

Injecting Drug Users under Thai Treatment Context

Niphatra Haritavorn
Department of Applied Anthropology
Macquary University, Australia

Background

The second wave of HIV transmission in Thailand which most commonly involved heroin use, is attributable to injecting drug users. There is limited documentation on the number of injecting drug users. However, the most frequently referred to quote puts the number of between 100,000-250,000 injecting drug users countrywide. Even though new HIV infection in Thailand has substantially decreased from 143,000 in 1991 to 19,500 in 2004, HIV prevalence among injecting drug users has increased from 38% in 1989 to 40% in 2004. This has raised the concern that HIV will spread into the general population via sexual partners as injecting drug users are less likely to use condoms with their regular partners (Perngmark, 2003). Recently, many epidemiological researches demonstrated that HIV prevalence among injecting drug users is in flux and advanced.

After the surrender of the drug lord, Khunsa to the Burmese Government in 1996, which had an enormous effect on Thai patterns of drug use, heroin became more difficult to access. The price rose extremely high, and as a result, injecting drug users became ambivalent, questioning whether to quit the drug and/or turn to other substances such as amphetamines or 'yabaa', (Peak, 2000). At first, drug users believed that 'yabaa' would have the same effect as heroin. When they found it did not diminish their craving for heroin, many resorted to injecting with other substances such as Midazolam which, in turn, substantially increases.¹

Social and economic factors play an important role in the spreading of HIV, particularly in the area of needle practice among injecting drug users. One injecting drug user stated the reason for needle sharing as follows: 'When the bodies needed drugs and there was no syringe and needle of their own, they might share with others' (Vongchak). More importantly, injecting drug use tended to shared equipment and needle among friends in their social networks (PSI, 2005).

Social constraint like incarceration (imprisonment) has forced many users to share needles and equipment involuntarily. Some injecting drug users mentioned experiencing acute withdrawal symptoms, borrowing needles, and injecting drugs with various unknown people in police holding cells where provision for cleaning equipment was not available (Buavirat et al., 2003). This has made holding cells and prisons hotspots for HIV infection.

The drug situation became worse when the Thai government announced its 'War on Drugs' campaign in February 2003. As a result of the killing of more than 2,000 suspected drug users, the 'war on drugs' gave rise to a climate of violence, human rights defenders, and failure of government policy. As Prime Minister, Taksin was later put amphetamine as 'three baht (US \$ 0.07) per tablets, this policy is factor that drive police officials seek to catch the drug dealer as many as they can. The outcome

¹ In the AIDS VAX B/E HIV-1 vaccine trial, Midazolam injection increased from 10 to 31% (Van Griensven et al, 2005).

of this campaign was that it was dramatically changed drug usage in Thailand, both at the social and individual levels.

At the social level, the 'War on Drugs' created a shift in drug demand in Thai society. Enforcement statistics indicated a remarkable decrease in the use of 'Yaba' while the availability of other illicit drugs, notably heroin, ecstasy, Ganja and Ketamine may have increased (Poshyachinda et al., 2005). Concomitantly, the numbers of those drinking alcohol and smoking increased substantially.

At the individual level, the 'War on Drugs' labelled injecting drug users as 'criminals' beset by deviance, lack of control, violence, and moral depravity. The Prime Minister's order (29B.E. 2546) stated that 'if a person is charged with a drug offence, that person will be regarded as a dangerous person who is threatening social and national security.' This ultimately created a climate of violence and discrimination against anyone who used drugs. As a result, many drug users stopped attending the treatment program for fear of being arrested. The 'War on Drugs' worked to discourage drug users from obtaining HIV testing or other medical services.

The advent of antiretroviral treatment (ART) in 1996 led to a revolution in the care of HIV/AIDS patients. Although the treatments are not a cure and present new challenges in the form of side-effects and drug resistance, they have dramatically reduced mortality and morbidity rates.

