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8.1 Introduction

With rapid globalization, illicit drug trafficking and misuse have become worldwide phenomena from which almost no nation has immunity. Due to the availability of drugs and cultural traditions of using illicit drugs, different types of drugs may be trafficked and abused in different regions and countries. Based on the types of drugs trafficked and abused, three dominant transnational drug markets are recognized globally, namely, markets for heroin, cocaine, and cannabis. While the markets for these traditional drugs have tended to remain steady at the global level over the past decades, amphetamine-type stimulants (ATS) have quickly gained popularity worldwide, in particular among a young user population.¹

Asia is renowned for its long history of opium cultivation and use. For this reason, the world's three largest opium producers are all located in Asia. Before Afghanistan's opium production surpassed that of the Golden Triangle in the late 1980s, Myanmar, as the major opium producer in the Golden Triangle, was the world's top opium-

producing country. It is now the second largest (UNODC 2010d).² Lao PDR is the world's third-largest opium producer. In addition to producing the most opium, Afghanistan also produces the most cannabis resin (UNODC 2010a).³ Asia, more precisely Southeast Asia, also claims the biggest share of the world's ATS market. Myanmar is also a major methamphetamine producer (UNODC 2010d), and India has become a source of ketamine (UNODC 2010c). Illicit drugs produced/manufactured in Asia are not only trafficked and consumed inside Asia, but they are also distributed to the underground market in other continents, such as North America and Europe.

Illicit drug trafficking has brought about significant societal, political, and legal consequences for Asian countries, in particular the major producer countries (Cornell and Swanström 2006; Dupont 1999). Studies have found that illicit drug trade in Asia has been closely linked to social instability, widespread official corruption, and transnational crime in the region (Chalk 2000; Cornell 2006). The drug trade not only challenges the national sovereignty of states (Dupont 1999) but also poses increased threats to

¹According to the reports from the United Nations, ATS refer to a group of synthetic substances comprising amphetamine, methamphetamine, methcathinone, and ecstasy-group substances (MDMA and its analogues). In different countries, ATS street names may differ (UNODC 2009b).

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²There are four countries in the Golden Triangle: Myanmar, also known as Burma, Lao PDR, Vietnam, and Thailand.

³This estimation was based on the high resin yields measured in Afghanistan (145 kg/ha), which are four times higher than those in Morocco (36 kg/ha measured in 2005)—another major cannabis production country (UNODC 2010a).

both regional and international security.⁴ As the second-largest illegal transnational business in the world (next to the arms trade), the illicit drug trade's link to terrorism has been also observed by scholars (Jackson 2006; McCoy 2000).

In Asia, a major source region for opium, cannabis, and ATS, the number of people who abuse illicit drugs is significant. The social harms brought about by illicit drug abuse are enormous. Asia, home to two-thirds of the world's population, has the second-highest HIV infection rate in the world. As of 2009, 4.7 million people in Asia were HIV infected. The high HIV infection rate is primarily drug related. The HIV infection rate among injecting drug users (IDUs) is as high as 16%, and in some countries, such as Thailand and Vietnam, the infection rate has reached 30–50% and 32–58%, respectively (UNAIDS 2010). The HIV/AIDS epidemic in Asia affects not only the drug users themselves but also their families, communities, and many aspects of the larger society as well. According to the United Nations Human Development Programme (UNDP) (2010), most of the world's multidimensional poor live in Asia (51% in South Asia and 15% in East Asia and the Pacific). The impact of HIV/AIDS on Asian countries, in particular those countries in poor economic shape, has been particularly devastating.

Due to the substantial consequences of illicit drug trafficking and drug abuse for Asian countries, this chapter focuses its discussions on two central issues: illicit drug trafficking and drug misuse in Asia. The first part of the chapter introduces illicit drug production in major producer countries in Asia as well as current markets and major drug trafficking routes; the second part of the chapter shows drug consumption patterns in Asia, the social consequences of drug use, and treatment modalities provided for drug users. Responses of the criminal justice system and an assessment of the effectiveness of the policies will also be addressed for both sections.

⁴For instance, countries in central Asia, on the major drug trafficking routes from Afghanistan to the Russian Federation and Europe, have seen national security at all levels impaired (Cornell 2005).

