ANNEXES:

ANNEX 1:
LITERATURE REVIEW

ROOT CAUSES OF ILLICIT DRUG AND ALCOHOL PROBLEMS IN MINORITY COMMUNITIES IN NORTHERN THAILAND, AND THE SHAN STATE OF MYANMAR

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1. INTRODUCTION

"The government's development projects are not in accordance with the ethnic peoples' way of life. The government doesn't understand their ways, and they don't even want to know. They use the hill-tribes to sell and lure tourists and then turn around and blame them for the country's drug and environmental problems."

(Ahpae Mafoe, Akha IMPECT representative quoted in Irrawaddy online, 2003)

Ethnic minorities, living mostly in the mountainous peripheries of countries in the Golden Triangle region (comprising parts of northern Thailand, northwestern Laos and northeastern Burma) have had a long and troubled association with illicit drugs. In Thailand, ethnic minorities (often called 'hilltribes') have become 'identified with a negative stereotype of forest destroying, opium cultivating, dangerous foreign troublemakers' (Buergin, 2003: 382). These groups were originally associated with opium production to fuel foreign opium wars, and involvement with communist insurgency (and therefore labeled as a 'security problem') during the Cold War period last century. More recently, these groups have been portrayed as the predominant cause of deforestation in Thailand, being clearly referred to in the 1985 National Forest Policy as the 'forest degradation problem' (ibid: 384).

Today, a common perception persists that ethnic minorities are largely responsible for the growing scourge of drugs in the Golden Triangle. The geographic proximity of these ethnic groups to drug production – particularly the Wa ethnic group in Shan State - provides the primary rationale for this blame: 'It is the grave misfortune of upland communities that they are located along trafficking routes of the opium grown in the Shan hills and the heroin and amphetamines processed in factories lining the Burmese side of the border' (Rutherford, 2003: 11).

Stereotyped racial attitudes towards minority peoples are common, and ethnic minority groups 'are blamed in general, fuzzy terms. In the eyes of many officials, these people are all dirty and ignorant' (Pers. Comm., Kampe, 2006). This blame seems to be based largely on stereotypes which are a product of labeling that has been occurring since early last century (Islam, 2003). Traditionally, certain hilltribe groups (such as the Lahu and Akha) cultivated and utilized opium in limited amounts for medicinal and recreational uses. Following international pressure from the US and Europe in the late 1950s, Thailand banned the production of opium. Unfortunately, because of their 'cultural affinity' with the crop, hilltribes provided a convenient image for others (including officials and those who profited from the drug trade) to label as been solely responsible for the opium problem in Thailand and beyond.

The perception of hilltribes as being 'more responsible' than other groups for the drug problem seems particularly entrenched in the government agencies responsible for dealing with illicit drugs, an Office of Narcotic Control Board (ONCB) official saying: 'I admit that government officials have prejudice towards the hill tribes and it is a problem that we all have to solve' (Pers. Comm., Pittaya, 2006). In Shan State, the media attributes 80% of the country's opium production on the ethnic groups living in the Wa-controlled areas (Milsom, 2005).

The truth, however, is that the vast majority of ethnic Wa are poor hill farmers, and as such do not profit from amphetamine-type stimulants (ATS) production. Most ethnic people in the Golden Triangle, then, find themselves to be pawns in a much larger game of illicit drug production and trafficking that is controlled by organized crime groups. Such groups include

paramilitary organizations in Myanmar, the police and military from both sides of the Thai / Myanmar border, and transnational crime syndicates and trafficking networks that operate in Asia and throughout the world.

While there is no doubt that people from hilltribe communities in the Golden Triangle continue to play roles as mules and small time dealers in the Golden Triangle, the clearest legacy from the involvement of ethnic minorities is a growing number of part -time users and more serious addicts. Many believe that the social and health problems as a result of illicit drugs are threatening to overwhelm some communities.

While a great deal of research on drug use (mainly opium) took place during the period of opium eradication and crop substitution in Thailand during the 1970s-early 1990s, comparatively little research has taken place since these projects and associated funding came to an end. Developing a picture about illicit drug problems in the Shan State has always been difficult due to the ongoing political problems in the country. In the meantime, the drug landscape has clearly shifted to other drugs and new problems, and the trends occurring in upland communities appear to have received little research attention. This report seeks to establish a more contemporary picture of illicit drug problems in upland communities in Thailand and the Shan State, thereby addressing a potential gap in the contemporary literature. The specific aims of this study are twofold: first, to examine the root causes of illicit drug-related problems affecting ethnic minority people and their communities in northern Thailand, and Kachin State and northern Shan State in Myanmar; second, to compose a list of best and worst practices in addressing problems with illegal drugs and alcohol, including a critique of policy and approaches in Thailand and Myanmar.

2. METHODOLOGY

This study has adopted both qualitative and quantitative methods of data collection through literature research and interviews with various experts dealing with illicit drugs and alcohol in the golden triangle region. Both English language and Thai language sources were reviewed, though Burmese or other languages (such as Shan) were not reviewed. The research team handled the English language and Thai language components. The findings from these two parallel research processes were discussed in detail between the research team as the basis for the final report.

The primary method of gathering and collating information has been through internet-based documentary sources (i.e., located on the world-wide Web). This involved searching the web sites of key organizations related to this study (e.g. UNODC, Asian Harm Reduction Network), using combinations of keyword searches in the Google internet search engine (e.g., drugs, Thailand, Myanmar, Shan State, hilltribes, minorities, alcohol, heroin, *ya baa*, HIV, human rights etc), and accessing expanded academic databases and online journals. A number of hard copy publications on illicit drugs in Thailand and Myanmar, which were borrowed from colleagues in Chiang Mai and Bangkok, were also reviewed. While a wider literature undoubtedly exists, time and resource constraints have limited the amount of literature that can be collected (so, for instance, hard copy publications from organizations working on drugs in other cities and provinces were inaccessible).

A number of interviews were conducted with experts April - May 2006. These interviews involved one or two interviewers with single respondents, based mostly on a set of pre-drafted interview questions that were tailored to the specific experience of the respondent. The format of the interview allowed an easy-going exploration of topics and did not require

strict adherence to the set questions. The interview approach sought to sample a representative range of experts from different disciplines, including development organizations, independent experts based inside and outside the region, and research and media organizations, particularly those who have been involved working with communities and individuals involved with illicit drugs in northern Thailand and Shan State. A list of interviews, and a sample list of select interview questions, can be found in Appendix 1.

Regarding the objectivity and accuracy of information and data regarding particular aspects of this study or geographic areas - particularly Shan State and Myanmar - the reader should note the following observation from Milsom (2005: 61-62) that: 'it is important to bear in mind how difficult it has become to address the drug issue objectively in this part of the world. Past conflict within Myanmar, conflict between ethnic groups, the hazy line between legitimate interests and illegitimate interests, and the selective use of information for pursuit of a particular cause, combined with limited access and security problems make it difficult to conduct any systematic study'. In the production of this report, the authors have gone to great lengths to present and analyse evidence from different perspectives, without stating definitive points of view. Readers are encouraged to weigh the evidence and ultimately reach their own conclusions.

The Thai literature review has been included as a stand-alone document at Appendix 2. Reference has been made to aspects of this Thai review within the main body of this report. An annotated Thai bibliography is in Appendix 3. A short analysis of major organisations working on illicit drugs in Thailand and Shan State is in Appendix 4.

3. BACKGROUND

3.1 CHANGING TRENDS IN DRUG PRODUCTION AND USE

Understanding the changing nature of drug production and use provides important context for later discussions on root causes of drug problems in upland/ethnic areas, and the policies that have arisen in response. The most significant trend is the domination of ATS in the Golden Triangle region since the mid -1990s. Following the mainly US / UN funded opium eradication and crop substitution programs of the 1970s and 80s in Thailand (and eradication of opium in Iran and Pakistan), the region saw an escalation in the production and use of heroin. 'The unintended consequence of this "successful" supply-side strategy', says Lyttleton and Cohen (2003: 86) 'was a switch to the consumption, mainly by injecting, of heroin, in highland communities in northern Thailand'.

While Methamphetamines (also called ATS, or *ya baa* in Thailand) have been available since the 1970s, it was not until the mid 1990s that the production and use of these drugs exploded in the Golden Triangle region, expanding its consumer base 'amongst urban and rural youth, students, laborers, sex workers, farmers and fishermen' (Lyttleton and Cohen, 2003). ATS use is said to have skyrocketed, and between 1993 and 2001, use apparently increased by over 1000% (Reid and Costigan, 2002: 211). Roberts et al (2004) cite four main reasons for this:

1. The disruption of the heroin trade resulting from the capture of the notorious Burmese heroin trader Khun Sa, and the resultant switch to investment for manufacture of other drugs

2. The economic crisis which put 2 million people out of work, leaving many vulnerable to being recruited into the drug trade

3. Marketing strategies – pyramid selling as a way of users paying for their drugs has proven a highly effective way of expanding the market

4. ATS profitability compared with other drugs- they are cheap and easy to produce and give very high rates of return.

Alternatively, Lyttleton and Cohen (2003) see ATS as a clear reflection of changing value systems fostered by particular development trajectories on which Golden Triangle countries have embarked.

These reasons will be discussed in greater detail in Section 4 of this report.

3.2 DRUG USE IN ETHNIC COMMUNITIES OF THAILAND AND SHAN STATE

The availability of information regarding illicit drug use in Thailand is significantly better than Myanmar. In Thailand, current estimates of all 'drug users' (estimates rarely distinguish between real addicts and occasional drug users) range as high as three million or possibly 5% of the population. Official estimates are that 300,000 people are hardcore *ya baa* addicts (BP, 9/2/2003). Office of Narcotic Control Board (ONCB) figures (cited in Reid and Costigan, 2002) break down drug use in Thailand as: Methamphetamines 75%, heroin 10%, and others 15% (including opium, marijuana, solvents, ecstasy and ketamine). While not debating that there is a widespread problem with illicit drug use in Myanmar and Thailand, some have queried the sense of crisis the government has promoted over illicit drugs, particularly the common portrayal of a nation of *ya baa* 'addicts'. Phongpaichit and Baker (2004: 160), for instance, attempt to bring a sense of perspective about the levels of *ya baa* use, quoting the ONCB that 'around 2 million people [in Thailand] had some experience of *ya baa*, and around 400,000 took it once a month'.

There is a general perception that opium and heroin are more prevalent in upland communities, while *ya baa* is more of a problem in lowland communities (particularly urban areas). For instance, 'data from the Northern Drug Dependence Treatment Centre shows that amongst patient admissions, 39% from the lowlands use *ya baa* compared to 3% among the hill tribe residents where opium and heroin remain popular' (Reid and Costigan, 2002: 211). However, other evidence points to an increased use of ATS in ethnic minority areas, and that these communities are increasingly using combinations of heroin and ATS. A number of respondents working in the field (Pers. Comm, Thomson, Kampe, 2006) said that *ya baa* was the number one drug being used in these communities. Peak (2000) quotes the findings of the Hilltribe Education Centre working in 38 villages in Chiang Rai Province (which has the highest levels of drug use of any Province in Thailand), that those over 35 generally smoke opium, and those under 35 generally 'chase' *ya baa* (smoke it), but not inject. Opium and heroin are considered to still be the primary drugs used in Akha communities (ibid). Using combinations of drugs (and alcohol) is also common. Jansiri for instance, reported villagers using *ya baa* and heroin, as the former makes one 'manic' while the latter evens out the mood of the user.

Myanmar remains the world's second largest producer of opium, and the majority of this is grown in the highland areas of the Shan state. Estimates of drug users are between 300,000-500,000, with between 150,000-250,000 of these being injecting drug users - IDUs (Reid and Costigan, 2002:148). HIV incidence in IDUs is one of the highest in the world, with an average of 63%, and some states as high as 90% (ibid). Poor, predominantly ethnic minority farmers grow opium poppies on a small scale, and it is estimated that between 250,000- 300,000 households depend on opium production to supplement marginal subsistence-based livelihoods (Jelsma et al, 2005). In reality, most farmers cultivate opium to offset annual rice deficits, and sell to middlemen in the village to buy rice, clothing and medicine (Milsom, 2005). Opium and heroin are now serious problems in Shan State, and drug use has tended to follow production and supply routes. The high rates of injected heroin use (and extremely high rates of HIV infection) are well known in mining communities in eastern Myanmar.

The extent of *ya baa* use and rates of addiction are largely unknown in Myanmar, and even the UNODC in Rangoon admit they have little idea of the scale of ATS use (Chouvy and Meissonnier, 2004). A decade ago, there was limited knowledge about ATS amongst the Wa, and ATS was marketed and sold by Asian businessmen as an energy pill, in a similar way that energy drinks such as Red Bull have been marketed in Asia. It was only after a number of serious incidents (e.g. psychotic episodes, murders and suicides) that the danger of the drug was realised (Milsom, 2005). There is anecdotal evidence that use is frighteningly high. There are reports of the common practice of the 'polite host' of any Shan household offering ATS pills to guests along with tea, and in some areas, farm workers being paid in ATS pills instead of money (SHAN, 2005). SHAN also reports that ATS is usually smoked rather than swallowed (ibid).

Anecdotal evidence is that the effects of opium addiction on people in opium-growing areas are serious. One expert working on a UNODC alternative development project in Shan State stated that an average of 15% of villagers in certain areas have addiction problems – usually male household heads who become incapacitated by opium addiction, and no longer work. The knock-on effects of the loss of a wage earner, combined with trying to finance the continuing addiction, has led to serious poverty and growing instances of domestic violence. This expert identified these issues as an area requiring critical attention for further research (Pers. Comm., Renard, 2006).

