Rapid Situation Assessment of Malaysia 2004

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Acknowledgements

This research was supported by CIPRA grant R03 AI 56379-01, Department of Health and Human Services, National Institute of Allergy and Infectious Diseases, National Institutes of Health, USA.

University Malaya/ Department of Medicine/Infectious Disease Unit Publishers.

First Published 2005

ISBN 983-100-252-0

Distributed in Malaysia by:

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Distributed in Australia by:

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Contents

Glossary

AHRN	Asian Harm Reduction Network
AIDS	Acquired Immunodeficiency Syndrome
ADK	Agensi Dadah Kebangsaan (Regional Drug Agency)
ATS	Amphetamine Type Substances
CHR	Centre for Harm Reduction
DRC	Drug Rehabilitation Center
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
NGO	Nongovernmental Organization
NSP	Needle and Syringe Program
PLWHA	People Living With HIV/AIDS
STI	Sexually Transmissible Infection
UNAIDS	Joint United Nations Programme on AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drug Control
WHO	World Health Organization

1. Executive summary

1.1 Introduction

In Malaysia illicit drug use was considered a menacing concern and an enemy of the people. The government has implemented various strategies to tackle drug use with the current goal of achieving a drug free society by 2015. Yet, even with increasing draconian punishments imposed for drug use there was a substantial rise in both new and relapse drug user cases. Of increasing concern was the unresolved HIV infected notifications, mainly found among injecting drug users (IDUs), but also of a potential generalized HIV epidemic occurring within the coming years. This situation assessment of Malaysia, examining drug issues from a public health and public security perspective, shows the complexity, challenges and responses of drug use and HIV/AIDS. This report has been produced on behalf of the Infectious Diseases Unit, University of Malaya Medical Centre, with assistance of the Burnet Institute, The Centre for Harm Reduction.

1.2 Methods

This project consisted of a three week desk based data collection and analysis exercise involving three researchers. Over 100 journal articles, reports, drug user profiles, abstracts, documents, conference presentations and books were collected and reviewed. A media review from 2001-2004 on drug related issues resulted in a further 120+ reports. The collated information was used to compile an overview of Malaysia largely focused on the current situation but also reflecting on previous data to provide context of developments. The headings used in the profile include: Current situation, Drug taking practices and risk factors, Prevalence and profile, Antiretroviral treatment for drug users, Government responses to illicit problems, Drug Policy, Government responses to drug use and HIV, National AIDS Policy, Formation of HIV/AIDS Policies and Non-government response to drug use and HIV.

1.3 Findings

1.3.1 Current situation

Malaysia was not a major producer of illicit drugs but close geographical proximity to the Golden Triangle and other Southeast Asian countries that produce heroin, amphetamine type substances (ATS) and other drugs, ensured the nation's vulnerability to a rising domestic drug use problem. The trafficking of heroin into the country still remains a concern as reflected by drug seizures but also because heroin accounts for most drug treatment admissions and most drug related arrests. The use and seizures of various ATS and cannabis was reportedly on the rise. Other drugs used include ketamine, opium, morphine, cocaine, benzodiazepines, cough mixtures containing codeine and solvents. Prices of various illicit drugs fluctuate and vary from one region to another and over time. As of September 2004, in Kuala Lumpur, it was suggested a single dose of heroin was around RM10, a single dose of ATS (unspecified type) was RM 10, and an ecstasy pill was priced between RM 50 – 100.

1.3.2 Drug taking practices and risk factors

The transition period from non-injecting to injecting drugs has shortened from a previous seven years to around three to fours years. Drug users shift to the injecting route for various reasons that include peer pressure; a price rise of heroin; decrease in heroin purity; a shortage in supply of heroin on the market; and a stronger desire to acquire a greater feeling of euphoria. When the quality of heroin decreased the trend in Kuala Lumpur was to 'chase' and mix the heroin with methamphetamine, commonly known as 'ice'. Poly drug use was reported to be on the rise. While it was unclear whether professional injectors still existed, the purchasing of ready filled syringes with no knowledge if the syringes were new or had been used was reported.

A principle high risk behavior of widespread sharing of needles and syringes as well as other injecting paraphernalia was found. In Kuala Lumpur injecting groups tended to be 2-3 persons and as a result of the frequent anti-narcotic raids, drug users were largely driven further underground and often away from public gaze. New injecting equipment was not always easy to access and there was a tendency among IDUs to use needles until they were blunt. Drug users were commonly sexually active and while this area was under researched, studies do show poor condom use with sexual partners.

1.3.3 Prevalence and profile

In 2002, the National Drug Agency (NDA) estimated more than 350,000 drug users in the country with the media in 2004 citing government sources ranging from 400,000 to 500,000. In 2003 the NDA registered 36,996 drug users with 55% classified as new cases. From January to March 2004 there were 1,931 new cases of drug users registered per month. The estimated number of IDUs ranged from 117,000 to 240,000. In 2003 a profile of drug users showed most were male (98%), Malays (70%), aged between 20 – 39 years old (71%) and those receiving no schooling or up to primary level only amounted to (16%) of the identified cases. In 2002, the number of convicted prisoners was 49,243 and among those 11,854 (24%) had committed an offense linked to the Dangerous Drug Act of 1952. Drug users sent to government drug rehabilitating centres (DRC) were on the rise and as of August 2004 the maximum number of inmates in the DRC was 14,700.

The HIV epidemic in Malaysia has primarily affected the IDU community with 76% of all HIV/AIDS cases found among this group. In recent years heterosexual transmission has been rising and permeating into the general community at large: a generalized HIV epidemic occurring within the next five years may occur. In August 2004 the 28 DRC found 1,448 HIV infected inmates and a similar number resided in the prison rehabilitation centre known as Kajang. From January till August 2004, 25,927 prisoners were tested for HIV and 1,870 (7%) were found HIV infected. The rate of HIV and tuberculosis co-infection in one study conducted between 2000 - 2003 in two prisons and three DRC in the state of Selangor was 11%.

1.3.4 Antiretroviral treatment for drug users

Despite antiretroviral (ARV) medications becoming more available and the majority of HIV infections found among IDUs, few drug users received ARV treatment. On the evidence available IDUs on the whole can benefit from receiving ARV treatment as other groups and there was no valid medical excuse for excluding them.

1.3.5 Government responses to illicit drug use problems

In line with ASEAN goals it was declared Malaysia would be a drug free society by 2015 and as a consequence there was a push to rid the nation of drug use through a series of intensive campaigns to arrest and round up drug users. In 2000 under the Lain-Lain Sek ADB (Dangerous Drugs Law/Act) 1952, 11,550 people were arrested and this increased to 19,738 in 2003. For a first time offence, compulsory treatment involved a maximum of two years in a DRC followed by two years of follow up care. Upon discharge from the DRC a former inmate is requested to report to the nearest police station on a daily basis for another two years although the drop out rate was about 70% and most were lost to follow up by the police. For second and third time offenders they were sent to prison from 5 – 7 years and caned for not more than three times. Forth time offenders were once again sent to prisons and the sentence was 7 – 13 years and was caned 3 – 6 times. Hardcore addicts could face jail terms of up to 13 years and six strokes of rotan under proposed amendments to Dangerous Drugs Act. Under the amendments a hardcore addict is defined as someone who has been ordered to undergo treatment at drug rehabilitation centers or has been convicted under Section 15(1)(a) of The Dangerous Drugs Act more then twice. Deputy Prime Minister Datuk Seri Abdullah Ahmad Badawi said those who committed the same offences for the third time faced jail terms of between 5 and 7 years and not more than 3 strokes of rotan. For subsequent offences, they face jail terms of between 7 to 13 years and whipping of between 3 to 6 times. He also added that hard core addicts will be placed in specially designated areas within a prison. (The Star 2002)

The relapse rates of inmates sent to DRC was often estimated at 70% to 90%. High relapse rates have resulted in chronic drug users being sent into a seriously overcrowded prison system. In 2003, the government spent about RM 44 million on treating and rehabilitating drug users in the 28 DRC and in 2002 a further RM 12 million was spent to develop and maintain such facilities.

1.3.6 Drug Policy

A National Drug Policy was originally launched in 1983 and revised in 1996 with a series of new strategies and priority areas of prevention, enforcement, treatment and rehabilitation and regional and international cooperation. Drug policies undoubtedly impact upon the way illicit drug consumption influences the HIV/AIDS scenario but contributions by health officials to the drug policy debate was minor.

1.3.7 Government responses to drug use and HIV

Harm reduction programs were consistently rejected in Malaysia as they were viewed as encouraging drug use, particularly needle and syringe programs. However, recently, advocacy efforts by NGOs and medical professionals have created an increasing interest in substitution therapy programs such as methadone and buprenorphine; in 2003 these programs were piloted showing good results. Prevention efforts towards an effective management of HIV was largely funded by the government with around US$10.3 million provided over the last two years and a further US$1.5 million was allocated to NGOs in the 2004 budget. As to how much of these funds were directed specifically towards activities associated with the drug using community was unknown.

1.3.8 National AIDS Policy

The National AIDS Policy was developed and approved in 1998 and was currently being revised with participation of various ministries, government agencies and NGOs affiliated with the Malaysian AIDS Council(MAC). The Association of Southeast Asia Nations (ASEAN), of which Malaysia was a signatory, had produced the ASEAN Work Programme on HIV/AIDS II (2002 – 2005). This document acknowledges interventions for drug users were relatively weak and in a previous meeting it was suggested harm reduction amongst drug users should be promoted. Currently little was done to implement effective, wide reaching prevention programs of any kind for drug users. The major obstacle was anti-drugs programs being the sole responsibility of the Home Affairs Ministry while issues of HIV/AIDS remained with the Ministry of Health.