8.2 Drug Trafficking in Asia

The legal framework for addressing illicit international drug trafficking is based on three major international drug control treaties: the Single Convention on Narcotic Drugs of 1961 (as amended in 1972), the Convention on Psychotropic Substances of 1971, and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. Following these treaties, the Commission on Narcotic Drugs and the International Narcotics Control Board were established. According to the United Nations, drug trafficking is defined as a global illicit trade involving the cultivation, manufacture, distribution, and sale of substances subject to drug prohibition laws. To advance the understanding of illicit drug trafficking and consumption in the world, the General Assembly of the United Nations in 1998 mandated UNODC to publish comprehensive data about the world's drug production, trafficking, and consumption. Starting in 1999, UNODC began to publish its annual report *Global Illicit Drug Trends*. In 2004, UNODC merged *Global Illicit Drug Trends* and the *World Drug Report*. In its report published in 2010, the United Nations identified three major illicit drug markets worldwide: the heroin market, the cocaine market, and the ATS market.⁵ In general, different drug markets have shown different trafficking patterns: heroin and cocaine trafficking is mainly involved in long-distance trafficking between continents while ATS and cannabis resin trafficking is primarily limited to the producers' regions (UNODC 2010a).

8.2.1 Opiate and Heroin Market in Asia

According to the *World Drug Report* (2010), global opium poppy cultivation declined to 181,400 hectares (ha) in 2009, a 23% reduction

⁵While cannabis production is found throughout most of Asia, it is not covered by *World Drug Report* 2010 because cannabis is mainly consumed locally in producer countries and is not subject to transnational market analysis (UNODC 2010a).

compared to 2007. While both global opium and heroin production fell since 2007, a significant increase in opium production (from 4,346 to 7,754 mt) in 2009 was evident (UNODC 2010a). In Afghanistan, the world's leading opium producer, the total opium poppy cultivation in 2010 largely remained the same as the previous year's at 123,000 ha, representing two-thirds of the opium cultivation in the world. However, yield fell from 56.1 to 29.2 kg/ha due to a plant disease (UNODC 2010b).⁶ In Myanmar, the second-largest opium production country, the opium poppy cultivation began to surge in 2006 (from 21,600 ha in 2006 to 38,100 in 2010) (UNODC 2010d). Lao PDR is still ranked as the world's third-largest producer of opium; however, its cultivation has significantly decreased in recent years (Reid et al. 2006).

Although Afghanistan has cultivated opium for centuries, opiate production began to surge in the 1990s. The Soviet Union's withdrawal in 1989 and the country's breakup in early 1991 are viewed as two major events that boosted Afghanistan's opium production (Mccoy 2000). Before the Taliban took power in 1996 and established the Islamic Emirate of Afghanistan in Kabul, the country was largely controlled by regional powers (Cornell 2006). Until today, the central government's inability to exercise its administrative power over different regions in the country is still the primary reason that opium cultivation thrives. Ninety-eight percent of opium production in Afghanistan is concentrated in nine southern and western provinces—areas under the strong influence of antigovernment elements or organized criminal networks. The United Nations Department of Safety and Security (UNDSS) classified the security level of these provinces as high or extreme risk (UNODC 2010b).

Lack of security is also the main reason the Golden Triangle was at one time able to become the world's largest opium cultivation area. In

Myanmar, the major producer country in the Golden Triangle, opium production regions are occupied by ethnic opposition groups that have a self-administrated autonomy outside government control (Kramer et al. 2009). Another similarity shared by Afghanistan and Myanmar is poorly developed local economies. According to the UNDP 2010 report, the Human Development Index (HDI) for both Afghanistan and Myanmar was in the low development category with a gross national income (GNI) per capita at \$1,419 and \$1,591, respectively. Opium production areas in these countries are found in extremely poor areas. A survey conducted in Afghanistan indicated that farmers were motivated to cultivate opium poppies mostly for economic reasons (47%) (UNODC 2010b).

Regardless of increasing heroin use in Asia in recent years, western Europe and the Russian Federation are still the two largest heroin consumer markets worldwide (UNDOC 2010a). For this reason, drug trafficking routes have been developed with a purpose of connecting the producer countries with these two consumer countries. Due to Afghanistan's proximity to western Europe and the Russian Federation, illicit drugs from there are trafficked mainly to these two destinations via three major drug trafficking routes: the Balkan route, the Northern route, or what might be called the Pakistani route, where neighboring Pakistan is simply used as a distribution center. Iran and Turkey are the major transit countries of Balkan route, and Central Asia is responsible for drugs trafficked from Afghanistan to the Russian Federation.⁷ Among Central Asian countries, Tajikistan is the most vulnerable nation affected by drug trafficking due to its long shared border with Afghanistan. Weak border control and ethnic connections on the two sides are also contributing factors (Engvall 2006).⁸ Drug trafficking in Tajikistan is primarily small scale; for example, about 80% of seizures made from

⁶The average farm-gate price of dry opium at harvest time (weighted by production) in 2010 reached \$169/kg (a 164% increase) compared to 2009. As a market response, the gross income for farmers also increased 36% (to \$4,900) (UNODC 2010b).