It should be emphasized that statistics on the use of drugs in minority communities in Myanmar were not found in the literature, forming a considerable gap in knowledge for any organizations that may wish to work with these groups.

3.3 ALCOHOL ABUSE IN ETHNIC COMMUNITIES IN THAILAND AND SHAN STATE

While not considered to be illicit, alcohol has been identified as a serious public health problem in Thailand, and according to figures by the FAO (1999), Thailand ranks as the fifth highest consumer of alcohol in the world (Globe, 2006). One interviewee, who has worked on drugs in the Golden Triangle region for 30 years, viewed alcohol as a much more serious issue in highland communities (in Thailand) than drug addiction, stating 'it's something that has been seriously overlooked' (Pers Comm. Kampe, 2006). Yet despite these facts, there is a surprising lack of literature or research (in Thai or English) on alcohol abuse amongst ethnic minorities in the Golden Triangle (this gap in the literature was confirmed during interviews). One Thai research institution commented in their annual report that: 'The need

for research and intervention on alcoholic related problems is becoming apparent as indicated from the rapid increase in consumption statistics from national surveys and other studies' (Chulalongkorn University Annual Report, 2004: 19).

The few references to alcohol in upland communities discuss this in the context of illicit drug use. In a general discussion of global indigenous health issues, one source (Infocus, 1999) states that: 'Alcohol abuse is a serious health problem among indigenous groups in the Americas and, in Thailand, hill tribe groups have high rates of opium and heroin abuse'. While this statement is clearly a general one, it is interesting to note the general underlying perception that the dominant public health/abuse issue in ethnic communities in Thailand is drugs, and because of this, an examination of the impact, and extent of alcohol abuse, in these communities has perhaps been largely ignored. The one instance of research (Barrett, 2003) that examines the relationship between alcohol and drugs in upland villages (in a sample of 31 villages) came to a number of interesting conclusions, namely: that almost all villages contained alcoholics or had problems with alcohol; that there is a correlation between high drug use in villages and higher instances of alcohol abuse' [which] suggests that villagers that are susceptible to illicit drug use also may be susceptible to other substance misuse behaviors and possibly for similar reasons' (ibid: 1634); that drug addicts tended to abuse alcohol when drugs were not available; and that 'drugs were considered to come from outside, while alcohol was considered to be a problem within the village' (ibid: 1642). A study of six highland villages by Rutherford et al (2005: 42) mentions that home brewed alcohol is popular, but that 'these vices pale in comparison to the scourge of opium'.

3.4 GOVERNMENT POLICIES TOWARDS DRUGS AND HIGHLAND COMMUNITIES

The general approach to dealing with illicit drug problems in the Golden Triangle has been summarized by one commentator as: 'Demand reduction and prevention of drug use [which] has tended to focus on extreme deterrence, coupled with large-scale abstinence and 'healthy living' initiatives, often with a heavy emphasis on religion, morality, and victim blaming' (Townsend and Garrow, 2004: 58). The opium eradication and crop substitution programs in the 70s and 80s in Thailand that were aimed specifically at ethnic highland groups,are now being repeated in Myanmar. These programs have yet to be properly assessed. While excellent histories of drug policies and programs in Thailand (eg, Renard, 2001) and Myanmar (e.g. Jelsma et al, 2005, Gibson and Haseman, 2003, Renard, 1996) are available, this section will focus on more contemporary drug policies in both countries.

3.4.1 THAILAND

In Thailand, there are a number of government bodies concerned with drugs including the Office of Narcotics Control Board (ONCB), whose mandate concerns all aspects of illicit drugs. They work jointly with the Ministry of Public Health on demand and supply reduction. The Food and Drug Administration handles development of laws and regulations, while the police and various parts of the military (such as the *Thahan Phran*, or paramilitary border guards) play strong roles in law enforcement and suppression activities. The Department of Medical Service is responsible for all aspects of treatment and rehabilitation. The Communicable Disease Center is responsible for all HIV/AIDS cases related to drug use. The Ministry of Education institutes AIDS prevention activities and other public education. All these organizations are separate entities, and many exist at the provincial and even district level (Peak, 2000). It is unclear how effectively these different bodies work together. More recently, the Ministry of the Interior launched a program aimed

at drug-free villages, 'in contradiction to harm reduction approaches…[which]…further exacerbates policy contradictions' (ibid).

Drug control (covering illicit drugs and the chemicals used to make them) in Thailand is covered under an umbrella of different laws, including: *The Narcotics Control Act 1976* (related to the power and duty of officials responsible for controlling narcotics), *The Narcotics Act 1979* (the Law on drugs), *Psychotropic Substances Act 1975*, *Emergency Decree on Controlling the Use of Volatile Substances 1990*, *Commodity Control Act 1992*. An additional suite of laws pertain to what are defined as 'special measures', and include: *Act for Measures for the Suppression of Offender in an Offence Relating to Narcotics 1991*, *Narcotics Rehabilitation Act 2002*, *Money Laundering Control Act 1999*, *Mutual Legal Assistant in Criminal Matters 1992*, *Extradition Act 1929* (ONCB Website, 2006). In addition, the 9th (current) National Economic and Social Development Plan B.E. 2545 - 2549 (2002 - 2006) has been deliberately designed to facilitate and mobilize all drug control measures.

3.4.2 THE THAI WAR ON DRUGS

The high profile war on drugs during 2003 has been the most prominent drug policy in Thailand in recent times. Despite the fact that the ONCB can provide no evidence that drug problems are worsening, the Thai Prime Minister recently put the war on drugs back on the agenda, and the outcome of this new phase is yet to be seen (Nation, 26/5/2006). The original 'war' has been both widely praised and condemned. It was an exercise initiated by the administration of then-Prime Minister Thaksin Shinawatra in response to a staggering increase in the use and supply of methamphetamines aimed 'to achieve a massive reduction in use and availability' within four months (Roberts et al, 2004). The Thai Government took an uncompromising stance towards alleged 'drug dealers' (a term not commonly defined during the war), the Interior Minister at the time stating that traffickers would be 'put behind bars or vanish without trace'. The number of people killed during the war from 1 February – 30 April 2003 varies through different accounts, but ranges between official figures of 2245 to 2700 (ibid). Tens of thousands more have also been arrested, jailed, or put through compulsory treatment programs.

Being located along well-recognized drug distribution networks leading from Myanmar, hilltribe communities and individuals came under particular scrutiny during the war on drugs. While no precise figures were kept on the number of ethnic people killed during the war, regular newspaper articles (eg, 'ethnic villagers live in fear as killings continue' Bangkok Post, 3/3/03) leave readers with little doubt about where the Thai authorities believe drugs in Thailand are traveling on their way from Myanmar. In addition, major newspapers produced regular articles that specifically singled out hilltribe people as being either arrested, surrendering or submitting themselves for rehabilitation. For example: '100 Akha tribes people have agreed to undergo drug rehabilitation' (BP, 2/18/03), '650 Hmong people arrested in Tak Province' (BP, 2/15/03). 'In Tak, 300 Hmong tribes people, drug users and dealers, surrendered to Mae Sot police on Friday' (BP, 2/16/03).

Some see the war on drugs as specifically targeting hilltribe people 'for harassment, arrest, and even extra-judicial killing, [which] has further stigmatized the hill tribes and greatly increased their insecurity (Physicians for Human Rights, 2004: 2), and that 'this [war on drugs] is widely believed to have been a vehicle for the police to intimidate highland people, activists, and others' (ibid). Few could deny that long-entrenched stereotyped attitudes towards minorities were evident during the war. In Tak Province, the local district administration even threatened that the Thai government would 'scrap the citizenship of

tribal people linked to drugs' (BP, 2/15/03), and that the government would take action against those considered to be 'posing a national security threat.'

The perception of the success of the war on drugs varies markedly. The campaign itself was highly popular amongst Thai society more generally, with some polls showing 90% in favor of the campaign (Phongpaichit and Baker, 2004). While there was a dramatic decrease in methamphetamines, commentators reported that addicts changed to other cheaper alternatives (eg paint thinner, glue), and that the *ya baa* industry may in fact have become more profitable. As Phongpaichit (quoted in Roberts et al, 2003) points out: 'It seems to me as an economist that, if you attack the supply but do little about the demand, then the result is rising prices, rising profitability, and hence increased entrepreneurship'. She continues: 'I suspect that is why such suppression-oriented approaches have persistently failed in other countries'.

Critics (such as Roberts et al, 2004, Human Rights Watch, 2004), point to other failures, including violence and corruption. This violence could include extra-judicial killings which some alleged were simply a way for gangs to eliminate their business rivals, or were a way of settling local disputes unrelated to drugs. There was also a failure of treatment: Many who were forced into treatment were not even drug addicts (and enrolled only to avoid persecution or execution), while many genuine addicts went into hiding and did not access services, thus exacerbating the spread of HIV. (Figures from the northern drug treatment centre say that attendance by addicts went down by about 80% following the war on drugs). Crime increased as addicts had to find new ways to finance a more expensive habit. Addicts switched to new, more dangerous drugs. In many instances, the head of the household, or chief breadwinner, was killed leaving many families without income.

It is interesting to note that following the Thai war on drugs, the glut of ATS pills remaining in Myanmar caused the price of ATS to halve (SHAN, 2005), perhaps fuelling increased rates of consumption there.

3.4.3 MYANMAR

The main body responsible for drug control in Myanmar is the Central Committee for Drug Abuse Control (CCDAC). The Ministry of Public Health is responsible for treatment and rehabilitation of drug addicts.

The main law covering illicit drugs in Myanmar is the *Narcotic Drugs and Psychotropic Substance Law 1973*, outlining suppression and prevention allowable under the law, as well as penalties (which can include the death sentence). Drug addiction is illegal in Myanmar, and users are legally obliged to register with the Ministry of Health or Government recognized medical centre for treatment. Those who do not register may face 3-5 years in prison under the Narcotics Act. Drug users must attend registration with their parents, where they are issued with a card that they must carry at all times.

Drug policies in Myanmar are, at best, open to very broad interpretation. While some see the Burmese authorities' own 'war on drugs' as having 'displayed good intentions over the last few years' (Chouvy and Meissonnier, 2004), others have labelled efforts as 'meaningless' (SHAN, 2005), pointing to tokenistic attempts at drug eradication and wide-scale involvement of the Government and military in the illicit drug trade. It is the contention of many that this involvement includes promotion of the drug trade as a matter of government policy (Gibson and Haseman, 2003). Following the surrender of the infamous Burmese drug lord Khun Sa, and since initiatives such as the 'National Plan Against the Drug Menace' in

1998, figures reveal that the amount of opium cultivated in Myanmar has decreased dramatically (e.g. UNODC, 2005, though these figures are disputed by some, who argue that surveyors are taken to areas where little opium is grown).

ATS is a very different story, however. Burmese authorities have shown less resolve in dealing with these drugs, pointing the finger at surrounding countries as being responsible for supplying precursor chemicals used to make ATS, and claiming that factories are extremely difficult to find in remote mountainous areas. Few would argue that little has been done on the Burmese side of the border to halt the production of ATS. Overall, there has been a large reduction in *visible* drug production and trafficking in northern Shan State, which many commentators see as being in response to heavy pressure from the Chinese, and the desire of the Wa leadership to engage in increased trade with China (Pers. Comm., Renard, 2006).

Two divergent approaches have developed in the international community about how to deal with illicit drugs in Myanmar (SHAN, 2005: 11). The first of these rationalizes that the only way to stop drugs will be through bringing peace and democracy to the country (see for example Gibson and Haseman, 2003). The 'other school of thought is attempting to work with the military government to improve law enforcement and implement development programs that will woo the populace away from involvement in the drug trade'. It seems clear that the latter school has prevailed.

In Shan State, the most significant drug policy in recent times was the commitment by the Wa leadership to make the State drug -free by 26 June 2005 (a policy that has clearly failed to reach this ambitious target). Commentators have debated the reasons behind this, but three factors stand out as likely. The first is the desire of local leaders to develop and become peaceful, in order to finally be accepted into the international community. Their moves to relocate drug production from along the Chinese border to improve trade relations are one example of this desire. The second reason is that the region has changed to become increasingly stable over time. No longer do large 'buffer zones' exist along national borders where drug production can continue unchecked, and Myanmar has increasingly received international pressure to address conflict and drug production, which in particular frequently spills over the Thai border. A final reason may be due to sustained international pressure (Milsom, 2005: 85-86).

To achieve reduction policies, the Wa leadership have embarked upon an alternative development program to compensate for lost livelihoods as opium is eradicated. However, development efforts in the Shan State by the Wa leadership, including roads, electricity, education and agricultural schemes to offset the loss of income for local people from opium cultivation 'have fallen short of meeting their goals', bringing food and economic security to perhaps 10% of the northern population of 300,000 (Milsom, 2005: 72). The 'New Destiny' Project which aimed at substituting a Chinese strain of rice for opium has been reported by SHAN (2005) as having 'failed in each locality'.

The impacts of the opium substitution programs on local people in opium growing areas has yet to be properly measured, but UNODC 'hopes to know by next year whether the impacts have been positive or negative' (Pers. Comm., Sanong, 2006). Two chief concerns were raised about the possible impacts: First, that in the absence of adequate development, people will have no means to survive (which may force local people to go back to growing drugs, or lead to an increase in drug production in other areas). A second major concern is the impact of the ban on human trafficking. There is currently no data being collected on the impact of this, and there has most likely been an increase in the movement of cheap

labor and sex workers from these areas (ibid). SHAN (2005) reports mass arrests and even extra-judicial killings of villagers breaking the ban, and there are also signs that economies in the area are shrinking and poverty is worsening now that opium money is drying up. Jelsma et al (2005: 12) predict that 'the impact of the opium bans is likely to be grave', citing statistics of mass migrations (including policies of forced relocation) that have occurred out of these areas already due to loss of income and associated impacts (reduced access to health care, decreased attendance in schools, and low food security – there are even reports of desperate people eating tree bark).

