



Drug use in Timor-Leste

- an assessment



Conducted by:
Aardvark Consulting Co. Ltd.



Commissioned by:
UNFPA, Timor-Leste

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From the author:

The author wishes to wholeheartedly thank all the people and organizations that have contributed to this report. Special mention goes to:

All the informants, of whom there were many:

- ✓ Respondents to the semi-structured interviews: people who use(d) drugs in Dili, and Maliana, a total of 20 courageous women and men who shall remain anonymous;
- ✓ Participants in the focus group discussion: Seven Ba Futuru staff members;
- ✓ Key informants from: Becora Prison and the Bureau of Prisons, Belun, Fundasaun Timor Harii (FTH), Ministry of Health, Ministry of Justice, Guido Valadares National Hospital (HNGV), National Police (PNTL), Office of the Prosecutor General, PRADET, Progressio, United Nations Integrated Mission in Timor-Leste (UNMIT), and WHO; and
- ✓ Informants that prefer to remain anonymous.

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Great effort has gone into producing an accurate and balanced report. We apologize for any inaccuracies, should they have occurred, and would be pleased to rectify them if needed.

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Foreword

While Timor-Leste is believed to be on the right track in achieving many of the Millennium Development Goals (MDG), as well as achieving national development targets, the country still faces enormous development, socio-cultural, and demographic challenges. The magnitude of these challenges creates drivers and vulnerabilities in the context of HIV infection. Two-thirds of the country's population is below the age of 30, which means that relatively large numbers of people are sexually active and susceptible to risk-taking behavior. Young people are not sufficiently equipped with the knowledge and life skills to reduce HIV risk in an increasingly challenging environment. Timor-Leste is reported to have high levels of gender-based violence, undermining women's ability to negotiate safer sex and making them more vulnerable to HIV and AIDS. In addition, the increasing mobility and migration of the population into and out of the country via tourism, overseas studies, and employment increases people's vulnerability. HIV affects people at every level, yet stigma, misunderstanding and misconceptions still exist.

Injecting drug use has been reported in recent behavioral studies, and there is general agreement that recreational drug use is on the rise. The extent to which injecting drug use is part of this increase in overall drug use is unknown, and given the potential impact of injecting drug use on HIV transmission, further investigation is necessitated.

UNFPA is committed to improving the response to 'Most At Risk Groups' to HIV and AIDS and to advancing evidence-based studies to inform and guide policy, decision-making, and strengthening interventions of the health sector response to drug use and to HIV. As such, we are pleased to present this assessment report, which is marked by forward thinking and commitment to action. There is no single solution to the issues surrounding drug use and HIV/AIDS; clearly, a multi-pronged and multi-sectoral response is called for. The findings and recommendations for action highlighted in this report are a solid and well-grounded starting block for a race in which we need to keep pace, while retaining vision and action towards future solutions.



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List of Acronyms

ATS	Amphetamine Type Stimulants
FTH	Fundasaun Timor Harii
GO	Government Organization
HNGV	Guido Valadares National Hospital
IEC	Information, Education, and Communication
MDMA	Ecstasy (methylenedioxymethamphetamine)
NGO	Non-Governmental Organization
PNTL	National Police Timor-Leste
SHC	Sharis Haburas Comunidade
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNMIT	United Nations Integrated Mission in Timor-Leste
UNODC	United Nations Office on Drugs and Crimes
V(C)CT	Voluntary, (Confidential,) Counseling, and Testing

Executive Summary

This report is the result of a three-week assessment in August - September 2011, consisting of approximately twenty interviews with key informants, one focus group discussion with youth workers and twenty semi-structured interviews with people who (used to) use drugs. Conclusions are of a tentative nature; further research is essential to gain further insight.

Drug use in Timor-Leste appears to be largely limited to Dili, the capital.

It is estimated that there are several hundred young people –both female and male– who regularly use amphetamine type stimulants (ATS). They are from all social backgrounds and live in the different parts of Dili. There are some ATS use related health issues. In addition, increase in unsafe sex appears to be associated with MDMA (Ecstasy) use.

Injecting drug use in the city (presumably of heroin) is limited to an estimated 25 – 50 persons. The hidden nature of injecting drug use in the country, the related fear to participate in interviews, and the short timeframe of the assessment made it impossible to successfully engage with a sufficient number of people who inject drugs to draw further conclusions. The characteristics of people who inject drugs, patterns, injecting behavior, drug use related issues, etc. could not be sufficiently gauged.

Low levels of drug use, issues with the current anti-narcotics law and law enforcement has led to a low number of drug use related arrests, and an even lower number of incarcerations. Currently, there are no drug use related convictions in prison, and a low number of pre-trial cases.

There are no GOs or NGOs that explicitly target people who use drugs, but several NGOs are well placed to start engaging with them.

There is no National Drug Policy in Timor-Leste that deals with illicit drugs and their use.

Recommendations include:

1. Draft, adopt, and implement a National Drug Policy that deals with illicit drugs:
Priority areas include:
 - a. Draft, adopt, and implement a new Law on Controlled Substances;
 - b. Train and equip the law enforcement agencies;
 - c. Assess the effectiveness of current primary drug prevention activities and adjust where needed;
 - d. Explore the establishment of a rehabilitation center, which could combine alcohol and drugs;
 - e. Reach out to people who use drugs with appropriate IEC strategies, and expand services where needed; and
 - f. Establish a working group to develop strategies to reach out to people who inject drugs, and where needed, develop and provide services.
2. Engage with people who inject drugs and research levels of injecting drug use, knowledge levels, injecting practices and trends, and related issues.

Introduction

This report is the result of a UNFPA commissioned drug²use assessment that was conducted in Timor-Leste in Aug – Sept 2011, called ‘the Assessment’. Its aim was to provide insight in the current scope and characteristics of drug use amongst sub-populations who tend to be most at risk at becoming HIV infected, including sex workers, men who have sex with men, and prison inmates. Originally, emphasis was to be on injecting drug use, because of its link with HIV/AIDS, yet non-injecting drugs would also have to be covered to some extent.

During the first weeks of the assessment it appeared, however, that the proposed emphasis on the most at risk groups needed to be abandoned: Outreach workers that target sex workers, men who have sex with men, and prison inmates could not find any suitable respondents and the prisons are apparently completely drug-free.³ In addition, the reluctance to talk with us about one’s own drug use appeared so strong that insisting on certain characteristics amongst potential respondents was a luxury we could not afford. Hence, the assessment targeted people who use drugs, regardless of their job, sexual practices or domicile. Ironically though, none of the interviewed people who use(d) drugs were sex workers or men who have sex with men.

Prior to the start of this assessment, the Ministry of Health in Timor-Leste has recruited an HIV/AIDS Research and Surveillance Specialist, and drug use was part of this person’s assignment. This led to a narrowing down of the subject of this assessment: No attention is paid to drug use amongst uniformed personnel and geographically it limits itself to Dili (the Capital), and Maliana (a town near the border with West-Timor of the Republic of Indonesia).

On-site data gathering took place in two periods for a total of 15 days between 7 August and 5 September 2011, and this report was due on 16 September. While a concerted effort was made to follow good academic practice and produce an insightful report, the reader will understand that this timeframe necessarily limited the scope and depth of the assessment and that a balance needed to be struck between academic rigor, procedural diligence, and ‘getting to the heart of matters’. In addition, due to the sensitive nature of the subject, ‘experiential’ sources were difficult to recruit in the given period. Needless to say, many sources will have to remain anonymous, and sometimes even the nature of the source will not be given. This has led to a report with relatively few references (footnotes) and with only a cursory description of the methodology. Anyone with a particular interest in sources and methodology is encouraged to contact the author of this report. Still, the confidentiality of those who preferred to remain anonymous will of course remain intact.

In the interest of legibility, we have tried to avoid jargon and obscure abbreviations.

²In this report the term ‘drug’ is used to include a somewhat arbitrary list of psycho-active substances that are illicit in many countries, including opium, heroin, cocaine, amphetamine type stimulants, magic mushrooms, cannabis, and related substances. Alcohol use and tobacco use are only covered when it occurred in combination with other drugs. Annex 1 provides further information.

³ While we were not in the position to verify this statement, we have no real cause to doubt it: None of the inmates are in prison as a result of a drug use related conviction and reportedly effective mechanisms are in place in the two prisons to monitor inmates’ behavior.

A. Drug use and HIV/AIDS

In the context of HIV/AIDS and other blood-borne diseases, non-injecting drug use is less harmful than injecting drug use. There is, however, mounting evidence that use of certain drugs, regardless of route of administration, may lead to an increase of less safe, or unprotected sex. Drugs that are of note in this respect are amphetamine type stimulants⁴, but also cannabis is linked to unsafe sex.

“The use of amphetamine-type stimulants by men who have sex with men has been associated with high levels of HIV infection in both high-income countries and other countries, particularly in South East Asia.”

UNAIDS & UNODC (footnote 4)

Injecting⁵ drug use occurs in at least 158 countries and territories around the world. The latest available data estimate that 15.9 million (range 11 to 21 million) people inject drugs globally. The largest injecting populations are found in China, the United States and Russia. In 120 countries, there are reports of HIV infection among people who inject drugs. In eight countries – Argentina, Brazil, Estonia, Indonesia, Kenya, Myanmar, Nepal and Thailand – HIV prevalence among people who inject drugs is estimated to be over 40%. Worldwide, approximately three million (range 0.8 to 6.6 million) people who inject drugs are living with HIV.

Extremely high proportions of people who inject drugs in all regions of the world are also affected by viral hepatitis (in particular, Hepatitis B and C), often with HIV co-infection. They are also at greater risk of tuberculosis, which is a leading cause of death among people who inject drugs, particularly those living with HIV. Overdose is another major cause of death among injecting populations around the world. Other major health harms faced by this group are injection-related bacterial infections, some of which can be fatal.

The large and diverse Asian region is home to significant numbers of people who inject drugs. They represent at least one-quarter of the total number of people injecting drugs around the world. HIV epidemic in many Asian countries are driven by injecting drug use. At the regional level, it is estimated that 16% of people who inject drugs are living with HIV. Several Asian countries have reported much higher national HIV prevalence rates amongst people who inject drugs – most notably Indonesia, Myanmar, Nepal, Thailand and Viet Nam, where between one-third and one-half of all people injecting drugs are likely to be living with HIV.

Traditionally, heroin was generally the injected drug of choice, yet this has been changing in numerous countries, including in Asia. It is important to note here that, in terms of the spread of HIV, it is irrelevant what substance is injected. In other words, transmission of HIV and other blood-borne infections is equally effective, regardless whether the drug in question is legal, semi-legal, or illegal. In fact, many of the new cases of drug use related HIV in South-Asia,

⁴UNODC & UNAIDS, Facts about Drug Use and the Spread of HIV, 2010, http://www.unodc.org/documents/frontpage/Facts_about_drug_use_and_the_spread_of_HIV.pdf, accessed 18 Aug 2011.

⁵ The next three paragraphs were literally taken from IHRA, Global State of Harm Reduction 2010, downloadable from http://www.ihra.net/files/2010/06/29/GlobalState2010_Web.pdf, accessed 15 Aug 2011.

appear to be linked to the injecting of 'cocktails' of drugs that are available over the counter.⁶ Also in countries such as China, Thailand and Indonesia, injecting of (semi-) legal substances appears to be on the rise. Pharmaceutical drugs are often used by people who inject drugs together or interchangeably with their drug of choice, both orally and by injecting. Such use is common when the drugs of choice are in short supply or when a cheaper or more easily obtained option is sought."⁷ This leads to new challenges with regards to the development of effective HIV prevention strategies in the context of injecting drug use.

B. Rationale and background

Given the above, it is hardly surprising that national institutions in Timor-Leste in the field of HIV/AIDS, as well as others, are concerned about the possibility that drug use may be or may become a significant factor in the HIV/AIDS situation in the country.

Given⁸ the impact of injecting drug use on HIV transmission it will be a priority to further investigate this issue in the immediate future. UNFPA in its commitment in improving the response to most at risk groups to HIV and AIDS and to advancing the evidence based study and ensuring that results from the baseline study will inform and guide policy, decision-making, practice and interventions. To this effect, UNFPA Timor-Leste will conduct a baseline drug use assessment and injecting drug use among sex workers, men who have sex with men and people in prison.

The focus will be to assess the emerging issue or current situation of drug use and injecting drug use in Timor-Leste. The results of the study will be a basis of strengthening interventions of the health sector response to drug use and to HIV, and can be used as a background document for the incorporation of the positive actions in the National HIV strategic plan 2011 to 2016.

C. Objectives

The Terms of Reference of the Assessment mentions the following objectives and these have been modified somewhat during the course of the assessment:

1. To provide an overview of drug use and injecting drug use among the identified sub-populations.
2. To identify factors that influence drug use and injecting drugs and in particular factors that may be encouraging or discouraging drug use.
3. To identify the awareness and perceptions about the different ways of using drugs among most at risk groups and people in prison.
4. To identify factors that influence the development of existing interventions (if any) and those that hinder or enable the development of interventions.

⁶ Further information on this may be found in the UNODC commissioned publication: Legal and policy concerns related to IDU harm reduction in SAARC countries, TD/RAS/03/H13, by the Lawyers Collective HIV/AIDS Unit, <http://www.lawyerscollective.org/files/Legal%20Policy%20Concerns%20related%20to%20IDU%20harm%20reduction%20in%20SAARC.pdf>, and in the Report of the Conference on Injecting Drug Use of Pharmaceuticals and the HIV Epidemic in the South Asia Region, UNAIDS, 2008, http://www.saathii.org/saathiiorc/index.php?option=com_docman&task=doc_download&gid=174&Itemid=5, both accessed 2 Aug 2011.

⁷ WHO, A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia-Pacific; 2010 – 2015, page 20, http://203.90.70.117/PDS_DOCS/B4528.pdf, accessed 18 Aug 2011.

⁸ The next two paragraphs are from the Terms of Reference for this assessment.