⁷Central Asian countries include Tajikistan, Uzbekistan, Turkmenistan, Kyrgyzstan, and Kazakhstan.

⁸The Tajiio population, situated mostly in the northern border area, constitutes 20–25% of Afghanistan's population.

2005 to 2007 totaled 10 kg or less, with the average size of 2.6 kg (UNODC 2010a). In the third drug trafficking route via Pakistan, drugs are trafficked to many destinations, including Iran (with Europe as the final destination), Africa, the Middle East, and other Asian countries (UNODC 2010a).

Myanmar, the second-largest opium-producing country, is also central to the global heroin trade. Its drug trafficking pattern has been greatly shaped by changes in the consumer market. While in the past heroin produced in the Golden Triangle area primarily supplied North America and non-Asian markets, beginning in the 1990s heroin trafficking became more focused on the Asian market, in particular East Asia (Dupont 1999). With China's economic reform and resulting open-door policy in the late 1970s, more border crossings were created along the border of China and Myanmar. China, initially a gateway for drugs trafficked to other Southeast Asian countries and North America, has gradually become a major consumer market with more than one million heroin users currently. As observed at cross-border drug trafficking points between Myanmar and China (Chin and Zhang 2007, p. 5), drug trafficking patterns similar to those in Central Asia have become apparent: drugs trafficked in large quantities have largely disappeared; instead, small quantities carried by large number of individuals are typical.

8.2.2 Amphetamine-Type Stimulants Market in Asia

ATS have gained popularity worldwide in the past decades. At present, the manufacture of ATS has spread throughout more than one-third of the countries in the world (UNODC 2010a). Asia, in particular East and Southeast Asia, has become the home of the world's largest ATS manufacturers. Unlike plant-based drugs, ATS can be made in small clandestine laboratories as long as the precursors are available. Unfortunately, China and India are the world's two largest producers of ephedrine and pseudoephedrine—the precursor chemicals for ATS.^{9,10} Due to the concealed

nature of ATS manufacture, only very limited number of ATS laboratories are uncovered by law enforcement. For example, in Myanmar, a major ATS producer in Asia, only 39 manufacturing facilities (mostly small scale) have been detected over the past decade (UNODC 2010c). Because of the clandestine nature of ATS production, it is impossible to estimate its scope. Clearly, gathering global ATS data is an urgent need.

In response to the increase in ATS manufacturing, UNODC launched the Global Synthetics Monitoring: Analyses, Reporting and Trends (SMART) Program in 2008. The region of East and Southeast Asia was chosen as the first focus region due to the area's extreme ATS problems. The first SMART annual report was published in 2009, and the second report became available in 2010. The data for these reports were gathered from the Drug Abuse Information Network for Asia and the Pacific (DAINAP), which was initiated by the United Nations Office on Drugs and Crime in 2005.¹¹ In general, those countries (or regions) with a longer history of ATS abuse, such as Japan, the Philippines, Singapore, and Taiwan, have well-maintained national data collection systems in place (Humeniuk and Ali 2004). Although South Asia was also included in SMART, only very limited information is available because unified national reporting systems largely do not exist in those countries.

While ATS manufacturing originated in Europe, it is evident that the abuse of ATS has quickly increased in Asia in the past decades. Responding to changes in drug-use culture and, most importantly, pursuing huge profits from the

⁹Ephedrine seizures, reported by India since 2002 (126 kg), reached their peak in 2008 (1,284 kg) (UNODC 2009b); in China, it was reported that a total of 1,113 tons of precursors were seized in 2008 (NNCC 2009).

¹⁰Alternative precursors are also detected in MDMA manufacture and substitute drugs (such as safrole-rich oils from Southeast Asia), which are not under international control or regulated by Asian countries (UNODC 2010a).

¹¹DAINAP is an Internet-based drug use information system which has 11 participating countries, including 10 countries from the Association of Southeast Asia Nations (ASEAN) and China. Information from DAINAP was supplemented with data from government sources and secondary research.

underground drug market, heroin manufacturers have diversified their production by either including synthetic drug manufacture or completely replacing heroin production (Humeniuk and Ali 2004). Now Myanmar has become the main producer of opium, heroin, and ATS in Asia. China is also considered a major producer of methamphetamines in Asia—1 of 31 countries where the largest number of ATS laboratories have been detected (UNODC 2010a). In South Asia, India is the main source of manufacture and trafficking of ATS. India has become a source of ketamine largely because the drug is manufactured legally in the country. In spite of increased controls on the substance by the Indian Government, the drug continues to be trafficked to countries in East Asia (UNODC 2008).¹² The quantity of ketamine seized by Indian law enforcement agencies has continuously increased over the past 5 years (UNODC 2010c).¹³ ATS manufacture and trafficking have also been active in other regions of Asia. The Middle East has emerged as a major new market with demand for pills called *Captagon*, the brand name for Fenethylamine (or Phenethylamine), a member of ATS. It was reported that close to 30% of global ATS seizures in 2007 were made in the Near and Middle East (UNODC 2009c). For the first time, ATS laboratories have been located in Iran and Sri Lanka (UNODC 2010a).