1.3.9 Formation of HIV/AIDS Policies

Coordinating various HIV/AIDS related programmes was the responsibility of the Ministry of Health. An Interministerial Committee on AIDS advises the cabinet on polices and strategies to address the epidemic. Concerns that some representatives were either not well informed of the issues and/or lacked significant prestige and of infrequent meetings have been suggested. There were two subcommittees, the National Coordination Committee on AIDS (NCCA) and the National Technical Committee on AIDS (NTCA). The NCCA never debates policy issues, largely because most participants have little knowledge about HIV/AIDS issues per se. Meetings were largely oriented towards health issues with legal aspects of drug use rarely spoken of. With the NTCA various technical aspects of HIV/AIDS were discussed and issues such as substitution therapy programmes have come onto the agenda. Introducing harm reduction into the HIV/AIDS policy debate remains a major challenge with opposition to harm reduction also having an ideological base, rooted in religious beliefs.

1.3.10 Non-government organisations' response to drug use and HIV

Over the years few NGOs have focused their attention towards the needs of both drug users and IDUs out of treatment and this has not changed. The NGO IKHLAS, have been operating since the late 1990s for drug users and other marginal groups in the community. Bleach was no longer distributed by IKHLAS to drug users but demonstrations of how to undertake cleaning techniques of needles was attended at the drop-in-centre. The NGO called YWAM conduct

outreach but with small resources their scope of work and coverage was limited. Currently IKHLAS runs a male drop-in-centre, women and transsexual drop-in-centre (many of whom were known drug users) and a medical clinic. The Malaysian AIDS Council formed in 1992 to help maximize the community response to HIV/AIDS remains a dominant force being the umbrella organisation for all 37 NGOs working on AIDS issues. With a single drug treatment approach of abstinence only still largely vigorously embraced by the government and the wider community, NGOs targeting their activities towards drug users, not in treatment, experienced difficulties with their operations.

2. Introduction

Malaysia has a long history of drug use, originating with opium consumption in the early 19th century. While there were various attempts to curb opium use it was not till the 1950s, with the introduction of heroin, when Malaysian authorities launched an anti-drug strategy largely as a result of drug related crime (Spencer and Navaratnam 1981; McCoy 1991). For decades illicit drug use has been considered a menacing concern and an enemy of the people. The government has implemented various strategies to tackle drug use and has a current goal of achieving a drug free society by 2015. Drug rehabilitation centres and prisons have become seriously overcrowded largely as a consequence of draconian punishments imposed for drug use and of the substantial rise in new and relapse drug user cases. With law enforcement activities ever more strident to tackle drug using problems high risk behaviours among drug users remain unresolved. Adverse health consequences of drug use vary and undoubtedly much focus was upon rising HIV infected notifications; up to 75% were attributable to injecting drug users. An exponential rise in the number of HIV/AIDS identified cases was alarming and a generalized HIV epidemic occurring within the coming years cannot be under estimated. While there were promising signs that substitution therapy programs for drug users received greater consideration by government officials, other forms of harm reduction - consistently viewed as encouraging drug use - was rejected. This situation assessment of Malaysia, examining drug issues from a public health and public security perspective, shows the complexity, challenges and responses of drug use and HIV/AIDS. This report has been produced on behalf of the Infectious Diseases Unit, University of Malaya Medical Centre, with assistance of the Burnet Institute, The Centre for Harm Reduction.

2.1 Methodology

This project consisted of a three week desk based data collection and analysis exercise involving three researchers. Over two weeks three researchers collected data / literature and in the last week one researcher was primarily responsible for the write up. Over 170 letters were sent out to non-government organizations, general practitioners, government and other organizations. Around 30 faxes were sent to a variety of other organisations. An estimated 100 emails were sent out, and from these initial communications further contact points were created and followed up. A series of key informant interviews from various sectors dealing in drugs use and HIV/AIDS issues were conducted. The main library data bases examined included PubMed, PsycInfo, Ovid Medline, CINCH (Criminology), and various Internet sites were trawled during the literature review. A request for information was placed on SEA-AIDS and the main library to collect documents was the Australian Drug Foundation Library. Over 100 journal articles, reports, drug user profiles, abstracts, documents, conference presentations and books were collected and reviewed. A media review was also undertaken from 2001-2004 on drug related issues and this resulted in a further 120+ reports. Personal

communications via email with various key informants involved in the area of drugs and/or HIV/AIDS was undertaken expanding and verifying some of the information already collected. The collated information was used to compile an overview of Malaysia largely focused on the current situation but also reflecting on previous data to provide context of developments. The headings used in the profile include: Current situation, Drug taking practices and risk factors, Prevalence and profile, Antiretroviral treatment for drug users, Government responses to illicit problems, Drug Policy, Government responses to drug use and HIV, National AIDS Policy, Formation of HIV/AIDS Policies and Non-government response to drug use and HIV.

2.2 Current situation

Malaysia was not a major producer of illicit drugs, confirming a similar trend of recent years. However, Malaysia with its close geographical proximity to the Golden Triangle (Myanmar, Laos and Thailand) and other Southeast Asian countries that produce heroin, amphetamine type substances (ATS) and other drugs, was vulnerable to a rising domestic drug use problem. Drug trafficking through the country often stem from Golden Triangle countries. Trafficking occurred overland via the long border Malaysia shares with Thailand and/or through various and extensive sea routes between the two countries. Both nations have long established fishing industries and it was reported that fishing boats not only trade in fish but traffick in drugs as a result of their easy access to various sea ports (National Narcotics Agency 2001; UNODC 2003, U.S. State Department 2004). It was reported that heroin was commonly smuggled though Bukit Kayu Hitam and Padang Besar while cannabis was often smuggled using the Kelantan – Thai borders around Rantau Panjang or Golok (Najib 2004).

Clandestine laboratory activities mainly confined to heroin conversion base to the hydrochloride salt form have been identified in the past (UNAIDS and UNDCP 2000) but more recently an amphetamine processing laboratory was uncovered in Semenyih, Selangor by a joint China-Malaysia police operation (Andres 2004). The trafficking of heroin into the country still remains a concern as reflected by drug seizures but also because heroin accounts for most drug treatment admissions and most drug related arrests (UNODC 2004). Seizures of heroin (Number 3) have fluctuated in the past seven years with 106 kilograms seized in 2000 increasing to 382 kilograms two years later. In 2003, 128 kilograms of heroin (Number 3) was seized. There were sharp dramatic rises in the seizures of raw opium from zero in 2002 to 63 kilograms in 2003. Substantial rises in the seizure of cannabis have reached record levels. From 1998 until 2001 around 1,500 – 1, 600 kilograms of cannabis were seized increasing to 2,199 kilograms in 2003 (Polis Malaysia 2004).

There were two commonly trafficked and used amphetamine type substances (ATS) in Malaysia called *Syabu* and *Yaba*. While seizures of *Syabu* have witnessed a decline from 208 kilograms in 2000, down

to 19 kilograms in 2003, the number of seized *Yaba* pills sharply increased from 15,000 in 2001 to nearly 42,000 in 2003. Ecstasy pills were first seized in the mid 1990s and even today much was believed to be brought in from the Netherlands (U.S State Department 2004). Seizures of ecstasy continue to rise from 66,000 pills in 2002, reaching 209,000 pills in 2003. A significant rise in the seizures of Ketamine from 1 kilogram in 2000, to 82 kilograms in 2003 was identified. Cough mixtures – mostly containing codeine - were seized by authorities: in 2003, 33, 596 litres were confiscated, a sharp rise from 4.978 litres in 2002 (UNODC 2003; Polis Malaysia 2004; U.S State Department 2004). Misuse of codeine cough mixtures were viewed as a serious problem as they were widely accessible from rogue pharmacies, medical clinics and underground sources where it was smuggled in from neigbouring countries (UNODC 2003). The use of solvents was not widely researched but a previous study in East Malaysia had shown it was used mainly among young children and teenagers and respondents had been sniffing glue between a few months to two years (Zabedah *et al* 2001).

In 2003, the United Nations Office on Drug Control (UNODC) undertook a project through a survey questionnaire to address the limitations of national drug information systems. These questionnaires completed by national drug control agencies and by UNODC counterpart agencies in various Asian countries focused on ATS and other drug trends. While substantial ongoing efforts were taken to drive down drug use in Malaysia, the following questionnaire findings show current drug trends, real or perceived remain a concern.

Drugs used and perceived trends over the past year (2003) in Malaysia

Trend	*Drugs used in the past year*	*Trend*	*Drugs used in the past year*
⇧	Cannabis	⇩	Amphetamine
⇧	Heroin	⇧	Methamphetamine
⇧	Opium	⇩	Ecstasy type
⇧	Morphine	⇧	Sedatives and Tranquillisers
⇧	Codeine	⇧	Ketamine
⇧	Cocaine	⇩	Solvents & inhalants

Note: ⇧ Increase; ⇩ Decrease; ⇔ Stable; ' – ' information not available.