5. To assess the nature and extent of drug use and injecting drug use and how the patterns are changing over time (after independence in 2002).
6. To describe the social characteristics and location of injectors.
7. To ascertain the impact of social, economic and cultural factors in Timor-Leste on drug use and the public health and social implications and ramifications of drug use in the country.
8. To make recommendations for policy planning or programs on appropriate interventions and actions.

D. Modalities

Aardvark Consulting Co. Ltd. was engaged for the conduct of the assessment. One of their Senior Consultants – Mr. Gerard de Kort – was identified as the sole implementer, assisted by UNFPA and local partners. The consultancy totaled 21 man-days, of which 15 were on-site for data collection (7 – 12 August and 22 August – 5 September 2011). The draft version of this report was submitted on 9 September, the final report on 16 September.

When the term ‘we’ is used in this report it refers to the Researcher and Interpreter, when applicable.

I. Methodology

A. Selection of sites

The capital, Dili, was an obvious choice. All relevant reports point to Dili as *the* place where drug use occurs, and very few make mention of drug use outside the capital.

Maliana – the District seat of Bobonaro – was chosen, because of its proximity to the Indonesian border. It also appeared that Fundasaun Timor Harii (FTH) had a drop-in-center in Maliana, through which the organization reaches out to men who have sex with men and sex workers. This would facilitate identification and recruitment of respondents.

Initially, there were plans to include Baucau, because it is the second biggest city and earlier research had indicated that there might be some drug use there. FTH employs two outreach workers in Baucau who could assist with the identification of respondents. However, while in Maliana and Dili it became increasingly clear that it would be better to focus on Dili, rather than to include a trip to Baucau. Reports from a number of people (including outreach workers from FTH, researcher from Ministry of Health, and a National Police official) indicated that drug use in Baucau was very likely to be extremely limited, whereas drug use in Dili was clearly significant enough to justify a closer look. Hence, it was decided not to travel to Baucau, and instead try to interview as many people who use(d) drugs as possible in Dili.

B. Data collection methods

1. Existing information

Prior to data collection in the field, a number of documents and websites were reviewed to obtain a tentative insight in the drug use situation in Timor-Leste.

2. Observations and recruitment

Entertainment venues, including discos and brothel-type places, and other gatherings (parties) were visited to assess the drug use scene and to identify potential interviewees who use(d) drugs.

3. Interviews with key informants

The complete list of consulted organizations that were involved in these interviews can be found in Annex 2. Approximately 20 such interviews were held; where needed, interpretation was provided. During these interviews initial insight was gained of the scope of (injecting) drug use, and information was sought on where and how to identify people who use(d) drugs for participation in the assessment.

4. One focus group discussion with people who work with 'at risk' young people

Ba Futuru⁹, meaning 'for the future', is Timor-Leste's preeminent national child protection and peace building organization. Ba Futuru staff are renowned for quality training skills and have provided educational training programs to more than 20,000 children, youth, teachers and community leaders since 2004.

⁹ This paragraph is taken from <http://www.bafuturu.org>, accessed 29 Aug 2011.

One of their activities of particular interest for this assessment is conflict resolution training workshops that Ba Futuru conducts at the community level. Through these, they are in contact with (former) youth gang members some of whom might have been involved in drug use. We conducted a focus group discussion with seven male Ba Futuru trainers (and one interpreter). The discussion focused on drug use amongst their target group, rather than on their own drug use.

5. Interviews with people who use(d) drugs

In Timor-Leste, there are no NGOs (or GOs,) that reach out to people who use drugs. This made it extremely difficult to identify respondents for this assessment. Drug use is a taboo subject in most circles and most people were very reluctant to participate. Especially people who inject drugs were (understandably) very apprehensive to talk to a complete stranger (and foreigner) about their drug use without really being sure that the information they provided was used confidentially and for their benefit. In order not to betray their trust, details of conversations are not included in this report and case studies are altered somewhat.

A Consent Form (See Annex3) was signed before the start of each interview. Interviewees received \$10 for their participation. Most interviews were done through an interpreter, and five were conducted in English. The interviewer took notes, which were discussed with the interpreter if needed. In Dili, interviews were conducted at sometimes odd hours and in various locations, including offices, houses, restaurants, hotels, and at the beach –as decided by the respondent. In Maliana, the interviews were conducted at the FTH office.

In total, we held 20 semi-structured interviews with people who use(d) drugs: 16 in Dili, and four in Maliana. Most interviews were held with people without knowing beforehand to what extent they had been using drugs. We only knew that our contacts thought they might be good people for us to talk to. In such cases we used the Interview guide for persons who use(d) drugs and affected community members (See Annex 4). This interview guide starts with questions about the respondent's knowledge about drug use in their town and then continues with questions about her/his own involvement in drug use. These interviews usually lasted about 45 minutes.

When we (thought we) knew beforehand we were going to talk to a person who was currently injecting drugs, we used the Interview guide for persons who inject drugs (See Annex 5). These interviews go into more detail regarding drug use pathways, injecting practices, overdose, etc. We conducted three of such interviews. They tended to last a bit over an hour. While the interview guide is in fact a questionnaire, the interviews were conducted in a more free-flowing manner. The guide was used to check if all relevant topics had been covered.

C. Recruitment of respondents amongst people who use drugs

In Dili, recruitment took place through several methods:

- ✓ FTH outreach workers introduced us to six respondents in Dili, some of whom in turn suggested further respondents. This led to a total of ten interviews.
- ✓ Three respondents were recruited at a disco, and interviewed elsewhere a day later (two others didn't show).
- ✓ A further three respondents were recruited at other gatherings.

Thus, in total sixteen people were interviewed in Dili.

In Maliana, respondents were recruited through FTH outreach workers that work with men who have sex with men and sex workers, yet the respondents did not necessarily belong to either of these groups. We set up interviews with people they knew who might be (or might have been) involved in drug use to gain knowledge of their drug use, and through them, of the overall scope and characteristics of drug use in their city.

After having interviewed twelve people, we started explicitly focusing on people who inject drugs. In other words, we emphasized to those people that appeared to be 'in the know' that we were especially interested in talking to people who inject drugs. This led to interviews with three people who had been injecting (one of them could be defined as a 'current injector', yet we (nor he himself) would not call this person 'drug dependent').

As mentioned, the hidden nature of drug use had a profound impact on the assessment. The extreme fear of the people who use drugs (and particularly those who inject) severely limited the number of people that we could interview. Since no NGOs are directly working with people who use drugs, recruitment had to start from scratch. Possibly, the fact that a foreigner was doing the interviews (through an interpreter) had a negative effect on the openness of people.

D. Processing, analysis, and reporting

The data collection phase yielded a large amount of data from a variety of sources. The existing information was verified during the interviews and the information from the various informants was compared and thus triangulated. In this manner, a clearer picture of the drug use situation in the country, particularly in Dili emerged.

Clearly, the number of interviews held with people who use(d) drugs under this assessment, is too small to be able to draw 'hard' conclusions. To protect people's privacy, the case studies presented in this report are fictitious, combining characteristics of a number of the respondents or changing them.

The findings are used to generate tentative conclusions on the extent, trends and characteristics, rather than to formulate definite statements on what exactly is the case, or strongly worded recommendations.

Nevertheless, we are convinced that the assessment has yielded useful information for the further development of effective strategies for people who use drugs.

II. Findings

A. Drug use

1. Prevalence

Desk research

During the desk research phase of this assessment, the first thing that became clear is the lack of ‘hard’ data on injecting drug use in Timor-Leste (and with that the timeliness of the assessment at hand). The UNODC World Drugs Report of 2011 makes no mention of Timor-Leste in the core text and in the Statistical Index the country does not feature, or there is “no recent, reliable estimate” on consumption of any of the listed drugs.¹⁰ The authors of the 2008-09 Situational analysis (in Timor-Leste) by the Burnett Institute¹¹ also appeared to have trouble finding hard evidence of injecting drug use occurring in the country: “anecdotal evidence”, “the authors were unable to confirm cases of injecting drug use”, “no data for injecting drug use”, etc.

The US State Dept Narcotics Report 2011¹² reports that “according to the National Police of Timor-Leste (PNTL), there are four types of narcotics available in the capital city of Dili: methamphetamine, MDMA (Ecstasy), marijuana and heroin’ and notes that ‘narcotics are sold in bars, karaoke lounges, massage parlors, and hotels”. There is no mention of injecting drug use, or of drug use in areas outside Dili.

In 2008 and 2010, behavioral surveillance surveys were conducted amongst sex workers and men who have sex with men in Timor-Leste. Relatively high percentages of injecting drug use were found and presented, but the original data is currently not available and the Ministry of Health urges caution in interpreting these findings.¹³

Interviews with key informants

The law enforcement (PNTL) representative noted that there is some drug use in Timor-Leste, especially in Dili, but that there is no evidence of injecting drug use.

United Nations Integrated Mission in Timor-Leste (UNMIT) officials, the Chief of the Becora Prison, and the Director of the Bureau of Prisons all agreed that currently none of the approximately 230 inmates in Timor-Leste is incarcerated in connection with drug use (there is one inmate who apparently has a drug history, but this person has not been convicted of drug use related charges). All state categorically that there is no drug use inside prison.

The Director General of the Guido Valadares National Hospital (HNGV) stated that - to her knowledge - over the last decade, there have been no admissions related to the use of drugs such as Ecstasy, methamphetamine, heroin, or cocaine. Cases of intoxication are limited to food (commonly fish), alcohol, a couple of cases of Fansidar (malaria treatment medicine), leading to Stevens-Johnson Syndrome, and

¹⁰UNODC, World Drug Report 2011 (United Nations Publication, Sales No. E.11.XI.10)

¹¹Situational analysis of drug and alcohol issues and responses in the Pacific 2008–09. / The Burnett Institute.

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¹² US State Dept Narcotics Report 2011, <http://www.state.gov/p/inl/rls/nrcrpt/2011/vol1/156363.htm#timorleste>, accessed on 10 Aug 2011.

¹³The researcher at the University of New South Wales states that final reports are expected towards the end of 2011.

an apparent suicide attempt using chloroquine. Admissions related to violence after alcohol use may also involve other drug use, but this cannot be verified. No cases of withdrawal symptoms have been observed after admission of patients, nor any cases of apparent injecting drug use prior to admission.

Other notable observations included:

- Tests and/or equipment to handle requests from the General Prosecutor to test urine/blood samples for traces of MDMA, methamphetamine, cocaine or heroin are not available at the hospital, so samples need to be sent to Australia.
- Typically, patients admitted with an opportunistic infection (Hepatitis B/C or TB), or an STI are sent for VCT. Approximately 50 of the People Living With HIV (PLWHA) are currently receiving ART.
- In Timor-Leste, there is some stigma attached to going to hospital, and even more when this would be in connection with alcohol use, drug use, HIV/AIDS, or mental illness. Therefore, there is a chance that we are currently only witnessing the tip of the iceberg. We should be vigilant and make sure we protect our future generations.
- There seems to be a need for an alcohol rehabilitation facility.

The Head of the Statistics Department at HNGV, Ms. Maria Hornai stated that currently (25 Aug 2011) 121 people in Timor-Leste are confirmed to be living with HIV, including two children.¹⁴ Upon visiting the hospital one day later, it appeared that HNGV this year (including August) has diagnosed 17 new cases of HIV. Interviews with management of the NGOs such as Belun, Ba Futuru, FTH, PRADET, and SHC showed that drug use is currently not 'on their radar'. None of these organizations could give any indication of the extent of drug use amongst their clientele, and injecting drug use was a 'dark hole'.

In informal interviews with several people it was argued that there simply isn't enough heroin, or enough money around to sustain a sizable heroin injecting population. While this may be the case, further research was warranted.

Observations

In Dili, observations in entertainment venues and informal inquiries in Dili made it rather clear that certain drugs are quite easily obtained. In particular, cannabis (marijuana - reportedly locally grown) and amphetamine type stimulants, especially MDMA (Ecstasy) are used in discos, at parties, and elsewhere. In one establishment on a particular night a number of people appeared to be under the influence of MDMA. Interviews with three people at a later stage confirmed this impression.

In the three brothel-type establishments that we visited, nobody appeared to be under the influence of any drugs and enquiries (into possible purchase of any) were dismissed squarely. The environment was not conducive to take this matter any further.

Maliana is a sleepy town of approximately 22,000 people, a four-hour drive from Dili. It pretty much shuts down when it gets dark. Nightlife in Maliana seems practically absent, reportedly also during the weekend. Some restaurants are open after dark, and they tend to close at about 10 pm.

¹⁴ UNMIT, Afternoon Edition, Communication and Public information Office, www.unmit.org, accessed 25 Aug 2011.

Semi-structured interviews and with people who use(d) drugs and one focus group discussion with people that work with ‘at risk’ young people.

* **Dili** (approximately 200,000 inhabitants)

In total, we talked to sixteen people: five were ‘ex users’¹⁵, eleven were ‘active users’. We conducted a focus group discussion with six people with whom we did not discuss their own drug use. Instead we focused on drug use amongst their target group: ‘at risk’ young people in communities in Dili.

The five ex users were all male and median age was 24 (18-29). Most of them had used Ecstasy and marijuana, and two had injected heroin. They were unemployed or did some odd jobs.

The eleven active users were ‘a mixed bag’: Well to do (self-employed) versus poor (unemployed), nine men, two women, single versus married (eight and three resp.), living with parents (three), living independently (five), living with spouse (three). Their average age was 25 (20 – 31).

The three respondents that were recruited at a local disco and two of the other respondents were well educated (had completed or were attending some form of tertiary education), of a higher social class, and relatively well to do. Interviews with them were conducted in English (without an interpreter). The remainder (n= 11) was from a lower class background, mostly unemployed or doing odd jobs occasionally. Table 1 summarizes selected findings from the interviews of people who use(d) drugs and the focus group discussion.