4. EXAMINING THE ROOT CAUSES OF DRUG PROBLEMS IN ETHNIC COMMUNITIES

4.1 INTRODUCTION TO THE GENERAL LITERATURE ABOUT DRUGS IN THE GOLDEN TRIANGLE

The explosion in ATS production and their use in the Golden Triangle region has meant that the majority of recent literature on illicit drugs in the region (both Thai and English) is dominated by consideration of these drugs, and in particular their impact on urban users - especially young people. While a great deal of attention has been given to production and trafficking of methamphetamines, particularly by UN agencies and the Thai Government (documents available on the UNODC and ONCB web sites are dominated by analyses of drug production and law enforcement efforts), most attention has been focused on the 'scourge' of *ya baa* on young people in schools, factories and urban areas. In the past ATS was seen as a useful drug used by 'truck drivers or fishermen working long grueling hours', and seen by employers and workers alike as a means to increase performance. Now, however, ATS is seen to appeal to 'all levels of Thai society' (Chouvy and Meissonnier, 2004). It has only been in the last five years that ATS has exploded into the 'school-age student population, the technical school / common laborer population who are in their early twenties' (Lewis, 2003: ix). The idea that 'drugs are killing our children' has been a common part of the rhetoric of government anti-drug policies, particularly during the recent war on drugs.

The complexity of the root causes of illicit drug and alcohol problems in upland communities are rarely encapsulated by individual publications, and there remain a number of gaps in the literature pertaining to specific aspects of drug problems in upland communities. Literature tends to mostly consider opium and heroin, and relatively little has been written regarding ATS in ethnic communities (though Lyttleton, 2004, has written an interesting paper that examines ATS use in Lao ethnic villages). Most analysis of illicit drug problems appears to focus on effect rather than cause, and where causes are identified, they are often reduced to simple reasons such as poverty, proximity to trafficking routes, or simple outcomes of development. While these reasons are all certainly valid ones, what's lacking are more holistic analyses that link these factors together. The complexity of determining causes of drug use in highland communities makes such analyses extremely difficult (though some effort has been made in a number of quantitative studies, for example Barrett, 2003, Crooker, 2002).

The following summary / analyses of the root causes of drug problems in upland communities in the Golden Triangle has been divided into headings for ease of reference. While much of the literature and interviews cite straightforward root causes of drug use (such as poverty), this research contends that a range of more complex socio-economic and cultural factors are also at play. As such, it should be understood that there is no easy way to

'itemize' reasons into a simple list. In reality, drug problems arise as a result of a complex mesh of interconnecting causes that commonly appear to be case-by-case specific. In the Thai literature review, this point was raised by local NGO workers in the field: that differentiation is important when looking at drug problems, and that not every community involved with drugs has the same degree, causes or effects from drugs (ONCB/UNDCP, 1992).

4.2 SIMPLE ROOT CAUSES OF ILLICIT DRUG PROBLEMS

The majority of explanations of why ethnic communities develop drug problems cite a number of relatively straightforward 'generic' factors as root causes. While these are undoubtedly important and significant, they form only part of the puzzle. These include:

4.2.1 POVERTY

Poverty is one of the most commonly cited causes of involvement with drugs in ethnic minority communities in both the Thai and English literature. Lyttleton (2004: 919), for instance, asserts that 'Continued drug use amongst highland populations emerges from the constant intersection of poverty and lack of access to services'. Poverty has been identified as the precursor for minority communities' involvement with cultivation, trafficking and use of illicit drugs for a number of reasons. In Shan state, it has been estimated that over 300,000 communities in upland areas grow opium poppies to supplement marginal subsistence-based livelihoods (Reid and Costigan, 2002). In many communities in Shan State and northern Thailand, acting as mules for drug traffickers, or direct involvement in distribution and sale of drugs, presents some of the only real opportunities for decent income (Pers. Comm., Renard, 2006). This is particularly the case where ethnic minorities in Thailand lack citizenship, and are unable to effectively participate in the formal labor sector:

> WE ARE BEING PROHIBITED TO FARM, BECAUSE WE CANNOT OWN LAND, BECAUSE WE ARE NOT CITIZENS. WE TRY TO DO AN HONEST JOB, BUT THOSE WHO HIRE US GIVE US LESS PAY AND MAKE US WORK HARDER BECAUSE WE HAVE NO THAI CITIZENSHIP," SAID THE HMONG. SO WHAT CAN WE DO WHEN SOMEONE OFFERS US MONEY FOR SOMETHING THAT WE CAN EASILY DO? HOW CAN WE REFUSE SOMETHING THAT WILL HELP US EARN MONEY? OUR FAMILIES ARE HUNGRY. WE NEED TO BUY THINGS."

(Hmong villager, quoted in Bangkok Post, 6 June 1999)

> SOME COMMENTATORS POINT TO THE 1998 ASIAN ECONOMIC CRISIS AS A MAJOR CONTRIBUTOR TO INCREASING DRUG USE (THOUGH HOW MUCH THIS MAY HAVE AFFECTED ETHNIC MINORITIES IN THAILAND IS UNCLEAR). IT WAS ESTIMATED THAT UNEMPLOYMENT INCREASED BY ALMOST ONE MILLION AFTER THE CRISIS, THAT OVER 1.5 MILLION PEOPLE ARE STILL UNEMPLOYED, AND 'IT IS ASSUMED THAT THESE

> PEOPLE ARE MOST VULNERABLE TO DRUG ABUSE AND DEALING'

(UNODCa, 2003: 14).

Others, however, have argued against this contention of poverty. Barrett's (2003) investigation on drug use in Karen villages in northern Thailand raises arguments that it is dissatisfaction with life rather than poverty per se' that leads to increasing drug use in upland villages:

> 'THE PROBLEM NOW IN THE VILLAGES IS NOT POVERTY BUT DISSATISFACTION, LACK OF AWARENESS AMONG INDIVIDUALS, AND LACK OF COMMUNITY SPIRIT AND HARMONY. THIS HAS LED TO PROBLEMS SUCH AS DRUG USE (AND ADDICTION) AMONG YOUNGER PERSONS, EXCESSIVE COMPETITIVENESS, TAKING ADVANTAGE OF OTHERS, NOT SHOWING CARE AND CONCERN FOR OTHERS, AND NEGLECTING THE NEEDY'

(Karen Parish Priest, working with communities, quoted in Barrett, 2003: 1622).

The ideas raised above in Barrett's study are important, and examined in many of the following sections.

4.2.2 PROXIMITY TO DRUG TRAFFICKING ROUTES

Those communities located on drug trafficking routes are seen to be the most vulnerable to developing drug problems of small time dealing and addiction: 'Particularly in Asia it has been shown that addiction rates correlate highly with drug producing areas and trafficking routes' (UNODC, quoted in Korpi, undated: 1). This is one of the most commonly cited reasons in the English and Thai literature. In a study of heroin use in 15 upland villages in northern Thailand, Gebert and Kesmanee (1997), found that 'accident of location' – proximity to trafficking routes directly influences the number of addicts, and that there is an increased chance of villagers (including community leaders) becoming petty dealers, thus exacerbating drug use in the village.

While proximity is a relevant and obvious cause of drug problems in ethnic communities, it is interesting to note the findings of Barrett (2003), who compared groupings of Karen villages judged to have low and high levels of drug use. Despite the fact that all villages were located near trafficking routes, he found that there was no clear reason why one group of villages should have higher levels of drug use than the other, indicating that much more complex causal factors are also at work.

4.2.3 LOW EDUCATION LEVELS

Lack of education came across as a common theme particularly in the Thai literature. The reasons why low education would play a role in increased drug use is never explained clearly, however the stereotype of hilltribe people frequently portrays these groups as backward and uneducated. The real problem may be misinformation and lack of awareness (due to remoteness, lack of access to information materials, inability to read Thai etc) rather

than lack of education per se. Marketing of different drugs by dealers and businessmen must certainly have played a role in uptake of certain drugs such as ATS. In both Thailand and Burma, ATS has been marketed as energy pills, while in Laos, ATS use has become widespread in highland villages, as people were told that it would cure them of their opium addiction (Pers. Comm., Thomson, 2006).

4.3 COMPLEX ROOT CAUSES OF ILLICIT DRUG PROBLEMS

A range of more critical literature on illicit drugs, combined with particular interviews, reveals a suite of more complex factors that often defy simple causal explanations. It should be noted that these factors are most commonly discussed in the broad context of the development process, 'where drugs and development remain tandem facets of the fraught modernization trajectory taking place' Lyttleton (2004: 919). As the rubric of development does not provide an easy unit of analysis, the following breakdown of factors attempts to 'un-pack' specific causes that have arisen as ethnic communities continue to grapple with the rapid pace of socio-economic and political change in the region.

4.3.1 BROAD SOCIAL AND CULTURAL FACTORS

A commonly stated perspective is that systemic changes in the social/cultural fabric of ethnic communities, resulting from rapid development, are the primary causes behind increasing illicit drug use. Lyttleton (2003: 86) quotes a study by the Northern Drug Treatment Centre in 1994 which found that:

> The highest rates of drug addiction (especially heroin) were found to be in areas targeted for multi-sectoral development due to the shift to cash economies, increasing social fragmentation, increasing contact with lowlands and wage labor. This underscores the inexorable focus of mainstream development on economic growth and the resultant and observable decline of levels of social capital and community cohesion.

Barrett (2003: 1618-1619) outlines two primary factors as leading to increased levels of drug use in highland villages. The first of these is attributed to the weakening of social controls (social norms, socialization, institutions, rules and sanctions over drug use within the village), and cultural influences (values, moral beliefs, religion). The influence of these factors, which in the past appear to have helped contain drug use in highland communities, has been weakened through rapid socio-economic and cultural changes, which have coincided with development programs and policies over the last few decades. Supporting this conclusion, Gerbert and Kesmanee (1997) found that village cohesion and leadership are important factors in keeping drugs out of villages, particularly where formal and informal village organizations and leaders remained strong and drug-free, and were involved with anti-drug policies in the village.

The second major influence, says Barrett (2003), have been the processes of acculturation and socialization that upland communities have experienced through increasing interaction with outside cultures (such as Thai lowland and Western cultures) as a result of the development process. This has resulted in changes in the cultural values and behaviors of upland communities, and may lead villagers to adopt positive definitions of drug use from the mainstream culture – for pleasure, recreation, or psychological relief – leading to increased experimentation with drugs. Barrett stresses that conforming with the host Thai culture is by no means voluntary, and is often a forced process to 'comply with Thai laws

and regulations regarding their rights to land, citizenship, adoption of Thai language, selection of leaders, education of children, and legality of drug use' (ibid: 1618). As a result, ethnic groups may lose their sense of a positive ethnic identity, whereby 'the displacement of traditional ways of life with more modern ways could have far reaching influences in social organization, family relationships, culture symbols, religious beliefs, values, ideals, and behavioral norms' (ibid).

Barrett notes that, 'Further studies should be done to assess relationships between satisfaction with life and illicit drug use among villagers'. Interviews and some of the literature undertaken during the production of this report would seem to support Barrett's conclusions - that analysis of these more complex and difficult-to-measure social indicators could reveal some of the deeper causes of drug problems in upland communities. Further to his comment above (which may be of use to other researchers), Barrett adds: 'This study primarily used a quantitative survey approach, and perhaps it would have been more useful at this stage to use a participatory- styled, qualitative research approach to yield explanations based on the viewpoints of village residents' (ibid: 1645).

There has been little data gathered in Myanmar on these social/cultural aspects, yet investigation so far is revealing similar trends. Various authors have said that Laos and Myanmar tend to mirror Thai social trends with a 5-10 year lag. In a UNODC community–based, demand reduction project in northern Shan State, the project found that 'A lack of recreational facilities for the youth tends to favor the use of drugs' (UNODC, 2006).

4.3.2 INCREASING WAGE-BASED AND MIGRANT LABOUR

A number of authors have identified the important linkages between increasing levels of wage labor, migrant labor, and increasing drug use, particularly ATS[1]. While detailed quantitative studies of linkages between migrant labor and increasing drug use in rural villages do not appear to have been carried out, a number of implications have been identified.

Taking drugs such as opium, heroin and ATS to deal with the increasing hardships of work is a well established fact: 'The more an addict works the more s/he is in need of drugs for physical relief from the aches and pains caused by labour' (Gebert and Kesmanee, 1997: 375). This has been found to be the case with rapidly increasing ATS use, in particular, (Lyttleton, 2004; Bezziccheri, 2003) in factories or on fishing boats where ATS can help deal with increased physical labor, longer hours, or boredom.

The marginalized position of ethnic people (through lack of citizenship and stigmatization) also means that these workers are often forced to travel elsewhere, and accept worse working conditions for lower pay than ordinary Thai citizens: 'Migrant workers…work longer hours than the mandated 8 hours in the legislation, with the average workday between 10-14 hours. These long work hours are encouraging the use of drugs, particularly amphetamines, amongst migrant workers' (Migrant Labor Seminar, 2003: 56).

Gerbert and Kesmanee (1997), in a study of upland villages, found no explicitly quantifiable correlation between the number of villagers going to work in towns and the number of drug addicts in villages. However, they concluded that it may have three important implications. Those who were leaving the village were mostly young (early 20s), and were thus: more likely to make unwise decisions due to inexperience outside the village after living such

[1] Most research seems to have been carried out on ATS use in factories and schools – see for example Chouvy and Meissonnier, 2004.

sheltered lives; may adopt aspects of urban culture such as drug use; and may be lured into illegal activities.