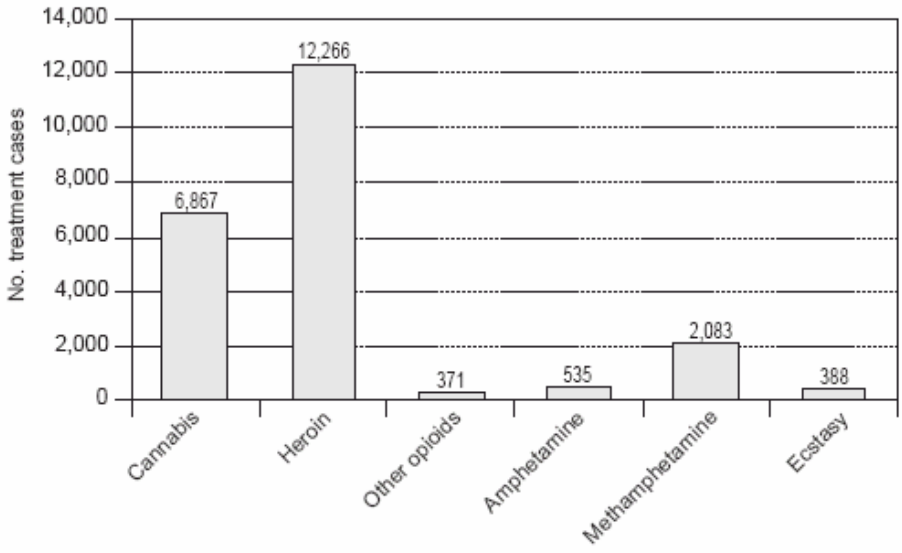
Source: UNODC 2004

Prices of various illicit drugs fluctuate and vary from one region to another and over time. In 2001, in Kepala Batas, Penang, it was reported the price of heroin ranged from RM 10 for a 3cm straw to RM 50 for a 8cm straw (US$1 = RM 3.80 in early 2001). It was suggested among IDUs needing to inject 4-5 times per day, an 8cm straw was required (Centre for Drug Research (CDR) 2002). As of August 2004, in Kuala Lumpur, a single dose of heroin was around RM10 (US$2.63 approx), a single dose of ATS (unspecified type) was RM 10, an ecstasy pill was RM 50 – 100 (US$13 – 26 approx) depending on quality and type, and opium was purchased for around RM 25 (US$ 6.50 approx) amounting to two doses. Morphine was available and consumed (UNODC 2004) but currently in Kuala Lumpur the drug

was rarely spoken of and information of its cost was unavailable (Ng L, personal communication 2004).

Although ATS was increasingly popular and appearing to be more accessible in 2003, it was still heroin, followed by cannabis that were by far the most common illicit drug for which people received treatment. The following figure was based on a registry system of drug treatment facilities and hospitals that treat drug users.

Number of people receiving treatment for drug problems in Malaysia by drug type, 2003



(Source. UNODC 2004)

2.3. Drug taking practices and risk factors

Since the mid 1990s only a limited number of known studies have examined drug taking practices and risk factors among drug users. A major study in 1995 surveyed 24,230 drug users and found that 24% were injecting drugs, 50% were inhaling the fumes of heroin 'chasing the dragon' and 24% were smoking cannabis (UNAIDS and UNDCP 2000). Around the same time a study of IDUs in Penang measured the time period from 'spiking' of cigarettes to chasing the dragon then finally injecting. It was found the process commonly took seven years (Kin 1996). In 2001, a study from Kepala Batas, Penang, showed on average drug users progressed from smoking and 'chasing' towards injecting over a period of two to five years (CDR 2002). While the transition period from non-injecting to injecting drugs would differ from one drug user to another, generally the time frame had shortened. Currently in Kuala Lumpur it was suggested the time frame from smoking and 'chasing' to injecting was around three to

four years (Ng L, personal communication 2004). Reasons as to why drug users shift to the injecting route varied: peer pressure; a price rise of heroin; decrease in heroin purity; a shortage in supply of heroin on the market; and a stronger desire to acquire a greater feeling of euphoria (CDR 2002). For a number of drug users, it was possible that financial circumstances gave rise to injecting practices as injecting proves to be a cheaper option when consuming drugs. It was not unusual for IDUs to shift back to a non-injecting route of drug consumption as a result of possible health complications and/or a result of the poor quality of heroin on the market (Ng L, personal communication 2004).

In 1998, 6,324 drug users from 26 drug rehabilitation centres were surveyed and 65% indicated they were IDUs. The Malaysian Drug Information System showed a trend towards smoking heroin increasing from 15% in 1998 to 19% in 2000 (UNODC 2001). It was reported the most common administration method of taking heroin was 'chasing the dragon' at around 70% (Kaur and Habil 2002). In recent times it was found that when the quality of heroin decreased the trend in Kuala Lumpur was to 'chase' and mix the heroin with methamphetamine, commonly known as 'ice' (Ng L, personal communication 2004).

It was previously reported professional injectors exist injecting multiple customers with the same non- sterile injecting equipment (Bolton 1996; UNAIDS and UNODC 2000). Contemporary information of this phenomenon was not able to be accessed. It has been reported that some drug users purchased heroin in pre-prepared syringes that were sold in villages (Bolton 1996; UNAIDS and UNODC 2000). This claim can be supported in a study in 2001 that reported two drug users purchasing ready filled syringes from a drug dealer in a nearby town but with no knowledge if the syringes were new or had been used (CDR 2002). It was likely the practice of purchasing ready filled syringes had not been abandoned when the draconian penalties associated with being caught with drug using paraphernalia was upheld and of the potential difficulty of acquiring a needle and syringe in some circumstances and locations.

The preparation of the heroin can vary from place to place and over time. In the mid 1990s it was reported heroin was placed into a tablespoon containing a mixture of water and lime juice or lime powder to prolong the liquefied form of heroin. Currently it was suggested drug users place the heroin into a metal bottle cap as they proved convenient receptacles to carry. Heroin was heated only in water as the heroin on the market could sustain itself in a liquefied form for a reasonable period of time (Navaratnam and Foong 1996; Ng L, personal communication 2004).

A principle high risk behavior found among IDUs all around the world remains the widespread sharing of needles and syringes as well as other injecting paraphernalia. As it can be common practice to share the drugs that have been purchased, this form of drug using etiquette extends to the sharing of drug injecting equipment. In 2003 it was

declared in Malaysia a 'Year of Total War Against Drugs' and to work towards a drug –free generation by 2015 (US State Department 2004). As in the past the vast majority of drug users remain acutely aware of the dangers of being identified by law enforcement and would be reluctant to be caught in possession of injecting equipment and/or purchasing such equipment from a pharmacy. Under section 37 of the Dangerous Drugs Act 1952 it remains illegal to carry injection equipment without a prescription and possession of needles may result in up to two years of imprisonment (Wai 1996; UNAIDS and UNODC 2000; Wolfe and Malinowska-Sempruch 2004.).

Needle and syringes can be purchased from a pharmacy and officially require a prescription although this was a moot point. The current average price for injecting equipment was RM.1- 2 (US$0.25 – 0. 52 approx). From an unofficial source the average price for a needle and syringe was RM 1.50 (US$0.39 approx).While it could be assumed that accessing injecting equipment would be difficult, in Kuala Lumpur it was suggested as being relatively easy (Ng L, personal communication 2004). However, although accessibility and cost may not be an issue for some drug users this situation was not applicable for all. A study in 2001 observed there was a tendency among IDUs to use the needles until they were blunt (CDR 2002) which would accentuate trauma to an injecting site increasing the risk of spreading blood borne viruses.

Early studies have shown widespread sharing of needles and syringes. In 1994, a study in a drug rehabilitation centre showed that 60% of the participants injected and of these 71% shared needles (Juita and Osman 1995). In the mid 1990s a further study showed 70% of the participants shared needles in their lifetime and more than half shared sometimes (Navaratnam and Foong 1996). Sharing of needles was not only found among males as one study on female drug users found their rate of sharing was nearly 50% (Yoong and Cheong 1997).

One other study found 77% of the participants admitted to sharing needles and syringes with 10 others and 23% shared with more than 11 peers (Ismail 1998). The injecting of drugs in groups has a long tradition but it was likely groups of injectors have decreased in size in order to avoid detection by law enforcement officials. In the early 1990s it was reported the sharing of needles took place with 2 – 10 others (Suarn *et al* 1993; Juita and Osman 1995). In 2001, the average sharing group number was 3 -4 persons and they tended to be a loose network which were not permanent (CDR 2001). Currently in Kula Lumpur the injecting groups tended to be 2-3 persons and as a result of the frequent anti-narcotic raids drug users were largely driven further underground. Shooting galleries were even more clandestine over the past two years and much more enclosed and remote from public gaze; mainly the basements of abandoned buildings or in isolated areas around the city (Ng L personal communications 2004). It was difficult to determine if shooting galleries were in all towns/cities of Malaysia as one study focused on IDUs was unable to find one (CDR 2002) but undoubtedly most injecting locations prove unhygienic.

A study involving 6,324 drug users in drug rehabilitation centres throughout the country found 64.6% administered drugs intravenously and of these 65.4% shared needles (Fauziah *et al* 2003). In 2001, in Kepala Batas, Penang, a study of 30 IDUs found that while each person carried their own needle and it was observed sharing of needles had not occurred, participants shared the cooker, drug solutions, rinsing water and the syringes. It was observed the drug users would insert their needle into the cooking device (bottle cap) and draw their quantity of the drug. Injectors would normally withdraw blood a few times into the syringe, mixing it with the drug before flushing or injecting it on the belief this would add to the euphoria. Empty syringes that were used by others as a group were observed to show traces of blood. Cotton swabs used as filters were also commonly shared. While the IDUs were aware that they were at risk of HIV infection through the sharing of contaminated needles this knowledge did not extend to all other drug injecting paraphernalia (CDR 2002).