The Thai government in tandem with the governments of other countries, tried to prolong and improve the quality of life of people living with HIV/AIDS (PLWH) by giving antiretroviral therapy. Once having realised the importance of ARV, many ARV programs were launched by governments, international agencies, and non-governmental organisations. Thai NGOs have been central to defend the Thai Government Pharmaceutical Organization to produce their own ARV generic drug, with the cost of a three cocktail around 30 \$US per month. The ARV program 'Napha' subsequently emerged and was implemented throughout the country.

Before long 'Napha' was recognised as an effective treatment program for People Living with HIV/AIDS. It reduced the stigma associated with PLHAs in the community and allowed them to live their lives like ordinary citizens. However, lack of access to ARV treatment has persisted in the country, raising concerns vis-a-vis access to treatment by vulnerable groups such as injecting drug users, ethnic minorities, migrant workers, and seafarers. Long ignored, dismissed, and harassed, injecting drug users potentially have the most to gain from universal HIV treatment which has become both expected and common place.

Statement of Problem

"No individual patient should automatically be excluded from consideration for antiretroviral therapy simply because he or she exhibits behaviour or other characteristics judged by some to lend itself to non-adherence. Rather, the likelihood of patient adherence to a complex drug regimen should be discussed and determined by the individual patient and clinician before therapy is initiated"

(The Panel on Clinical Treatment for HIV infection in the USA)

In society worldwide, drug addiction is to say the least problematic. People fear drug user because they see them as a problem at all levels of society. In general, when people believe that ‘drug addict,’ may impact the funding of family education, and a craving for drugs which may drive addict into stealing money to buy drugs for personal use. Also, drug use may lead to prostitution, theft, violence, and an overall of crime. This attitude has lead be one factor causing failure to provide effective treatment for injecting drug users.

Treatment for injecting drug users is still limited in Thailand. In general, a treatment program for drug users, including a form of detoxification and cognitive behaviour therapy is known as ‘matrix program,’ but there is concern that this program is applicable to amphetamine user rather than injecting drug users.

Even though WHO strongly recommend providing ‘methadone’ as substitute substance for injecting drug users, the long-term methadone in Thailand is available widely, with free of charge, only in Bangkok. Notably, the hepatitis treatment is costly in Thailand which is impossible for them to be cured. Despite of the success of methadone, there is argument that methadone is more addictive than heroin.

Human right issue has been raised under the treatment program for injecting drug user. They were treated badly and discriminated from policymakers, caregivers, and individuals. Injecting drug users represent the most vulnerable groups currently requiring access to antiretroviral treatment. In many countries, IDUs are routinely excluded from ARV treatment due to the belief that they are unlikely to persist with treatment. They are thus viewed as non-compliant, untreatable, and undisciplined, which means that they are usually refused access to treatment.

Kiatying-Angkulee et al. quoted that as one health worker as saying: “I won’t give treatment to an IDU unless he stops using drugs. How can I trust him? He cannot even stop using drugs so how can they adhere to the AIDS medicine?” Due to health worker’s perspective, they should give antiretroviral to others rather than giving to individuals whose behaviour is illegal and socially unaccepted.

This type of attitude can easily be exploited to exclude injecting drug users from treatment programs. Some health workers remain opposed to treating HIV-positive drug users because of prevailing judgemental attitudes about drug users. As well, the majority of Thailand’s public health providers has little experience of treating HIV-positive drug users.

There is a shortage of both trained health workers and information about treatment that is applicable to the Thai context. IDU treatment is subject to discrimination, uncertainty over drug interactions, or outright neglect. Many drug users fear harassment or being arrested. They are not confident that health officials will safeguard their privacy. Reinforced by popular culture and scientific research, both the public and methadone clinic assume that heroin users cannot tell the truth because lying is an attribute characteristic of such people (Freidman et Alicea, 2001).

The pattern of drug consumption and access to treatment can be misleading in some instances because of differences in body size, gender, race, religion differences, and other between person differences. The pattern of drug and treatment consumption of female injecting drug user may vary which depend on motherhood, relationship with partner and et. For female injecting drug user, methadone provides them with an opportunity to leave abusive relationship with men and to gain a sense of who they are (Freidman et Alicea, 2001).