Chouvy and Meissonnier (2004) expand upon these ideas. With increased rural/urban mobility, they say families are becoming increasingly itinerant in their work, particularly the movement of rural people to other provinces and urban areas. When drug habits are picked up through factory work, school etc (and there is ample evidence to say that a culture of ATS use has developed in many such places), then these are often brought back home to the village during visits throughout the year (such as important national holidays like Thai New Year). This increased mobility, says Chouvy and Meissonnier (ibid: 131) has led to an explosive increase in the use of ATS in rural villages: 'On returning home to their village, young urbanites are inclined to propagate drug habits among their rural counterparts. *Ya baa* takes root there all the more easily, because of rural youths' well known fascination with urban ways'. The influence of these processes on use of illicit drugs in ethnic villages is largely unknown.

4.3.3 NEW VALUES AND CONSUMERISM

While most of the critical literature points the finger at the rubric of development as the root of drug problems in upland communities, others see new patterns of consumption as the biggest problem. When confronted with the question about whether higher levels of development correlate with higher drug use in upland communities, Kampe (Pers. Comm., 2006) replied:

> No, not necessarily. You can see a correlation in both ways. Look at Australia, Europe and the US. They have lots of development, but also lots of drug problems. It is not necessarily development as such, but it is the changed patterns of consumption [in Thailand]. Before in communities [ethnic communities in Thailand] there was no drug abuse. But then the Government and international organizations came to these communities with a different vision, different dreams…The big problem is the one-sided and narrow-minded approach to development that if you have more money, then life will be better.

Lyttleton (2004: 915) supports this view. 'It can be argued that rapid ATS spread has both elevated and become symptomatic of commodity-based desire at new levels throughout mainland Southeast Asia. As ethnic communities find themselves increasingly acculturated into mainstream societies, they are exposed to the value systems of these societies'. In Thailand, the growth of a consumer culture over the last ten years is clear to see. 'People [from minority communities] get hooked on outside life. This is mainly youth who have led a very sheltered life in the village. They see all these consumer things and they want them, but they cost money' (Kampe, Pers. Comm., 2006). A wide literature exists examining the explosion in ATS due to its use 'by workers to perform longer hours' (Bezziccheri, 2003: 5). 'It's to do with a new need to consume – goods or drugs' said one respondent. 'You need to work, to earn more money, to consume more things, so you take more drugs [to help achieve this]' (Sanong, Pers. Comm., 2006).

4.3.4 PEER INFLUENCES

Peer influences are a well-recognised factor leading to new users taking drugs. Gebert and Kesmanee (1997: 378) documented many cases where peers have persuaded friends to experiment with drugs in the village. Others have noted that increased drug use in youth is

associated with a 'soft rebellious' stance commonly observed amongst Thai youth (Chouvy and Meissonnier, 2004: xii). There is little written on this in an ethnic context. An examination of the processes of experimentation and use of illicit drugs – particularly *ya baa* - by Thai adolescents is covered in Lirtmunlikaporn (2004).

4.3.5 DIMENSIONS RELATED TO AGE AND GENDER

Gerbert and Kesmanee (1997: 377) point out that as women in hilltribe (and other) communities are usually responsible for productive and reproductive functions, and these traditional responsibilities have 'prevented all but very old or ill women from becoming drug addicts, *even* when they lived in households with addicts'. However, increasing numbers of young women are becoming addicted to drugs due to 'a breakdown in family cohesion and increasing uncertainty of roles and relations of both men and women…in an extremely rapidly changing socio-economic system' (ibid), and that 'unfortunately, young women addicts…have turned to prostitution to support their addiction'. This same study also revealed that increasing numbers of unmarried males were also becoming addicts.

Examining the demographic distribution of drug use in communities, some researchers found certain trends about drug use in villages. Use by villagers over 60 years of age tends to be considered as traditional medicinal use, rather than recreation, escape or pleasure (Renard, 2001). There is a strong sense in the literature on drugs in the Golden Triangle that it is young people who are taking the majority of drugs (mostly ATS), and one might assume that this is also the case in minority communities. In one study in Karen villages in northern Thailand, for instance, Barrett (2003) found that the majority of heavier drug users were young males. While these trends are important to heed, it should be noted that since development projects ended in the late 1990s, there has not been a great deal of recent quantative data gathered on drug trends in ethnic minority villages (though see Barrett, 2003, Crooker, 2002). It should also be noted that very little is known about the demographic patterns of drug use in Shan State.

Baker (2000) analysed the correlation between drugs (primarily *ya baa*) and child prostitution in northern Thailand. While Baker states that there is a definite connection between *ya baa* and children selling their bodies, he also makes the point that opinions about the extent of this seemed to differ, particularly between the students (drug takers and potential prostitutes) and those who are outside this group, such as journalists and teachers. While there are instances of young girls selling themselves for sex to pay for *ya baa*, the students themselves (in a qualitative self-assessment carried out by Baker) saw drugs as one of the least contributing factors for entering prostitution (ranked 5th out of 5 factors). The only deviation from this was in Akha respondents, who said that the drug habits of parents was a strong motivating factor in children being sold into prostitution. In the end, Baker concludes that: 'The connection between the drugs and child prostitution needs further investigation. How many children are using the drug, how many are hooked, how many children are hooked and do not have money, and finally, how many children are actually selling their bodies in order to gain the drug? The answers to these questions are unknown' (pp. 18-19).

4.3.6 STRUCTURAL CAUSES OF DRUG PROBLEMS

While the previous reasons can be explained in relatively straightforward terms, there is a large category of causal factors that can lead to drug problems which cannot be so easily analyzed – particularly relating to the marginalised position of ethnic people within wider

societies. 'People don't think of the emotional dimensions of drug use – they see it as being in response to something obvious such as poverty' says Lyttleton (Pers. Comm., 2006). 'Concepts such as structural violence and social suffering have not being looked at'. He continues: 'How is a young ethnic guy going to react when he is working for almost nothing in a factory, [and he is positioned] at the bottom of the food chain [social order] – how does this contribute to the decisions he makes in taking drugs?'

Social suffering can be defined as 'the assemblage of human suffering that results from what political, economic and institutional power does to people, and human responses to social problems as they are influenced by these forms of power' (Kleinman et al, 1997). Structural violence refers to similar issues, and 'occurs whenever people are disadvantaged by political, legal, economic or cultural traditions. Because they are longstanding, structural inequities usually seem ordinary, the way things are and always have been' (Du Nan Winter and Leighton, 1999). Some of these kinds of issues pertaining to hilltribes and human rights are discussed in Rutherford (2003), but relating them more specifically to drugs would be a useful exercise.

4.4 LINKAGES TO DIAKONIA TARGET ISSUES

As the analysis above has already indicated, the linkages between Diakonia priority issues (such as HIV, human trafficking, human rights) are discussed in the literature, but to varying degrees. These linkages have long been acknowledged, for instance Djedje and Korff (undated: 11-12) write that 'it was realized at the end of the 1990s that illicit drug abuse needs to be understood in the context of other social and economic problems which both precede it and result from it, e.g. HIV/AIDS, commercial sex, labor trafficking, abuse of illicit drugs, crime'. Dirksen (2001) writes that 'any efforts to reduce demand must deal with the complicated linkages within these socio-economic practices…the context of drug abuse is a very holistic one and must be dealt with in a holistic, not simplistic, manner (Dirksen, 2001). The German Aid agency, GTZ (who have worked in highland areas in Thailand for almost 20 years) produced a report entitled 'Development Orientated Drug Control' (2004), which analyses some of these linkages identified through their activities around the globe. A simple diagrammatic representation of this can be seen in Table 1 below.

Development problems and drug problems are closely connected with one another		
Development problems		**Drug problems**
Poverty		High-risk drug use
Social exclusion		Drug addiction
Crises and conflict	⟷	Illegal drug production
Violence		Trafficking in illegal drugs
Corruption		Reduced economic and social capability
Crime		
Human rights abuse		Health deterioration/damage (e.g., HIV/AIDS)
Weakening of social structures		

Table 1: Source, GTZ (2004:11)

The most widely discussed and studied linkages regarding upland communities are undoubtedly between HIV/AIDS, injected drug use and commercial sex work. This is not surprising given that Thailand, Myanmar (and nearby Cambodia) have the highest rates of HIV infection of any country outside Africa (Eastern Horizons, 2003: 10). There has been significant study on this in upland communities in Thailand (eg, Razak et al, 2003) but much less in Myanmar (e.g., see SHAN, 2005). These linkages are commonly discussed in the context of harm reduction approaches, which appear to have been relatively successful in Thailand, and almost completely unsuccessful in Myanmar. Just like drug users, it is well recognized that people with AIDS are stigmatized in Thai society, which discourages many from disclosing their condition and seeking help, restricting their access to vital services and information (Elias, 2005).

Linkages between ATS use and HIV are just beginning to be established, and Peak (2000) states that 'research is critically needed to examine the mechanisms by which ATS use, or ATS and alcohol use combined, could lead to HIV infection'. It was revealed during one interview that the Research Institute for Health Sciences (RIHS - based at Chiang Mai University) has been carrying out such research for the past two years (Pers. Comm., Thomson, 2006). Results of this have mixed implications. While ATS users do not generally like to inject *ya baa*, and therefore may not prove to be a huge problem leading to new HIV infections, data in Chiang Mai has demonstrated a worrying trend of increased sexual behavior and unprotected sex amongst young *ya baa* users. These trends in upland villages are unknown (Per. Comm., Thomson, 2006). The gap in information on the social aspects surrounding *ya baa* use will be the focus of an upcoming regional project by RIHS (ibid).

Linkages between the marginalized position of ethnic communities in Thailand (lack of citizenship and land tenure) and the problems that arise as a result of this are well covered in the literature (e.g.). In terms of drugs, it is well recognized, for instance, that poverty and lack of access to education, health care or legitimate work opportunities have made ethnic communities vulnerable to 'various types of drug use and crime, HIV/AIDS…and brothel owners [who] have networks of agents combing the villages, seeking out troubled families caught in the cycle of debt with few options' (Eastern Horizons, 2005: 19). A range of literature discusses the implications of resource tenure over forests and water, but this is usually discussed in the context of human rights and natural resources management, and the precise linkages to illicit drugs are not elaborated upon.

Literature on human trafficking in northern Thailand and Shan state exists, but no linkages were discussed between drugs and human trafficking in any detail. While related literature speaks about the 'forced or coerced use of drugs and alcohol' of trafficked women (Berkhaulter, 2004: 2), publications such as *Driven Away*, (2004) examining the trafficking of women from Shan State into China, do not examine these linkages, nor other linkages such as the relationship between drug and human trafficking networks.

In summary, while it is generally known that there are strong linkages between drugs, human rights, HIV, human trafficking and poverty, this is rarely discussed in detail in the literature. There was not a single publication that was able to provide a holistic explanation of how these issues intersect, or how they become links in a chain of causality. The implication is that a very wide range of literature needs to be examined in order to understand these linkages properly. Kampe (Pers. Comm., 2006) provides a possible explanation for this situation:

> Issues tend to be compartmentalized. I don't think that anyone from the government or foreign [development] organizations has done anything about

> addressing this situation. They all know [about the linkages], but they have funding for their own specific interests [such as drug addiction or human trafficking]. Because of this, they have no incentive to examine these linkages.

Producing a logical, simply written document discussing these linkages would certainly be a worthwhile exercise.

5. DEALING WITH ILLICIT DRUGS IN THE GOLDEN TRIANGLE – SUCCESS OR FAILURE?

The general literature on approaches to solving illicit drug problems in the Golden Triangle is overall highly critical, and gives the perception that there have been many more failures than successes. Much has been written and criticized about past approaches to drug control in highland areas of Thailand, particularly during the days of opium eradication and alternative development. However, there has been little critical assessment of the effectiveness of drug control approaches since this time. Most Myanmar analysts see little hope for success in solving illicit drug problems in the country without major fundamental changes occurring, including: a stable government with the ability to end drug- fuelled insurgency wars; government recognition of the legitimate political aspirations of various ethnic groups; and provision for local people of realistic livelihood alternatives to the drug trade (Gibson and Haseman, 2003). Othman (2002) suggests that illicit drug problems cannot be solved in Myanmar without addressing threats to human security issues that encompass basic rights and livelihoods. An often forgotten factor also remains that Western countries need to address drug problems within their own borders, which ultimately drives much of the demand for illicit drug production in Myanmar.

The following section attempts to analyze the effectiveness of the three main drug control approaches being used in the Golden Triangle - supply reduction, prevention, and treatment.

5.1 SUPPLY REDUCTION

Supply reduction (essentially law enforcement) is an approach that has taken a large proportion of available funding for drug control in the region. This involves interdicting the production, trafficking and selling of illicit drugs. This usually involves the police and military in respective countries, including large-scale cross-border initiatives supported by international organizations such as the USDEA and UNODC. Little further comment beyond the information contained in section 3.4 is required on the impact of these approaches on ethnic groups (in terms of high rates of arrest, incarceration and deaths – particularly in Thailand during the war on drugs).

More generally, however, the recent Thai war on drugs provided much ammunition for critics of supply-reduction policies, who point out that it is useless to stem supply if the causal factors concerning why people take drugs in the first place are not dealt with. While the war on drugs undoubtedly reduced the availability of drugs in Thailand, the 14,000 factories and 15,000 schools declared drug-free may well be 'the trees that hide the forest' should these root causes not be dealt with (Chouvry and Meissonnier, 2004).

5.2 PREVENTION AND HARM REDUCTION

Korpe (undated: 3) describes prevention as 'the cornerstone of drug control', as 'other methods are useless unless the individual comes to the conclusion that drug use is against his/her own interests'. Prevention includes primary approaches (directly stopping people using drugs such as through education or law enforcement) secondary approaches (convincing users to quit), and tertiary approaches (harm reduction approaches, such as preventing needle sharing). A great deal of education and awareness-raising occurs in Thailand, particularly in schools, and specifically targeted at youth.

