COMMUNITY-BASED DRUG ABUSE CONTROL, SOCIAL CAPITAL, AND THE 'WAR ON DRUGS' IN NORTHERN LAOS

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The 'war on drugs' in Laos

Opium reduction projects in Lao Peoples Democratic Republic (Lao PDR) are an integral part of the 'war on drugs' led by the United States and the United Nations International Drug Control Programme (UNDCP).[1] UNDCP formulated a Comprehensive Drug Control Program (Masterplan) for Lao PDR for period 1994-2000. Notably priority was given to supply reduction through alternative development. In 1996 the Lao Government revised its drug control law (Article 135 of the Criminal Code on Drug Trafficking or Possession) and prohibited the production of opium. In December 2000 the Prime Minister issued a decree (No.14) ordering the total elimination of opium cultivation by 2006 (later altered to 2005). Drug control policy is the responsibility of the Lao National Commission for Drug Control and Supervision (LCDC) established in 1990. LCDC carries out its mandate through provincial and district drug-control committees set up in 2001.

Opium supply reduction projects have been largely placed in the hands of foreign aid agencies, often with additional funding from UNDCP, the United States and the government of Lao PDR. In this paper I am concerned with the s of two foreign aid agencies (which I shall identify as Agency A and Agency B) in the districts of Sing (Muang Sing) and Long (Muang Long) in Luang Namtha province in northern Laos.[2] These programmes also include a demand reduction component that targets highland opium growers and includes the detoxification and rehabilitation of opium addicts. They commenced in 1997 and are implemented by agency and local government staff in collaboration with provincial and district drug- control committees and in parallel with a wide range of rural development projects (substitute crops, land development, education, health) that now come under the umbrella of 'alternative development'.

[1] Now called United Nations Office on Drugs and Crime (UNODC).
[2] The paper is based primarily on my field research in October and November 2002 in Muang Long, conducted with the permission of the Lao National Commission for Drug Control and Supervision and the support of Agency B.

'Alternative development' (once called 'crop substitution') is an integral part of current supply-side policy. It functions through a system of incentives and disincentives. The incentives of development assistance are conditional upon reductions in the cultivation (and in some cases consumption) of illicit drug-crops. There is thus a kind of contract between the community and the development agency. Disincentives may take the form of withdrawal of assistance and law-enforcement measures if communities (or individuals within them) fail to keep their side of the bargain (Farrell 1998:415). In short, the policy has a punitive bottom-line.

Agency A's Integrated Food Security Project, now called PORDENA (Poverty-Oriented Rural Development) and Agency B's Luang Namtha Drug Supply and Demand Reduction Project in Long district (now called the Long Alternative Development Project) clearly fit this model, in that they are based on a system of incentives and disincentives. Agency A and Agency B have provided a wide range of development assistance to target villages. The contractual element is quite explicit in that villagers sign written agreements regarding the cessation of opium cultivation and consumption. Disincentives take the form either of refusal of development assistance or withdrawal of assistance already given.

The population of each district, Sing and Long, numbers approximately 24,000. The lowlands are inhabited predominantly by Tai Lue and the highland population comprises Akha, Yao, Hmong, Lahu and Lanten. The numerically dominant ethnic group in both districts is Akha, with about 45 per cent of the total population in Sing district and 75 per cent in Long district. The supply and demand reduction projects have targeted only the highland groups.

At the commencement of these supply and drug demand reduction projects in 1997 the great majority (about 90%) of highland communities in Sing district cultivated opium but few households grew enough for their own consumption. In Long district only about 60% of highland villages grew opium but a number of villages, close to the Mekong River, grew extensive areas (as much as 80 ha in two cases) mostly for export. The rate of opium addiction in the dominant population – the Akha – was about 9% of total population.

Community-Based Drug Abuse Control

Both Agency A and Agency B identify their detoxification projects as grounded in the principles and practices of Community-Based Drug Abuse Control (CB-DAC) - a particular form of community-oriented drug-use control developed by the Thai-German Highland Development Program in northern Thailand. CB-DAC has its philosophical roots in PAR (participatory action research) that has had widespread influence over the past 30 years on NGOs in the Third World. CB-DAC thus emphasises grassroots community participation, ‘ownership’ of development projects by the community, dialoguing between the community and development workers, and the role of development workers as mere catalysts in an emerging awareness of local problems (‘critical awareness’).

In Sing and Long districts CB-DAC is focused on the detoxification of highland opium addicts. The program is divided into three phases with following ideal goals:

a. Preparatory phase:

- Village data collection, to be discussed with villagers so that they can identify problems and suggest solutions.
- Discussion of the causes of addiction.
- Raising awareness of the community about the harm of drug abuse.
- Outlining of the responsibilities of village organisations before and after detox.
- After addicts ‘volunteer’ for detox formal agreements are signed with individual addicts. This is followed by the collection and destruction of smoking equipment.
- Medical checks on volunteers (those with TB and high blood pressure should be excluded).

b. Detoxification phase:

- 14-21 days in schoolrooms or camps built by villagers.
- ‘Cold turkey’ plus medical support in form of traditional herbal drinks, paracetamol, valium, vitamins, etc.
- Village participation in the building of the camp, provision of food to the addicts, and social support (visiting, massages, singing, etc.).

c. Follow-up phase

- Health checks and treatment.
- Counselling by project and district staff, village organizations, and family members to 'give support and encouragement to the recovering addict'; the provision of food aid.

