program Manager
Myanmar	International Non-Government Organisation	Technical Advisor
Nepal	I Work with All	Researcher, Community Advocate, Program Evaluator
Philippines	Civil Society Organisation	Technical Advisor
Philippines	Civil Society Organisation	Social Media Manager
Philippines	Civil Society Organisation	Researcher
Philippines	Civil Society Organisation	Management - Program Director
Philippines	Non-Government Organisation	Communications - Engagement Strategy
Philippines	Treatment - Organisation Promoting Better Policy for treatment	Communications - Officer
Romania	PWUD Network	Technical advisor
Russia	Community-based Organisation	Communications - Information Manager
Scotland	University	Researcher

Sweden	Hospital	Nurse
Sweden	Hospital	Nurse
Tajikistan	Non-Profit Research Organisation	Researcher
Tajikistan, Kazakhstan Kyrgyzstan	Civil Society Organisation	Management, Technical Advisor
Thailand	Civil Society Organisation	Health Worker
Thailand	Civil Society Organisation	Management - Member of management board
Thailand	Civil Society Organisation	Outreach worker
Thailand	Civil Society Organisation	Communications - Officer
Ukraine	International Civil Society Organisation	Management - Project Manager
United Kingdom	Research Organisation	Technical Advisor, Researcher, Trainer
USA	Treatment - Drug Treatment	Medical Practitioner - Physician Clinician
USA	Treatment - Drug Treatment	Technical Advisor
USA	Non-Government Organisation	Communications - Advocacy and Communications

Appendix 11 - Interview Respondents' Organisation Details

Table 21: Survey Respondents' Countries, Organisations and Roles

Organisation	Previous Organisation 1	Previous Organisation 2
Thai Academic	Foreign Academic	Foreign Academic
International NGO	International NGO	Foreign Academic
International NGO	Foreign Government	Foreign Government
Foreign Academic	Foreign Government	Foreign Government
United Nations Agency	United Nations Agency	Foreign Government
International NGO	Foreign Government	International NGO
International Financial Organisation	International NGO	Regional NGO
Regional NGO	International NGO	International NGO
Regional NGO	International NGO	International NGO
Foreign Academic	Thai NGO	International NGO
International NGO	United Nations Agency	International NGO
Thai Academic	Thai Academic	Thai Government
Thai Government	Thai Government	Thai Government
Thai Government	Thai Government	Thai Government
United Nations Agency	Thai Government	Thai Government
Thai NGO	Thai NGO	Thai Government
Thai Academic	United Nations Agency	Thai Government
International NGO	Thai NGO	Thai NGO
Thai NGO	Thai NGO	Thai NGO
Thai NGO	Thai NGO	Thai NGO
Thai NGO	Thai NGO	Unassigned
United Nations Agency	United Nations Agency	United Nations Agency

Appendix 12 - Parent and Child Nodes Related to the Four Queries

The following table shows the most common themes which occurred under each of the four queries:

1. facilitated drug policy formulation;
2. facilitated drug policy implementation;
3. hindered drug policy formulation; and
4. hindered drug policy implementation.

Table 22: A Four Quadrant Matrix of Parent and Child Nodes

	Formulation	*Implementation*

Hindered	1. Thai Culture & Social values
	2. Government Administration & Politics
	    a. Prime Minister
	    b. War on Drugs
	    c. Departmental Jurisdiction Issues
	    d. Need for Leadership
	3. Public Opinions of PWUD
	4. Thai Media
	5. Legislation
	    a. Law reform
	6. Office of Narcotics Control Board
	7. Ministry Health
	8. Ministry Justice
	9. Thai Military
	10. United Nations
	    a. International Narcotics Control Board
	    b. Commission on Narcotic Drugs
	11. Role of USA
		1. Thai Culture & Social values
		2. Office of Narcotics Control Board
		3. Royal Thai Police
		4. Funding & Resources
		5. Harm Reduction
		    a. Needle and syringe programs
		6. Global Fund & other donors
		7. Government Administration & Politics
		8. Law Reform
		9. Public Messages, Education about Drugs
		10. Ministry Health
		11. Treatment and Rehabilitation
		    a. Compulsory centres for drug users
		12. Role of USA

Facilitated	1. Office of Narcotics Control Board
	2. Thai NGO & CSO
	3. Human Rights
	4. United Nations
	    a. UNODC
	5. ASEAN
	6. Research & Evidence
	7. Global Fund & other donors
	8. Thai Monarchy
	9. International non-government organisations
		1. Royal Thai Police
		2. United Nations
		    a. UNODC
		3. Thai NGO & CSO
		4. Government Administration & Politics
		5. Thai Monarchy
		6. Office of Narcotics Control Board
		7. Technical assistance & Guidance
		8. Funding & Resources
		    a. Global Fund & other donors

In the NVivo Analysis Software coded themes were called 'Nodes' and the relationship between themes and related sub themes was termed 'Parent' and 'Child' Nodes. For example, United Nations constituted one theme of coded responses within which various United Nations agencies were discussed. Most prominent among these agencies was the UNODC which was coded under the Parent Node 'United Nations' theme as a subtheme or Child Node. In this Table, the Parent Nodes have been allocated a number with their 'Child Nodes' beneath.