Notably, drug consumption is dynamic. Currently, in Thailand, hard core injecting drug user turns to other substance to inject such as Midazolam, methadone etc. These substances cause more hazardous to their health. For injection, many of them mixed methadone and Midazolam together which somehow easily cause overdose.² Moreover, injecting drug user may face the problem of resistance to any pain killer medicine.³

This research aims to elucidate how injecting drug users gain entry to treatment programs in the Thai context, and to demonstrate the ways in which Thailand's health care systems can better meet IDUs' needs and by extension help them access treatment programs effectively.

Objective:

- To understand process of internalization of injecting drug user in Thai society
- To describe the treatment context of injecting drug user in Thailand
- To investigate correlated demographic characteristics, such as race and gender, that contribute to access to treatments.
- To identify and describe the social and cultural factors associated with injecting drug users and HIV/AIDS
- To examine the delivery of health care to infected injecting drug users in relation to other problems these patients face.

Research Questions

How do the methadone and ARV programs work for IDUs? What do health workers think about IDU? What is addictive social behaviour in the Thai context? How does the health care received by HIV-infected persons who have histories of injecting drugs compare with the health care received by those of other at-risk groups? What are the social and cultural factors associated with IDU and treatment? What do injecting drug users think about themselves and others? How does the emergence of biomedicines such as methadone or antiretroviral affect society and what are the consequences for society?

² Last month, one of my friend, a staff at drop-in center died. His death is caused by the overdose of drugs. Nobody know exactly what he injects, but some said he used Midazolam and Methadone. Some say his guy always use heroin, but somehow may mix with other stuffs. Every feel with grief and frustrated the reason that he died because he is well-trained staff on drugs. I heard some of his friend complain that, "why why, I don't understand. He knew the consequences of using those drugs." I felt the same thing as well because during training a few weeks ago, he demonstrated how to save people from overdose. He is such a capacity man.

³ One of injecting drug user I met in training broke his arm because of accident. He told other that the doctor want to do operation, but his body is resistant to any pain killer because he inject a lot of his injection habit. Other guy share the experience that when he was admitted to hospitals, the doctor needed to inject the highest level of pain killer medicine.

Rationale and Significance

Research into the epidemiology of injecting drug users and HIV/AIDS in Thailand is well-documented. Failure to provide qualitative information means to exclude scholarly analysis from the larger political contexts, cultural meanings, and explanatory dynamics vis-a-vis the socially taboo behaviour surrounding addiction and infection that their protocol attempts to document (Bourgois, 2001). However, quantitative studies alone cannot provide the answer to 'why' and 'how' the HIV epidemic occurs. Clearly there is a paucity of 'thick description' of the phenomena.

The need for qualitative research in the field of injecting drug users in Thailand is clear qualitative research studies may reveal the perceived barriers to condom promotion and explore how perceptions among Thai-Buddhist and Thai-Muslim IDUs may influence their recognition of their HIV status and the need to protect their loved ones (Perngmark, 2004). To this end, more qualitative studies of injecting drugs users should be undertaken.

Failing to provide this qualitative information may lead to misinterpretation and less efficient interventions. More importantly, access to treatment by injecting drug users has become a very important issue since Thailand has little experience in providing antiretroviral to injecting drug users. Most of the research evidence is based on studies undertaken in developed countries which are not applicable to the Thai context; thus, local research is needed to identify the barriers to accessing treatment programs. The result of this work will help other people understand their lives.

Conceptualization

The identities of injecting drug users and health professionals have been created through interaction with multiple agencies in society. The identity of injecting drug users has been created out of labels imposed by members of society, who view drug addicts' behavior as 'deviant.' As opposed to the comparatively low status of drug addicts, health professionals occupy a highly prestigious status in society. This creates a gap in communication when IDUs and health professionals interact at treatment centres. Methadone and antiretroviral drugs are used by the aforesaid professionals as 'thing' through which to exercise their power.