Table 1: Available drugs, prevalence, origin, and price

<i>Drug</i>	<i>Prevalence</i>	<i>Origin</i>	<i>Price US\$</i>
<i>Cannabis: mostly marijuana and some hashish</i>	Easily available when in the network. Frequently used in certain groups.	Marijuana locally grown; hashish from Indonesia.	Present (free) or \$10 - \$15 / joint.
<i>Magic mushrooms and “korneta”</i>	Easily available when in the network. Rarely mentioned.	Locally grown.	Usually free.
<i>‘Pills’ ATS; mostly MDMA; also methamphetamines</i>	Easily available when in the network. Quite commonly used by young people.	Largely from Indonesia and Australia.	\$2.5 - \$25 per pill
<i>Cocaine</i>	Available when in the network; hush, hush.	Largely from Australia, and Indonesia.	\$150 – \$200 per hit
<i>Heroin</i>	Available when in the network; hush, hush.	Australia and Indonesia.	\$100 – \$200 per hit

¹⁵ For this assessment, this meant that they stated that they hadn’t used any drugs during the past three months. ‘Active users’ then meant that they had had used drugs during the past three months.

1. *Cannabis: Marijuana (ganja), and hashish (coklat).*

Marijuana appears to be quite easily available (also in Maliana) as long as one is “in the network”. Groups of friends tend to smoke together at someone’s home or at a party in a hotel room. It is mostly smoked in cigarette form, mixed with tobacco, and sometimes pure. It is locally grown (“in the mountains”) and often people don’t really pay for it. Those that had to pay for it tended to buy it in a pre-rolled joint, which would cost \$10-15. Some people mentioned *coklat* (chocolate), which evidently refers to hashish, and which is usually smoked mixed with tobacco in a cigarette, and occasionally using a *bong*(water-pipe of sorts). It seems to be smuggled in from Indonesia.

2. *Magic mushrooms and korneta*¹⁶.

A few respondents mentioned (magic) mushrooms as drugs that they had used or that they knew were being used by others, usually eaten in noodle soup. They tend to be free, i.e. made available by someone in the group. Similarly, *korneta* was mentioned by several respondents as a drug that they used occasionally and that was being used by people to get ‘high’. Mostly, though, it seemed that this happened very much in the past.

3. *“Pills”; amphetamine type stimulants*

We interviewed 19 people who had at some stage been using pills, presumably amphetamine type stimulants. Seven of them hadn’t been using for three months or more, yet had been using very regularly before that. The others were ‘regular’ users (once a week or more), and some of them could be considered ‘problematic users’, see section 2.

There was a lot of talk of pink/red/grey/light blue pills, which might have been MDMA (commonly known as ecstasy) or methamphetamine (locally known as *sabusabu*). After having been shown photos of a number of different pills, respondents in Maliana unanimously identified the photo to the right -of MDMA-¹⁷ as the type in question. In Dili, there appeared to be some variety in terms of color and shape. Effects to the individual mentioned were similar to the effects that tend to be associated with ecstasy, yet some examples of resulting behavior that were mentioned would be more in line with what would more commonly be expected after using methamphetamine (aggressive behavior). In short, it was impossible to ascertain what drug was being used. There was also sporadic mention of crystal methamphetamine.



MDMA,^(footnote 17)

We interviewed one dealer of “pills”. He said, on average, he did 10 -12 transactions per day, (but on some days many more) both methamphetamine and Ecstasy, with the latter being in much greater demand. His clientele was more or less evenly divided between the two (main) sexes. Also other respondents reported that both young women and men tend to use pills. Many respondents use(d) several to many pills on one day/evening. Often alcoholic drinks are used to water down or mix the pills

¹⁶*Korneta* or ‘cornet flower’ that produces feelings of euphoria. The leaf or blossom of the plant being cooked, and mixed with alcohol and/or instant noodles for consumption (From Belun, 2010, Early warning and early response, Policy brief: Policy and its links to alcohol).

¹⁷ MDMA (methylenedioxymethamphetamine) / Ecstasy, http://www.usdoj.gov/dea/photos/mdma/mdma_ck.jpg, measures in inches, accessed 10 Aug 2011.

(or powder). In both Maliana and Dili, *tuasabu* – a palm wine – was mentioned, whereas cocktails were used in the disco scene.

The three respondents (one female) that we recruited in a local disco, were convinced they were using Ecstasy (and definitely not methamphetamine), and reported effect would support this. These respondents all knew many people –again both men and women– who regularly use Ecstasy. All current users that we interviewed stated that they knew many others that used on a regular basis, typically a couple of times per week. In short, we conclude that there is a sizable number of young men and women who use Ecstasy in Dili.

Women who use drugs...

Typically, women who use drugs represent a particularly hard group to reach. From a number of sources, though, it became quite clear that women are well represented in the drug using population. In fact, several sources indicated an approximate even divide between the sexes, especially with regard to Ecstasy use.

Most respondents that 'knew' methamphetamine thought of it in powder form, hence the most plausible conclusion would be that both are being used, yet that methamphetamine use was more common several years ago, while currently MDMA seems more prevalent. In addition, recurrent statements about aggression after taking pills amongst militia during the Indonesian occupation (more than a decade ago) support this conclusion.

Several people had been using pills on a regular basis for many years, about half had been using for about a year, and the remainder had stopped using. Four men mentioned getting married as the main reason why they stopped using. Their wives didn't know of their drug use, and they wanted to keep it like that.

Everyone in Dili who was using Ecstasy knew many other people who did the same. We feel we can state quite confidently that in Dili there are several hundreds of people that are currently using Ecstasy on a regular basis.

4. *Cocaine*

While a few people mentioned cocaine as a drug that is available in Dili, only one had used it and two others personally knew someone who had used it. Reportedly prices are high and use is therefore probably limited to the very rich and possibly some foreigners.

5. *Heroin*

One respondent who was recruited in the bar scene, was regularly using Ecstasy, yet had never used heroin and had never injected. She insisted, however, she knew a number of people (men) who regularly inject and knew of the existence of a scene that consists of "hard core addicts". The total number came to approximately fifteen people. After probing the respondent on details, it appeared she had never seen actual injecting, yet other details she provided were such that we consider this respondent trustworthy. She refused to try to refer any of them for an interview.

Another person we interviewed had injected heroin regularly for five years, typically three injections per week. He had never used another mode of administration for heroin. He had reportedly been completely drug free now for four years. His friends were still injecting regularly, but he had dissociated himself completely from them in order to stay clean. He had occasionally gone to a clinic with associated health

problems, yet during detoxification he had only received help from his family. He had continued to live with his parents and is now 25 years old. Whereas needles and syringes were easily available at chemists, sharing needles and other equipment was common.¹⁸ He tried to set up interviews for us with people that currently inject, yet this led to the two botched interviews described elsewhere.

Another respondent had injected six times in the last three months. He had been injecting a lot more frequently (several times a week), yet had been successful in reducing his use over the last year – without outside help. He personally knew more than ten people who are currently injecting and they inject a lot more often than him. He had started injecting in 1996 in Indonesia, basically out of curiosity. Over the years, he had used cocaine, heroin, (both injecting), methamphetamine (water pipe), MDMA, barbiturates, (both in pill form), and marijuana (smoked). While he and his friends always use new or their own needles and syringes (which are easily available from chemists), cookers and filters were commonly shared. He was aware of the associated risk of HIV, and several of his friends had gone for VCT. He had never experienced overdose himself, yet some of his friends had on several occasions. In such cases, friends would help with drinks and efforts to resuscitate. He had not witnessed any lethal overdose cases. In terms of the future, he said that by Sept 2012, he would still be using drugs, he would have a job, and he would still be married. He had never sought any help in relation to his drug use. Drug treatment or assistance in reducing drug use was the greatest need at the moment.

A 25-year old student of Social Sciences who had only injected once in his life categorically stated that he currently knew more than 50 people who are regularly injecting. He said he would try to set us up with some of them, yet this assessment had come to an end. The one injecting episode was in 2004; it occurred with two friends who were regular injectors. One of them injected him. The same syringe, yet a new, clean needle was used. He had also used Ecstasy (about twice a week) for three years, he has decreased his use over the years, and has been clean for a bit over a year now. He knew many people that use Ecstasy - all over the city, both male and female.

It would seem that there at least two “groups of friends” that regularly inject drugs.

All in all, injecting drug use appears to be limited to a small number of people. We conservatively estimate the number of people who are currently injecting drugs (presumably heroin) to be between 25 and 50. While we have some further information on location and social characteristics of these groups, we deem it inappropriate and unnecessary to publicize this.

A commitment from the government and one or more NGOs to engage positively with this group (i.e. in the form of a needs-based approach that is based in harm reduction principles, rather than a punitive approach) is required. Such engagement, which could start with further research, would determine a more precise number, as well as determine social characteristics, injecting behaviors and related issues.

6. *Alcohol*

While alcohol was not meant to be part of this assessment, problematic alcohol use appeared to be very much part of the lives of many of the young people we interviewed. Most respondents used amphetamine type stimulants commonly in combination with (or after) alcohol and associated issues (whether they be in the field of health, financial, behavioral, or otherwise) should at least in part be ascribed to alcohol use.

¹⁸ Since injecting had last occurred more than four years ago, no detailed questions about injecting practices were asked.

* **Maliana** (approximately 22.000 inhabitants)

FTH's building is located in the heart of the town. They work with eight peer outreach workers for men who have sex with men and five for (female) sex workers who conduct HIV/AIDS related activities, including IEC and condom promotion. As such, we assumed that they were in a good position to identify and recruit people who use(d) drugs . While this might be the case, it appeared that FTH's workers and clients in Maliana do not use drugs. They were, however, able to arrange interviews with four people who used to use drugs, outside their client base. They could not, however, refer us to any people who were currently using drugs, and willing to talk to us. Three further people refused to be interviewed out of fear of getting into trouble.

Also in Maliana, the apparent fear amongst potential respondents to talk to us was possibly even bigger than in Dili. Maliana is a small town, and news spreads fast. We decided not to consult the district police out of consideration of this fear. Another piece of information that was repeated several times was that most people that use drugs have moved to Dili.

We interviewed four persons who had previously used drugs. They were all male and their average age was 23 (18 – 32). One was married, with his wife living abroad, the others were single, living with their parents.

Findings and tentative conclusions for Maliana include:

- Marijuana is easily available, if one knows the people that grow it in the surrounding mountains. Three of the four respondents stated they had smoked *ganja* and they all agreed that it was locally grown.
- Pills were used by three of the four respondents; Most probably amphetamine type stimulants. These pills were either swallowed or mixed in drinks (after having been crushed), with friends at parties or at home. One respondent mentioned that at his first time it had been added without his knowledge and he realized afterwards that he had been drugged. Commonly, friends or 'seniors'/'brothers' (*maun boot*) from Dili presented or sold (app. \$15) the pills to them.
- Availability seems to be linked completely to the one source who might or might not have been to Dili recently. It would appear that Dili, rather than the border with Indonesia, acts as the source of supply.
- Police don't seem to mind too much, and only seem to come into action when they are called in because of aggression or unrest. Two respondents mentioned having been put in police jail for 2 hours and 3 days respectively, as a result of aggressive behavior connected with drug use. No one had gone to court over drug use (or possession).
- None of the respondents had been using any drugs for the last three months and for one person it had been four years.
- None of the respondents had any knowledge of a possible connection between drug use and HIV, and no one acknowledged any connection between their own drug use and their sexual behavior.
- Quite a few people seemed to know the "one (and the same) person" who injects drugs and who reportedly also supplies drugs. This person refused to talk to us. We did not hear of any other injecting drug use and were quite convinced that if there were any that it would be very limited. Three of the four knew some people who were currently using "pills".

2. Causes, reasons, effects, and associated problems

Frustration, boredom (unemployment), and curiosity were mentioned as the main causes. Most respondents cited feelings of being down, or wanting to feel happy as the main reason for taking pills. Stress relief, feeling happy, confident, energetic, talkative, horny, and “forget problems” were often mentioned as the positives. Others included: imagination, inspiration and dreams. Effects would last for several hours to the whole day, depending on the number of pills taken.

With regards to non-injecting drugs, apart from weight loss (which was mentioned by several respondents), no negative health effects were reported. When probed, several respondents mentioned problems associated with their drug use, including aggression, one apparent suicide attempt, and traffic accidents.

Yet, the overall image of drug use that arises is rather positive. Despite the extreme fear of getting caught, no one had had serious issues with the police (let alone with Justice) and no one reported any drug use related issues at school, at work, or at home. In short, most respondents could be described as “happy users”, while some were trying to reduce or stop using. The latter were typically long-term users who were surprised at how difficult it appeared to stop using. They would suffer from severe withdrawal symptoms that would then lead them to renew their drug use.

From the people who (used to) inject drugs, we heard of several related health issues amongst this group. These include: generally deteriorated health (skinny, inactive), TB – possibly related to drug use (when blood was tested for blood donation purposes, the person tested positive), and overdose. HIV/AIDS and Hepatitis were not mentioned; respondents said that disease was typically not discussed in the groups of friends. Symptoms that are probably associated with withdrawal came up in two interviews. Overall, we have too little information to paint a distinct picture of injecting drug use related issues.

3. Knowledge and behavior surrounding sex and HIV/AIDS

Of the 17 respondents that had never injected drugs, 15 were interviewed through an interpreter. Only one of them had any knowledge of a possible connection between drug use and HIV/AIDS. He actually mentioned injecting drug use and increase of unprotected sex as a result of drug use as the two possible connections. Ironically, he had acquired this knowledge while he was studying in Indonesia.

The five respondents, who did the interview in English, were all aware of the relationship between injecting drugs and HIV/AIDS, and one mentioned increase in unsafe sex as a possible effect of drug use.

There was little doubt, however, that in practice taking ‘pills’ was associated with an increased sex drive and with increased feelings of affection for persons of the opposite sex from both sexes. Several (male) respondents mentioned that they would visit a female sex worker (after having taken pills) and a clear connection was made between being under the influence of the drug and the urge to make use of her services as well as the fact that the sex was unprotected. The pill dealer said that he regularly had (unprotected) sex with young women in exchange for pills.

Six of the respondents had been tested for HIV. The test was voluntary and confidential, and counseling was provided. They all had collected the result.

Amongst the people who inject drugs that we interviewed, there was awareness of the need to use new (or one's own) needles and syringes, and the link with HIV/AIDS was made. Other equipment was shared. With only three people interviewed we don't want to elaborate on knowledge levels or injecting practices.