Long district: Phase 1 and Phase 2

Agency B has targeted only 19 villages comprising different highland ethnic groups (16 Akha, 1 Hmong, 1 Lahu and 1 Lanten). For the 8 villages detoxed during Phase 1 (1997-1998) the relapse rate was 58% after 3 yrs. This was more or less consistent with relapse rates for the 60 villages targeted by Agency A in Sing district. Here the overall relapse rate for 60 villages is 53%, though for those who had detox in 1997/98 the rate is 70%. The relapse rate for Phase 2 villages in Long district was an exceptionally low 2% after two years.[3]

Why the significant differences in rates of relapse between Phase 1 and Phase 2? The reasons given in an Agency B report (Drug Supply & Demand Reduction Project Long District) are as follows:

Phase 1:

- Absence of a cohesive District Drug Control Committee.
- 'Ownership ' of the project by government workers and project staff.
- Planning more guided by wishes of project and government staff.
- Addicts not well prepared for detoxification.
- No consistent follow-up activities by district officials.

Phase 2:

- More participatory, with project and government staff more responsive to villagers schedules.
- Villagers have a greater sense of 'ownership' and interest in outcome.
- Access to experience and knowledge of other villages (following institution of a system of 'shared experience').
- The setting up of Detoxed Addict Associations (or Opium Free Associations) to provide mutual support for detoxed addicts and prevent relapse.

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[3] A survey I conducted in October/November 2002 of 5 Phase 2 villages revealed a still very low relapse rate of about 8%.

- Longer preparation and follow-up.
- Networking.
- Development workers as 'catalysts' for emerging awareness of drug problems.

Social capital

Pierre Bourdieu, in his seminal analysis of social capital, defined the concept as 'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition' (Bourdieu 1985:248, cited in Portes 1998:2). A more straightforward definition is that of Portes: 'social capital stands for the ability of actors to secure benefits by virtue of membership in social networks or other social structures' (1998:4).

It is clear from the above that social capital is an important dimension of CB-DAC philosophy as conceived in relation to the demand reduction projects in Sing district and Long district: emphasis on community participation based on traditional social structures, the fostering of new social groups such as Village Development Committees and Detoxed Addicts Associations, and the development of new forms of inter-village social interaction based on 'shared experience' and 'networking',[4] as well as the building of closer ties between village elites and government officials and agency development workers. There has been more investment in social capital in Long district,[5] which has contributed to the very low relapse rates in Phase 2 of Agency B's programme.

Social capital is defined in terms of the 'benefits' that accrue from various forms of social cooperation. Fukuyama notes that such benefits may comprise 'a common pool of resources that are shared within communities' (2000:107). In the case of Sing and Long districts I would argue that the common pool of resources that has become of crucial importance to highland communities are those resources provided by the foreign aid agencies. Some of the resources allocated by the agencies go to

[4] 'Shared experience' includes visits to other villages (usually during the preparatory phase) by village leaders who have had experience with detoxification, and networking meetings (or workshops) where discussions are held between village leaders, district officials and agency development workers. Seven of the Phase 2 villages in Muang Long were organised into a network with one of the village headmen elected as chairman. By the time of my research in October/November 2002 the network had held one workshop and planned another for December that year.

[5] The institutions of 'shared experience' 'networking' and 'opium-free associations' exist only in Muang Long and were introduced following an advisory visit by a CB-DAC expert from northern Thailand.

individuals (e.g. livestock) but many are for the benefit of the community as a whole: roads, medical dispensaries, schools, fisheries, irrigation schemes, rice banks, etc. In some respects these resources replace those highland agricultural resources diminished by reduced swidden production (dry rice and opium) and government resettlement schemes (see Cohen 2000). I would also argue that the 'politics of the commons' in this region centres on the issue of 'conditionality' and the contract between the community and the aid agency that makes development assistance conditional upon opium supply and demand reduction (including detoxification of addicts). The threat of refusal of assistance or withdrawal of assistance combined with law enforcement provides a powerful sanction in favour of compliance and considerable pressure on community leaders to develop formal and informal controls with their communities to ensure the preservation and continuation of aid.

However, it is apparent that conditionality and law enforcement provide only the *necessary* but not *sufficient* conditions for low relapse. These sanctions, integral to 'alternative development', apply to both Sing and Long districts but the former has relatively high relapse rates and the latter exceptionally low rates, at least for Phase 2. The additional factor that explains the low rates of relapse in this phase is the very effective systems of social control through local regulations and penalties. Thus, Phase 2 villages, as well as the standard system of monetary fines for individual relapsees and regulations against growing and selling opium, also consistently refused to accept addicts from other villages as residents or as visitors to the homes of detoxed addicts. In Jamai village detoxed addicts are not allowed to stay overnight in upland field huts. And in Jamai and Huaymor villages relapsed addicts are threatened with exile from the village and in Huaymor this regulation has been enforced in one case. Furthermore, in Phase 2 villages the system of surveillance by village leaders or youth group members of either new or detoxed addicts is more regular and thorough than is the case for Phase 1 villages.