5.2.1 DRUGS AND THE PROMOTION OF FEAR

Thai anti-drug campaigns have been accused of having the sole aim of promoting fear. It is a common approach in Thailand to exaggerate the risks of drug use in order to dissuade people from using them (Chouvy and Meissonnier, 2004). The outcome of this approach has led to the failure of drug prevention programs in achieving their objectives. Target user groups are confronted with exaggerated effects of drug use displayed in disturbing images on posters and other literature (often depicting the outcome of drug use as broken families, murder, insanity, jail or death). This has been a common tool used in projects in upland villages. Comparing this with their own experiences of drugs, many users dismiss these effects as exaggerated or even completely false. 'The danger here', says Chouvy and Meissonnier, (2004: 95) 'is that such messages can undermine the credibility of the authorities or sponsoring organizations involved, as consumers themselves know the actual effects'.

A carry-over effect of these campaigns is that existing drug users become stigmatized and feared in the eyes of society at large. A quick perusal of Thai newspapers reveals regular sensationalized stories of *ya baa* addicts committing random, crazed acts of violence, portraying these users as people to be feared, as they could become psychotic at any time[2]. Society also considers drug addicts to be 'dirty', and they are generally pitied and despised (ibid).

Analyses of drug projects in upland villages in the Golden Triangle region have encountered these problems. Lyttleton and Cohen (2003: 90) found that in Akha villages in Laos, drug users frequently became labeled with an 'addict identity…to form a community subgroup of stigmatized degenerates', and that 'there is a very real danger that these drug users will resort to the furtive consumption of (potentially) more harmful drugs, such as ATS or heroin'.

5.2.2 HARM REDUCTION

There are mixed reports on the effectiveness of harm reduction approaches in Thailand and Shan State. Harm reduction approaches for heroin injection in Thailand appears to have been working. HIV infection related to heroin injection has decreased dramatically over the last few years, and seems to have occurred through a mixture of saturation of public health messages from the Government and NGOs, and stricter law enforcement (Pers. Comm., Thomson, 2006). Thailand has been criticized for not instituting a formal needle exchange program as part of a harm reduction program: 'In practice, no syringe exchange program

[2] This certainly happens, however, psychotic effects from ATS are the exception rather than the norm, usually occurring in hyper-sensitive people or advanced addicts, those who mix ATS with other substances such as alcohol and heroin, and especially those who inject ATS on a daily basis (Chouvy and Meissonnier, 2004).

exists in Thailand with government support, despite significant government expenditure on other aspects of HIV prevention.' (Human Rights Watch, 2004: 47). However, given the dramatic decrease in the incidence of injected HIV infection, some have questioned the need for such a program, saying that public health messages have been highly effective (though Peak, 2000 says that most support for HIV/AIDS educational materials excludes the drug-user population).

However, many are critical of harm reduction approaches. Lyttleton (2003: 86) says that drug policies in Thailand and Laos do not adopt a harm reduction orientation. The dominant mindset views illicit drugs as 'inherently and unequivocally bad, the cause of manifold economic and social problems (rather than a symptom), and therefore must be totally eliminated'. While harm reduction for injected heroin users has been effective, there is a concern that harm reduction approaches for other drugs have been neglected:

> EVERYONE HAS BEEN FOCUSING ON HEROIN USERS AND HIV IN THEIR HARM REDUCTION EFFORTS – BUT WHAT ABOUT THE 3-5 MILLION ATS USERS? WHAT HARM REDUCTION APPROACHES HAVE BEEN TRIED FOR ATS, OR CRYSTAL METHAMPHETAMINES? THERE HAVE BEEN SUCH ENORMOUS PROBLEMS TRYING TO PUSH A HEROIN HARM REDUCTION PROGRAM. THE GOVERNMENT HAS PROVEN VERY DIFFICULT TO CONVINCE.'

(Pers. Comm., Thomson, 2006)

On harm reduction efforts in Myanmar, one respondent said: 'Everything in Myanmar is a façade. They will set up a harm reduction facility, and then arrest the NGO workers, and nothing happens. They agree [to do harm reduction] just to keep donor money flowing in' (Pers. Comm., Thomson, 2006). As evidence he continued, 'Is there really an agenda of harm reduction in Myanmar? You need 60% coverage of the entire injecting population to have any sort of serious impact in a harm reduction sense. There is nowhere near this happening. I am dubious that there is any going on at all'.

Both Thailand and Myanmar have developed anti-drug campaigns around important public figures and celebrities. For example, in Thailand, Princess Ubolratana's 'To Be Number One' campaign, and in Myanmar, a group of celebrities have started a campaign called 'Stars Against Drugs', and a group of eight NGOs have formed 'The Rainbow Group', which also campaigns against taking drugs (Eastern Horizons, 2003).

5.3 TREATMENT

In Thailand, there are three main government approaches used to treating and rehabilitating drug users: voluntary, convicted and compulsory. First time users of hard drugs are commonly referred to treatment centers, and 'the Narcotic Addict Rehabilitation Act 1991 is aimed at enforcing the compulsory treatment of an alleged offender to recover from narcotic addiction' (Reid and Costigan, 2002: 211). This compulsory treatment was seen on a massive scale during the Thai war on drugs, where tens of thousands of 'drug offenders' were sent to rehabilitation camps in Thailand.

Services for drug users in northern Thailand are uniformly viewed as inadequate, and focus

almost solely on detoxification. In Chiang Rai Province, for instance, the government has requested that every hospital initiate treatment and prevention programs for treating drug users and HIV. However, only two treatment centres have been established in the north, and of the 15 community hospitals in the Province, only 50% offer various forms of treatment (Peak, 2000). Of this, one respondent said: 'In most hospitals, their ability to dispense methadone is almost zero. Much of the time, staff are not trained properly in administering methadone – how much, and how to administer it as part of a program' (Pers. Comm., Thomson, 2006). Treatment for ATS is usually based on abstinence, assisted by valium, multi-vitamins and anti-depressants (the Northern Drug Treatment Centre gives this in a 21 day course of treatment, and which often requires payment for service).

Peak continues that the general opinion in rural based hospitals is that drug users can access treatment in Bangkok, Chiang Mai or Mae Hong Son. He says that health workers recognize the high failure rates of the available treatment programs and wish to have community support before embarking on other harm reduction strategies. One respondent (Pers. Comm., Lyttleton, 2006) said that some religious organizations had set up a small number of treatment programs in the hills of northern Thailand, but had no more details on these.

Minority peoples find it particularly hard to access such treatment, as one respondent related (Pers. Comm., Thomson, 2006):

> They [hilltribes] have much less access because they are so remote, and are so stigmatized in Thailand. [For example] It is very hard to bring someone down to the northern drug treatment centre. It's expensive for one thing. I would shudder to think of the number of drug users in remote villages along the border who have gone crazy [ie, now in a drug-induced psychosis].

The unfortunate reality is that there are few options for drug treatment for poor remote ethnic communities. The remoteness of many of these, combined with poverty and lack of citizenship, make it extremely difficult for those in need to access treatment that is mostly located in central lowland areas. The solution, says Thomson (Pers. Comm., 2006), is to begin mobile treatment centres that can come to these communities.

The general "demonization" of drug addicts in Thailand is another barrier to treating this group. For example, in discussing a story in a school textbook about a family reformed from drug and alcohol addiction, Chouvry and Meissonnier (2004:122) comment that, 'the moral is explicit: a person is not a victim of drugs but rather a culprit. If he consumes then he has only himself to blame. This orientation is one of the main obstacles to rehabilitation programs for drug addicts'. Lyttleton and Cohen's (2003) study showed how blame and a lack of 'social capital' has led to high relapse rates in ethnic villagers who participated in opium rehabilitation programs in Thailand.

From the little that has been written about treatment in Shan State (and Myanmar in general), options for drug addicts are limited. Official statistics quote that there are 40 drug treatment centres throughout Myanmar (Xinhua News Agency, quoted in SHAN, 2005). Reid and Costigan (2002: 146) say that 30 have been established since 1997, and break this down into 6 main treatment centers, 22 subsidiary centers, and 2 comprehensive centers. SHAN (2005: 39)reports that:

Despite high rates of addiction in Shan State, state-run treatment centres are virtually non-existent. This has led communities to set up their own treatment centres. However, at least

two treatment centres set up by a ceasefire group were shut down by the military authorities when they became too successful.

Reid and Costigan (2002: 146) states that: 'It is clear the current capacity to assist drug users is totally inadequate', and that even though the Ministry of Public Health is responsible for providing rehabilitation and after care for those leaving rehabilitation, there is currently only one rehabilitation centre in the country offering social and practical skills training. The UN reportedly has two treatment centers running in Shan State, and another one was closed in 2000 'due to an overwhelming number of drug users applying for treatment' (ibid).

Treatment for addicts is apparently free, although it has been suggested that payment is not uncommon. Treatment can run from 5-6 weeks (first visit) to several months (second or third visit), and focuses on detoxification using opium tincture followed by medications such as diazepam and analgesics. Relapse rates have been estimated to be 60-70%. Lack of qualified staff and the mixture of methods used may well have driven many addicts underground who, if caught, will be arrested and put in jail (ibid).

The basis of drug treatment in Myanmar is total abstinence, and substitution therapy has only recently been considered on a pilot basis (ibid). This is seen to be a major barrier to effective treatment due to the high rates of relapse.

6. BEST AND WORST PRACTICES

A primary aim of this research was to establish 'best practice' and 'worst practice' approaches to dealing with drug problems. Worst practices is a rather impractical term, and the authors of this report consider that 'mistakes and lessons learned' has been covered throughout preceding sections. Regarding best practices, very little has been uncovered. During interviews, none of the respondents could identify what they would necessarily consider to be best practice (a surprising response indeed), and no one thought anything happening in Myanmar was effective at all.

Scarce literature was found dealing with best practice in anything other than a broad sense. At the global level, the UNODC has produced a 'Treatment and Rehabilitation Toolkit' aimed at disseminating best practices (www.unodc.org). These include: "Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers", "Contemporary Drug Abuse Treatment", and "Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide". These are good general overview documents, but provide no specific help in addressing problems in upland villages. Other government and non-government groups have also produced numerous reports on best practice in different contexts – though most of these appear to pertain to addicts in Western countries, and their relevance to the completely different cultural and socio-economic context in the Golden Triangle region is unclear.

6.1 PROJECT APPROACHES

There have been numerous assessments of project-based approaches to solving drug problems in the Golden Triangle, detailing numerous lessons learned (see for example, Rutherford et al, 2005; Renard 2001; Lyttleton and Cohen, 2003). Almost all of these focus on opium reduction and treatment for opium addiction. No literature was found regarding project-based approaches to dealing with ATS.

Kampe (Pers. Comm., 2006) says that there are no best practices (ie, he thought there has not being a project that could be described as best practice), just 'best processes'. Based on over thirty years of experience working with communities on drug issues, he related his view of best process for organizations wishing to work at the community level. Firstly, go to the community and dialogue with them, building up mutual trust and respect through an exchange of knowledge and ideas. Next, establish common interest on things you would both like to 'work on'. Find out the gaps in knowledge and fill these in as a basis for planning. The outside organization must then be very upfront about exactly what it can, and cannot, offer. Be clear and honest – if you can only give 2 years funding, don't indicate that more might be forthcoming somewhere down the track.

6.2 TREATMENT

6.2.1 AMPHETAMINE-TYPE STIMULANTS (ATS)

There currently appears to be no effective treatment for ATS. One of the main treatment approaches in Thailand is 'boot camps' run by the Thai army, navy and airforce, whose objectives are to provide drug users with 'rehabilitation, discipline, and job skills so that they would return to society and become good citizens' (Lirtmunlikaporn, 2004: 21). These treatment approaches experience an 80-90% relapse rate (Lirtmunlikaporn, 2004). Thailand has also adopted a treatment approach called 'the Matrix model' – which is a psycho-therapeutic model of abstinence developed in Europe to treat crystal methamphetamine users. The Thai government thought this was a good approach, and instituted this nationwide without changing either the cultural context (European to Thai), or the drug context (crystal meth to *ya baa*). The Research Institute for Health Sciences carried out an assessment of the Matrix model, and found it to be unsuccessful, due to the fact it was time-consuming (involving long psycho-therapeutic sessions), required specialist training, and was completely culturally inappropriate (Pers. Comm., Thomson, 2006). A common trend following treatment, Thomson says, is 'you get back amongst your social group of peers, and they get you back into it. I've also seen people who have overdosed and died on valium following treatment'. 'Ultimately', he says, 'most *ya baa* addicts who stop, do so without assistance, when they are ready, and with a supportive environment around them'.

A qualitative study of ATS use in Thai youth (Sattah et al, 2001) found that the most important thing is to stop young people from initiating use to begin with. The study also found that having positive attitudes towards the drug and peer influences encouraged use, and that peer family support was also very important in stopping ATS use.

6.2.2 HEROIN

This research did not find any reference to best practice for heroin addiction. The standard harm reduction strategy of needle exchange instituted in many other countries does not take place in Thailand, and methadone treatment is extremely limited. There is evidence that harm reduction approaches, mainly involving messages of safe injection, have stopped the incidence of injected HIV transmission (Pers. Comm., Thomson, 2006).