B. Responses

a. Drug policy and legislative framework

National drug policy

The National Drug Policy¹⁹ (synonyms also used; National Medicine, or; National Pharmaceutical policy for Timor-Leste) deals with the development, provision and use of medicines within both the public and the private sector. The overarching goal is to secure safety and protect the individual patient and the public. The National Drugs and Medicines Pharmaceuticals Policy aims to contribute to improved health and wellbeing of all people in Timor-Leste.

In other words, Timor-Leste's National Drug Policy does not deal with illicit drugs. For all intents and purposes, there appears to be no national policy or program that deals with narcotic drugs, other than the Narcotics Law.

The Narcotics Law

An analysis of the legislative framework related to narcotic drugs leads to the following overview²⁰:

- There is no general law of the Timor-Leste Parliament or Government concerning the criminalization of illicit drugs or drug-related activity.
- However, a small number of specific offences exist in the Penal Code and the Highway Code concerning driving under the influence of illicit drugs.
- In the absence of a general Timorese criminal law concerning drugs, the Indonesian Law on Narcotics is in force, amended as necessary.
- The phrase *mutatis mutandis* ('amended as necessary') means that where the law is inconsistent with existing Timorese Law (for example, use of the death penalty or grants of authority contrary to existing law), or simply cannot be executed (for example, penalties in Indonesian Rupiahs or references to Indonesia or Indonesian agencies that do not exist in Timor-Leste), those provisions do not apply, or are amended such that the law may otherwise apply.
- Other Timorese law regulates other aspects of drug sale, manufacture, import, export, etc. from an administrative perspective.

The Indonesian Law on Narcotics, 22 of 1997 includes three schedules²¹ of drugs:

¹⁹This paragraph is taken from: <http://vivatl.wordpress.com/2011/01/06/88/>, accessed 5 Augustus 2011.

²⁰Based on consultation with a PNTL Legal Officer.

²¹The following description of the 'schedules' is an effort to explain the categories for non-experts, and should not be considered a legal, or final word on what they mean or include. Largely based on E-mail communications with a chemical expert, 14-16 Aug 2011.

Category I includes opioid analgesics (painkillers) and their raw materials, derivatives or synthetic analogs of morphine (i.e. heroine) and fentanyl (a potent synthetic narcotic painkiller) analogs. Raw materials include poppy, raw and refined opium, coca bush and leaves, cocaine and cannabis. Use of these drugs may cause opioid dependence.

Category II is an expanded list of potent opioid analgesics. This includes other less common derivatives of morphine, different classes of synthetic opioids and some synthetic intermediates for the preparation of opioids.

Category III is very similar to Category II. This list focuses on opioids only.

In addition to the issues mentioned earlier, the following is worth noting with respect to the current law and Penal Code:

- The schedules do not cover amphetamine type drugs (such as Ecstasy, *sabu-sabu* and ice), or the precursor chemicals (for the production of synthetic drugs).
- The list includes methadone (used in maintenance therapy for heroine dependence) and racemethorphan (dextromethorphan which is 50% of racemethorphan), which is used in formulations for cough relief.
- Some substances in this list are discontinued medicines.
- The Law does not distinguish between weights, volumes, etc; instead it only criminalizes particular substances. There is no mention of use, possession, or trafficking.

There are plans to develop (and presumably adopt) a new Narcotics Law. The process and the timeframe for this are unclear, especially since there are more laws on the table and the political will required to move quickly might not be there. With the elections coming up in 2012, one would expect that final adoption will not occur before 2013.

Law enforcement and Justice

The law enforcement (PNTL) representative indicated that several drugs cases per year are sent to Justice, but typically these are dismissed due to 'poor quality of evidence'. Photos that were shown during the interview would indeed suggest that amphetamine type stimulants are being used, typically in tablet form. Also, water pipe like constructions have been confiscated, presumably for the use of methamphetamine or possibly cocaine, but this was unclear. Drugs in powder form have also been seized. It was, however, impossible to determine (from photos!) what kind of substance it was. Reportedly, the street value was \$30/gram... Several entertainment venues in Dili were "under observation" in connection with suspected drug use.

Similarly, the 2011 US State Dept Narcotics Report on Timor-Leste²² reports: "Law enforcement capacity is limited, due especially to low levels of education and training among the police force and insufficient investment in infrastructure, equipment, and logistical capacity. Nevertheless, with support from international peacekeepers, the PNTL has made modest efforts to identify and raid establishments associated with narcotics trafficking. Despite a limited number of arrests, however, a similar lack of capacity in the prosecutorial and judicial system has hampered efforts to prosecute and convict those arrested. Another obstacle is the ability to analyze narcotics samples seized promptly. To date, PNTL has

²² US State Dept Narcotics Report 2011, <http://www.state.gov/p/inl/rls/nrcrpt/2011/vol1/156363.htm#timorleste>, accessed on 10 Aug 2011.

relied upon Australian counterparts, who send narcotics to Australian government laboratories for analysis. PNTL officials have cited delays and lack of responses as a hindrance to prosecuting suspects. In some cases, positive reactions acquired through narcotics test kits have been sufficient for prosecution.”

A significant²³ challenge for the police is the lack of a scientific testing facility. In the absence of forensic testing, police are only able to use the Narcotics Identification Kit (NIK). This is a presumptive test kit that can identify the presence of drugs and provide some information on what the drug is. However, it is a field kit and not, in the ordinary course, of sufficient scientific rigor to support a court case. However, due to lack of a proper facility, they are all the PNTL have at their disposal.

The General Prosecutor confirmed that the lack of a testing facility (lab) and low capacity at law enforcement (in terms of collecting intelligence and evidence that would hold in court) are the two main issues in terms of the ability to successfully prosecute drug related cases. With substances having to be sent to Australia (or Indonesia) for testing before prosecution can start, valuable time is lost and often the suspect and/or witnesses are gone when the result comes back. Typically, 6 months is the longest someone can be held in pre-trial custody.

This year, no new drug use related cases have come to her desk, yet the General Prosecutor was quick to point out that this doesn't mean there are no drugs in Timor-Leste. Most (older) cases pertain to possession of relatively small quantities of methamphetamine and the odd case of cocaine. She was not aware of any injecting drug use in the country. Most cases involve young men and women in Dili and there was information that some of the women might be addicted, which then led to dealing. It is assumed that the land borders are the main point of entry.

The fact that amphetamine type stimulants are not in the current Narcotics Law does not hinder prosecution of cases of possession or trafficking thereof. The list of the United Nations is used as the de facto 'current list'.

The General Prosecutor considers drug use an important issue and has been active in several areas:

- Signed a Memorandum of Understanding with the National Hospital regarding testing;
- Pushed for a small laboratory at the PNTL;
- Drafted a new Narcotics Law and submitted it to the government; and
- Monitors drug related case files and puts a team of two - instead of the customary one - prosecutors on cases she deems important.

Another informant stated that “while evidence such as genetic material is occasionally sent to Australia for testing, (suspected) substances have never been sent to Australia (or Singapore, or Indonesia) for testing. There is currently no Memorandum of Understanding with any country in place that would facilitate such procedure.”²⁴

Hardly any of the people who use(d) drugs reported serious issues with law enforcement in relation to their drug use. Some people knew of one or two cases of people having been arrested and then kept in prison for a long time (up to more than one year - without having been convicted).

²³Based on E-mail communication with an UNMIT official, 14 Aug 2011.

²⁴ This statement came from a reliable source who wishes to remain anonymous.

b. Demand reduction, harm reduction, care and support

Given the limited extent of drug use and the fact that drug use is hidden from public view and injecting use is completely out of sight, it can hardly be surprising that there are no organizations in Timor-Leste that explicitly target people who use drugs.

In addition, there are no drug treatment facilities in Timor-Leste, so people who use drugs and their caregivers are completely left to their own devices. Surprisingly, also alcohol treatment (or rehabilitation) is notably absent, whereas there is a clear alcohol problem in several segments of society.

The NGOs listed below may (inadvertently) have people who use drugs amongst their clientele. We'd like to stress though that this is an assumption only, and that a proper analysis of the reached group would be required to ascertain to what extent this is the case. Current staff appear ill equipped to conduct such analysis, and people who use drugs are currently not prioritized. They are listed here as a group of NGOs that seem well positioned to play a part in the interventions that are suggested in the next chapter.

BA FUTURU²⁵, meaning 'for the future', is Timor-Leste's preeminent national child protection and peace building organization. Ba Futuru staff is renowned for quality training skills and have provided educational training programs to more than 20,000 children, youth, teachers and community leaders since 2004. One activity of particular interest for this assessment is conflict resolution training workshops that Ba Futuru conducts at the community level. Through these they are in contact with (former) youth gang members some of whom may have been involved in drug use.

BELUN²⁶ was established in 2004 to bolster civil society in Timor-Leste and reduce underlying tensions that may lead to violent conflict. Belun's mandate is to serve communities within Timor-Leste, develop the organizational capacity of the partners, reduce tensions and prevent conflict in Timor-Leste. BELUN means "friend" or "partner" in the national language, Tetum.

The members of the Belun team have been working for over five years to strengthen civil society organizations and provide services needed to communities in all 13 districts of Timor-Leste. While the majority of the Belun team comes from a long history of working together with Care International in Timor-Leste and Columbia University's Center for International Conflict Resolution (CICR), members also have extensive experience working with the government and other non-governmental organizations, bringing added insights and capacities to the organization.

FTH (Fundasaun Timor Harii) is essentially an HIV/AIDS organization that works with sex workers and men who have sex with men including from the drop-in-centers in several cities in Timor-Leste. As such, they have an affinity with stigmatized and harder to reach groups, and have the infrastructure in place to start work with people who use drugs within a relatively short timeframe. They have also been instrumental in the conduct of this assessment and appear keen to take this kind of work forward.

²⁵<http://www.bafuturu.org>, accessed 29 Aug 2011.

²⁶<http://www.beluntl.org/>, accessed 29 Aug 2011.

PRADET²⁷ (Psychosocial Recovery and Development in East-Timor) was constituted as a national NGO in 2002 to provide a psychosocial service for people who are experiencing trauma, mental illness and other psychosocial problems in East-Timor.

Services are delivered by local counselors who have solid experience in psychosocial health, with a strong focus on responding to stress, trauma, grief, sexual assault, domestic violence and mental illness. In addition, PRADET also provides counseling, advancement of children's rights, child protection, conflict resolution and advocacy to improve clients' rights in the community.

Currently PRADET is the only organization in Timor-Leste providing information and training about the use and abuse of alcohol and the impact on the community.

Sharis Haburas Comunidade (SHC) is a local NGO that, amongst other similar activities, provides services and information in the areas of HIV/AIDS/STI and provides physical, spiritual and psychological assistance to prisoners and prison staff, and prepares prisoners for release.

²⁷<http://www.pradet.org/about>, accessed 29 Aug 2011

III. Conclusions and recommendations

In this chapter, the conclusions from the previous chapter are summarized in Sections A & B. Based on these conclusions, recommendations are formulated in Section B. Responses.

A. Drug use

1. Prevalence

In summary, conclusions for Dili include:

1. Cannabis and magic mushrooms are being used on a small scale.
2. Many – we estimate several hundred– individuals, largely young people, both male and female, are using Ecstasy on a regular basis.
3. Methamphetamine use seems less widespread and might be decreasing.
4. Injecting drug use appears to be limited to a small number of people. We estimate the number to be 25 – 50 people. Further engagement and research would have to determine a more precise estimate, characteristics, as well as related issues.

In summary, conclusions for Maliana include:

1. Active drug use is limited to a very small number of people.
2. Drugs used tend to be cannabis and Ecstasy, yet this also seems quite rare.
3. Injecting drug is not a significant issue.

2. Causes, reasons, effects, and associated problems

Conclusions include:

1. There are some issues related to non-injecting drug use, including loss of weight, mental health issues, traffic accidents, withdrawal symptoms, and inability to abstain.
2. There are many people who use drugs in a non-injecting manner, who apparently have few issues with their use.
3. There are some indications of injecting drug use related issues, but information is currently too scarce to draw firm conclusions.

3. Knowledge and behavior surrounding sex and HIV/AIDS

1. Amongst non-injecting people who use drugs, there was little to no knowledge about injecting related drug use.
2. Use of amphetamine type stimulants was regularly associated with increased unsafe sex.
3. There was some HIV/AIDS awareness amongst people who use drugs and approximately one third of the respondents had gone through VCT.
4. Information available amongst people who inject drugs is too scarce to draw conclusions on knowledge levels and injecting practices.

B. Responses

Introduction

While traditionally punitive approaches were the hallmark of national responses to (injecting) drug use, with the arrival of HIV/AIDS and the fact that people who use drugs (together with sex workers and men who have sex with men) form a potential bridge to the 'general population', health approaches – and more recently human rights approaches – have made inroads in national policies that deal with (injecting) drug use.

In 2010²⁸ there were 93 countries and territories worldwide that support a harm reduction approach, eleven more than the number reported in 2008. This support is explicit either in national policy documents (79 countries – eight more than in 2008) and/or through the implementation or tolerance of harm reduction interventions such as needle exchange (eighty- two countries – five more than in 2008) or opioid substitution therapy (seventy countries – seven more than in 2008).

Lessons learned from other countries in Asia speak for themselves in terms of what can go wrong if a country decides to implement a strictly punitive approach to drug use once it is confronted with larger numbers of people who inject drugs. A case in point is Thailand; see textbox below²⁹. Hence, in the development of policies and programs it is important to include public health approaches, rather than law enforcement approaches only.