As reviewed in this section, Afghanistan and Myanmar are the two major players in the world's illicit drug market in Asia. Drug markets centered in those countries have also been firmly established. Though it is relatively easy to identify drug-producing countries, it is more difficult to locate major drug trafficking routes due to their dynamic nature. As observed in Afghanistan and Myanmar, the emergence of drug trafficking routes is determined by two major factors: the

location of the producer market and the location of the consumer market. How drug trafficking routes develop is primarily determined by the distance between these two markets. In the case of heroin trafficking, there is a subtle difference between the Afghanistan and Myanmar markets. While heroin produced in Myanmar tends to be trafficked within the region, heroin produced in Afghanistan is trafficked to regions beyond Asia. Unlike the heroin market, however, ATS produced in Asia is consumed locally, and intraregional drug trafficking is more typical with its relatively less expensive network and quick money return (Dupont 1999).

8.2.3 Criminal Justice Responses to Drug Trafficking

With increased globalization and economic activity between countries, it becomes more challenging to control drug trafficking. While geography plays an important role in drug trafficking, as reviewed previously, a country's political, social, and economic factors are also linked to the effectiveness of its criminal justice system's responses to drug trafficking. Above all, the weakness of state institutional capacity is one of the major concerns in responding to drug trafficking (Jackson 2006). Weak states are more vulnerable to the drug trade, and the drug trade in turn further weakens the state's administrative power (Cornell and Swanström 2006), as is evident in Afghanistan's and Myanmar's experience with the drug trade. In Myanmar, due to the cease-fire agreement between the government and armed ethnic opposition groups, the latter gained a self-administered autonomy that rendered them largely out of the government's control. Meanwhile, drug production and trafficking are also driven by local economic factors. For example, in Tajikistan, about 30% of its population is financially depending on the illicit drug business. Largely due to this reason, it is not unusual that Central Asian countries' budgets rely heavily on drug trafficking, as demonstrated in Kyrgyzstan and Tajikistan (Jackson 2006). In Myanmar, the

¹² Ketamine has also emerged as an adulterant in the manufacture of ecstasy in East and Southeast Asia (UNODC 2008).

¹³ The quantity of ketamine seized by Indian law enforcement has increased from 60 kg in 2005 to more than 1 mt in 2009 (UNODC 2010c).

Burmese Government also acquires a substantial amount of money from drug lords. For this reason, drug control in Myanmar is often politicized and pursued without much vigor (Chin 2009).

Meanwhile, the failure to control drug trafficking effectively in Asia is also attributed to widespread corruption among government officials, even top officials in major producer areas such as Afghanistan and Central Asian countries. Government officials frequently get involved in criminal networks and drug trafficking. It certainly weakens border control when corruption became so prevalent. For example, on the northern border of Afghanistan, a major drug trafficking route to Central Asia, border security is largely out of the control of the central Kabul administration. On the side of Central Asia, a similar level of corruption exists (Walker 2005). In East Asia, corruption has also spread among government officials and members of the security forces (Dupont 1999). Controlling drug trafficking certainly imposes challenges to these undeveloped states.

In terms of a legal framework to stop drug trafficking, Asian countries have adopted harsh drug policies against drug-related offenses, including the death penalty. All six countries listed by the International Harm Reduction Association as high commitment states, where the death penalty is exercised with regularity, are located in Asia: China, Iran, Saudi Arabia, Vietnam, Singapore, and Malaysia. The majority of executions for drug offenses are carried out by these countries (Gallahue and Lines 2010). According to the Criminal Law of P. R. China, drug dealing is strictly prohibited; criminal responsibility for heroin dealing or trafficking is determined by the quantity of drugs involved; the death penalty might be imposed on whoever sells or traffics more than 50 g of heroin, or 1,000 g of opium. Regardless of harsh punishment on drug offenses, not only did the total amount of illicit drugs trafficked in China tremendously increase in the past two decades, but a wide variety of illicit drugs, such as ATS, also began to emerge in the underground drug market one after another.

8.3 Drug Misuse in Asia

According to the World Drug Report (2010), between 155 and 250 million people (3.5 to 5.7% of the world's population aged 15–64) abused illicit drugs at least once in 2008. The largest drug use population (129–190 million) used cannabis.¹⁴ In 2009, opiate users were largely from East/Southeast Asia (2.83–5.06 million), with users in the Near and Middle East as the second (1.89 and 3.82 million) (UNODC 2010a). The ATS user population ranked second (between 14 and 53 million), and they were primarily methamphetamine users.^{15, 16} It is predicted that the ATS user population will exceed that of opiate and cocaine users soon.