In the late 1980s it was reported the vast majority of drug users used only a single drug (Navaratnam and Foong 1989) but a trend in the number of poly drug users was noted over the years. In 2001, the drug mixed with heroin depending on its availability was commonly benzodiazepines such as *triazlam*. Benzodiazapines were purchased from pharmacies legally or illegally (CDR 2002). Another report stated most heroin users used a combination of other drugs such as morphine, cannabis, cough mixtures, ATS, opium, benzodiazepines and alcohol. The spread of poly drug use was a serious factor in the risk of drug overdose (Kaur and Habil 2002). The frequency of injecting drugs appears to have increased in correlation with the purity of the heroin and what was available. In the early 1990s it was common to inject on average twice per day but by 2001 this increased to 4 -5 times (CDR 2002). An increase in the number of injections increases the vulnerability and the risk of acquiring blood borne viruses. Drug users were known to inject various drugs available on the market and while an epidemic of ATS use was identified in Malaysia as in most of Asia (New Strait Times 2003a; UNODC 2004) and most was ingested or inhaled, 'ice' was injected by some people. Buprenorphine was also known to be injected but this was unlikely a widespread practice (Ng L, personal communication 2004).

Drug users were commonly sexually active and while this area was under researched, these risk factors require important consideration. The likely broader impact of the epidemic of HIV infection among drug users spreading to their sexual partners and onwards warrants concern. Unsafe sexual behaviour among non-injecting and IDUs was documented over the years. In the early 1990s a study among female drug users, of whom most were sex workers, found the majority had two or more sexually transmitted infections, a small number were HIV infected, and some had a history of sharing needles (Isa and Sivakumaran 1993). Studies on male IDUs reveal high sexual risk behaviours. One study undertaken in a detoxification unit found most participants acknowledged having sex with sex workers (88%) and never using condoms while another study found 60% of sexual partners of female IDUs never used condoms (Singh and Crofts 1993;

Wai *et al* 1996). In a survey of sexually transmitted infections amongst sex workers conducted in 1999, the prevalence rate for HIV was noted to be 11% (Ministry of Health Malaysia, WHO/WPRO 2000.

In 1998 research of over 6,000 male drug users found 78% were sexually active: 55% with girlfriends, 31% with sex workers and 5% with male partners. While condom use among the separate groups was not remarked upon, it was reported 80% of the respondents did not use condoms and that unprotected sexual intercourse frequently occurred outside of long term relationships (Fauziah *et al* 2003). A further study in 1998 among nearly 2,000 respondents in 16 drug rehabilitation centres (DRC) found 64% were sexually active of which 90% did not use condoms. In the same study it was shown that 20% of the respondents were HIV infected and of these 81% shared needles and 28% reported being sexually active (Jusoh 2003). A more recent study in 2001 among IDUs showed that respondents with wives did not use condoms while those visiting sex workers used condoms only as a result of the insistence of the sex workers (CDR 2002). The use of condoms even among those informed of their HIV status was likely to remain a challenge. In 1997 a study on 128 couples with HIV infections in the Kuala Lumpur Hospital found only half of the respondents used condom, even after receiving counseling (Jusoh 2003).

International research show drugs can and do enter prisons and that drug use was commonplace in many penal institutions. An explanation for this was that among those incarcerated, a drug habit had already been well established prior to imprisonment. Worldwide the rates of injecting drugs inside prisons were high often ranging from 0.3 – 74% and risk factors were high (Jurgens 2003). In Malaysia there was little information available on this topic. In 2003 allegations that detainees in prisons and DRC were accessing drugs from prison and police staff created media headlines (New Strait Times 2003b). Drug use inside Malaysian prisons dating from the 1970s was suggested to be common. The administration mode of drug use was generally inhaling largely because injecting drug equipment was difficult to access and finding a safe and secure hiding place was considered a significant challenge. As a general rule the cost of drugs inside penal institutions were 5 – 6 times greater than that of street prices (Ng L. personal communication 2004).

The situation inside DRCs was slightly different because although drug use inside such facilities was suggested to be common, accessing injecting equipment was easier. The reason for this resulted from inmates who when working in poultry farms or in other such environments as part of their vocational training programs, had an opportunity to purchase needles and syringes. Recent reports have revealed that a number of Pusat Serenti officers and visitors have been arrested for supplying drugs to inmates (New Straits Times 2004b). Drug use inside private DRC was suggested as occasional but mainly rare (Ng L. personal communication 2004). When injecting drug equipment was smuggled into prisons and DRC the scarcity of such equipment was likely to result in widespread sharing among the many

drug users confined to such environments. Such behaviors and the high risk of HIV transmission under these circumstances were highly unlikely to be eliminated altogether (UNAIDS and UNODC 2000).

In 2004, there was one known outreach program only, based in Kuala Lumpur, introducing drug users to the concept of using household bleach for cleaning injecting equipment. In the past this program distributed bleach packages to clients but this was not the case today. It was reported that the clients found carrying bleach bottles in their bags burdensome. However this was not the only inconvenience. Drug users found the cleaning process using bleach too time consuming. Importantly in this current heightened fear of being arrested by the police there was a reluctance to remain too long in the shooting galleries to ensure injecting equipment was cleaned appropriately. This same program does conduct educational classes about cleaning injecting equipment using bleach but was undertaken irregularly (Ng L, personal communication 2004).

2.4 Prevalence and profile

While there were various estimates of the number of illicit drug users in Malaysia, the current literature does suggest an ever increasing number of people use illicit drugs (Mohamed 2004). When the registration of drug use commenced in 1970 the figure reported was 711 individuals and five years later increased to just over 5,000 (Navaratnam and Foong 1989). In the mid 1980s it was reported at 119,000 (Navaratnam and Foong 1989) and throughout the late 1980s and into the 1990s estimates ranged from 180,000 to 400,000 of which 170, 000 to 200,000 were believed to be opioid users (UNAIDS and UNODC 2000). In 2001 the annual prevalence of cannabis use for those aged between 15 – 64 years was estimated at 0.5% of the population (UNODC 2004b). In 2002, the National Drug Agency estimated there were more than 350,000 drug users in the country (Huang and Hussein 2004) with the media in 2004 citing government sources of figures ranging from 400,000 to 500,000 (Chua 2004; Star 2004; Sunday Star 2004). In 2003, the National Drug Agency Director General stated that if the problem of drug use was not contained the number of drug users may reach 600,000 in ten years time (New Straits Times 2003c).

Since 1988 until 2003 there were over 235,000 drug users registered with an average of 14,000 new drug users recorded each year and of these 50,000 were believed 'hard core' users. However, the numbers were cumulative and only recently have efforts been made to remove cases from a database of those that may have died or left the country (New Straits Times 2003d; Sattler 2004; Mohamed 2004). These figures have once again been revised and following a series of intensive law enforcement operations figures the ADK website show from 1988 till March 2004 there were now 293,987 drug users registered and from 2000 till March 2004 73,750 were classified as 'hard core addicts' (National Drug Agency Website 2004). Between 1988 and 1996 it was reported by the National Drug Information System that there were 127,000 non-duplicated drug users cases

(UNAIDS and UNODC 2000). In 2002, 31,893 drug users were identified and of these 17,080 were new users (54%) while the rest were classified as relapse cases (Mohamed 2004). A further rise in 2003 showed 36,996 drug users and 55% were classified as new cases: an average of 1,683 new drug users were placed onto the registration system every month and 56 on a daily basis (Sunday Star 2004; Bin Musa 2004; National Drug Agency Website 2004). From January to March 2004 there were 1,931 new cases of drug users registered per month (Chua 2004).

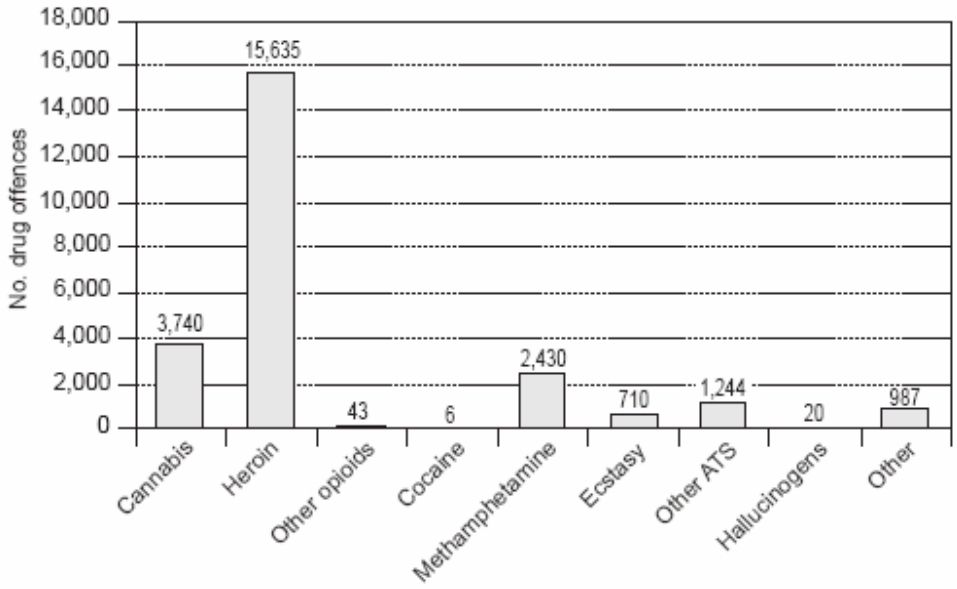
Various estimates of the number of IDUs have been reported over the years. In the early to mid 1990s the figure was 20,000 – 90,000 (Peak 1995; Navaratnam and Foong 1996). At the end of the 1990s the estimated figure was revised and reported at 200,000 (WHO and Ministry of Health 1999). In 2002 a consensus meeting convened by WHO and Ministry of Health estimated the number of IDUs could be 170,000 to 240,000 (Futures Group 2003; Huang and Hussain 2004). In 2004 the United Nations Reference Group on drug injecting issues suggested 150,000 to 240,000 IDUs with a middle range figure of 195,000. If the middle range figure was accepted it was reported that among the 13 million people aged between 15 – 64 years in Malaysia the prevalence of those injecting drugs would be 1.47% of the population (Acejas *et al* 2004). Another estimate of the number of IDUs was made and using statistics from 2002 it was suggested Malaysia had just over 117,000 IDUs (Mohamed *et al* 2004).