This is further exemplified by the approach that was taken in Australia³⁰; see textbox below. The Australian Ministerial Council on Drug Strategy approved the National Drug Strategy 2010 – 2015 earlier this year, which incorporates harm reduction as one of the three elements of harm minimization of a varied range of integrated approaches. It is a useful example of how alcohol, tobacco, illegal drugs, pharmaceuticals, and other substances can be combined into one policy.³¹

With a new legislative framework under development in Timor-Leste, an approach that takes the best from lessons learned elsewhere and ignores knee-jerk reactions, over-simplified solutions and populist measures is called for. We would like to recommend an approach that combines supply reduction, demand reduction, and harm reduction:

1. Supply reduction³² strategies aim to disrupt the production and supply of illicit drugs and control and regulate licit substances.
2. Demand reduction strategies aim to prevent the initiation of harmful drug use. This includes abstinence based strategies and treatment to reduce drug use.
3. Harm reduction strategies aim to directly reduce drug-related harm to individuals, families and communities.

²⁸ This paragraph was taken from IHRA, Global State of Harm Reduction 2010, downloadable from http://www.ihra.net/files/2010/06/29/GlobalState2010_Web.pdf

²⁹ See text box, <http://www.idpc.net/sites/default/files/library/Harm-reduction-policies-in-Thailand.pdf>, accessed 25 Aug 2011.

³⁰ <http://www.anex.org.au/harm-reduction/what-is-harm-reduction/>, accessed 1 Sep 2011.

³¹ [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/\\$File/nds2015.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf), accessed 8 September 2011.

³² The explanation of these three terms and the remainder of this section is taken from: <http://www.anex.org.au/harm-reduction/what-is-harm-reduction/>, accessed 6 September 2011.

It is a philosophy embedded in principles of public health and human rights. Whilst the reduction of the supply and demand for drugs focuses on avoidance and abstinence, harm reduction addresses the potential to reduce harms in pre-existing drug use which may also lead to abstinence. Harm reduction recognizes all drugs have the potential to cause harm.

Harm reduction does not condone licit or illicit drug use, but acknowledges that despite efforts to control supply and demand, many will continue to use drugs. When people continue to use drugs, harm reduction recognizes that society benefits from efforts to reduce the harms associated with drug use.

Textboxes: **Experiences from three other countries**

Lessons learned from Thailand

The current focus on enforcement and punishment, along with the reliance on compulsory drug treatment centers, has done little to control drug use in Thailand. The unintended consequence of this approach has been to push drug users into precarious and dangerous environments that have directly led to risky drug using patterns and persistently high rates of HIV transmission.

Adopting a harm reduction approach to deal with injection drug use could have a major impact on reducing HIV transmission as well as engaging drug users into better health care and effective drug treatment. This will require strong leadership in key government Ministries and related agencies so that the central stakeholders can roll out harm reduction programs. Thailand has the potential to greatly reduce the transmission of HIV among injection drug users and become a regional leader in harm reduction.

World Bank & Ministry of Public Health, Thailand, 2011, Harm reduction policies and interventions for injection drug users (footnote 29).

Success in Australia

The timely embrace of harm reduction interventions meant that, in Australia, HIV infection continues to be rare among both injecting drug users and the wider community. In countries where needle and syringe programmes were not immediately established, including the USA, HIV spread rapidly among injecting drug users and, in turn, to the wider community. In Australia, the level of HIV infection among people who inject drugs has remained around 1 per cent, compared to other countries with levels over 50 per cent.

Australia's HIV/AIDS Strategy has received international recognition. According to UNAIDS Best Practice Collection:

[In Australia], early and vigorous HIV prevention programmes aimed at injecting drug users resulted in stable and low rates of HIV prevalence among drug users and related population groups. It is generally agreed that this prompt – and sustained – action fundamentally altered the course of the country's epidemic.

2011, Anex, Australia (footnote 30).

Drug possession decriminalized in Portugal

Surprisingly, Portugal—a small country known for its conservative values, strong Catholic tradition, and recent emergence as a democracy—has become an international model for drug policy reform. In a dramatic departure from the norm, Portugal decriminalized drug possession in 2000. By moving the matter of personal possession entirely out of the realm of law enforcement and into that of public health, Portugal has given the world a powerful example of how a national drug policy can work to everyone's benefit. In the past decade, Portugal has seen a significant drop in new HIV infections and drug-related deaths. Instead of languishing in prison cells, drug dependent individuals in Portugal now receive effective treatment and compassionate programs that integrate them back into society. Even law enforcement has benefited, as police officers are now free to focus on intercepting large-scale trafficking and uncovering international networks of smugglers. As a result, public safety has increased.

2010, Open Society Foundations, Drug policy in Portugal, the benefits of decriminalizing drug use (footnote 33).

a. Drug policy and legislative framework

In summary, there is no national drug policy or programme that deals with illicit drugs, the current Narcotics Law is problematic, and law enforcement is ill equipped, which leaves the courts with few tools to successfully prosecute. The current legal framework surrounding drugs is untenable for the long term. Drafting and adoption of a National Drugs Policy, including a new law that deals with controlled substances is crucial.

We would like to caution, however, against a rushed process. Timor-Leste is in the envious position to work on a national drug policy without being confronted with large numbers of people who use drugs and associated health and social problems. Contrary to most countries in the Asian region and beyond, there are few drugs related arrests or prosecutions, drug use related convictions are extremely rare, and the prisons are reportedly drug-free.

In this context, two key recommendations are suggested:

1. Draft, adopt, and implement a National Drug Policy that deals with illicit drugs

Rather than focusing on a new law only, the development of a National Drug Policy, including a National Drug Strategy, and a National Action Plan (Programs, Projects, Activities) should receive priority.³³ We would like to stress the following characteristics:

1. *Well informed, evidence-based*: Currently, there is too little knowledge on drug use in Timor-Leste to adequately formulate an appropriate policy and legislative framework. Further, more in-depth, research should be conducted to identify the exact issues and to develop effective responses.
2. *Participatory*: A broad selection of stakeholders should be involved in the drafting stage. This would minimally include the medical sector, education, law enforcement, justice, NGOs that work with people who use drugs, and international experts (UNODC, UNAIDS, WHO, International Network of People who Use Drugs (INPUD) / Asia Network of People who Use Drugs (ANPUD). The principles of ‘meaningful involvement of people who use drugs’ and “Nothing about us without us!” should be adhered to.
3. *Balanced*: Lessons from countries in the region (and beyond) show that policies and programs are more effective if they adopt an approach that integrates supply reduction, demand reduction and harm reduction principles and elements.
4. *Nuanced*: Careful consideration should be given to the distinctions between: types of drugs, possession of paraphernalia, possession of drugs for personal use³⁴, possession of drugs for dealing, and trafficking of drugs.
5. *Humane and compassionate*: Substance dependence is a chronic, relapsing condition, which is difficult to control due to compulsive drug use and craving, leading to drug-seeking and repetitive use, even in the face of negative health and social consequences.³⁵

³³A useful guide on how to develop a National Drug Policy can be downloaded at:

[http://www.cicad.oas.org/main/pubs/How to Develop a National Drug Policy CICAD-CARICOM.pdf](http://www.cicad.oas.org/main/pubs/How%20to%20Develop%20a%20National%20Drug%20Policy%20CICAD-CARICOM.pdf).

³⁴http://www.soros.org/initiatives/drugpolicy/artides_publications/publications/drug-policy-in-portugal-20110829/drug-policy-in-portugal-20110829.pdf, accessed 6 September 2011.

³⁵ 2008, WHO – Regional Office for South-East Asia, WHO - Western Pacific Region, UNODC – Regional Center for East Asia and the Pacific: HIV/AIDS care and treatment for people who inject drugs in Asia and the Pacific: an essential practice guide, ISBN 978 92 9061 320 6. http://www.wpro.who.int/nr/rdonlyres/c8cc1519-d40b-4af0-92cd-1e94712ff025/0/hivaidscareandreatment_10march_web.pdf, accessed 17 Aug 2011.

6. *Compliant with international conventions.* The global drug controls system is increasingly being criticized for being outdated and possibly fundamentally flawed. (See textbox below)³⁶.

International drug law

The present global drug control system is now 100 years old. It was inspired by the realization that no country could regulate drug use in isolation, since these commodities were so readily bought and sold across borders and jurisdictions. Effective control would require states to work together as an international community.

Three conventions make up the instruments of international drug law:

- a. The 1961 UN Single Convention on Narcotic Drugs which draws together previous drug control legislation and forms the unified legal bedrock of the current system;
- b. The 1971 UN Convention on Psychotropic Drugs; and
- c. The 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

The overall objective of the conventions remains as it was specified a century ago - to limit the production, distribution and use of drugs to scientific and medical purposes. The three conventions provide the mandate and underpin the functioning of the UN agencies most involved in drug control:

- The Commission on Narcotic Drugs
- The United Nations Office on Drugs and Crime
- The International Narcotic Control Board

The three drug control conventions are not 'self-executing' – they require signatory states to enact and enforce national legislation in order to comply with their treaty obligations. However, the international system provides the overarching regulatory framework, and its agencies assist national governments in meeting their requirements under the treaties.

Only a few governments have not signed up to the treaties underpinning the global drug control system, which has been viewed for many years as exemplifying the spirit of international co-operation in the name of humanity. Recently, however, there has been a growing realization that the system is far from perfect, and needs to be fundamentally reviewed. This insight was supposed to have guided the UNGASS review of drug control in 2009, which ended by largely reaffirming the current arrangements, thereby representing a missed opportunity of considerable proportions.

International Drug Policy Consortium, (footnote 34).

Priority areas for the development of a National Drug Policy include:

Draft, adopt, and implement a Law on Controlled Substances.

Special care should be taken to make sure that the new law is harmonized with the Constitution, the HIV/AIDS National Strategic Plan, as well as Human Rights Conventions that Timor-Leste has signed on to.

³⁶ The textbox is completely taken from: <http://www.idpc.net/policy-advocacy/global-advocacy/global-drug-control-system>, accessed 15 August 2011.

Train and equip the law enforcement agencies.

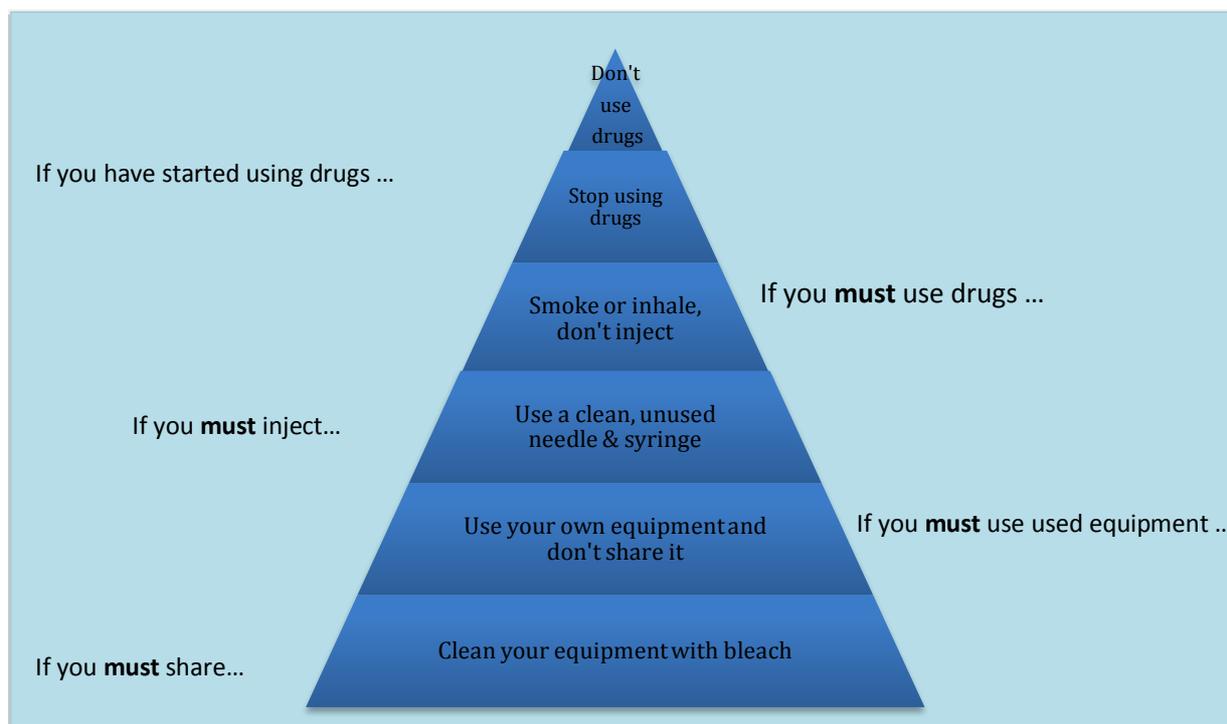
1. *Knowledgeable and skilled:* Law enforcement at all levels should receive further training in detection techniques, identifying substances, and following up.
2. *Well equipped:* Law enforcement -PNTL- should have access to the services of a local drug testing facility. Possibly, the best location for such facility would be the National Hospital.

b. Demand reduction, harm reduction, care and support

By all accounts, Timor-Leste is in the fortunate position to not have a significant injecting drug problem inside its borders. As such, it has the unique opportunity to focus on prevention of injecting drug use rather than having to deal with the negative social and health consequences of a large injecting population. (Meanwhile, the issues and needs of the current injecting population (small as they may be) need to be assessed and met as soon as possible; see below).

The so-called ‘hierarchy of objectives’ (see Figure 1) in harm reduction exemplifies what a comprehensive response could look like.

Figure 1: Hierarchy of objectives (or: “Easier said than done!”)



Assess the effectiveness of current primary drug prevention activities.

“Don’t use drugs”, “Just say no”, and “Stop using drugs” are messages which are typically used in (primary) drug prevention and demand reduction programs and policies, and disseminated in schools, in hospitals, by NGOs, and others. This assessment did not review to what extent this is the case in Timor-Leste, let alone its effectiveness. Evidence from other setting suggests these are not evidence informed

and useful approaches. Approaches that teach life skills, and meaningfully involve and develop young people and retain them in education training and employments have more positive outcomes.

Explore the establishment of a rehabilitation center, which could combine alcohol and drugs.

There are currently no specialized facilities for drug treatment, while problematic alcohol use, alcohol dependency, and drug use appear sizable issues. We recommend that the government explore the establishment of a rehabilitation center (or clinic at the National Hospital), which could combine alcohol and drugs. Treatment should be voluntary, low threshold, compassionate, and time-limited – i.e. three months being the maximum period of stay.