Biomedicine in Thailand

'Medicines' as 'objects' are substances used to treat illness that is, to bridge the gap between the healer and the patient. Van der Geest and Whyte describe the value of medicine as a 'thing' embedded in social lives. It allows private individual treatment, and transacts from one interpretative setting to another, retaining the value but changing the meaning. As a 'thing', 'medicine' becomes alive in accordance with the surrounding context and the interaction between curer and patient.

Each culture has its own characteristic perception of 'disease,' a concept which has led to a later study later called 'ethnomedicine.' In the past, basically, the Thai medical system centred on Ayurvedic medicine, a text based upon naturalistic systems. Disequilibrium and illness was related to factors such as climate, seasons, habitat, and age. (Cohen, 2006) People tend to somatize their sickness based upon this belief system, using terms such as '*lom*' (wind).

The rapid influx of a western medical style has shaken the Thai way of life, impacting the country's medical system. Bio-medicine is considered a therapeutic technology, a product of westernisation, which exercises its power via health professionals. In rural Thailand, drugs were hitherto likened to commodities of which villagers exhibited definite knowledge and demonstrated preferences for at drug stores and grocery shops (Sri-Ngernyuang, 1996). For Thais, biomedicine has become the symbol of modernisation.

Biomedicine, which was introduced into Thailand in the 19th century, in time became the 'official' government medicine. Hospitals, medical schools and various associated personnel were roughly structured around a western model. A number of students were trained as 'modern doctors' or physicians practicing with western medicines or biomedicine. The local healer, meanwhile, continued to use herbal and occult treatments of either natural or supernatural origin (Cunningham, 1970). The emergence of biomedicine, which has resulted in Thais lessening their dependence upon herbal and traditional medicines, has overtly change drug use in Thailand.

After World War II (post-1945), pharmacies with an a vast range of modern European, American, Japanese and Taiwanese pharmaceutical drugs were found in market settlements throughout the country. They became readily available in villages in a number of forms, and became part of the popular medical culture of the area (Weisberg, 1984). In Northern Thai villages, drug advertisements appeared on the backs of drug trucks, in the form of handbills, and on radio. Importantly, the government encouraged people to use more biomedical than herbal medicines. In 1977, a national-wide Primary Health Care Program was launched in Thailand, which included a Village Drug Fund that provided essential drugs such as paracetamol, oral rehydration salts, and chloroquine (Le Grand et al., 1993). Most of the drugs provided were biomedical.

Biomedicine became popular due to the swiftness of its efficacy and the fact that it was easy to obtain. Without realising the power of biomedicine, its distribution became widespread over the country, dispensed from outlets such as grocery stores. Sri-Ngernyuang notes that in the case of drug consumption in Thailand in 1996, it was estimated that about 52 percent of drugs were purchased through private channels while 48 percent were obtained at government-run health and drug outlets. Lack of standardisation was one of the reasons why traditional medicine could not survive the confrontation with Western medicine. However, the fact that biomedicines became available in grocery stores and easy to obtain gave rise to concerns vis-à-vis inappropriate drug use. Untrained sellers relied on remembering which drugs were to be used for which illnesses.

Medicine has power over people: power relations between people may be mediated through objects, symbolisation, medicalisation, and the process of globalisation (Whyth et al.). Nichter's research into medicine in South India describes the mixed perceptions of villagers toward Ayurvedic medicine and biomedicine. Local people who referred to biomedicine as 'English' medicine, explained their perception that biomedicine was powerful yet dangerous whereas Ayurvedic medicine was typically spoken of as 'having no side effects'.

Haafkens examines the use of Bemezodiazapines which were prescribed for mental distress by psychiatrists in the Netherlands. Instead of diagnosing patients' mental problems, psychiatrists prescribed drugs which in some cases caused addiction. Methadone and antiretroviral drugs are frequently used as a means of social control. Methadone, while effectively reducing injecting drug users' cravings, often results in drug users becoming addicted to the substance. Methadone is used as a substitute by health workers to control injecting drug user's behaviour. Injecting drug users are required to attend health facilities every day to take their methadone in front of the health workers, who fear that otherwise drug users may either not take the methadone or sell it. Drug users are prohibited from taking methadone home, a condition that has created an atmosphere of distrust between the drug users and the health workers.