Regardless of types of drugs abused, between 16 and 38 million drug users (10–15%) in 2008 were “problem drug users” (UNODC 2010a).¹⁷

8.3.1 Patterns of Illicit Drug Abuse in Asia

Opium has been used in Asia for several centuries both for medical and recreational purposes, but its popularity has diminished with the emergence of ATS.¹⁸ While heroin still ranked as the

¹⁴Between 12.8 and 21.8 million people (0.3–0.5% of the world population aged 15–64) used opiates in 2008 (UNDOC 2010a). In Asia, opiate users were largely from East/Southeast Asia (2.83–5.06 million) (UNDOC 2010a).

¹⁵Ecstasy users were also included in this category (between 10.5 and 25.8 million), but ketamine users were not counted (UNDOC 2010a).

¹⁶While amphetamine is preferred in Europe, about half of the stimulant users in North America use methamphetamine (UNDOC 2009c).

¹⁷UNODC defines “problem drug users”—those who inject drugs and/or are considered dependent, facing serious social and health consequences (UNODC 2010a, p. 16).

¹⁸Between 12.8 and 21.8 million people (0.3–0.5% of the world population aged 15–64) used opiates in 2008 (UNDOC 2010a). In Asia, opiate users were largely from East/Southeast Asia (2.83–5.06 million) (UNDOC 2010a).

primary drug of use in China, Malaysia, Myanmar, Singapore, and Vietnam, most countries in Asia witnessed stable or decreasing trends in heroin use (including Myanmar, an opium producer country). Lao PDR is the only country in Southeast Asia that reported increased opium use in 2009 (UNODC 2009c). As a general phenomenon, both opium and heroin use tended to decline in Asia while the use of methamphetamine pills has increased tremendously (UNODC 2009c; UNODC 2010d). However, in Afghanistan, illicit drug use has shown a completely different pattern. Cannabis, opium, and heroin are the top three drugs abused there, with a significant increase in opium and heroin use since 2005 (53% and 140%, respectively) (UNDOC 2009a).¹⁹

In East and Southeast Asia, ATS, in particular methamphetamine, make up one of the top three drug categories consumed in all countries in the region. While methamphetamine is a primary drug abused in East and Southeast Asia, the so-called *captagon* (often containing amphetamine) has gained popularity in the Near and Middle East (UNDOC 2010c). It is evident that drug use culture in these countries is beginning to favor ATS substances. At the present time, more than two-thirds of the world's ATS users live in the region, and the number is still growing (UNODC 2010c). Regardless of differences in social, cultural, and economic factors, young people in the area are more likely to use ATS in club settings for social, recreational reasons or simply to improve productivity and concentration (Humeniuk and Ali 2004; UNDOC 2009c). Unlike in Afghanistan, young people in the Golden Triangle (Wa area), with its increased involvement in the methamphetamine trade, have begun to switch their drug use preference from opium or heroin to methamphetamine, and a large consumer market for ATS use also has formed in Thailand (Chin 2009). The abuse of methamphetamine began in East Asian countries at different times. In Japan, methamphetamine

use began as early as the 1940s after the Second World War (Sato 2008); in South Korea it emerged in the mid-1980s (Chung et al. 2004). However, in China, ATS use did not start until the early 1990s.

To understand the scope of illicit drug abuse, some Asian countries or regions, such as China, Hong Kong, Macao, Malaysia, Myanmar, and Vietnam, maintain a system of registration for apprehended drug users. According to these databases, China, Indonesia, the Philippines, and Thailand all have drug use populations of more than one million. However, the real number of drug users is estimated to be much larger because many drug users may never have been caught by police, in particular ATS users. Only a few Asian countries use a national household survey (as does Thailand and the Philippines) or national surveillance of drug use (as does China and Cambodia) to compile information about drug users (Devaney et al. 2007). However, in South Asia, the data system often fails to differentiate between various synthetic drugs (UNODC 2010c).

As indicated in the United Nations report, the lack of data in some parts of Asia and the Pacific Islands is still an obstacle to estimating the scope of the drug use problem (UNDOC 2010a). According to the UNODC, while cannabis users and opiate users are reported systematically by Asian countries, ATS and cocaine users are only reported by East/Southeast Asian countries; for all other regions, including South Asia, Central Asia, and the Near and Middle East, not even estimates can be provided (UNDOC 2009c). To improve the understanding of ATS abuse in Asia, UNODC Regional Centre for East Asia and the Pacific launched the project *Improving ATS Data and Information Systems (TDRASF97)* in 2002 in an attempt to aid the countries in the region in developing and analyzing their national data.²⁰ As previously addressed, the SMART Program

¹⁹In Afghanistan, there are approximately one million adult drug users, who represent about 8% of the population aged 15–64 (UNDOC 2009a).