In 2003, a profile of drug users compiled by the National Narcotics Agency showed most drug users were male (98%) The breakdown according to race was Malays (70%), Chinese (14%), Indians (10%), Lain – Lain (4%), Others (1%) and Foreigners (1%). The majority of drug users were aged between 20 – 39 years old (71%). The education standards varied with (36%) having only achieved third form secondary school education. Those receiving no schooling or up to primary level only amounted to (16%) of the identified cases. The State of Penang has for some years been home to the greatest number of identified drug users with 6,201 in 2001 and 3,772 in 2003. The situation was changing and in 2003, the Federal Territory of Kuala Lumpur had a total of 5,480 identified drug users. It was likely the rise was linked to increased law enforcement activities to seek out drug users. In 2003, the number of new cases was 14,904 (53.25%) while the relapse cases totaled 13,084 (46.75%) (National Narcotics Agency 2004). As of July 2004, there was a rise in the number of students involved in drug peddling and drug distribution, with 139 students arrested under the Dangerous Drugs Act 1952, compared to 59 arrests for 2003. It was found that a higher ratio of female students were becoming involved in drug use and distribution (Chin 2004).

According to UDODC data sources, the number of recorded offences related to illicit drugs in 2003 was 24,815. As can be seen by the figure below most offences were related to heroin (63%), followed by various forms of ATS (18%) and then cannabis (15%). It was reported heroin and ATS were fairly easy to access at street level (UNODC

2004). It should be noted that some statistical data from various sources were conflicting but common themes emerged.

Number of drug-related offences in Malaysia by drug type, 2003



(Source: UNODC 2004)

In 2002, the number of convicted prisoners was 49,243 and among those 11,854 (24%) had committed an offense linked to the Dangerous Drug Act of 1952. The annual admission of convicted prisoners in 1996 (then a total of 27,678) through to 2002 had experienced a substantial incremental rise. A large number of people were also found under the category of remand of Magistrate and Session Court in 2002 (N = 37,882) and while the types of offence these people had committed was not available, it can only be assumed, like those convicted prisoners, many committed crimes linked to illicit drugs (Prison Annual Admission 2002). Of the reported 160,000 crimes in 2000, about 75% or 120,000 of the property crimes were linked to those with chronic drug problems (Malay Mail 2002).

The number of drug users entering government drug rehabilitating centres (DRC) was on the rise and becoming increasingly overcrowded as law enforcements rules became more stringent. In 2001, it was reported 8,178 people entered DRC (National Narcotics Agency 2001) but as of August 2004 the maximum number was 14,700. (the 'actual' number means how many beds the facility was supposed to accommodate (N = 9,300) highlighting overcrowding was a problem. In August 2004, the weekly admissions numbered 278 individuals. The government also funds a rehabilitation centre in the Kajang prison and as of August 2004 the number of detainees was 15,000, a stark contrast to the 8,688 in 2001 (National Narcotics Agency 2004).

The first AIDS case was reported in 1986 (Goh et al) and since then an exponential rise in the number of HIV/AIDS notifications has occurred. By December 2001 there was a total of 44, 278 cases of HIV/AIDS reported to the Ministry of Health. In the same year the

highest number of HIV cases since 1986 was reported totaling 5,938. This trend has not abated. In 2003 it was reported of a cumulative total of 58,012 HIV infections, 8,294 were AIDS cases and the number of AIDS deaths amounted to 6,130 (Jusoh 2003; Ministry of Health 2004). It was reported that Malaysia has the fifth fastest HIV infection rate in the Asia-Pacific region and the actual number was significantly higher than the current notifications (UNAIDS 2003). In 2003 most cases of HIV/AIDS were found in males (93%), but a rise of HIV infections has been detected among females: in 1998 it was 297 cases increasing to 673 cases by 2003. The male to female ratio of reported infection has decreased from 70:1 in 1990 to 9:1 in 2003. (Mesyuarat Penyediaan , "National Strategic Plan on HIV/AIDS" 2004). In 2003, when HIV/AIDS cases were broken down by ethnicity the majority of infections (73%) were in Malays followed by Chinese (15%) and Indian (8%). Those aged 20-39 years old were most affected by HIV/AIDS (79%) in 2003 (Ministry of Health 2004).

The HIV epidemic in Malaysia has for over 15 years primarily affected the IDU community and the prevalence figures have remained disturbingly high. From 1986 – 2002, 76% of all HIV/AIDS cases, were found among IDUs. Of the 6,756 HIV infections reported in 2003,(75%) were among IDUs (Mesyuarat Penyediaan , "National Strategic Plan on HIV/AIDS" 2004). In the mid 1990s it was suggested sexual transmission would likely be increasingly important in the years to come (Lye *et al* 1994). In recent years heterosexual transmission have risen, permeating into the larger community at large: in 2002 this mode of transmission accounted for 17% of reported HIV/AIDS cases (Sattler 2004; Huang and Hussian 2004; Ministry of Health 2004). It was possible that a generalized HIV epidemic occurring within the next five years may occur (Lowe and Sundararaman 2003).

It has been suggested that as drug users were routinely tested before entry to DRC and prisons, current figures were likely to be an over-estimate of the types of transmission based on risk factors (UNAIDS and UNODC 2000; Huang and Hussian 2004; MAP 2004). However, even among IDUs in north Malaysia that agreed to be tested, 17% of the participants were HIV positive (Navaratnam and Vicknasingham 2003).

It has been reported that the number of sex workers in Malaysia was between 43,000 to 142,000 and as the sex trade was often conducted underground it was hard to monitor and control (WHO 2001). In 2000 a study in Kuala Lumpur among sex workers found a HIV infection rate of 7% (Jusoh 2003). A nationwide assessment of how many sex workers inject drugs was not known. However, a drop-in-centre in Kuala Lumpur for women and transsexuals found that from January till July 2004 an average of 300 – 450 clients visited the service per month, most were sex workers, half were drug users and among those half were believed to be injecting (Ng L, personal communication 2004).

In the late 1990s it was reported the HIV prevalence within the 28 DRC was thought to range from 10- 27% and the overall range of sero-prevalance among IDUs in the nation was thought to range from 30 to 40% (UNAIDS and UNODC 2000). This was revised by the Ministry of Health who estimated the HIV rate among IDUs at 18.5% with a range of 13.3% to 25.6% (UNODC 2004). In 2001 it was estimated the number of HIV infected IDUs in Malaysia was 24,000 (WHO 2003). In 2001, it was reported approximately 15% of the drug users admitted into government DRC tested HIV positive (National Drug Agency 2002). In August 2004, the statistics from the 28 DRC found 1,448 HIV infected clients and a similar number (N=1,453) resided in the prison rehabilitation centre known as Kajang (National Drug Agency 2004).

In 2001, 35,765 inmates of both DRC and prisons were HIV tested using the rapid test screening kit and 10% were found HIV positive (Jusoh 2003). In 2001 it was reported HIV prevalence across the nation's prisons was 6% and in 1997 the Kajang prison recorded a prevalence of 13% (Dolan *et al* 2004). From January till August 2004, 25,927 prisoners were tested of which 1,870 (7%) tested HIV positive (Sran SK, personal communication 2004). According to the prison statistics Malaysian prisons in 2004 housed 1,954 HIV positive inmates. In a prison population reported to number 42,977 in 2004, 5% were HIV infected. From 1991 – 2004, 978 inmates were tabled on the deaths of inmates report (Prison Statistics 2004). In 2002 the HIV prevalence in prisons was reported at 10.7% (Sattler 2004). It was reasonable to suggest that the main HIV transmission mode based on risk factor among prisoners was injecting drug use.

Drug users have not only experienced an epidemic of HIV/AIDS but various other adverse health consequences related to their behaviour. Other blood borne viruses such as Hepatitis B and C were common to endemic among IDUs. In the late 1990s a small cross sectional study among IDUs in Kuala Lumpur found a rate of Hepatitis C antibody to be 100% (Yoong and Cheong 1997). An earlier study found the prevalence of Hepatitis C among IDUs was 85% (Sinniah and Ooi 1993). Other health consequences resulting from drug injecting included bacterial, fungal and parasitic infections due to the use of un-sterile injecting equipment. Abscesses and thrombophlebities were commonly experienced due to contaminated needles and various respiratory infections and states of malnutrition were observed (CDR 2002).

The co-infection of HIV and tuberculosis (TB) was also increasingly more prevalent as shown by recent research. In 2000- 2003 TB screening was done on 6,435 HIV inmates in two prisons and three DRC in Selangor State. The study found of the HIV inmates screened, the HIV/TB co-infection was11% (range 7% – 15%) (Venugopalan 2004). Although TB treatment was on offer this new trend was of grave concern when there were logistical difficulties performing chest x-ray screening: X-rays can only be done at the nearest hospital/health clinic and for each inmate they require at least 4 wardens as an escort for safety protocols, which places stress on the manpower resources in

these institutions (Venugopalan B, personal communication 2004). Mental health problems were also of concern among IDUs and in one study suicidal tendencies among heroin dependent patients showed two popular methods were by overdose or poisoning using heroin or benzodiazepines (Hussain 1998). Further studies examining this topic have not been able to be accessed.