Medicines are empowering in that they offer users a means of control. This may, however, lead to drug dependence which is the most obvious form of subjection. It may leave people dependent upon doctors and drugs to understand and deal with their problems. Kitatying-Aunkulee et al. emphasise health workers' use of antiretroviral drugs as 'things' with which to control patients. Health workers set specific regulations, e.g. if an HIV patient needs to access the ART program at the facility, he or she must bring their partner with them, adhere to treatment regularly, and allow home visits by health workers. If the patient does not follow these regulations, he or she will be dropped from the program. In the case of drug users, there is a requirement for them to stop using drugs before starting antiretroviral treatment.

Methadone and antiretroviral drugs provide health professionals with the power to maintain order during the treatment. Medicines, in this case, represent a social regime and become the means of both control and rebellion. People see this as medication's primary purposes not really a cure, but a form of control. Non-compliance, not taking the medicine, or quitting the treatment program can represent an assertion of autonomy on the part of patient, who may feel that medications and doctors impinge on their lives in unwelcome ways.

Methadone maintenance as 'drug treatment' is an example of bio-power at work. Bougois (2000) raise this concern in his research into heroin addiction, arguing that methadone may prove more harmful than heroin. Bourgois's concerns centre upon the side effects of methadone that affect both the physical and mental lives of patients and the further addiction to methadone. Moreover, both antiretroviral drugs and methadone have physical effects as well as mental effects, i.e. adverse health effects while taking methadone as a substitute substance may stop the craving for heroin, on the other hand, the dose of methadone might be attractive to the addict.

The power of the two drugs overlaps because there is drug interaction between the methadone and antiretroviral drugs. Antiretroviral treatment has only become available in Thailand over the last few years. Medical reports suggest that the amount of methadone needs to be increased if drug users take antiretroviral drugs at the same time, medical knowledge that is widely known in Thailand. Some drug users stop using antiretroviral drug to maintain the balance of methadone and stop feelings of craving.

Health professions view both methadone and antiretroviral drugs as pharmaceutical medicines that only treat addictive behaviour and HIV/AIDS symptoms. It was widely

assumed that after taking methadone, users would stop taking drugs because methadone would reduce any feelings of craving. The outcome of antiretroviral drug treatment was measured by CD4 counting.

Health or normality is defined by reference to certain physical and biomedical parameters, such as weight, height, and blood count for example. When this range is 'abnormal,' it may indicate the presence of 'disease' (Helman, 1990). The failure of detoxification treatments results in the return of craving symptoms. If drug users continue to take drugs after entering the treatment program, they demonstrate uncontrolled behaviour, and for this they may be punished. If they return a low CD4 count after taking antiretroviral drugs, it is assumed that the patient is non-compliant, and may be a result of drug resistance. If the patient reaffirms his/her medical adherence, they will be asked to submit to a blood test.

Kleinman defines the difference between disease and illness. Disease is a description that practitioners created in terms of recasting of illness in terms of theories of disorder. Biomedicine becomes the object of treatment whereas illness tends to be more subjective because it concerns the experiences of both patients and processes. Importantly, illness is more concerned with patients' feelings. I would suggest that the effectiveness of treatment would be based on the 'etic' point of view (of practitioners) while the effectiveness of illness would be based on the 'emic' point of view (of patients).

During 1980, the most commonly heard of illness among northern Thai women was 'wind illness.' Muecke (1979) studied the perception of Thai women vis-a-vis 'wind' illness. In the 'emic' view of the villagers, the term 'wind illness' can be applied to several symptoms such as headaches, muscle aches, dizziness, vomiting, paralysis, and loss of consciousness. When it came to the health profession, this illness was not recognised as a disease. Muecke's finding supported the notion biomedicine is primarily concerned with disease, and indigenous medicine with illness (Muecke, 1979).