Reach out to people who use drugs with appropriate IEC strategies, and expand services where needed.

“(If you must use drugs), smoke or inhale, don’t inject” is a message that appears very appropriate to Timor-Leste’s current drug use situation. We would like to urge the concerned parties to swiftly engage with people who use drugs (and do not inject). Initial focus could be on development and dissemination of IEC materials that highlight the negative consequences of injecting drug use. Such campaigns should be honest, unbiased and should be tailored to young people, both in and out of school. Probably an NGO should be tasked with reaching out to people who use drugs and develop appropriate messages, packages, and means of dissemination. If needed, other services could be developed and offered, depending on an analysis of the issues and needs amongst the target group.

Establish a working group to develop strategies to reach out to people who inject drugs, and where needed, develop and provide services.

The bottom three messages in the pyramid above are very much associated with harm reduction related work, such as substitution treatment, needle and syringe exchange programs, and medically supervised injecting facilities. While in Timor-Leste, there might not yet be an immediate need for the full-fledged development of such range of interventions, the situation appears to be serious enough to warrant a more in-depth research into injecting drug use in Dili.

Currently, the injecting population is not served by any GO or NGO. Although numbers appear to be small, the issues are likely to be severe and effective responses can only be developed through engagement with the target group. We recommend the immediate setting up of a working group of sorts to

NGOs and people who use drugs...

NGOs tend to have more affinity (than GOs) with people who use drugs and therefore might be more suitable to develop and implement non-punitive approaches.

We would like to stress here, though, that working with people who use drugs requires capacity building, but - most of all - the ‘right attitude’. People who use drugs should be consulted at all stages and taken seriously. If they are an integral part of the solution, appropriateness, effectiveness, and thus sustainability increase.

People who use drugs are not criminals, they are not victims, and should not be solely viewed as patients. They are clients who might require services occasionally. Some might need to be empowered to take control of their own lives and, like anyone else, they are entitled to have influence over the programs and policies that affect them.

develop strategies to reach out to this currently un-served group. Representation from the following sectors would be ideal: people who use drugs, health (HIV/AIDS), the NGO sector, law enforcement, and justice. Other participants could be academia, religious leaders, and the business sector.

There are several NGOs, notably Belun, FTH, PRADET and SHC, that are doing work in related areas, and they could be called upon to assist (or take the lead) in developing and implementing strategies to address some the issues that are highlighted in this report.

II. Engage with people who inject drugs and research levels of injecting drug use, knowledge levels, injecting practices, and related issues.

Too little is currently known about the scope and characteristics of injecting drug use in Dili to responsibly develop interventions.

It is crucial to ensure that people who use drugs are intimately involved in all areas of policy development, prevention and treatment planning, and monitoring and evaluation. We therefore suggest that an NGO take the lead in the next stage of engagement with people who use drugs. In that manner a more long-term and meaningful relationship with the target group can be forged.

Below, we suggest a swift way forward, taking into account some reflections on the way the conduct of the assessment unfolded.

Looking back and looking forward

The interviews with key informants were easily set up and the first phase of the assessment went smoothly. Yet, in Maliana, it already appeared that setting up interviews with people who use drugs was never going to be straightforward. We couldn't find anyone who was actively using willing to talk to us. Several active users, including one who injected, refused an interview.

Also in Dili, there were a lot of apprehensions and only after we had done a number of interviews were we able to identify people who were actively using drugs, yet still, none of them were injecting. It was only towards the very end of the planned data-gathering stage that we managed to talk to a couple of people who had injected, including one 'active' user.

In retrospect, the timeframe was too short to properly engage with people who inject drugs. While non-injecting use is relatively openly discussed amongst certain sub-groups, injecting drug use is a different story altogether. The fact that there are no NGOs that target people who use drugs led to a rather haphazard approach. We would be on stand-by until we heard of someone who wanted to talk to us. We then went to the agreed spot and hoped we could conduct an interview.

There were several occasions that potential respondents didn't show up (changed their minds, fear of being interviewed, overslept) and there was always quite some distrust amongst potential and actual respondents. As a result, the assessment has not yielded a great deal of information on injecting drug use. Most information that is there is 'secondary' in the sense that it comes from people who are talking about others. This lowers trustworthiness of the data.

Another minor issue was interpretation:

1. Occasionally information could not be properly interpreted (jargon, obscure practices).
2. The 'three-way' nature of an interview with an interpreter can take the flow out of an interview.
3. Privacy and confidentiality issues increase with the number of people involved.

For an immediate follow-up of this assessment the following approach is suggested:

1. Two interviewers from FTH are trained in the conduct of semi-structured interviews into injecting drug use. Probably a three-day training would suffice.
2. These interviewers are on stand-by to conduct interviews with people who inject drugs who appear ready and willing to be interviewed. Approximately ten interviews would probably be sufficient to get some insight in injecting practices, and the issues that are faced by people who inject drugs.
3. Data are collated, translated and consolidated in the revised final report.

Since contact has been made, we might now be able to interview people who inject drugs relatively easily and quickly, and we are quite confident that we would be able to successfully approach ten people who are currently injecting drugs. It would build the capacity of FTH staff and it would be a start for FTH to engage with this currently un-served group. A budget for this extension has been submitted and it is suggested that the above be implemented in the coming month, so that an adjusted version of this report would be ready well before the end of 2012.

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Annex 1: Drugs and their effects, a summary

Amphetamine Type Stimulants (ATS)³⁷

- **Amphetamine**

One of a class of sympathomimetic amines with powerful stimulant action on the central nervous system. The class includes amphetamine, dexamphetamine, and metamphetamine. Pharmacologically related drugs include methylphenidate, phenmetrazine, and amfepramone (diethylpropion). Amphetamine, (also known as ya ma, yaba, crystal, shabu, point, meth, ice, speed) comes as a crystal, powder, wax (known as „base“, often discolored yellow or red) or pill. It can be smoked, snorted, injected or swallowed. Symptoms and signs suggestive of intoxication with amphetamines or similarly acting sympathomimetics include tachycardia, capillary dilatation, elevated blood pressure, hyperreflexia, sweating, chills, anorexia, nausea or vomiting, insomnia, and abnormal behavior such as aggression, grandiosity, hypervigilance, agitation, and impaired judgment. In rare cases, delirium develops within 24 hours of use. Chronic use commonly induces personality and behavior changes such as impulsivity, aggressivity, irritability, suspiciousness, and paranoid psychosis (*see amphetamine psychosis*). Cessation of intake after prolonged or heavy use may produce a withdrawal reaction, with depressed mood, fatigue, hyperphagia, sleep disturbance, and increased dreaming. Methamphetamine may damage the unborn baby and should be avoided by pregnant women. It may also damage the heart, kidneys and liver. Poor dental health is also commonly reported in methamphetamine users. Methamphetamine use has been associated with increased sexual risk taking behavior such as more sexual partners and more unprotected sex, as well as injection related risk taking behavior such as needle sharing. Currently, prescription of amphetamines and related substances is limited principally to the treatment of narcolepsy and attention-deficit hyperactivity disorder. Use of these agents as anorectic agents in the treatment of obesity is discouraged.

- **Ecstasy (MDMA – 3,4 – methylenedioxyamphetamine)**

Ecstasy, or MDMA, which may come as a powder or in a pill, is a common recreational drug in many countries. It causes euphoria, stimulation, empathy, reduced anxiety, increased social outgoingness, profound realizations, and strong positive emotions about others. Its undesirable effects include teeth clenching, changes in vision, reduced appetite, mood swings, upsetting emotions or thoughts, increased body temperature which may be fatal, sensation of thirst which may increase the intake of water to fatal levels, the possibility of psychosis with both single use and long term use, and the possibility of damage to the brain with longer term use.

Benzodiazepines

One of a group of structurally related drugs used mainly as sedatives/hypnotics, muscle relaxants, and anti-epileptics, and once referred to by the now-deprecated term “minor tranquillisers”. These agents are believed to produce therapeutic effects by potentiating the action of gamma-aminobutyric acid (GABA), a major inhibitory neurotransmitter. Benzodiazepines were introduced as safer alternatives to barbiturates. They do not suppress REM sleep to the same extent as barbiturates, but have a significant potential for physical and psychological dependence and misuse. Short-acting benzodiazepines include halazepam and triazolam, both with rapid onset of action; alprazolam, flunitrazepam, nitrazepam, lorazepam, and temazepam, with intermediate onset; and oxazepam, with slow onset. Profound anterograde amnesia (“blackout”) and paranoia have been reported with triazolam, as well as rebound insomnia and anxiety. Many clinicians have encountered particularly difficult problems on discontinuing treatment with alprazolam.

Long-acting benzodiazepines include diazepam (with the fastest onset of action), clorazepate (also fast onset), chlordiazepoxide (intermediate onset), flurazepam (slow onset), and prazepam (slowest onset). The long-acting benzo-diazepines may produce a cumulative disabling effect and are more likely than the short-acting agents to cause daytime sedation and motor impairment.

Even when benzodiazepines are taken in therapeutic doses, their abrupt discontinuation induces a withdrawal syndrome in up to 50% of people treated for 6 months or longer. Symptoms are more intense with shorter-acting preparations; with the long-acting benzodiazepines, withdrawal symptoms appear one or two weeks after discontinuation and last longer, but are less intense. As with other sedatives, a schedule of slow detoxification is necessary to avoid serious complications such as withdrawal seizures.

³⁷ The descriptions in this annex are from the WHO, Lexicon of alcohol and drug terms: http://www.who.int/substance_abuse/terminology/who_lexicon/en/, accessed 15 Aug 2011

Some benzodiazepines have been used in combination with other psycho-active substances to accentuate euphoria, e.g. 40-80 mg of diazepam taken shortly before or immediately after a daily maintenance dose of methadone.

Benzodiazepines are frequently misused in conjunction with alcohol or in opioid dependence. Fatal overdose is rare with any benzodiazepine unless it is taken concurrently with alcohol or other central nervous system depressants.

Cannabis

A generic term used to denote the several psychoactive preparations of the marijuana (hemp) plant, *Cannabis sativa*. They include marijuana leaf (in street jargon: grass, pot, dope, weed, or reefers), bhang, ganja, or hashish (derived from the resin of the flowering heads of the plant), and hashish oil.

In the 1961 Single Convention on Narcotic Drugs, cannabis is defined as “the flowering or fruiting tops of the cannabis plant (excluding the seeds and leaves when not accompanied by the tops) from which the resin has not been extracted”, while cannabis resin is “the separated resin, whether crude or purified, obtained from the cannabis plant”. The definitions are based on the traditional Indian terms of ganja (= cannabis) and charas (= resin). A third Indian term, bhang refers to the leaves. Cannabis oil (hashish oil, liquid cannabis, liquid hashish) is a concentrate of cannabis obtained by extraction, usually with a vegetable oil.

The term marijuana is of Mexican origin. Originally a term for cheap tobacco (occasionally mixed with cannabis), it has become a general term for cannabis leaves or cannabis in many countries. Hashish, once a general term for cannabis in eastern Mediterranean areas, is now applied to cannabis resin.

Cannabis contains at least 60 cannabinoids, several of which are biologically active. The most active constituent is 9-tetrahydrocannabinol (THC), and TH C and its metabolites can be detected in urine for several weeks after usage of cannabis (usually by smoking). Cannabis intoxication produces a feeling of euphoria, lightness of the limbs, and often social withdrawal. It impairs driving and the performance of other complex, skilled activities; it impairs immediate recall, attention span, reaction time, learning ability, motor co-ordination, depth perception, peripheral vision, time sense (the individual typically has a sensation of slowed time), and signal detection. Other signs of intoxication may include excessive anxiety, suspiciousness or paranoid ideas in some and euphoria or apathy in others, impaired judgment, conjunctival injection, increased appetite, dry mouth, and tachycardia. Cannabis is sometimes consumed with alcohol, a combination that is additive in its psychomotor effects.

There are reports of cannabis use precipitating a relapse in schizophrenia. Acute anxiety and panic states and acute delusional states have been reported with cannabis intoxication; they usually remit within several days. Cannabinoids are sometimes used therapeutically for glaucoma and to counteract nausea in cancer chemotherapy. Cannabinoid use disorders are included in the psychoactive substance use disorders in ICD-10 (classified in F12).

Cocaine

An alkaloid obtained from coca leaves or synthesized from ergonine or its derivatives. Cocaine hydrochloride was commonly used as a local anaesthetic in dentistry, ophthalmology, and ear, nose and throat surgery because its strong vasoconstrictor action helps to reduce local bleeding. Cocaine is a powerful central nervous system stimulant used non-medically to produce euphoria or wakefulness; repeated use produces dependence. Cocaine, or “coke”, is often sold as white, translucent, crystalline flakes or powder (“snuff”, “snow”), frequently adulterated with various sugars or local anaesthetics. The powder is sniffed (“snorted”) and produces effects within 1-3 minutes that last for about 30 minutes. Cocaine may be ingested orally, often with alcohol, and combined opioid and cocaine users are likely to inject it intravenously. “Freebasing” refers to increasing the potency of cocaine by extracting pure cocaine alkaloid (the free base) and inhaling the heated vapours through a cigarette or water pipe. An aqueous solution of the cocaine salt is mixed with an alkali (such as baking soda), and the free base is then extracted into an organic solvent such as ether or hexane. The procedure is dangerous because the mixture is explosive and highly flammable. A simpler procedure, which avoids use of organic solvents, consists of heating the cocaine salt with baking soda; this yields “crack”.

“Crack” or “rock” is alkaloidal (free base) cocaine, an amorphous compound that may contain crystals of sodium chloride. It is beige in color. “Crack” refers to the crackling sound made when the compound is heated. An intense “high” occurs 4-6 seconds after crack is inhaled; an early feeling of elation or the disappearance of anxiety is experienced, together with exaggerated feelings of confidence and self-esteem. There is also impairment of judgment, and the user is thus likely to undertake irresponsible, illegal, or dangerous activities without regard for the consequences. Speech is pressured and may become

disjointed and incoherent. Pleasurable effects last only 5-7 minutes, after which the mood rapidly descends into dysphoria, and the user is compelled to repeat the process in order to regain the exhilaration and euphoria of the “high”. Overdose appears to be more frequent with crack than with other forms of cocaine.