6.2.3 OPIUM (AND COMMUNITY BASED DRUG ABUSE CONTROL)

Most of the success of community-based drug abuse control (CB-DAC), which began in the Golden Triangle with the Thai German Highland Development Programme in the mid-1990s, has been with opium addicts. With a focus on letting communities lead the way, some say this early work came up with some good results with opium users (Pers. Comm., Kampe, 2006). However, others such as Gerbert and Kesmanee (1997), say that people's participation was not taken seriously, as it was 'founded unconsciously on enforcement and punishment' (e.g. expulsion from village after relapse), and addicts were blamed when they relapsed maintaining 'their low self-esteem and low self-confidence,' resulting in a relapse rate of 95 – 100% in many areas.

Lyttleton and Cohen (2003) say that the Norwegian Church Aid (NCA) CB-DAC project in northern Laos has had a very high rate of success with rehabilitation of opium addicts amongst Akha villagers. The NCA approach was guided by principles developed during the Thai German Highland Development Project. Lyttleton and Cohen (2003: 89-90) say that the NCA project was able to learn lessons and address problems effectively, reducing the rates of relapse from 58%, down to as little as 2%. Important ingredients included: greater community participation, leadership and ownership of the process; better scheduling of activities to suit seasonal work requirements; more detailed awareness of how drug abuse damages the community; detailed strategies to minimize relapses, such as several stages of counseling and fines; and extended lead-up times to detoxification, allowing addicts to develop sufficient commitment to go through detoxification. Of particular importance, say the authors, was the positive social capital that built up through this process, meaning that the surrounding community assists the reforming addicts, rather than stigmatizes them.

7. CONCLUSION

It is clear that the illicit drug landscape in the Golden Triangle has shifted radically since the days of upland opium production by minority groups, when development agencies, the Thai Government, researchers and development workers spent many decades and large amounts of money attempting to understand and solve the illicit drug problem in upland communities. What is less clear, however, is the nature and extent to which ethnic minorities in northern Thailand and Myanmar have been affected by these changes (and related to this - whether 'ethnic groups' remains a useful distinction when analyzing drug problems and communities in the modern day Golden Triangle region). Despite the fact that ethnic groups are still blamed for a great proportion of the region's illicit drug problems, researchers, policy makers and development agencies have done surprisingly little recent investigation about the impact of illicit drugs on these communities. Most research on the explosion in methamphetamine use has focused on urban contexts and young people, mainly in Thailand. Of particular concern is how little is known about the impacts of illicit drugs on communities in Myanmar, and the almost complete lack of empirical (or even anecdotal) information on ethnic groups living in remote regions.

This report has sought to establish the root causes about why ethnic minority groups in northern Thailand and the Shan State of Burma develop problems with illicit drugs. These causes are both complex and, often, place specific. This research has identified some simple causal factors, such as poverty, proximity to trafficking routes and lack of education. More complex factors, brought about through the development process and modernity, include social and cultural factors, increased movement of migrant labor leading to the spread of

illicit drug networks, peer influences, and new value systems and consumerism. All of these factors can be mediated by age and gender considerations. Moreover, illicit drug problems in ethnic communities evolve within a context of significant structural violence – particularly from the State, but also society more generally.

This report has found surprisingly little in the way of best practice approaches to addressing illicit drug problems. While the literature has been good at finding failures, there has been very little uncovered in the way of successes. Reading between the lines, it is clear that most approaches to dealing with illicit drugs in the Golden Triangle have failed to understand the root causes of illicit drug problems in the first place. Dominant approaches have tended to focus predominantly on the symptoms of illicit drug use, relying on fear mongering and heavy-handed suppression/law enforcement in response. Until those who deal with illicit drug problems grapple with identifying and analyzing these root causes as the basis of their search for appropriate solutions, the concept of 'best practice' in the Golden Triangle region will perhaps remain elusive.

APPENDICES TO THE LITERATURE REVIEW:

Literature Review Appendix 1: List of interviews and sample interview questions

Dr Sanong Chinnanon
United Nations Office on Drugs and Crime
27/04/06, UN Building, Bangkok

Dr Ronald Renard
Consultant and expert (currently working with UNODC project in Shan State)
1/5/06, Chiang Mai, Thailand

Ms Wandee Suntivutimetee
Editor, Salween Post
Chiang Mai, Thailand

Mr Ken Kampe
Freelance Expert on Indigenous Issues and drugs in Thailand
Chiang Mai, Thailand

Mr Nick Thomson
Project Consultant (based in Chiang Mai)
Research Institute for Health Sciences, Chiang Mai University
17/5/06, Chiang Mai, Thailand

Mr Pithaya Jinawat
Director, ONCB Region 5
Office of the Narcotics Control Board
26/5/06, Chiang Mai, Thailand

Dr Chris Lyttleton
Senior Lecturer, Department of Anthropology at
Macquarie University, Sydney, Australia
31/5/06, Sydney, Australia

Sample of Core Interview Questions

Much of the literature seems to discuss drug problems in term of 'addiction'. Do you think that equating all drug use with addiction has hindered the ways in which governments, development organizations, and society in general perceive drugs problems?

Do you think that the root causes and complex linkages between production, trafficking, consumption and related factors, are generally well understood in the Golden Triangle?

What do you see as the main causes of drug problems in upland communities in northern Thailand/Shan State?

Does drug use correlate proportionately with proximity to production and trafficking networks, or levels of poverty?

What role do you think upland minority communities play in the context of illicit drugs in the Golden Triangle? Are they not involved/involved with illicit drugs: traffickers, mules, dealers, or addicts? Do you think your view reflects mainstream society?

Do you perceive there to be a correlation between levels, or pace of, development and seriousness of illicit drug problems in highland communities?

Do you think that drug problems have become better or worse in highland communities over the past 20 years?

Do you think that drug problems are relatively more serious in upland areas in the Golden Triangle, or in urban areas in Thailand and Myanmar? Why / why not? What are the linkages between these two contexts?

How would you rate the success/effectiveness of policies related to drugs in Thailand and Myanmar (especially Shan State)? In what ways have you seen these policies impact upon ethnic communities in the Golden Triangle in more recent years?

LITERATURE REVIEW APPENDIX 2:

Organizations working on illicit drugs in Thailand and Shan State

Compared with the period between the 1970s and 1990s, there are now relatively few international organizations working in Thailand on illicit drug issues. With development, and the eradication of opium, many of the larger donors and development agencies have moved to 'more problematic' areas, and in theory the Thai government is now the main 'player' in solving drug problems in the country. For instance, NCA and GTZ (in Thailand for two decades) have now moved most of their activities to Laos. The Australian aid agency, AusAID is currently running an illicit drug initiative, involving organizing a cadre of drug and alcohol social workers. Nationally, CARE Thailand is undertaking some activities on trials of anti-retroviral drug treatment, and the Research Center for Health Sciences of Chiang Mai University continues to undertake a variety of research and trials (Pers. Comm., Thomson, 2006). In terms of local NGOs, these groups work only on treatment, or peripherally through their involvement with people's organizations, dealing mainly with natural resources management issues (apparently due in part to the dangers of working on drug issues).

The work of UNODC in Thailand appears to be mainly related to law enforcement and policy. More generally, UNODC has come in for some fairly strong criticism in recent years, for still pursuing long standing policies focused on eradication which 'condones the use of repressive means and the destruction of drug crops' (GTZ: 15). A report commissioned by the UNODC on its alternative development approaches around the world is even more critical, saying: "In today's circumstances, UNODC projects are almost irrelevant – the skill resources are not available to initiate truly innovative pilot projects and other agencies are doing the pilot work under non-drug agendas (Brown et al, 2005: 58)." They add that, "Few potential implementation partners and donors are interested in drug control, but UNODC finds it difficult to build partnerships rooted in sustainable and comprehensive development approaches such as humanitarian assistance, poverty alleviation, basic human needs, human rights, conflict prevention, good governance, crime prevention, ethnic minority issues, environment, and internally displaced persons (ibid)."

On this last point, Kampe (Pers. Comm., 2006) said that a lack of coordination and cooperation between agencies - such as between UNODC and other organizations – means that information is not shared, and less is achieved. Different organizations tend to make similar mistakes, as analysis and dissemination of institutional knowledge is generally quite weak. An area of opportunity for more effective outcomes, says Kampe, is to pair large organizations with smaller local NGOs, "which do more effective qualitative work at smaller scales (ibid)."

The main organization working on illicit drugs in Myanmar is the UNODC, who are undertaking demand reduction, supply reduction, HIV/injecting drug use and human trafficking initiatives. These projects can be viewed at: http://www.unodc.org/myanmar/en/projects.html. One program that is encouraging innovative partnerships is the KOWI (Kokong and Wa) Initiative (Brown et al, 2005). KOWI is a broad partnership been implemented by a range of partners (e.g. JICA, World Food Program, CARE Burma, World Vision), and whose aim is to provide "emergency and pre-emergency interventions to sustain opium reduction and avoid a humanitarian crisis…including a phased, multi-sectoral program of activities in Kokang and the Wa Regions, spread over three cycles of 5 years (www.unodc.org)." UNODC is the coordinating agency in the Wa region, while JICA is coordinating activities in Kokong.

ANNEX 2:
CITIZENSHIP AND THE UPLANDS

The picture that emerged from this study is somewhat skewed by the choice of villages. Any study looking at just a few villages would have the same problem. (While any study with a large number of villages would lose the depth and detail of a study like this one.) Citizenship in Thailand is in large part determined by geography: the closer you are to the border, the more likely it is you'll have a problem with it. On the other hand, in areas of particular security concern like northwestern Chiang Rai Province, where our Akha study village is located, the process of gaining citizenship – or at least of determining residence status with hilltribe cards -- was sometimes streamlined for administrative convenience.

Let's look at two examples. Almost all Karen living in Chiang Mai Province, where our Karen study village is located, have Thai citizenship. Their villages are far from the border and long established. Further west in the Salween River Basin, along the 1,000-plus kilometer stretch between Burma and the provinces of Mae Hong Son, Tak, and Kanchanaburi, the border is porous and convulsed with the Burmese civil war and refugee movements. Many Karen there, even those born in Thailand, are plagued by problems of the stateless. In our study village in Chiang Mai, citizenship is not an issue.

Another example: The Akha are one of the more recent arrivals in Thailand, with many arriving in recent decades. Lewis (2003) writes that "there were probably not more than 2,500 Akha living in Thailand by the end of World War II. In 1964, there were about 7,000 and by 1983 about 24,000" (1984). In 2002 the Chiang Mai University Tribal Research Institute estimated the total number of Thai Akha to be more than 65,000. Thus it appears clear that much of the Akha population was not born in Thailand. But several years ago the Internal Security Operation Command (ISOC) announced agencies would grant Thai nationality to 55,000 highlanders under a security project in Mae Fa Luang and Mae Chan districts of Chiang Rai. These two districts are the main population centers for Akha in Thailand. In the Akha study site, according to both local and state figures, 90 to 95 percent of the villagers have citizenship cards.

But this village is in the lowlands. It is easily accessible from the district center. It is nearby to a hilltribe center, which has the responsibility for helping villagers with citizenship problems. And it is a principal target village of the AKHA Foundation, which also works on citizenship. Absent these favorable conditions, in more remote villages even closer to the border, it is not uncommon to find the majority of a village's population stuck without citizenship.

The Lahu village was markedly different. In the case of the Lahu village, citizenship came up again and again in discussions with the village research team and other interviewees. Government figures state that only about 6 percent of the adult population of the village lacks citizenship, but the villagers argue it is greater than 20 percent. Many of the villagers have only gotten citizenship in the last five or ten years, so their personal stories are replete with reference to past troubles with citizenship.

This village is a useful snapshot for examining the extremes between anti-hilltribe bigots, at one pole, and hilltribe advocates at the other extreme. It must first be noted that ignorance of and bigotry against hilltribes is the norm in mainstream Thai society. So the "poles", such as they are, are extremely unbalanced. The authors have encountered such bigotry on countless occasions. The refrain is usually thus: the hilltribes (usually lumped together under the pejorative for Hmong, or "Miao") are foreigners who have no rights to citizenship

or any of the protections and privileges that statehood provides. Of course, from a human rights perspective it does not matter where someone was born when it comes to protection against violence and indignity. The civil right to vote is one thing. Human rights to dignity and freedom from fear and extreme deprivation are different. Borders are irrelevant to human rights – at least in theory.

The other extreme is different. The usual pro-hilltribe NGO discourse about citizenship fails to address a big part of the citizenship puzzle: a significant minority of upland people illegally immigrated into Thailand and have no right to Thai citizenship. Such a statement in no way means that these people do not have rights. It just means that in most places in the world, immigrants do not enjoy an easy path to full citizenship. This is also true in Thailand. Asking the Thai government to offer citizenship wholesale to all the victims of oppression by the Burmese dictators and the ethnic warlords is obviously out of the question. As long as Burma continues with its half-century of madness, Thailand is going to have a big problem with immigration.

The impasse between opposing points of view is an unbridgeable chasm. On one hand, many imply that all hilltribes are illegal aliens, while on the other hand people imply that they are all wrongly denied Thai citizenship. This impasse obscures the question of the human rights of migrants. The safety and welfare of stateless people is an area where this divide can potentially be bridged.

In the Lahu study village, it is clear that the majority of people were born in Burma. It is to the Thai state's credit, including a corrupt system that offers some flexibility to those who can afford it, that so many have gained citizenship. It is the judgment of the authors that most of the villagers we met, with cards or without, would be glad to have the opportunity to be law-abiding productive citizens who work for the betterment of society. Their socio-economic reality, however, denies them this opportunity. Citizenship is part of this, but only one part. Because the stateless are usually the worst off in economic and social terms, we will begin with them.