2.5 Antiretroviral treatment for drug users

In recent years there has been a dramatic decrease in mortality and morbidity among those with HIV/AIDS following the introduction of antiretroviral (ARV) medications. However, this was not the case among drug using populations in Malaysia - as in many other Asian countries - despite access to ARV becoming more available. Over the last one year ARV therapy has become generally more affordable in Malaysia with the importation of generic drugs. The average cost for a combination regime consisting of two nucleoside reverse transcriptase inhibitor (NRTI) plus one non-nucleoside reverse transcriptase inhibitor is approximately RM 240 per month. However of the estimated 9500 HIV infected patients who need ARVs only 2100 are currently receiving treatment (TREAT Asia Report 2004). Although the majority of HIV infections in Malaysia were found among IDUs they represented a minority of those receiving ARV treatment (Oppenheimer *et al* 2004). Since 1998 in Malaysia all those with HIV can receive free AZT but the two other drugs required for triple therapy still needed to be purchased privately (It was recently reported that free combination of highly active antiretroviral therapy (HAART) was provided to five categories of patients (Oppenheimer *et al* 2003; Thomson 2004). However with the reduction in the cost of ARVs, the policy has been changed to two ARVs being given free with patients needing to purchase 1 ARV agent.. In a study on ARV for HIV infected patients in Kuala Lumpur it was found of the 315 patient receiving HAART seven were IDUs (2%), although it was not clear if drug use was ongoing (Kamarulzaman 2003). It must be noted that on the evidence available IDUs on the whole can benefit from receiving ARV treatment as other groups and there was no valid medical excuse for excluding them (Oppenheimer *et al* 2003; Open Society Institute 2004).

2.6 Government responses to illicit problems

The government has a long held belief that drug use was a serious problem and a threat to the country. The government previously aimed to have a drug free society by 2023 which was to be achieved by providing treatment and rehabilitation to drug users, either by rehabilitation in an institution or under supervision in the community (National Narcotics Agency 2001). However, the pace of progress towards this goal appears to have proved frustrating and it was suggested that in order to bring their programs in line with ASEAN goals it was declared Malaysia would be a drug free society by 2015 (Sattler 2004). Ever increasingly various government officials have repeatedly termed drugs as ‘public enemy number one’, ‘every addict a potential pusher’ and ‘drug abuse as one of the greatest threats still

haunting the nation'. In the push to rid the nation of drug use there have been intensive campaigns to round up drug users. In corridors of airports, schools and offices there were graphic images of hangman's nooses with slogans such as "Dadah Means Death" and "Dadah Kills". The government announced in 2003 a social evils campaign with a focus on drugs and sex workers to be the principle targets of the law enforcement (UNAIDS and UNODC 2000; Abdullah 2002; Kuppusamy 2003).

In a further move the National Drugs Agency will have law enforcement powers when carrying out its duties which would compliment anti - drug law enforcement currently carried out by the police (The Star 2004). A review of the number of arrests according to the Drugs Laws of Malaysia 1952, show the outcome when intense law enforcement efforts upon ridding the nation of drug use by 2015 was implemented. In 2000 under the Lain-Lain Sek ADB (Dangerous Drugs Law/Act) 1952, 11,550 people were arrested and by 2003 the figure was 19,738. Examining the Ops Tapis (Tangkapan Penagih Dadah) law in 2000 the arrest figure was 80,893 increasing to 137,159 by 2003 [Ops Tapis occur when a complete law enforcement force along with respective other agencies unite to arrest drug users over a certain time frame] (Polis Malaysia 2004). It was little wonder that with so much focus placed upon drug users and the consistent climate of fear, misunderstanding and demonisation of drug users, the public possessed a negative attitude towards those dependant on drugs: the perception was of those addicted to drugs not having the will power to stop drug consumption with supportive family network lacking (Low *et al* 1995).

A person was defined as a drug user if they tested positive through urine testing, and it was not necessary to be in possession of any drugs or drug using parapahanelia. While it was claimed by some that drug testing strips were not of a high quality and the results not always accurate the police were not legally bound to use the strips and could order an official urine test conducted in laboratories approved by the Ministry of Health on suspicion alone (Yahaya 2002). The penalty for having a positive urine toxicology and the certification of a doctor was an automatic admission to treatment for a minimum of two years, although it was suggested some can be discharged after a year and a day as not uncommon (UNAIDS and UNODC 2000; National Drugs Agency 2001; Sattler 2004). Previously in the mid 1980s the time frame for rehabilitation was set at six months in government run centres (Lee 1985) and by the early 1990s compulsory treatment involved a maximum of two years in a DRC followed by two years of follow-up care (Scorzelli 1992).

It was reported that based on a court order an individual could volunteer for treatment or be sent for compulsory treatment (Sattler 2004). Upon discharge from the DRC there was a request the person report to the nearest police station on a daily basis for another two years although the drop out rate was about 70% and the majority

were lost to follow up by the police. For second and third time offenders they were sent to prison from 5 – 7 years and caned for not more than three times. Fourth time offenders were once again sent to prisons and the sentence was 7 – 13 years and were caned 3 – 6 times (Sran SK, personal communication 2004). Hardcore addicts could face jail terms of up to 13 years and six strokes of rotan under proposed amendments to the Dangerous Drugs Act. Under the amendments a hardcore addict is defined as someone who has been ordered to undergo treatment at drug rehabilitation centers or has been convicted under Section 15(1)(a) of The Dangerous Drugs Act more then twice.
Deputy Prime Minister Datuk Seri Abdullah Ahmad Badawi said those who committed the same offences for the third time faced jail terms of between 5 and 7 years and not more than 3 strokes of rotan. For subsequent offences, they face jail terms of between 7 to 13 years and whipping of between 3 to 6 times. He also added that hard core addicts will be placed in specially designated areas within a prison.(The Star 2002). In the mid 1990s there were seven after care centres which offered six month residential programs (UNAIDS and UNODC 2000) but the current state of this program was unknown.

It was internationally recognized that Malaysia's drug laws were very stringent. A mandatory death penalty for trafficking could include possession of 15 grams of heroin or morphine, 1,000 grams of opium or 200 grams of cannabis. Possession of any amount of any illicit drugs, including cannabis can result in a caning. Possession of less than 5 grams of heroin (an average 10 days supply) can result in a life sentence (Haring 1991; Scorzelli 1992; UNAIDS and UNODC 2000). It was reported that Malaysia has one of the stiffest drug laws in Asia with the Malaysian Dangerous Drugs Act 1985 prohibiting the possession of syringes by anyone without a prescription (Mahathir 2004a; Open Society Institute 2004). The laws in place have yet to curb the epidemic of drug use and played a substantial role in exacerbating the HIV rates among IDUs (Mahathir 2004b).

In 2004 there were 28 government funded DRC as well as a prison rehabilitation centre in Kajang. Eleven of the DRC focus on group therapy, eight on self-realizing therapy, six on family therapy, two on work therapy and one on individual therapy (National Drug Agency 2004). Since the early 1990s the DRC have largely modeled themselves loosely on a therapeutic community concept and utilize a phase system which the inmate follows with increased responsibility and privileges based on behaviour (Scorselli 1992). There have been calls since the early 1980s to develop more flexible and individualized programs for those confined to an institutional setting (Johnson 1983) but largely this was not adopted; a military approach and minimal concern for innovation was the norm (Lee 1985; Arokiasamy and Taricone 1992; Habil 2004). However, recently nine DRC already in existence were being targeted to adopt a different methodology although uncertainty exists of the type of methodology to use; it was suggested innovation and openness to ideas would be considered (Sran KS, personal communication 2004). There is now a move to categorise these DRC into three levels: one for hardcore addicts,

secondly those that will focus on youths between the ages of 14 and 21, and thirdly those who voluntarily enter rehabilitation programmes. (New Strait Times 2004c)

Currently over a period of two years an inmate will follow a program structure of four phases which would include a set time period spent on various activities.

Program structure for Drug Rehabilitation Centres

Phase 1: Learning stage 3 to 5 months	**Phase 2: Enforcement 4 to 7 months**	**Phase 3 : Self Realization 4 to 7 months**	**Phase 4 : Interrogations process 4 to 7 months**
• Self responsibility free movement 25% • Every activity is compulsory • Emphasis on physical and psychological recovery • Introduction on concept of recovery • Guidelines on rules and regulations • Explanation on importance of positive and negative • Morning and evening march	• Own responsibility 50% • Carry out phase one activities •Emphasis on emotional development •Self respect •Morning march •Counseling, religion teachings and moral values •Vocational training	• Own responsibility 75% • Involve in vocational projects • Free movements within the facility • Involvement in societal activity • Training on self realization / respect • Training on Morning and evening march • Counseling • Classes on cultural values and vocational training • Psychological	• Own responsibility 100% • Active involvements in community based projects • Free movement within the facility • Training on Morning march on weekly basis • Ready to be released

• Psychological evaluation		évaluations • Values on inmates improvements	

The relapse rates of inmates that have been to DRC, remain high with figures often estimated at 70% to 90% (Scozelli 1992; UNAIDS and UNODC 2000; Habil 2004; Pengasih Malaysia 2004). Others have claimed that outside of the DRC programs relapse rates were considerably lower at about 35% (Pengasih Malaysia 2004), but systematic or scientific evaluations of such programs - crucially over an extended period of time, acknowledging addiction was a chronic relapsing condition - have not been known to be conducted. Nationwide however, there was an apparent general agreement that the success rate of drug users remaining abstinent was low.

At the end of the 1990s it was estimated that at least 40,000 to 50,000 drug users have undergone rehabilitation once (UNAIDS and UNODC 2000). Case relapse figures range from around 13,000 to 17,000 per annum from 1992 until 2003 (National Drug Agency 2004) and there was an acknowledgment that since 2000 till May 2004, there were nearly 74,000 'hard core addicts' (National Drug Agency Website 2004). The current rehabilitation approaches were seriously flawed and not effective. A movement was emerging to have first time offenders sent to DRC to be segregated from 'hard core addicts' in an attempt to ensure bad influences were minimised (Bingkasan and Chin 2004).