²⁰Countries participating in the project are Cambodia, China, Indonesia, Lao PDR, Myanmar, the Philippines, Thailand, and Vietnam while government agencies in Australia, Brunei, Darussalam, Japan, Malaysia, and Singapore participate in the network. The project is supported through funding provided by the governments of Australia and Japan (UNDOC 2007).

was created in 2008. According to its report, it is estimated that between 3.4 million and 20.7 million persons in the region used amphetamines in 2009 (UNODC 2010c).

8.3.2 Consequences of Illicit Drug Abuse

Illicit drug abuse has significant consequences for both the individuals who abuse drugs and society at large. While drug users quite often are involved in income-generating activities to finance their drug use, substance abuse also brings about other social harms, HIV/AIDS in particular. Drug injection and needle and syringe sharing have been linked to increased HIV/AIDS. While injection is commonly used to administer heroin, it is also used to administer ATS in some Asian countries with growing numbers (Devaney et al. 2007; Humeniuk and Ali 2004; Kramer et al. 2009).²¹ Since the first case of HIV due to drug injection in Asia was identified in Bangkok in 1987, the drug-related HIV infection rate has substantially increased in the region (UNDOC 2009a).

One of the most problematic issues related to injection is needle and syringe sharing. In a recent large-scale survey ($N=2,614$) conducted in Afghanistan, the majority of IDUs (87%) had shared a needle and syringe with other drug users (UNDOC 2009a). A cross-sectional study conducted in Vietnam among young and female drug users under age 25 recruited from drug treatment centers ($N=560$) and the community ($N=240$) also indicated that over half of them began injecting heroin or opium (57%) after a year's smoking. Among injectors, 23% shared needles and 71% were sexually active (among them, 77% had unprotected sex) (Thao et al. 2006).

Among the world's drug use population, a large number of users inject drugs—between 11 and 21 million people worldwide are injection drug users. Although the heroin epidemic emerged in China only in the late 1980s, China has been listed as one of the four countries

worldwide with the largest population of IDUs.²² According to the United Nations, East and Southeast Asia is reported as one of the regions in the world (and the only region in Asia) with both the largest number and highest concentration of HIV infection rates (UNODC 2009c).²³ In 2008, 4.7 million (3.8 million–5.5 million) people in Asia were living with HIV, the second-highest concentration in the world next to sub-Saharan Africa. India alone accounts for roughly half of Asia's HIV prevalence. In the same year the total number of AIDS-related deaths in Asia reached 330,000 (260,000–400,000). For East Asia, the rate of HIV-related mortality in 2008 was more than three times higher than that in 2000 (UNAIDS 2009).

Infection rates among IDUs in northern Myanmar are among the highest in the world. Myanmar, Cambodia, and Thailand are the countries affected most by HIV/AIDS in Asia (Kramer et al. 2009). In Central Asia, countries that are located on the main drug trafficking route with high concentrations of poverty and poor health care systems, such as Uzbekistan, Tajikistan, and Turkmenistan, have been struck much harder by HIV (Walker 2005). A survey conducted with female regular sex partners of drug users and injection drug users ($N=4,612$) in Bangladesh, Bhutan, India, Nepal, and Sri Lanka also indicated a low condom use rate (21%) between male drug users and their female sex partners. Due to the high HIV infection rates in these countries, a big concern is whether HIV infection will easily spread to the general population (Kumar et al. 2008).

8.3.3 Criminal Justice Responses to Substance Abuse

Illicit drug use is highly criminalized in many Asian countries. With a rapidly increasing prison

²¹The most common means of administration for ATS substances are smoking, snorting, and fume inhaling.

²²China, the United States, the Russian Federation, and Brazil together account for 45% of total IDUs (UNODC 2009c).