Appendix 13 - Ministers of the Government of Thailand

Under the constitution of Thailand, the cabinet is restricted to no more than 35 members. Members of the Cabinet, unlike the prime minister, do not need to be a member of the House of Representatives.

To be eligible to be a minister an individual must meet the following qualifications:

- Be a Thai national by birth.
- Be older than 35 years of age.
- Have graduated with no less than a bachelor's degree.
- Not be a member of the Senate (former senators must wait 2 years after their term of office to be eligible)

The individual must also not be:

- addicted to drugs,
- or have ever been bankrupt,
- a monk or a member of the clergy,
- disenfranchised,
- mentally infirm,
- under indictment or conviction,
- or have ever been
- expelled by a state agency for corruption or incompetence,
- a paid civil servant
- member of the judiciary
- or ever been removed from any office by the Senate of Thailand

Appendix 14 - Thailand Heads of Government 2001-20014

Thailand had 12 heads of government and two successful military coups in the 12 years between 2001 and 2014.

Table 23: Thailand Heads of Government 2001-20014

Government Leader	Position	Dates	Notes
Thaksin Shinawatra	Prime Minister	9 Feb 2001 – 9 Mar 2005 9 Mar 2005 - 5 Apr 2006	Removed by coup d'état
Chitchai Wannasathit	Acting Prime Minister	5 Apr 2006 - 23 May 2006	
General Sonthi Boonyaratglin	Leader of the Council for National Security	19 Sep 2006 - 1 Oct 2006	Leaders of the coup d'état which formed the Council for National Security
Air Chief Marshal Chalit Pukbhasuk	Leader of the Council for National Security	19 Sep 2006 - 1 Oct 2006	
General Surayud Chulanont		1 Oct 2006 - 29 Jan 2008	Appointed by Council for National Security Declaration
Samak Sundaravej	Prime Minister	29 Jan 2008 - 8 Sep 2008	
Somchai Wonsawat	Acting Prime Minister Prime Minister	8-17 Sep 2008 18 Sep 2008 - 2 Dec 2008	
Chaovarat Chanweerakul	Acting Prime Minister	2 Dec 2008 - 15 Dec 2008	
Abhisit Vejjajiva	Prime Minister	17 Dec 2008 - 5 Aug 2011	
Yingluck Shinawatra	Prime Minister	5 Aug 2011 - 7 May 2014	
Niwatthamrong Boonsongpaisan	Acting Prime Minister	7 May 2014 - 22 May 2014	Appointed by Assembly Resolution and later Removed by coup d'état
General Prayut Chan-o-cha	Leader of National Council for Peace and Order	22 May 2014 – 24 Aug 2014	Leader of coup d'état which set up the National Council for Peace and Order
General Prayut Chan-o-cha		24 Aug 2014 to present	Prime Minister appointed by the National Council for Peace and Order and the National Legislative Council

Appendix 15 - OECD DAC Criteria for Evaluation of Development Assistance

The following criteria and definitions are from the Organisation for Economic Co-operation and Development Assistance Committee (OECD DAC), Criteria for Evaluation of Development Assistance (OECD Development Assistance Committee, 2008, 2010).

Relevance

The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor. In evaluating the relevance of a program or a project, it is useful to consider the following questions:

•   To what extent are the objectives of the program still valid?

•   Are the activities and outputs of the program consistent with the overall goal and the attainment of its objectives?

•   Are the activities and outputs of the program consistent with the intended impacts and effects?

Effectiveness

A measure of the extent to which an aid activity attains its objectives.

In evaluating the effectiveness of a program or a project, it is useful to consider the following questions:

•   To what extent were the objectives achieved / are likely to be achieved?

•   What were the major factors influencing the achievement or non-achievement of the objectives?

Efficiency

Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted. When evaluating the efficiency of a program or a project, it is useful to consider the following questions:

•   Were activities cost-efficient?

•   Were objectives achieved on time?

•   Was the program or project implemented in the most efficient way compared to alternatives?

Impact

The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the activity on the local social, economic, environmental and other development indicators. The examination should be concerned with both intended and unintended results and must also include the positive and negative impact of external factors, such as changes in terms of trade and financial conditions. When evaluating the impact of a program or a project, it is useful to consider the following questions:

• What has happened as a result of the program or project?

• What real difference has the activity made to the beneficiaries?

• How many people have been affected?

Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.

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