All government funded DRC were free of charge for inmates (Kaur and Habil 2002). In 2002, the Human Rights Commission of Malaysia visited two rehabilitation centres and it was reported detaining large numbers was essentially unsatisfactory and lowered the outcome of effectiveness. As a result of the overcrowding not all detainees could be provided with the skills training provided nor could all the detainees interested in vocational training be accommodated (Human Rights Commission of Malaysia 2002). It was unlikely such problems in 2004 have been resolved while an increasing number of detainees were found in most DRC.

In addition to the DRC there was also 60 private drug rehabilitation centres approved by the National Drug Agency and there were 121 private clinics that have been approved by the Ministry of Health to treat drug users (National; Drug Agency 2004; Mohamed 2004). It was reported that there were 300 private medical practitioners who received specific training and qualified them to treat drug users. But up until early 2004, 168 doctors only, trained by the Malaysian Medical Association, had been issued with certificates to treat drug users. The main reason appears to be a concern the certificates may contravene some drug laws and that drug substitution therapies may be misused in the treatment of drug users (New Strait Times 2004).

Statistics of Private Drug Rehabilitation Centres approved by the National Narcotics Agency

Centers	No	Total Clients
Religious	**40**	1256
Medical	**7**	174
Therapeutic	**1**	95
Work Therapy	**3**	75
Medical & Religious	**3**	50
Psychology	**1**	10
Hydro Therapy Ice	**1**	10
Unknown	**1**	15
Closed	**3**	
Total	**60**	1685

(Source: National Drugs Agency 2004)

High relapse rates have resulted in further drug related offenses in which the outcome for chronic drug users was being sent into a prison system that has become seriously overcrowded (International Centre for Prison Studies 2004). In 2004, the Malaysian Inmates Report show nearly 43,000 prisoners but the capacity of the prisons in total should be 24, 850 (Prison Stats 2004; Sran SK, personal communication 2004). In 2003, the Human Rights Commission of Malaysia visited nine of the 36 prisons in the country and overcrowding was common: the Penang prisons were housing 2,481 inmates but the gazetted number was only for 1,200. Similar findings were shown in other prisons (Human Rights Commission 2003).

In addition to the overcrowding in 2004, up to 1,954 HIV positive inmates and an increasing number were infected with TB. Health training programs for prison officers were provided with basic information about HIV/AIDS along with counseling materials for selected officers to conduct the training. However, as of August 2004, only around 200 out of 1,200 officers have attended the training sessions. Currently there were no health programs conducted for the inmates (Sran SK, personal communication 2004). For HIV infected prisoners there were processes implemented for segregating this group from other inmates but still no HIV treatment program was on offer (Open Society Institute 2004). It was unclear how many inmates were transferred for medical attention to hospitals but this was largely determined as to how many guards were on duty at the time (Sran SK, personal communication, 2004). It can be assumed problems would emerge during episodes of transfer. Inmates found to be HIV infected were segregated in both DRC and prisons however there was no further isolation currently in place when HIV positive inmates were found to be co-infected with TB due to space constraints in such institutions (Venugopalan B, personal communication 2004). The further risk of TB spreading among other HIV infected inmates housed in segregated buildings cannot be under estimated.

Between 1994 and 2003 RM 1.037 billion had been spent to manage and develop 28 Pusat Serenti nationwide (New Straits Times 2004b). In 2003, the government spent about RM 44 million on treating and rehabilitating drug users in the 28 DRC and that in 2002 a further RM 12 million was spent to develop and maintain such facilities (Ismail and John 2004). In 2001 it was reported that the cost of each inmate in a DRC was RM 362 per month (New Strait Times 2001) and was likely this amount has increased annually. In 2004 it was estimated the per person costs was RM 12.7 per day. The excessive costs of running the DRC that consistently do not meet desired expectations, has led to some discussions on the need to privatize the system but currently it was reported the DRC were not planning a move to privatization (Sran SK, personal communication 2004).

2.7 Drug Policy

A National Drug Policy was originally launched in 1983 and revised in 1996 with a series of new strategies and priority areas of prevention, enforcement, treatment and rehabilitation and regional and international cooperation. The prevention strategy was focused on efforts to create an environment to protect individuals and the community from drug use. Essentially both the primary and general prevention was based on demand reduction principles through education and promoting positive religious, moral and cultural attitudes and values to reject drugs and encourage healthier lifestyles. The enforcement strategy comprises of interdiction (reduce the supply of drugs reaching the community), legislation (impose severe penalties with regards to trafficking and possession of drugs) and lastly intelligence (focused on controlling syndicates and individuals involved in drug smuggling). Treatment and rehabilitation was focused on eliminating drug dependency and preventing relapse among drug users. Lastly international cooperation was regarded as a strategy to control and prevent drug use and trafficking and strengthen international control and prevention (Navaratnam *et al* 2002).

The key component of drug policy was zero tolerance and these polices were largely the responsibility of the law makers. Striving to eliminate the supply and demand of illicit drugs and create a drug free Malaysia by 2015, the result was an acceleration of draconian punishments towards drug users. A committee for the formation of drug policy involves government cabinet ministers from the highest levels. Drug policies undoubtedly impact upon the way illicit drug consumption significantly influences the HIV/AIDS scenario and of the further implications for wider public health issues. Yet, health officials do not appear prominently on this committee and consequently their contribution to the drug policy debate was minor.

2.8 Government responses to drug use and HIV

It was suggested a history of productive collaboration between the Ministry of Home Affairs and the Ministry of Health has resulted in outcomes of merit such as the creation of materials for use in HIV counseling with drug users in treatment (Sattler 2004). Currently

there were selected wardens within some DRC and prisons that have been formally trained in HIV counseling but as yet the impact of this strategy has not been evaluated. There were reports of harm reduction measures inside some DRC and prisons but these measures simply refer to avoiding injecting drugs, using condoms during sexual intercourse, partner notification and to refrain from donating organs and blood (Venugopalan B, personal communication 2004). The introduction of needle syringe programs as a harm reduction approach has for many years been rejected outright in the belief such programs would encourage drug use (UNAIDS and UNODC 2000; UNODC 2003; Marsiglo 2004) despite a global review of evidence by the World Health Organization reporting that this was not the case (WHO 2004).

Studies on the use of naltrexone post detoxification have been conducted since the early 1990s (Navaratnam *et al* 1994) and was available in recent years when prescribed by medial practitioners (Kaur and Habil 2002). However, naltrexone was known to be costly and international research shows a poor acceptance of the drug and consequently relapse to heroin was very common (Tucker and Ritter 2000). For many years methadone was not supported by government policy as it was suggested it would compromise the nation's goal of becoming a drug free society (UNAIDS and UNODC 2000). As a result of this strictly enforced policy the demand among drug users to seek assistance from alternative sources has emerged: in the north of Malaysia some people have been crossing the border into Thailand and enrolling as patients to receive methadone maintenance conducted in the Narathiwat Provincial Hospital. Malaysians were known to be enrolled in both the short and long term programs that were known to extend up to two years (Sattler 2004).

Recently, advocacy efforts by NGOs and medical professionals have resulted in an increasing interest that substitution therapy programs should be explored and piloted. In 2003 the government consented for a methadone maintenance program to be undertaken. In the study of 46 subjects, 30 completed the program (others defaulted for various reasons) who received a daily dose ranging from 10 mg to 45mg. Only two participants complained of mild side effects, the majority reported an improvement with their carer, 61% reported an improvement in their work performance or gained employment, and none reported involvement with crime or high risk behaviors (Gill *et al* 2004). A reduction phase of taking methadone was reported to start on day 57 but the use of long term treatment was unknown. In another study the substitute therapy drug buprenorphine was used for 30 confirmed opiate users over a period of 14 weeks. An average dose of 14 mg was supplied, minimal side effects were experienced, 80% completed the treatment duration and urine opiate toxicology was extremely minor (Hatim and Habil 2004). Although the clinical trials showed impressive results, substitution drug therapy still had its many skeptics that cannot be ignored (Izzaddin and Teoh 2004).

In the past the government supported an NGO (IKHLAS), based in Kuala Lumpur to distribute bleach for the cleaning of needles and at

one stage a small scale distribution of needles and syringes to IDUs in the area (Reynolds 1999). Currently distribution of injecting equipment was strictly outlawed and the same NGO ceased distributing bleach as drug users found the cleaning process too burdensome and law enforcement agencies' increased targeting of drug users thwarted such cleaning techniques in various injecting sites of the city (Ng L, personal communications, 2004). Activities and approaches that could prevent HIV among drug users were seriously lacking or did not exist. In 2003, it was suggested that 20 – 30% of IDUs were covered by outreach programs (Futures 2003) but this was highly unlikely: a recent review of the NGO, IKHLAS drug user program found that on a monthly basis, over 11 months, around 1,800 – 2,000 people were served (both genders) but most were not considered IDUs (IKHLAS 2004). Estimates of the number of IDUs in Kuala Lumpur were not known but the number was likely to be considerable when acknowledging the nation wide figures.

One review found HIV prevention education linked to drug use was not found in either public or non-government drug treatment facilities. Acknowledging the chronic relapsing nature of drug users it was suggested that treatment centres should explore a unique opportunity to educate this particularly vulnerable group about the risks of HIV infection and transmission (Sattler 2004). But to do this requires the approval and guidance of the government. This was despite a reported 600 HIV infected inmates in DRC in 2001 and by August 2004 the figure was 1,448 (Sayuthi 2001; National Drug Agency 2004). Prevention efforts towards an effective management of HIV was largely funded by the government with around US$10.3 million provided over the last two years and US$1.5 was allocated to NGOs in the 2004 budget (Mahathir 2004b). As to how much of these funds were directed towards activities associated with the drug using community was unknown.