The litany of ills suffered by the stateless is well known to the student of northern Thailand. Let's take a look at Onima, featured in section 8.2.2.1. She can't legally leave the district to work. Her district is poor, with no industry or tourism. There is already competition with illegal laborers, so wages are pitifully low, as little as 80 baht a day (USD2). Enforcement is arbitrary – or at least so it seems to those out of the power loop – so she never knows if it is worth risking the roadblocks to the city. Sometimes she is lucky. Sometimes she is not. Other villagers recounted stories of being arrested and sent back to Burma. While no villager offered any accounts of physical abuse or rape, roadblocks and police stations are no strangers to these sorts of rights violations.

If Onima is sick or beaten by a man, she has to think hard whether to seek treatment or redress from the police. The state health care scheme ("30 baht for any illness") might be rife with problems, but they don't matter to her. Without a card, she has to pay out of pocket. Going to the police with a problem could be like jumping from the frying pan into the fire.

There are some problems suffered by the stateless that are common to their neighbors with citizenship, though more severe. For instance, some advocates emphasize that without citizenship, one cannot legally own land. But in all three villages involved in this project, no one had legal title to their land! Without a card, one cannot own a motor vehicle. The vast majority in the three villages couldn't afford to, anyway. (And in Thailand, there are many ways to get around the lack of legal documents to property.) Without citizenship, one cannot

obtain a high school certificate. This is a serious problem, certainly, but a more serious problem is that the vast majority of uplanders do not finish high school anyway, card or no card.

It is the authors' judgment that this Lahu village is quite representative of the norm for Thai Lahu, whereas the Akha village is quite extraordinary, making comparisons difficult. That being said, it is useful to look at an Akha village with strong leadership, strong cultural preservation activities and stories of success. The usual stories of decline and victimization can be demoralizing. Sometimes we need hopeful stories.

ANNEX 3:
ANALYSIS OF THE GRASSROOTS METHODOLOGY

EXPLANATION OF THIS ANNEX

This is an annex to the methodology discussion in 3.2. We hope that by dissecting the grassroots research process, not only will important findings emerge about the content of the research project, but we can also discuss the lessons learned about research approaches. The majority of the people who were closely involved in this project – the village teams, the university researchers, the indigenous NGO facilitators, the translators – said they saw value in grassroots research and want to do it again. The authors found the work very difficult, but we also hope to continue in this kind of work. To that end, we take the risk of revealing our weaknesses and failings, in the hope that the feedback we receive will help us do a better job next time.

For readers experienced with donor reports and research papers, this section will seem too personal – complete with plenty of names and personal pronouns. But this project became personal for many of us. We spent a lot of time in the villages or discussing the project together. Things happened that really helped us understand the problems, the dangers, and the struggle of life in the uplands. One of our researchers was beaten up by her husband for working with us. Another disappeared for weeks because of family conflicts. Two girls in one of the youth groups went to work in a massage parlor in the middle of the project. Another telephoned researcher Non to tell him she was in his home province, Lamphun, picking longan fruit for a few weeks. We helped plant rice with the Karen. Ate sweet corn with the Lahu. Drank whiskey with the Akha. Encounters like this transformed the "research project" into something else for us.

This section is organized like this: we will compare our initial expectations with the activities and events that actually transpired. (That is, we copied and pasted sections from the research plan developed in January 2006 and then in autumn 2006 detailed what actually transpired.) The idea is to be open about what we feel are both strong and weak points about our research approach. (The text from the original plan is in "quotes" and the paragraphs indented. The analysis is not.)

Towards a Holistic Understanding about Drugs:

A Grassroots Research Project

Grassroots Research Training and Action Plan

Draft v. 1

February 10, 2006

Diakonia Golden Triangle Programme

and the Unit for Social and Environmental Research (USER), Chiang Mai University

Table 2. Project phases (from plan)

Phase	Date (in 2006)	Place	Participant number [1]
Preparation	Jan-Feb.	office and field	10+
Scope and Methods	Mar. 9-18	mobile, Chiang Rai to Chiang Mai	20+
Data gathering	March-June	Field	55+
Analysis	Late June	Bo Kaeo, Chiang Mai	20+
Reporting	Late July	USER office, Chiang Mai	20+

[1] including USER staff and observers

Section 1.4. Innovations

Community members as principal researchers

> "According to the principles of grassroots research (a type of participatory action research) that USER is trying to develop and promote, community members are themselves the principal investigators of the project. USER staff will contribute data and analysis from our interaction with the partners and communities, but our central role is to facilitate the process. (This includes responsibilities for the final written and video products.)"

From the beginning, the community members were not "principal investigators." The authors were. We did develop a positive and productive dialogue with the village teams, but the driving force in the project were our visits to communities. During these periods, we interviewed the members of the village teams, or worked together with them interviewing other villagers or officials (e.g. a hospital doctor, the head of the hilltribe center, a school principal, etc.) The idea was that a lot of this interviewing, after the initial training period,

would be conducted by the local teams on their own. Not much of that seemed to actually happen.

There's a good reason for that. After the phase 2 training workshops, when Jeff was in China in April and May, and before Tu and Non[3] joined the team, a dangerous gap opened in the project. Things basically ground to a halt. This gap was caused by a combination of Jeff's limitations in delegation and the USER teams' limitations in initiative. For whatever reasons, the USER team did not visit the field during Jeff's absence, with the exception of the Karen village scope-and-methods workshop in May. In June, two of the five USER staff working on the project left the organization. There was also confusion over the use of funds between the USER team and office management, which delayed field visits. The long absence of the USER team during this period, and inadequate telephone communications among USER, the partners and the communities[4] (difficult in the best of times) led the villagers to suspect that the project had derailed. Without our attention, the data-gathering plan basically collapsed.

In May Jeff returned from China. Money matters were cleared up with the office, and Tu and Non joined the team in June. The project reemerged with vigor.

Some lessons: **Communications** are critically important, and that means physical presence in the field. Grassroots research in the northern Thai uplands cannot be served by technology – at least not with the infrastructure that currently exists. You need people on the ground, working closely with the villagers. They have seen too many outsiders come with big ideas and grand plans and then just disappear. When we didn't show up for a while, they assumed we were the same.

Another problem that Jeff encountered was lack of authority with the USER staff. The Diakonia project was just one of many tasks that they were required to perform, and with no extra money. When deadlines were set for written reports and they passed with no result, Jeff had no recourse other than to scold or plead. Nor did he have any mechanisms for incentive other than "thank yous" and cold beer (paid for out of his own pocket). When USER management agreed to allow hiring part-time staff from outside the organization, this problem was solved. **Recruiting autonomy** meant that the pool of potential staff went from a handful at USER to hundreds throughout the region. Tu and Non were recruited and surpassed even the high expectations with which they were hired. They were compensated adequately, offered bonuses if they saw the project through to completion, and given clear instructions and deadlines. If they failed to perform, they could be replaced. Now that the project is wrapping up, they can return to their neglected studies. It is a safe guess, however, that if they were offered more of such work in the future, they would accept it.[5]

> "(Grassroots research) is a concept sometimes difficult to communicate to potential partners and allies in grassroots development. It is often assumed locally that the grassroots researchers (GRRs) must be the possessors or repositories of data

[3] Alongkorn Jantian and Siraseth Nethngam

[4] The Karen village has no phone system and no cellular signal. The Lahu village has a public phone, but the "reception" system (e.g. leaving messages) left much to be desired.

[5] The readers might have concerns about out-sourcing, a phenomenon in the United States with negative repercussions for job security and wages. This is a real concern, but should be balanced by the fact that Tu and Non's wages were very competitive for graduate students, that they were learning and practicing new skills, and that the work was relevant to their studies. Jeff feels there are enough institutions and NGOs already in existence in northern Thailand and has no desire to create any more. A flexible network system can better employ the energy of existing organizations and people without creating more bureaucracy. Anyway, like his assistants, Jeff doesn't have a full-time salaried job and he doesn't want one.

> themselves. This is not the case. The grassroots researchers' own knowledge and experience will be important to the project, of course, but their role is to be researchers – to act as conduits and interpreters between sources of information and the audience. The participants of the project – the 12 core grassroots researchers – do not need to come to the workshop as experts in problems about drugs. Certainly, some of the participants will be recovering drug addicts. All have likely been touched in some way by drugs. But they do not need to be community experts. Indeed, this would be undesirable, as "experts" do not necessarily make the best investigators."

It was not until very late in the project that this concept was really grasped by the village participants. Many never grasped it. Some of the participants, especially in the Lahu community, were forever under the impression that this project was a form of welfare program, distributing wages for labor and with the promises of even more money to come. (This included per-visit fees to use one of the leaders' washrooms as well as a rental fee for the use of the church.) We emphasized early and repeatedly that this was not a welfare program, that the money distributed was for lost time but not the main point of the project, but it never really seemed to sink in. (The dynamic between the Lahu village, the partner staff, and USER, was always confused and confusing, though quite amiable.)

This is a good time to discuss money. Talking about money is not easy, and that was true in this project. Money is a chief source of conflict everywhere, no less so in upland villages. The USER staff involved with the project were very loathe to bring up the subject with the villagers, even when Jeff exhorted them to do so. In the Thai NGO universe, the orthodoxy is that money corrupts. Community participation in progressive development (read: non-state) should largely be volunteer (read: no pay), with usually some money available for food and travel. There is good reason for this thinking. Government payment of wages for labor in development projects has often (usually?) been channeled through patronage systems, thus reinforcing social hierarchy and domination. And it was corrupt, with plenty of skimming and mis-directing of funds. Furthermore, big-spending international organizations can spoil villagers, paying for dances and "traditional" ceremonies. The swelling expectations of villagers for wages make it impossible for small domestic NGOs to compete.

On the other hand, USER researchers were not working for free. We felt it would be wrong for us to ask the villagers to work for free. And to ask poor people to sacrifice labor is just not practical. The people in these communities worked hard, either growing food or selling their labor in order to buy food. A day spent working for free with us could mean a day without food tomorrow. Asking them to do so would be neither moral nor sustainable. A community facing the bulldozers of a dam builder or the chainsaws of a logging concession might be properly motivated to engage in grassroots research for free, if it is going to mean a stay of execution and some publicity. Our communities were facing trouble, but nothing so tangible or imminent.

So we deemed it necessary to at least compensate people at local wage levels, and maybe a bit better to encourage goodwill and effort. But once you make that decision, a whole range of tricky questions arise. Are the participants there to help their communities – the whole rationale for the project – or for the money? Are they part of the local ruling clique, or is money distributed equally? In the Lahu village, the villagers told us that they were chosen to participate because the offer of 100 baht per day was too low to tempt the village headman and his clique. If the money had been better, they would have taken all the spots.

The question of how much money to pay the local participants was confounded by the question of how much time they would be spending on the project. From the beginning, the idea was that …

> "the grassroots researchers will not be working full time. In the sense of formal research, this will not even be a part-time job. The success of this phase will be determined by the ability of the participants and mentors (USER and partner organization staff) to integrate research into daily life. The goal of this project is not to create a cadre of professional grassroots researchers. The ultimate goal is community self-sufficiency in problem analysis and action. Research should be a big part of that.
>
> The "workplace" of a grassroots researcher is wherever she finds herself. In the field, in the home, at school, in the office – wherever she finds herself communicating with people, or even just observing what they're doing. These natural, everyday activities become the research process. The difference is, the grassroots researcher has a particular line of inquiry, she has tools like interview guides and surveys, and she is writing down the information. So when a farmer/researcher is taking a break with friends in the heat of the day, or waiting for a ride to the fields in the morning, or relaxing after a hard day of work at a neighbor's house, she will turn the conversation toward the topic of her research, and she will take notes. (In the case of those who cannot write, teamwork comes into play and they will collaborate with the core grassroots researcher in their team.)"

The meetings in the village were sometimes rather surreal situations, especially, again, in the Lahu village. The question on nearly everyone's mind was, "how much money do we get out of this?" but USER took the longest time to clarify the question. We had 5,000 baht per group, per village. There were usually four people in each group. With three groups in each village (youth, women, policy), that was 15,000 baht, or USD375, for each study village. With wages for a hard day in the fields as little as 100 baht (USD2.50), this figure was not insignificant. But what should it be spent on? In the first place, the money was only for the phase 3 data gathering in the field. There were other funds for the meetings in Chiang Mai, and there had been compensation for the phase 2 training.

So the money was for data gathering. It could be spent on petrol for trips to the district office, and for refreshments for "focus groups". We discouraged the idea of paying informants for their interviews, but finally gave in if the local researcher insisted. But a few tanks of gas and bottles of Fanta were only going to use up so much money. The question undoubtedly on many people's minds was, "How should we divvy up this money?" If people were doing interviews for an hour per day some days, not at all other days, and some people in the group were contributing more than others, how should the money be divided?[6] Finally we agreed on a number of interview subjects per group, agreed on a deadline, and let them decide how to manage the money.[7]

Some lessons: The use of money in grassroots research should be carefully considered, clearly explained and transparent. In this project, all the participants – international, Thai, upland – made money in the medium-to-low end of the wage range prevailing in the labor markets in which they compete. These facts should be honestly discussed. Otherwise, the rumor mill runs at full steam. In this project, the problem was complicated by the sensitive

[6] It gets pretty depressing dividing 100 baht into eight hour days (=30 cents an hour!!).

[7] A detailed investigation of how money was distributed would be fascinating but pointless. The stories that filtered in ranged from benign to ugly.

subject of drugs and by the fact that no one had ever heard of anything like grassroots research. It was completely alien to them, insufficiently explained, and some people naturally fixated on the issue of money. A follow-up phase in the same communities – or in a different place, but working together with the same people – would go much more smoothly.