²³This report also included Eastern Europe and Latin America (Eastern Europe and Central Asia also had very high HIV infection rates).

population and annual arrest rates, Southeast Asia would appear to have the toughest laws in the world against drug users (Gallahue and Lines 2010). Myanmar is one of those countries that has criminalized drug addiction. According to its antidrug law published in 1993, if drug addicts fail to register with government medical facilities or are unsuccessful in treatment, they are subject to 3–5 years' imprisonment (Kramer et al. 2009). In Thailand, according to its "war on drugs" policy initiated in 2003, drug users who failed to participate in the drug treatment programs provided by the government were subject to the compulsory drug treatment for 4 months (Vongchak et al. 2005). In Afghanistan, consumption of opium products may also result in a prison term for 3 months (Todd et al. 2005). Harsh punishment for substance abuse raises concern about compulsory drug treatment centers in some Asian countries, which often have exercised arbitrary detention and failed to follow due process of law (Harm Reduction International 2010).²⁴ As a result, a large number of drug users have been incarcerated merely because of drug consumption. For example, in Thailand, the number of drug-related incarcerations increased five times (from 12,860 to 67,440) between 1992 and 1999 (Beyrer et al. 2003). In China, while the central government began to emphasize community-based treatment programs in the recent years, the total number of drug users who served time in compulsory treatment programs still reached 173,000 in 2009 (NNCC 2010). As far as incarceration is concerned, inadequate health care inside these facilities is another issue. Forced or involuntary testing for HIV in compulsory drug rehabilitation centers has also been reported in several countries, such as China, Malaysia, and Vietnam (Harm Reduction International 2010).

Despite such deterrents to drug use, post-release relapse rates are extremely high in Asian countries. A study conducted in China with female heroin users indicated that the success

rate among those who were released from compulsory treatment programs was extremely low (Gao 2011). Another study that examined recidivism rates of male drug users in Taiwan suggested that the recidivism of illicit drug users in Taiwan after detoxification in the detention center was substantially high (Chiang et al. 2009). Meanwhile, regardless of growing drug-related prison populations, no Asian prisons have needle and syringe exchange programs inside the facilities, and India, Indonesia, and Malaysia are the only countries that provide limited opioid substitution programs to inmates (Harm Reduction International 2010). In recent years, a change in antidrug laws from compulsory rehabilitation to community-oriented programs has been witnessed in Asian countries. For example, in China, 47,000 drug users were directly admitted to community-based treatment programs together with 35,000 drug users who were released from compulsory rehabilitation programs (NNCC 2010).

While incarceration of drug users alone has seldom led to successful abstinence, drug treatment programs have been viewed as a more effective approach to changing drug users' behaviors. However, drug treatment programs are only provided to a limited number of drug users globally. In 2008, there were only between 12 and 30% of problem drug users worldwide who had received treatment though the majority of them felt they needed it (UNODC 2010a). Hong Kong opened the first methadone maintenance treatment (MMT) in Asia and was credited for its overall quality and wide coverage (Reid et al. 2008). Thailand, Indonesia, China, and Malaysia, all developed the program one after another. After China initiated its methadone program in 2003, more than 500 methadone treatment clinics were developed in 23 provinces (including autonomous regions and municipalities) by the end of 2007; in all, 95,000 drug users were treated (Yao 2008). Several other Southeast Asian countries are also making efforts to develop meaningful drug treatment programs. In 2008, Vietnam initiated its pilot methadone treatment program with 1,800 heroin users and plans to develop the program across the country (Hung 2010). Cambodia, which has been criticized for its boot-camp style

²⁴ Forced detoxification and labor are also commonplace inside these facilities (Harm Reduction International 2010).

compulsory drug rehabilitation centers, opened its first methadone clinic for heroin users in 2010 (De Launey 2010). However, there are still no drug treatment programs available for addicts in the Wa area of Myanmar—an area with severe drug trafficking and abuse problems. Drug addicts there have to deal with their addiction all on their own (Chin 2009). While there are other drug-related programs available for traditional drug users, such as needle and syringe (NSP) and opioid substitution therapy (OST) programs, only just over half the countries in Asia have these programs. In several Asian countries, the current drug laws of Asia are a major obstacle for the implementation of these programs. For example, Malaysia, Thailand, Brunei, Hong Kong, and Macao do not allow needle–syringe exchange programs (Reid et al. 2008).

While traditional drug treatment programs in Asia focus on opiate dependency due to the large number of opium and heroin users in Asia, the dramatically increased ATS use population in the region certainly demands new treatment programs for ATS users. However, only very limited treatment services are currently available to them, including specialized drug treatment services provided in general hospitals, and psychiatric facilities (UNODC 2010c).

8.4 Future Trends and Conclusions

The previous sections briefly reviewed and discussed illicit drug trafficking and abuse in Asia. Although the illicit drug trade is involved in a complicated chain network, only drug production, drug trafficking, and drug consumption are essentials. Drug trafficking connects the drug supply with drug demand so that the illicit drugs can reach the end customers—drug users. The large profits obtained from illicit drug trafficking suggest that this illegal business will not vanish in the near future. What we have learned from past experience is that it is impossible to completely remove drug trafficking businesses from the underground drug market even by using the toughest sanction on drug offenses—the death penalty. As reviewed previously, while most

Asian countries have adopted harsh sentencing policies against illicit drug trafficking, it is still a thriving business in the region. Soon after one drug trafficking network is destroyed, a new one will emerge and replace the previous one because of the internal drive for profits.