2.9 National AIDS Policy

The National AIDS Policy was developed and approved in 1998 and was currently being revised with participation of various ministries, government agencies and NGOs affiliated with the Malaysian AIDS Council(MAC). It was acknowledged use of contaminated needles and widespread sharing of injecting equipment by IDUs remains the main mode of HIV transmission and most notifications of HIV infected individual was found among IDUs. Issues specifically focused on harm reduction and/or reaching out to drug users as a separate issue was not identified. The focus was of promoting towards behaviour change through practicing a healthy lifestyle and raising the level of awareness of HIV/AIDS issues within society. Prevention activities focus upon traditional demand reduction approaches with the task of implementation designated by various agencies and organisations involved in prevention of drug use and of HIV prevention (Reid and Costigan 2002).

In 2001, the Association of Southeast Asia Nations (ASEAN), of which Malaysia is a signatory, met in Brunei Darussalam and what emerged was the ASEAN Work Programme on HIV/AIDS II (2002 – 2005). This

document raised the topic of HIV prevention, treatment and care among drug users, acknowledges interventions for this group was relatively weak: a previous meeting in 1999 reported that the promotion of harm reduction amongst drug users should occur. Various activities were suggested of which some included: the need to source financial and technical support to initiate harm reduction activities and; to encourage the development of and study the feasibility of establishing pilot projects to reduce the vulnerability among IDUs (ASEAN 2002). A regional policy review of the ASEAN Summit Declaration had already proposed that signatories undertake analysis of laws, regulations, policies and programmes related to HIV prevention, treatment and care of drug users in consultation with different sectors in-country (ASEAN 2001).

In July 2004 at the Second Asia-Pacific Ministerial meeting on HIV/AIDS in Thailand, of which Malaysia was represented, the Joint Ministerial statement reported its alarm at the rapid escalation of HIV transmission, particularly among IDUs. It was reported of the need for a commitment to expand prevention efforts recognizing the special needs of various groups in society, including IDUs. With regard to policy and legislative preparedness the following statement was made:

> *'We commit...to further develop an enabling environment that provides equitable access to essential HIV/AIDS prevention, care and treatment. In particular we will strive to ensure that non-discriminatory laws and policies that protected vulnerable groups and people living with HIV/AIDS from violations of their human rights are in place' (Joint Ministerial Statement 11 July 2004, Thailand).*

In Malaysia it was long recognized that IDUs were vulnerable to HIV, yet little was done to implement effective prevention programs of any kind, although it must be noted the recent piloting of substitution therapy programs (methadone and buprenorphine) was cause for some hope. The major obstacle for the way forward was anti-drugs programs being the sole responsibility of the Home Affairs Ministry and issues of HIV/AIDS with the Ministry of Health. A result of this jurisdiction was the Ministry of Health consistently finding it difficult to implement broad ranging effective prevention programmmes for all drug users (Mahathir 2004a).

2.10 Formation of HIV/AIDS Policies

An examination of the formation of HIV/AIDS policies in Malaysia has exposed various challenges and problems when addressing issues associated with illicit drug use problems. Coordinating various HIV/AIDS related programmes was entrusted to the Ministry of Health. An Interministerial Committee on AIDS advises the cabinet on polices and strategies to address the epidemic The Committee was

Chaired by the Minister of Health and Ministers from various Ministries, as well as a representative from the Malaysian AIDS Council (Huang and Hussein 2004). However, it was not uncommon for the Ministers to send along representatives that were either not well informed of the issues and/or lacked significant prestige. The meetings were held extremely infrequently and agenda papers were noted as very outdated (Fahmee N and Mahathir M, personal communications 2004).

There were two subcommittees, the National Coordination Committee on AIDS (NCCA) and the National Technical Committee on AIDS (NTCA). The NCCA was chaired by the Secretary General of the Ministry of Health (MoH) and comprised of secretaries of various Ministries. It was supposed to meet every six months but as a result of successive changes of the Secretary General the last meeting was held in 2002. The Secretary Generals were civil servants and not professional health officials and as a result issues were often not understood adequately. There was only one seat for an NGO and this was reserved for MAC which was an umbrella NGO body. With around 24 government agencies also represented at these meetings the potential of a sole NGO being present was likely to prove a disadvantage. In 2002 the NCCA evolved into a Country Coordinating Mechanism (CCM) when applying for the Global Fund for Tuberculosis, AIDS and Malaria money. According to the Global Fund rules the CCM required a broad ranging membership which comprised of nine members from government, nine members from NGOs and nine members from others for example academia. The potential for improved consultation on HIV issues, that previously the NCCA were not involved in, such as illicit drug use, was a bonus. Unfortunately the Global Funding was not approved and the CCM no longer meet. Currently an organisation called PENGASIH, an affiliate member of MAC, attends the NCCA meetings. They provide drug use services ranging from drop in centres, a shelter/home, outreach and job placements for drug users. Government DRC's were represented by the National Anti Drug Agency (ADK). The NCCA never debates policy issues, largely because most participants have little knowledge about HIV/AIDS issues per se. With the MoH at the helm of these meetings all issues were oriented towards health with legal aspects and implications rarely spoken of (Fahmee N and Mahathir M, personal communications 2004).

The NTCA comprises of directors from various divisions in the MoH and deans from various medical faculties from public universities in the country. Various technical aspects of HIV/AIDS were discussed and issues such as substitution therapy programmes were raised at these meetings (Fahmee N and Mahathir M, personal communications 2004). The policy making process would undoubtedly experience many delays and the communication of polices from the MoH right down to the health personal at the community were likely to be problematic (Huang M, personal communication 2004). Introducing harm reduction into the HIV/AIDS policy debate remains a major challenge. It has been suggested that the opposition to harm reduction has an ideological base, rooted in religious beliefs (mainly

Islamic) and that intoxicants were forbidden (Mohammed and Pathi Mohd 2002; Marsiglio 2004). Also ongoing political pressures in support of supply and demand reduction approaches only remained firm. As for the influence of the US Drug Enforcement Agency on PEMADAM (an NGO working in the area of drug prevention that was formed in 1976), with its long established anti-harm reduction stance, it was suggested this should not be underestimated (Mahathir M, personal communications 2004).

2.11 Non-government organisations' response to drug use and HIV

Over the years very few NGOs have focused their attention towards the needs of current drug users and IDUs and this has not changed. The NGO IKHLAS, have been operating since the late 1990 for drug users and other marginal groups in the community. Currently it runs a male drop-in-centre, a woman and transsexual drop-in- centre as well as a medical clinic (Crofts *et al* 1998; UNAIDS and UNODC 2000; Ng L, personal communication 2004). As previously mentioned bleach was no longer distributed by IKHLAS to drug users but demonstrations of how to undertake cleaning techniques of needles was attended at the drop-in-centre. In the past outreach was not considered a government HIV prevention strategy thus funds for NGO to do such activities was limited (UNAIDS and UNODC 2000). The current government view on outreach was unknown.

The outreach program of IKHLAS has been sub-contracted to another NGO called YWAM (Youth with a Mission)**.** Two outreach workers were employed but volunteers also assist. Outreach work was conducted in two hospitals and a few locations in Kuala Lumpur covering a radius of about 20 kilometers. Sometimes outreach staff was involved in follow up of those in DRC, visiting the drop–in –centres as well as the families of drug users. On average outreach staff connected with about 25 clients each week. The work focused on information, education and communication on various aspects of harm reduction. However, the distribution of bleach and/or injecting equipment was not undertaken. Most outreach workers originated from the drug using community (Tan E, personal communications 2004). Outreach work was also conducted by the NGO PENGASIH who involved themselves in running a shelter home and a job placement service.

Currently the IKHLAS male drop-in-centre services between 1,500 to just under 2,000 clients per month, with a daily number ranging from 68 – 96. From this centre they undertake referrals to halfway houses, recovery houses and HIV community homes. As part of IKHLAS the women and transsexual drop-in-centres services between 244 – 450 clients per month, with a daily number ranging from 10 – 20. It must be noted half of this client group was believed to be drug users and of these half injected. The medical clinic addressing various ailments serviced between 236 – 348 clients per month and of these approximately 35% - 40% were related to wound dressings. IKHLAS does not receive financial support from the government and its

current funding contract was uncertain (Ng L 2004; Ng L personal communication 2004).

In addition to the government DRC there were various private drug rehabilitation centres registered by the National Drug Agency as previously discussed. Apart from some information of sexual risk behaviors and use of condoms there were no known rehabilitation centres that provide any other information of the principles of harm reduction in a way that could effectively impact upon the residents. The Malaysian AIDS Council (MAC) was formed in 1992 to help maximize the community response to HIV/AIDS: the government believes MAC and affiliates were best placed to reach marginalized populations, including IDUs. MAC remains the umbrella organisation for all 37 NGOs working on AIDS issues and in 2003 the Ministry of Finance allocated approximately US$10 million to be given to these NGOs via MAC over a period of 10 years. It was highly likely that NGOs targeting their actives towards current drug users, not in treatment, would incur difficulties in their operations. This was largely because drug users suffered ongoing intense discrimination and open hostility towards their deviant behavior but also a single drug treatment approach of abstinence only was vigorously embraced by the government and the wider community (UNAIDS and UNODC 2000; Low *et al* 1996; Low and Sundaraman 2003; Mahathir 2004b).

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