Repeated administration of cocaine, known as a “run”, is typically followed by the `crash` when use is discontinued. The `crash` may be viewed as a withdrawal syndrome in which elation gives way to apprehension, profound depression, sleepiness, and inertia.

Acute toxic reactions may occur in both the naïve experimenter and the chronic abuser of cocaine. They include a panic-like delirium, hyperpyrexia, hypertension (sometimes with subdural or subarachnoid hemorrhage), cardiac arrhythmias, myocardial infarction, cardiovascular collapse, seizures, status epilepticus, and death. Other neuropsychiatric sequelae include a psychotic syndrome with paranoid delusions, auditory and visual hallucinations, and ideas of reference. “Snow lights” is the term used to describe hallucinations or illusions resembling the twinkling of sunlight on snow crystals. Teratogenic effects have been described, including abnormalities of the urinary tract and limb deformities. Cocaine use disorders are among the psychoactive substance use disorders included in ICD-10 (classified in F14).

Ketamine

Ketamine is an anesthetic which has psychedelic and dissociative properties. It works by blocking one of the brain chemicals that usually makes it easier for nerve cells to transmit a signal. It produces a range of dose dependent effects including euphoria and stimulation at lower doses, physical relaxation, sensory distortion, hallucinations, numbing, loss of co-ordination, out of body sensations (the separation of mind and body), confusion, paranoia, nausea, anxiety, discomfort with the intensity of the experience which may be frightening, reduced breathing and loss of consciousness.

Psychological dependence may occur and chronic use can result in problems with memory, psychological wellbeing and concentration, delusions and problems with the bladder. The state produced by Ketamine, particularly at higher doses where dissociation and severe co-ordination impairment are experienced, may increase the risk to the user of accidents and falls.

Mushrooms (psilocybin)

A psychoactive drug that induces hallucinations or altered sensory experiences, commonly consumed in soup, tea, noodles, omelet.

Opiate

One of a group of alkaloids derived from the opium poppy (*Papaversomniferum*) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression. The term opiate excludes synthetic opioids. *See also:* opioid.

Opioid The generic term applied to alkaloids from the opium poppy (*Papaversomniferum*), their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma, and respiratory depression in high doses.

Opium alkaloids and their semi-synthetic derivatives include morphine, diacetylmorphine (diamorphine, heroin), hydromorphine, codeine, and oxycodone. Synthetic opioids include levorphanol, propoxyphene, fentanyl, methadone, pethidine (meperidine) and the agonist-antagonist pentazocine.

Endogenously occurring compounds with opioid actions include the endorphins and enkephalins(see opioid, endogenous). The most commonly used opioids (such as morphine, heroin, hydromorphine, methadone, and pethidine) bind preferentially to the u-receptors; they produce analgesia, mood changes (such as euphoria, which may change to apathy or dysphoria), respiratory depression, drowsiness, psychomotor retardation, slurred speech, impaired concentration or memory, and impaired judgment.

Over time, morphine and its analogues induce tolerance and neuroadaptive changes that are responsible for rebound hyperexcitability when the drug is withdrawn. The withdrawal syndrome includes craving, anxiety, dysphoria, yawning, sweating, piloerection (waves of gooseflesh), lacrimation, rhinorrhoea, insomnia, nausea or vomiting, diarrhoea, cramps, muscle aches,

and fever. With short-acting drugs such as morphine or heroin, withdrawal symptoms may appear within 8-12 hours of the last dose of the drug, reach a peak at 48-72 hours, and clear after 7-10 days. With longer-acting drugs such as methadone, onset of withdrawal symptoms may not occur until 1-3 days after the last dose; symptoms peak between the third and eighth day and may persist for several weeks, but are generally milder than those that follow morphine or heroin withdrawal after equivalent doses.

There are numerous physical sequelae of opioid use (principally as a result of the usual, intravenous, method of administration). They include hepatitis B, hepatitis C, human immunodeficiency virus infection, septicaemia, endocarditis, pneumonia and lung abscess, thrombophlebitis, and rhabdomyolysis. Psychological and social impairment, often reflecting the illicit nature of non-medical use of these drugs, is prominent.

- **Heroin and morphine**

Heroin and morphine (M.S Contin) are very similar drugs, both of which are used to treat pain, with clinical use of heroin less common than the use of morphine, and both of which are problematic drugs of abuse. They act on opioid receptors which are normally involved in pleasure and reward, and the body's own pain management system. Their effect is to slow down the signals in the brain. The effects they produce are very similar, and include euphoria, intense relaxation, pain loss, apathy, and reduced physical and mental arousal. These effects will differ in people suffering from pain, and are rapidly reduced as tolerance develops quickly, meaning higher intake of the drug is needed. Negative effects include dry mouth, constipation, loss of consciousness (some may consider this a positive effect), nausea and vomiting which can be fatal if the vomit blocks the airway or is inhaled and introduces infection into the lung, and reduce breathing which can be fatal. Overdose is also common and even non-fatal overdoses can have lasting effects on the brain and other organs due to the lack of oxygen during the overdose.

Heroin and morphine may be dangerous to unborn babies particularly at higher doses or with long-term use. However withdrawing from these opioids during pregnancy may also place the unborn baby at risk of injury or death. In cases of pregnancy in opioid users, medical help should be sought.

- **Oxycodone (OxyContin, Percacet)**

Oxycodone is a strong painkiller, although not as strong as morphine or heroin. It is commonly used medically to manage severe pain, and is also commonly used for non-medical purposes. It generally comes in pill form, which is often cleaned of the wax coating before being crushed for injection. The effects, side effects and overdose are similar to those of heroin or morphine. Injection of pharmaceutical pills can be dangerous due to the other filler agents in the tablets. For this reason it is essential to filter pills for injection. A syringe filter, or „wheel filter“ is desired if injecting any tablet (or powder), but a piece of cotton wool or clean cigarette filter is better than nothing. Oxycodone may be harmful to the unborn baby at high doses and should be avoided in pregnancy without medical supervision.

Annex 2: List of consulted organizations

Organization
<i>Ba Futuru</i>
<i>Becora Prison</i>
<i>Belun</i>
<i>Bureau of Prisons</i>
<i>Fundasaun Timor Harii (FTH)</i>
<i>Ministry of Health</i>
<i>Ministry of Justice</i>
<i>National Hospital</i>
<i>National Police Timor Leste (PNTL)</i>
<i>Office of the Prosecutor General</i>
<i>PRADET</i>
<i>Progressio</i>
<i>Sharis Haburas Comunidade (SHC)</i>
<i>UNMIT</i>
<i>WHO & UNAIDS</i>

Annex3: Consent form³⁸

My name is Gerard de Kort. I am working with UNFPA, Timor-Leste on a drug use assessment (see below for details). I am talking to people about drug use. Information you tell me will be used to write a report to plan services in the future. Your participation is anonymous and identifying information will not be reported in any way. Things that you have said may be reported as anonymous quotations, however you will never be identified at any stage after this interview.

I will ask you a number of questions about drug use and related issues. Some of the questions will be about illegal activities. Some of the questions will be about personal behaviors such as drug taking or sexual experience. I am interested in your experiences and opinions. There are no right or wrong answers. You are free to refuse to answer any questions.

You have been asked to participate because you have been recommended as someone who may have knowledge/experience about issues related to drug use. You will be compensated \$10 for your time.

You may withdraw your participation in the project at any time without consequences. The interview will last at most 60 minutes. If there are some important issues, we may ask to interview you again.

Signature of the interviewer that a verbal consent was obtained, and of the interviewee that \$10 was received.

Date: _____

Received \$10

Objectives

1. To provide an overview of drug use and injecting drug use among the identified sub population.
2. To identify factors that influence drug use and injecting drugs and in particular factors that may be encouraging or discouraging drug use.
3. To identify the awareness and perceptions about the different ways of using drugs among most at risk groups and people in prison.
4. To identify factors that influence the development of existing interventions (if any) and those that hinder or enable the development of interventions
5. To assess the nature and extent of drug use and injecting drug and how the patterns are changing over time (after independence in 2002)
6. To describe the social characteristics and location of injectors.
7. To ascertain the impact of social, economic and cultural situation in Timor-Leste to drug use and the public health and social implications and ramifications of drug use in the country.
8. To make recommendations for policy plan or programs on appropriate interventions and actions

³⁸Adjusted from: 2008, UNHCR, WHO, Rapid Assessment of alcohol and other substance use in conflict affected and displaced populations: a field guide, http://www.who.int/hac/network/unhcr_al_eng2.pdf, accessed 5 Aug 2011.

Annex 4: Interview guide³⁹ -persons who use(d) drugs or affected community members

[The verbal consent form is read and explained and consent is obtained prior to conducting the interview.]

Date:

Location:

Interviewer name: Gerard de Kort

Interpreter name:

Interviewee: Gender:

Number:

Start Time:

Thank you for agreeing to participate in this interview. Do you have any questions? Thank you, I would like to start now.

1. First I would like you to tell me a little bit about yourself: how old you are, where you come from, how long you have been here, how you earn money, who you live with, how far you went in school, and so on. These questions are for background information only.
 - a. Where do you live in?
 - b. Who do you live with? Are you married? Children?
 - c. How long have you lived here?
 - d. Where do you come from?
 - e. How old are you?
 - f. How do you earn money?
 - g. What is the highest grade of schooling that you completed?

2. Please tell me about drug use here **in this city** (not your personal drug use; in general).
 - a. What drugs are being used?
 - b. Per drug - What is the route of administration (e.g. swallow, chew, inhale, smoke, inject)?
 - c. Is it used alone or with others (specify, for example, sexual partner or the person providing the substance; always the same or does it change)?
 - d. Where is it used (home, bar, public space)?
 - e. When and how often is it used (time of day, day of the week)?
 - f. Who uses it?
 - g. Is it legal? Is its use approved of by the community?
 - h. How has its use changed since coming here?
 - i. Where does it come from?
 - j. How much does it cost?
 - k. What are the perceived benefits of its use for the community?

3. Is anyone injecting drugs?
 - a. Which drugs?
 - b. Who? (No names) Many people?
 - c. Have they always injected or switched towards injecting? (When?)
 - d. Why are they injecting?
 - e. Where do needles and syringes come from?
 - f. How are drugs prepared for injection?

³⁹Ibid.

- g. Are people sharing needles? Syringes? Other equipment?
 - h. Are needles and syringes reused? What happens to the needles and syringes after use?
4. Do you know of any benefits or problems associated with drug use?
 - a. Do you know of anyone in financial difficulties because of their drug use?
 - b. Do you know anyone who got injured or injured someone else while using drugs?
 - c. Do you know anyone who is dependent on drugs? How can you tell?
 5. Let's move to HIV and drug use
 - a. Is there a link between drugs and HIV transmission?
 - b. Do particular substances have more impact / stronger link than others?
 - c. Particular routes of administration?
 6. Do people you know ever have sex because of their drug use? (or vice versa) Can you explain?
 - a. When / Where does this happen?
 - b. Who do they have sex with (e.g. usual partner, a spouse, the person providing the substances, a stranger, a sex worker, or someone else)?
 - c. Do they use condoms or do they have safe sex when they have sex?
 - d. Do people you know ever exchange sex for substances?
 - e. Do people you know ever sell sex in order to buy drugs?
 7. Where or to whom do people go if they want help with problems from drugs?
 - a. What could be done to assist with problems linked to drug use?
 - b. What services should be provided?
 - c. By whom?
 8. Can you tell me about **your own** experience with drugs?
 - a. Have you yourself ever used any drugs? Which ones?
 - b. How old were you?
 - c. Are they grown or made locally?
 - d. How do you obtain them (no names)?
 - e. How much do they cost?
 - f. Does the location and price vary by time of day, season, etc? Are they always available?
 - g. Have you ever injected drugs? How often do you inject?
 - h. What made you switch to injecting use? How old at first time?
 - i. Who did the first injection?
 9. Can you describe to me the last time that you used (if applicable: injected) drugs?
 - a. When was it (date, time)? Where?
 - b. Who else was there (no names)? Did they use it too? How did you use it?
 - c. Where did it come from? How close to where you bought the substance did you use it?
 - d. If injected – where did the injecting equipment come from? Was it new? If not, how was it cleaned?
 - e. If other people were there, did they use the same equipment? How was the drug prepared? Communally or individually?
 10. What are the main reasons you use drugs?
 11. What is good about taking drugs?

12. How is your drug use related to your sex activity, if at all ('regular sex', MSM, sex work)?
 - a. Which came first? (i.e. sex work or drug use?)
 - b. Do you usually/often have sex under the influence of drugs?
 - c. Do you use a condom then, is it safe sex?

13. Have you ever experienced any problems from using drugs?
 - a. How does taking drugs affect the people you live with?
 - b. Do they take drugs as well?
 - c. Does it create conflict?

14. Have you ever gone to someone or somewhere for help with drug use?
 - a. Who or where?
 - b. For each service - what was good and what was not so good about the service?

15. Have you ever had an HIV test (I do not want to know the result)?
 - a. When? Where?
 - b. Did you receive counseling?
 - c. Was the result confidential?

16. In your opinion, what would help you to avoid problems related to drug use?

17. Is there anyone else who we should interview? (We are particularly interested in people with injecting drug use experience.)

18. Is there anything else you would like to tell me about drug use in this community?

19. I have no more questions. Do you have any questions for us?

Thank you very much for participating in the project and spending time being interviewed today.

End time: _____

Annex 5: Interview guide and answer sheet - persons who currently inject drugs⁴⁰

I. Interview and background information

- 01 Interview ID number
- 02 Project site: **Dili**
- 03 Interviewer
- 04 Date of interview
- 05 Where is the interview being carried out?
- 06 Age
- 07 Sex
- 08 Where were you born?
- 09 How long have you been living in the Dili area? Years
- 10 What is your attained level of education?
- 11 During the last 6 months what was your **main** source of money for you to live on?
- 12 Are you now living alone? (Who with?)
- 13 What is your current marital status? Living together?
- 14 During the last 6 months, where did you live most of the time?