To some extent, biomedicine can only cure 'disease' under the watchful eye of the health professional. Effectiveness is justified based on medical skills learned at medical school. The treatment of HIV patients and drug users should be viewed as treating 'illness' rather than 'disease.' There should be suggestion of 'pollution'.

There is little doubt surrounding the effectiveness of ARV for it makes the lives of PLWHs better. It is effective in terms of curing the disease because it kills the virus. After the patient takes ARV, they hope to live their lives as others do. Most HIV women are forbidden to become pregnant again. If pregnancy is detected, health workers stop giving ARV. Patients ask: Why can't I have family? Why can't I live my life like others? Clearly, ARV is not successful in terms of curing the illness. It cannot provide all of the answers in the same way that methadone cannot always help users back into society successfully.

Methodology and Data Collection

Methodology

In this research, the standard methodology of anthropology will be utilised, namely ethnography, which will be employed in order to capture the informants' social

meanings and ordinary activities. Ethnographic research has clearly made a significant contribution to understanding and describing the culture and social consequences of injecting drug use.

As part of data collection, multidisciplinary methods will be applied including review of literature, and participant-observation, a process wherein the researcher put him/herself “in the shoes” of the people they study as a way of “seeing local realities” through local eyes. I will use direct observation, recorded filed notes and in-depth interviews with injecting drug users in a bid to elicit their ‘emic’ point of view

Data Collection

For the purpose of this research, I will interview health workers working in drug user treatment programs or relevant fields to determine their attitudes toward drug use and user. The results will be analysed using context analysis which will afford a rich description of the phenomena.

Bearing in mind the sensitivity of this issue, I will collaborate with Thai Drug user Networks and other relevant organizations i.e. gatekeepers and crucial entry-points. This will provide me with access to IDU groups. I will volunteer to work in the organization and this too will help me to learn and interpret the special meanings given to specific forms of behavior such as languages-use.

To complement the findings, Focus Group Discussions (FGDs) will be conducted with IDUs. In these FGDs neutral and open-ended questions will be used to stimulate lively discussion. At the end of data collection ethnographic data such as quotations from in-depth interviews, diary entries, and other personal documents will be extracted from observation field notes as well as transcripts of conversation.

In ensure the protection of participants’ confidentiality, specific techniques will be applied. The investigators may provide participants with a tape-recorder, ask them to record their stories and mail the tapes directly to investigator. Telephone interviews maybe used in cases where participants express their fear of being recognized in public. In this case, in the interests of safety, there will be no follow-up.

IDU groups are defined both as hard to ‘reach groups’ and ‘invisible populations’. To avoid disclosing their identities, interviews will be conducted at places where the participants feel most comfortable. Verbal consent for data collection will be obtained and participant’s will be assured that their anonymity and confidentiality will be protected.

This research which is part of a wider ‘community project’ will be carried out formally as full-time study between August 2006 till August 2007. During my fieldwork I will observe and participate informally in local community daily life with injecting drug user NGOs and health workers. With the help of NGOs, I will use ‘snowball sampling’ and the chain referral method to create a ‘web of trust’ Data Collection will take be undertaken over a total of twelve months between August 2006 till August 2007, according to the following timeline:

August – December 2006: Participant observation with IDU NGO. During this time, the data will be collected by mean of participation in the daily life of former IDU in order to discover their interpretations, social meaning, language and activities.

January – February 2007 (2 months): Collect data in Sumut Prakarn

March – April 2007 (2 months): Collect data in Chiang Rai

May- June 2007 (2 months): Collect data in Had Yai

Facilitated organisations: Alden House, Thai Drug User Network, Thai AIDS Treatment Action Group, Thai People Living with HIV Network, Social Pharmaceutical Unit Faculty of Pharmaceutical Sciences, Chulalongkorn University, Bangkok, and Health Service Centres

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