Regarding illicit drug production in Asia, as previously addressed, the two largest opium and heroin producer countries, Afghanistan and Myanmar, are located in Southwest Asia and Southeast Asia, respectively. While these two nations have different social, economic, and cultural traditions, they share one thing in common: opiate poppy production areas located in poor areas of these undeveloped countries. According to the Afghanistan Opium Survey by the United Nations and field research conducted in the Golden Triangle (Chin 2009; Kramer et al. 2009), the main reason farmers cultivate the opiate poppy is survival. In the case of the Golden Triangle, farmers in both Myanmar and Laos have not been provided alternative livelihoods despite opium bans, which not only cut off the farmers' financial sources from opium cultivation (UNODC 2010b). Realistically, there is no reason to believe that opium cultivation will be eliminated from the area if farmers cannot find a legitimate way to make a living. Rather, they may choose to cultivate opiate poppies secretly in remote sites that may be hard to detect by outsiders (Chin 2009).

While the primary reason for farmers to cultivate opium is to secure family income, the government's determination to ban opium may have a strong impact on its cultivation. In a survey conducted in 2010 with farmers in Afghanistan, the farmers (25%) listed the government ban on opium cultivation as a primary reason for stopping opium cultivation (UNODC 2010b). This finding suggests that if the central government of these drug producer countries and the countries making up the drug trafficking gateways had a strong determination to control illicit drug production, this determination would produce some significant impacts on drug production. However, there are three major obstacles to reach this goal. As suggested in the fieldwork conducted in Myanmar, the illicit drug trade—drug money

coming from drug lords—has contributed greatly to the Burmese Government's financial sources. Therefore, drug control in Myanmar is very much politicized rather than put into action (Chin 2009). Compared to Afghanistan, the Myanmar Government is under pressure both from international society and its neighboring countries, in particular the Chinese Government, to control its drug cultivation. Still, the fact that the central governments in both Afghanistan and Myanmar can hardly control their opiate cultivation areas is another obstacle for implementing any meaningful solutions. Lastly, impoverished economies in these major producer countries and countries on the major trafficking routes make it impossible to make any radical changes without financial support from the international society. It should be understood that drug trafficking is not independent from all the other problems that these drug-producing countries face.

Based on the available information, while global seizures of ATS have remained at very high levels in recent years, due to the clandestine nature of ATS manufacture, it is even more difficult to estimate the scope of the problem and make corresponding strategies. Based on increasing demands from the consumer market, more and more young people favor these synthetic drugs, providing sufficient reasons to believe that the manufacture of ATS will not shrink in the near future. Meanwhile, the sharp increase in the heroin price in 2009 due to reduced yield related to poppy disease also forced some heroin users to switch to synthetic drugs. With demands from the consumers' market and the convenient access to the two largest ATS precursor countries, India and China, there is no clear indication that the ATS production and abuse will go down, at least in the near future.

For certain geographic areas where opium or heroin use has been a tradition, the influences of traditional drugs will remain. For example, according to a recent survey conducted in Afghanistan, more than half of the drug users had placated their children with opium, and drug users quite commonly had at least one other family member who was also a drug user (UNODC 2009a). With family traditions like

these, the influence of traditional drugs on the next generation is apparent. The most troublesome issue for drug users, however, is access to drug treatment programs. The lack of treatment facilities, in particular in poorly developed areas such as the border of Myanmar, Thailand, and China, intensifies demand (Chin 2009). While Central Asia is one of the few regions in the world where the HIV epidemic remains clearly on the rise, strong resistance to OST still widely exists. For example, such a program was discontinued by the Uzbek Government in 2009 (Latypov 2010). In addition, while the demand for special health care is high among drug users, such facilities are rare among Asian countries (Reid et al. 2008).

Illicit drug trafficking and abuse have been global issues for centuries. Based on a historical analysis of several countries' successful experience (the United States, China, Turkey, and Thailand), McCoy (2000) suggests that supply reduction is the key to success while the role of the state is critical, in particular, in increasing state control over illicit drug production regions and restraining official corruption. Based on the observation of the Golden Triangle, other scholars agree that while supply reduction is essential, a successful strategy also needs to include demand reduction (Chalk 2000; Chin 2009). Specifically, the implementation of crop-substitution programs in producer countries, a far-reaching mass movement against illicit drug abuse, and increased international and intra-regional counter-narcotics cooperation and enhanced border control and anticorruption measures seem more promising (Chalk 2000; McCoy 2000; Walker 2005). Due to increased globalization, importantly, any interventions should be coordinated regionally or internationally, as proposed by the United Nations (UNODC 2009c).

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