I: Drug use

- 01 Which drugs do you know are currently available in Dili? (maybe better asked at later stage in interview)

Name of drug	Mode of administration	How many people you personally know that use it regularly?	Price

⁴⁰ Adjusted from questionnaire: 2000, WHO, Drug injecting study, Phase II, Questionnaire, [http://cedoc.cies.edu.ni/general/2nd_Generation%20\(D\)/Surveillance%20Guidelines/Substance%20use%20surveillance/WHOIDUstudyquest.pdf](http://cedoc.cies.edu.ni/general/2nd_Generation%20(D)/Surveillance%20Guidelines/Substance%20use%20surveillance/WHOIDUstudyquest.pdf), accessed 10 Aug 2011.

02 Let's go through your personal drug use. Which drugs have you used (in order of first use)? Note change of mode of administration of the same drug on new row.

	Name of drug	From Month / Year	Till Month / Year	Mode of admin
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

03 How old were you when you first drank any alcohol? (If ever)

04 How often did you drink alcohol in the last 3 months?

05 In a typical day, in the last 3 months, how many drinks did you **usually** have?

First injection

06 Conclude from above:

For example: So, the first time you injected you were __ years old. You injected < name of drug>, and you had not used that drug before in another manner?

07 The very first time you injected, who injected the drug into you? What was his/her relationship to you? What was the sex of that person?

08 That first time, did you inject with a **used** needle and/or syringe given, lent, rented, or sold to you by someone else (including your partner)?

09 When you shot up that very first time, was it in the Dili area?

10 In what type of place did you inject for the very first time?

11 The very first time you injected, how did you get your drug?

12 Why did you start injecting?

[Do not read out list. Write number if mentioned. Probe only with "anything else?"]

- 01 Type/quality of drug available inadequate for non-injection
- 02 I thought it would be a better high
- 03 My friends/companions were injecting and I wanted to try
- 04 Pressure from friends/companions

- 05 Worried about the health consequences of sniffing/snorting
 - 06 I was at a party and others were doing it
 - 07 Curiosity
 - 08 I was depressed
 - 09 Everyone was doing it
- 13 Before your first injection, did you think you'd just try it once or twice and then stop, or did you think you'd become a regular injector?
- 14 Before your first injection, did you know anyone who had severe problems as a result of injecting?
- 15 Before your first injection, did you know about HIV or AIDS?
- 16 Before your first injection, did you know anyone who had AIDS?
- 17 Before your first injection, did you worry about developing HIV or AIDS?
- 18 During the month or two before your very first injection, were most of your friends and companions drug users or not?
- 19 During the month or two before your first injection, among all of the drug users that you knew, were most of them injectors or were they non-injectors?

Development of drug injection

01 Now think about the month or two **after** your first injection compared with the month or two **before** your first injection. Would you say ...

[Read out each category in turn. Circle one response for each.]

	No	Yes	Ref	DK
1 You continued to see most of your old friends/companions from before?	0	1	8	9
2 You had more drug-using friends/companions than before?	0	1	8	9
3 You tended to see more of people who injected than before	0	1	8	9
4 You made new friends who had started injecting before you met them	0	1	8	9
5 You made new friends who started injecting at the same time or after you met them?	0	1	8	9

- 02 Have **you** ever initiated or introduced **anyone else** into injecting drugs?
- 03 How old were you when you started injecting at least once a week on a regular basis?
- 04 In your lifetime, about how many times have you injected drugs?
- 05 What is your primary method of taking drugs now? (check with above)
- 06 When did you last inject drugs?

Current injecting (Last three months)

- 01 In how many of the last 3 months did you inject drugs?
- 02 Did you have any injection-free months during the last 3 months? *Why?*

--	--	--	--	--	--	--	--

Now I am going to ask you some questions about specific drugs you have used in the last 3 months. For each drug mentioned, for the months in which you used it, I am going to ask separately about injected use and about non-injected use.

- 03 How often did you inject _____ [*name of drug*]? Others?
- 04 How often did you use _____ [*name of drug*] in a non-injected way? Others?

		03 Injected	04 Non-injected
1	Speedball (heroin & cocaine		
2	Heroin alone		
3	Cocaine alone		
4	Methamphetamine		
5			
6			

- 05 During the last 3 months, in an average month when you injected, how many days per week did you inject?
- 06 During the last 3 months, on an average day when you injected, how many times per day did you inject?

Times per day

II. Injecting behaviors

In the next section, I would like to ask you a few questions about how you injected drugs in the last 3 months (including any occasions when another person injected **you**). I am interested in the times you have injected with a **USED** needle and/or syringe, that is a needle and/or syringe that you thought someone else had already used.

01 When you injected in the last 3 months, how often was it with used needles and/or syringes given, lent, rented, or sold to you by someone else (including your partner)?

02 Of the times you injected with used needles and/or syringes in the last 6 months, how often did you (make an effort to) clean them?

03 From how many different people in total did you get used needles and/or syringes in the last 6 months?

04 In the last 6 months when you used needles and/or syringes given, lent, rented, or sold to you by someone else, how often did you clean them first?

05 In the last 6 months how did you **usually** clean needles and/or syringes that someone else had used (if at all)?

[Do not read out response options. Circle one response.]

Water	01
Boiling water	02
Soap or detergent	03
Bleach	04
Alcohol	05

06 Now I will read you a list of reasons why you might have shared needles and/or syringes in the last 6 months. Do any of these apply to you?

	No	Yes	N/A
1 Other drug injectors put pressure on me to share	0	1	8
2 I thought it was safe because I cleaned it	0	1	8
3 I am careful who I share with	0	1	8
4 I was in prison	0	1	8
5 I didn't have my own needles and/or syringes	0	1	8
6 Needles and/or syringes are hard to get	0	1	8
7 Needles and/or syringes are expensive	0	1	8
8 Any other: _____	0	1	8
9 Any other: _____	0	1	8

07 In the last 6 months, at any time did you inject with a pre-filled syringe? A pre-filled syringe is one that is filled with a drug solution before it is offered for sale.

08 In the last 6 months, at any time did you inject drugs using a syringe after someone else had squirted drugs into it from his/her **used** syringe (frontloading/back-loading/splitting)?

09 In the last 6 months, at any time did you share a cooker/vial/container, cotton/filter, or rinse water when you injected drugs?

10 In the last 6 months, at any time did you draw up your drug solution from a common solution shared by others?

- 11 In the last 3 months, at any time did you receive an injection from a "hit doctor"; i.e., a person to whom you paid money, drugs, or other goods or services to help you inject?

Now I would like to ask you a few questions about the times you have given, lent, rented, or sold your needles and/or syringes to someone else (not including when someone else injected you).

- 12 When you injected in the last 3 months, how often did you give, lend, rent, or sell to someone else a needle and/or syringe you had already used?
- 13 How many different people in total have you given, lent, rented, or sold used needles and/or syringes to in the last 3 months?
- 14 In the last 3 months, at any time did you help someone to inject for the very first time? How many people?
- 15 In the last 3 months, did you get **any** new and unused needles and/or syringes?
- 16 In the last 3 months, how did you get **new** and **unused** needles and/or syringes? Which source did you use most frequently?
- 17 In the last 3 months, did the police (authorities) ever confiscate any injecting equipment from you?

III. Last injecting event

Now think about the **last time** you injected drugs, and the people who were there at that time.

- 01 Can you remember the date you last injected drugs?
- 02 Where did you inject on that occasion?
- 03 How many other people injected drugs at that same time and place?

04 Describe the event:

- 01 Did you go out and get the drugs you injected?
- 02 Did you pay for the drugs you injected?
- 03 Did you prepare the drugs for injection?
- 04 Did you share a cooker?
- 05 Did you share cotton/filter?
- 06 Did you share rinse water?
- 07 Did you draw up drug solution from a common solution shared by others?
- 08 Were the drugs purchased in the form of a ready-to-use solution in a bottle?
- 09 Were the drugs purchased in a pre-filled syringe?
- 10 Did you inject with a needle and/or syringe that someone else had used first?

- 11 Did anyone (including a dealer) squirt drugs from their syringe into yours before you injected (frontloading/back-loading/splitting)?
- 12 Did you inject anyone?
- 13 Did anyone else use a syringe after you had squirted drugs into it from your syringe?

05 Did you share any of the following?

[Read out each item in turn. Circle one response for each.]

	No	Yes	Ref	DK
1 Cooker	0	1	8	9
2 Cotton/filter	0	1	8	9
3 Rinse water	0	1	8	9
4 Common drug solution from which you both drew up	0	1	8	9
5 Needle and/or syringe	0	1	8	9

06 Did either of you squirt drugs from his/her syringe into the other person's syringe before they injected (frontloading/back-loading/splitting?)*[if "yes"]* Who was the recipient?

Neither of us	0
The other person squirted drugs into my syringe	1
I squirted drugs into the other person's syringe	2
We both did it to each other	3
Refused	8
Don't know/remember	9

07 Who went out and got the drugs?

08 Who paid for the drugs?

09 Who prepared the drugs that you injected?

10 What did you do with the needle and syringe after you injected with it?

IV. AIDS knowledge and behavior

I would now like to ask you some questions about HIV and AIDS.

01 Have you ever heard of HIV or AIDS?

02 How often do you talk about HIV or AIDS with anyone? Who?

03 Now can you tell me all the ways that people can become infected with HIV?

04 What percent of people who are infected with HIV do you think will become seriously ill?

- 05 Since you first heard about HIV/AIDS have you done anything to avoid catching the virus yourself or to prevent someone else getting it from you?
- 06 Do you know any people who are infected with HIV or who have AIDS?

V. Medical history and service utilization

- 01 How would you describe your current health?
- 02 Do you suffer from any chronic diseases?
- 03 Have you ever been tested for the HIV virus?
- 04 Where did you get tested?
- 05 Voluntary, counseling, confidential, got result?
- 06 How long ago did you last receive any medical services? I'm talking about services intended to help you when you were sick or ill, or to check on your health.
- 07 Do you currently have difficulty getting medical treatment if you are sick or ill?
- 08 Can you get medical treatment if you need it?
- 09 Have you ever received any treatment intended to help you modify your drug use?
- 10 Do you currently have difficulty getting drug treatment if you need it?
- 11 Why can't you get drug treatment if you need it?
- 12 In the last 6 months how often have you had contact or involvement with any AIDS prevention activities?

VI. Overdose

Now I am going to ask you some questions about overdose on narcotics. Overdose means that someone lost consciousness or stopped breathing as a result of taking narcotics by injection or any other route of administration.

- 01 Have you ever been present when another person overdosed on narcotics to the point where they lost consciousness?
- 02 How many times has that happened?
- 03 Please think about the last time that happened. How long ago did that occur?
- 04 What did you and the others present do?
- 05 Have you known anyone who died of an overdose of narcotics? [If "yes"] How many people?
- 06 Have you ever overdosed on narcotics to the point where you lost consciousness?
- 07 How many times has that happened?
- 08 Please think about the last time you overdosed on narcotics. How long ago did that occur?
- 09 What narcotics or other substances had you *injected* on that occasion?
- 10 What narcotics or other substances had you used in *any non-injected* way on that occasion? This includes alcohol.
- 11 Were you alone the last time you overdosed on narcotics?
- 12 Did you receive help from anyone after the last time you had overdosed on narcotics?
- 13 If you were to seek medical help for an overdose of narcotics, do you believe that you would be treated well by people with the expertise to help you?
- 14 If you were to seek medical help for an overdose of narcotics, do you believe that you would be reported to law enforcement authorities?

VI. Conclusion

Just a few more questions now.

01	Think ahead to about twelve months from now. Do you expect any change in any of the following? <i>[Read out each item in turn. Circle one response for each.]</i>		<i>No</i>	<i>Yes</i>	<i>Ref</i>
	1 Your primary mode of drug administration	0	1	8	
	2 Your level of drug consumption	0	1	8	
	3 Your employment status	0	1	8	
	4 Your main source of income	0	1	8	
	5 Your health status	0	1	8	

VII. Travel (OPTIONAL)

Now I would like to ask you some questions about the different places you have traveled to in the last two years and any drug injecting activity there.

- 01 Have you injected drugs outside this city area in the last two years?
- 02 In any of those places did you inject with needles and/or syringes given, lent, rented, or sold to you by people you met in those places?
- 03 In any of those places did you give, lend, rent, or sell needles and/or syringes you had already used to people you met in those places?
- 04 In any of those places did you inject drugs using a syringe after someone you met in those places had squirted drugs into it from his/her syringe (frontloading, backloading, or splitting).
- 05 In any of those places did you share cookers, cotton, rinse water, or other injection paraphernalia with people you met in those places?
- 06 In any of those places did you draw up a drug solution from a common solution shared by other people you met in those places?
- 07 In any of those places did you have sex with anyone you met in those places?

VIII. Drug roles (OPTIONAL)

Now think back over the last 3-month period. In the last 6 months have you engaged in any of the following activities ***in order to get money, drugs, or other goods or services?***

- 01 Have you sold drugs, or been part of a drug-selling operation in exchange for money, drugs, or other goods or services?
- 02 Have you sold needles and/or syringes in exchange for money, drugs, or other goods or services?
- 03 Have you been paid money, drugs, or other goods or services by people to help them inject ("hit doctor")?
- 04 Have you owned or operated a place where people could inject drugs in exchange for money, drugs, or other goods or services?
- 05 Have you let sex traders bring clients to a room, car, or other space you control, in exchange for money, drugs, or other goods or services?
- 06 Have you provided clients for a man or woman who sells sex in exchange for money, drugs, or other goods or services?
- 07 Have you acted as a lookout for a sex trader (to warn when the police are coming) in exchange for money, drugs, or other goods or services?
- 08 Have you provided physical protection for a man or woman who sells sex (acted as a guard for a sex trader) in exchange for money, drugs, or other goods or services?



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