We recommend this approach for working with potential grassroots researchers in the future: 1) identify the issues of the greatest importance in the minds of local people; 2) hire "consultants" who speak the language of the locals and who have experience with grassroots research (or at least grassroots NGO work); 3) have these people spend considerable time in the community explaining the idea of grassroots research and how it might help the communities to help themselves. This should be done in a natural setting – not in the big meeting room! 4) have these consultants help identify community members with interest and potential to do grassroots research[8]; 5) hold a challenging and competitive training workshop, for which the trainees are modestly compensated; 6) collaboration with the project should be contingent upon passing the training (not upon being the village head's niece); 7) contract the successful trainees for a specified period of time, with clearly detailed objectives, and pay at least twice the prevailing wage; 8) offer them bonuses for seeing the project through to completion; 9) provide them with recognition through the participating university, including certificates, memorabilia like T-shirts, etc.; and 10) offer the most outstanding grassroots researchers opportunities like training-of-trainers. In general, pay well for excellence.

> "In general, three working groups will be organized for this project: policy, women and youth. The specific research questions for each working group will be drawn from the scope and methods workshop in March. The policy and youth groups can be made up of women and men both. This approach seeks to find a culturally appropriate, comfortable and empowering means of ensuring the participation and voice of women and youth."

The initial idea was to segregate the men so they did not dominate the proceedings. That proved to be a good idea. In the Lahu village, it saved the entire project. Without the women, we would have learned very little about that community. The girls in the youth groups, for their part, were indispensable. As everywhere in the world, men know precious little about the struggles of their daughters. This is especially true when most of the girls have migrated to the cities.

The majority of the participants in this project were women. Besides the women's groups, the youth groups were mostly women. The policy groups were all male. While this segregation might seem to be quite contrived, we found it necessary and productive. In many societies – certainly not just in these upland societies – women do not feel comfortable speaking openly in front of men, certainly not with strangers present. And certainly not about things like drugs, booze and violence. The segregation into these groups, alternated with sessions involving all groups together, served the project well. The main exception was the Akha women's group, which is discussed in section 6.5.

Cross-cutting participation model

> "The participation model employed in this project will be multi-functional. It will a) allow for diversity of voice; b) ensure data quality; c) build relationships and

[8] Potential does not imply facility with English, computers, or even fluency/literacy in the national language. Rather the potential should rest with qualities like curiosity, energy, compassion, leadership, etc.

> understanding amongst diverse groups; and d) be interesting and fun for everyone involved."

The first two objectives in the paragraph above were met. The second two … that is less clear. As discussed above, there was considerable diversity of voice in this project. When outsiders visit minority communities, they usually communicate only with the male leaders, or maybe chosen representatives of the women and girls. When Thai officials come to talk about drugs, they do not usually ask recovering drug addicts what they think about the matter. The illiterate, the stateless, the non-Thai speakers – their voices are rarely heard beyond the edge of the village. One of the strengths of this project is that such voices are heard in the case studies in this report.

When those voices are muffled, of course, big parts of the story are not heard. The diversity of the participation in this study means that information could be cross-checked with many different sources. This made the business excessively confusing, just as real life is confusing. For instance, if you ask when heroin began to be a problem and why, you'll get as many different answers as you have sources. Keep asking, and patterns emerge. The need for persistence, frequent visits, open-ended questions, multiple sources and good translation all become clearer and clearer as you proceed. [9]

As far as building relationships and "understanding amongst diverse groups", disharmony and conflict could just as readily be the result. In the Karen community, the villagers generally said that our presence was good for encouraging community discussions. The women said that they rarely come together as a group anymore, and they were glad to do so at the behest of this project. The men in the Akha policy group are old childhood friends who do not often have the time to gather anymore. Some of their compatriots said they were moved to see the men together again. On the other hand, there was a lot of tension between the men and women in the Lahu village. The women and girls were insistent about openly discussing problems of drugs and alcohol. The men were not. When we expressed our disquiet that our presence might be leading to conflict, the women generally laughed us off, saying that the conflict had long been there. Still, it made us pretty uneasy.

As far as fun, we certainly enjoyed ourselves, and we think most of the participants did as well.

Diversity of voice

> "There is great opportunity in this project for diverse voices to make themselves heard. This will be a methodological challenge, especially given the cultural and language diversity, but a challenge well worth facing. It is expected that through this network of grassroots researchers, a constellation of sources will feed into this project. The policy group will connect with state officials, university academics, developers and politicians. This group will also be able to learn from recovering addicts and reformed dealers from their communities. The women group can connect with all the above as well (especially women officials, feminist academics, etc.) but will have a special mission of tapping into indigenous knowledge, especially knowledge that cannot be accessed with Thai language or formal academic research methods. The youth group can communicate with juvenile prisoners (e.g. by letter writing), gang members and others with a perspective about drugs that is usually ignored."

[9] As you participate in grassroots research, the formal researcher with his clipboard and survey and three-villages-in-one-day schedule takes on an absurd aspect in your mind.

Yes, all very good in theory. In practice, little of this happened unless the USER team was on the ground. During the two working group meetings in Chiang Mai, we did bring the villagers together with some very knowledgeable people working on uplands issues. And during some of the field visits, we accompanied the grassroots researchers to interview officials or other sources outside the village. In our absence, not much of this happened. There was insufficient training, direction and role modeling. And people were busy earning a subsistence living. Sometimes the officials hesitated to give information to mere villagers. In a couple of cases, we obtained data from sources that the villagers could have gotten themselves very easily, but did not. Convincing youth to contact prison inmates or gang members could work, but only in certain cases and with much persistence. In truth, meeting these worthy but ambitious objectives would have taken a lot more personal coaching. We would have needed to probably quadruple the time we spent in the field. With the capacity built in this project, it could be done if given the opportunity.

Iterative and sequenced workshop

> "The research process will be sequenced carefully, repeatedly practicing methods and exploring ways to integrate them into the daily lives of the grassroots researchers. These methods will lead to data building which will lead to analysis which will lead to more data gathering and improvement which will lead to reporting. Past failures of dispensing complicated knowledge in a classroom setting and then denigrating local people as stubborn or foolish when they naturally fail to grasp it will not be repeated in this project."

Again, nice idea. Unfortunately, some of these "past failures" *were* repeated, though we don't believe there was any denigrating going on. If anything, we denigrated ourselves for our own failings. The data building did lead to analysis and back to more data gathering and so on, but that was so because we visited the field so many times. The iteration was probably maddening for the villagers, but it was ultimately very useful. The history of drugs – and all the other issues we were looking at – is very complex. It is not a waste of time to ask a question many times and to many different people.

In the end, we scrapped the idea of segregating the analysis and reporting phases. We instead began writing *for* analysis. We worked to get our understanding of things down on paper, discussed them with the villagers, and then revised them as necessary. We encouraged the researchers to write articles and reflections for us themselves – in Thai, in Karen, in Lahu, whatever – but we never received anything. Again, this would take a great deal more time in mentoring than we had to give. In the end, the three authors sat down for two weeks and wrote continuously, in English and in Thai – and with breaks to argue and pull hair out of our own heads – before returning to the villagers and other sources with the draft to verify information.

Field-based, hands-on workshops

> "The first and second workshops will be held in villages. The entirety of phase 3 (data collection) will be held in the field. This will give the participants a chance to practice research methods and discuss the pertinent issues in a real-life setting. Immediately after methods are introduced, modeled, practiced and critiqued, the participants will employ them in the village, for instance interviewing farmers, youth, local leaders, state officials, etc. Inevitably, problems and questions will emerge. These can then be addressed in the workshop, BEFORE the participants return to their homes and begin collecting data. The opportunity to directly access

> communities in the workshop setting will also help to ground and refine the research questions the participants develop."

The phase 2 workshops in each of the three villages were not a complete disaster, but they essentially recreated the classroom in the village. We held the workshops in "centers" like the village church. We talked far too much *about* doing research and *did* far too little of it. There was a bit of a frantic effort to explain the project, to introduce the Diakonia priority issues and to agree on a data-gathering plan – all in three days! That was a mistake. With better preparation[10] in the field, better sequencing of knowledge exchange and immediate and frequent post-workshop visits, the system would have worked far better. Later in the project, we adapted better by stressing oral histories as the principal data collection method and case studies as the way to analyze and present information. That is, the researchers had their interview guides, but they didn't begin by asking the questions on their list. They just had the subject tell them their stories, and saw that the questions were addressed, through gentle guiding when necessary. This way, unexpected but useful information was free to emerge.

> "Researchers need to be able to read and write, correct? Wrong. In this project, the core group must be able to write Thai or an ethnic language because they will be the ones recording the data collected. The people they recruit as assistants in their local teams, on the other hand, are not required to be either literate or able to speak Thai. (See part 2.3.3.2 below.) Many if not most older Akha, Lahu and Karen men and women are unable to write Thai or any other language. The easy way is to exclude them from the project, but this would come at the expense of a vast body of knowledge, experience and information. The teamwork inherent in this research process makes possible the inclusion of such people as participants, not just objects of research or mute observers."

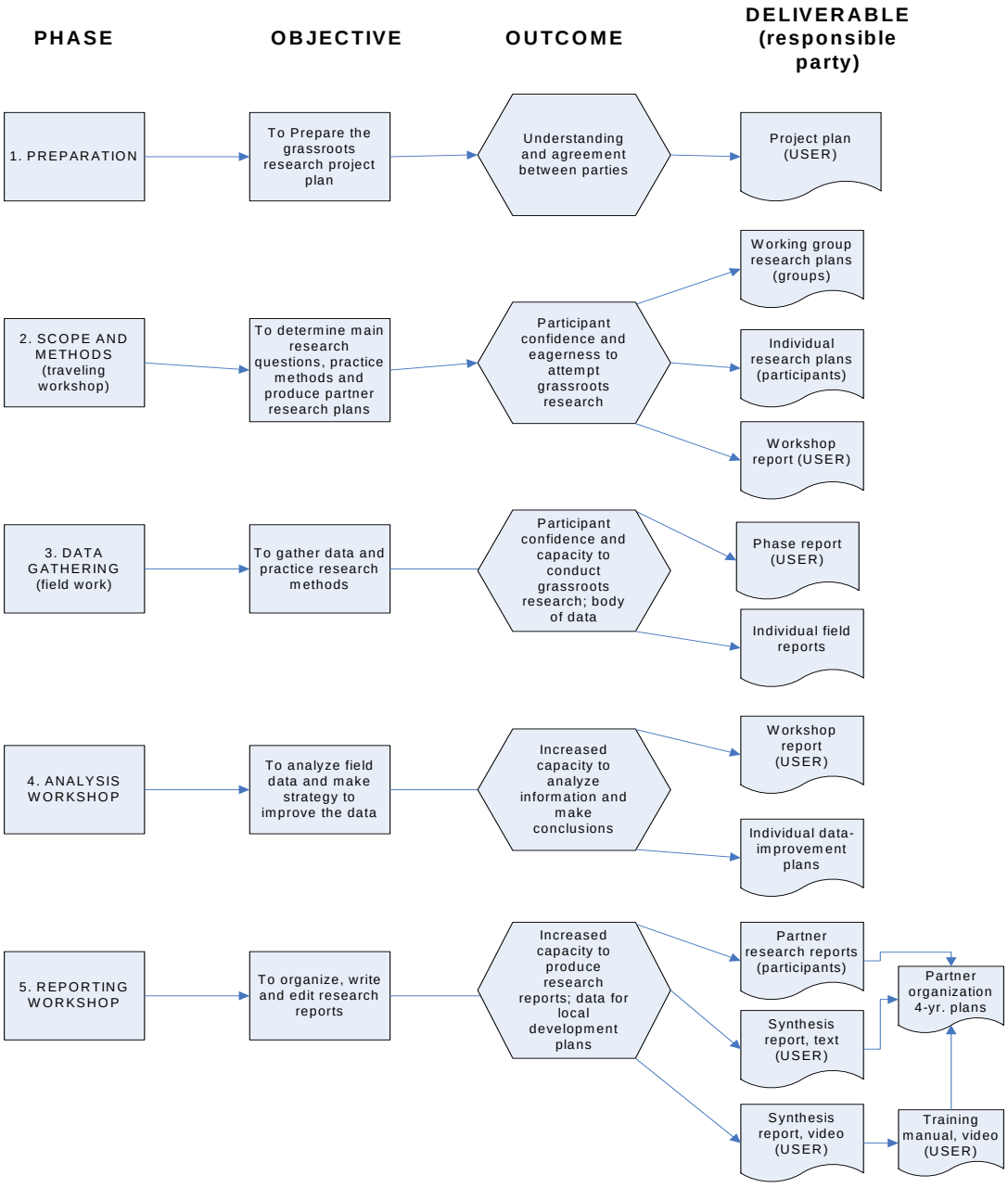
There never really was a "core group" as envisioned in the project plan. Instead, some of the villagers were more committed and active than others. Many of the most active participants were illiterate. This was not a serious obstacle. (Indeed, those with good Thai writing were no more active than those who could not read the language.) Some of the groups used their working budget to hire other villagers who could write Thai. Others worked together with their family members or friends. While the concept was difficult to communicate at first, the idea that team-work could circumvent the problem of literacy eventually sank in. What was a more difficult nut to crack was the idea that an interviewer should diligently write down – in any language – the subjects' answers. This lesson is not reserved for "grassroots" researchers, as any teacher of college students understands.

That point leads to the matter of documentation, which was another strong point of this project. We took pains to hire documenters at each stage of the project. During the workshops, during the group meetings in Chiang Mai, during the evaluations, during our own meetings, we usually had someone sitting with a computer and writing down everything that everyone said. When the villagers attended the Chiang Mai meetings, we had Impect staff working with each group from each village, entering the data from their field notes into the computer. The result is a huge amount of information that was available for analysis, and is still available for further study or project evaluation.

There is much more to discuss about the methodology of this project, but this will have to do. The authors welcome any questions or requests for clarification.

[10] See the recommended approach for working with potential grassroots researchers above.

FIG. 1 PROJECT OVERVIEW



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