Notably one of the functions of 'networking' (*kheua khaai*) and 'shared experience' (*thortthon bothian*), according to the chairman of the network of Phase 2 villages, is 'to compare regulations to determine the best for relapsed addicts'. It is therefore likely that networking operates to reinforce and even expand the village and inter-village regulatory system. The Detoxed Addict Associations (which comprise between 5 and 7 members each) in Phase 2 villages seem to operate in a similar way. In answer to the question what they talked about when they met, there was never any

mention of mutual psychological support against relapse. Rather the answer was invariably that they formulated proposals for more assistance from Agency B or discussed village regulations concerning opium, including reporting fellow villagers to the district authorities. In Taohom and Jakhamtanh villages some of these groups, at their meetings, actually proposed that Agency B refuse assistance to relapsed addicts and in Huaymor another group suggested that the local district government be asked to confiscate the land of relapsees (i.e. wet-rice land that the project had developed by tractor)[6].

It is my view that this rigorous system of social control is closely related to the reputation and status of village leaders, in particular the village headmen. Leaders of Phase 2 villagers seemed to be especially concerned with preserving their image and image of their villages as 'model' villages with exemplary opium-free records. Each new addict or relapsed addict blemishes this record and results in loss of 'face'. Notably an important consequence in Long district of the more prolonged and personalised interaction between these village leaders and agency and local government staff (nurtured through dialogue) and the promotion of concepts of 'shared experience' and 'networking' has been to expand the orbit of social capital – what Fukuyama terms the 'positive radius of trust' (2000:101) - beyond the highland village. This has created a new social arena in which the reputation of village leaders is judged.

Social costs

This system of rigorous social control is no doubt effective from the viewpoint of producing low levels of relapse and attendant economic benefits for rehabilitated addicts. For those opium addicts who have undergone detoxification and have been successfully rehabilitated the benefits, particularly economic, are considerable. Improved livelihood for rehabilitated addicts is exemplified in a wide range of economic gains: the development of new wet-rice fields, the building or new houses or renovation of houses (e.g. roofing), acquisition of rice-mills, small tractors, fish

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[6] With regards to Muang Long I am not suggesting here that low relapse in Phase 2 villages is only a consequences of punitive threats. Factors such as the economic costs of continuing addiction and the very real economic benefits of remaining free of addiction provide strong incentives to remain opium free. But I suspect these punitive measures create powerful, intimidating sanctions against the waverers.

ponds, livestock, and increased rice for household consumption. Furthermore, women have most to gain as the burden of opium addiction falls heaviest on them and drug-reduction programs are empowering for women (see Cohen & Lyttleton 2002).

However, there is a downside to the development of social capital and the mechanisms of social control entailed. Thus Portes notes: 'The research literature on social capital strongly emphasizes its positive consequences. Indeed it is our sociological bias to see good things emerging out of sociability…However, the same mechanisms appropriable by individuals and groups as social capital can have other, less desirable consequences…sociability cuts both ways' (1998:10,12). One negative consequence of detoxification programmes in Sing district and Long district is the creation of an 'addict identity' and stigmatisation and marginalisation of relapsed addicts (see Cohen and Lyttleton 2002). 'War on drugs' rhetoric imbues detoxification programmes in the two districts and inculcates a new discourse on the unmitigated evils of opium, not the least its role as an impediment to 'development'. There is an increasing distinction between addicts and non-addicts and this process of discrimination has produced a new category of 'degenerate addict'; and relapsed addicts are increasingly burdened by a sense of shame. The headmen (and other village leaders) of 'model' villages play a critical role in this shaming process by frequent surveillance and verbal confrontations with relapsed addicts. Shaming thus has become an additional weapon in the headman's armament of social control strategies.

Furthermore, the concern with the image of village headmen (and 'their' villages) leads to lack of empathy and responsiveness to the health needs of addicts who face the prospect of exile or at least strong pressure to detoxify, irrespective of the serious illnesses they suffer (e.g.TB). For example, in the Akha village of Langphamai in Long district one 46yr old male addict had smoked for 9 years. He detoxed himself in 1997 but relapsed after 2 years. He reluctantly joined the Agency B detox in 1999 because he said villagers forced him into it. He relapsed again after 6 months. He attributed relapse on both occasions to the fact that he suffered from TB. Yet the headman insisted that he either detox again or leave the village. In the Lahu village of Phorthammai there was a young man who had refused to join the Agency B detox in 2001. Seemingly emboldened by copious amounts of whisky during lunch he complained angrily and loudly that he had a continuing problem with hernia. He had been to Long district hospital but the doctor said he could not perform an

operation in Long. He had spent a bout a million kip locally on various kinds of medicine. The government, he declared emotionally, should help addicts with their medical problems first before banning opium cultivation and smoking. He has a point!

Conclusion

The UNDCP and Lao PDR 'war on drugs' in the opium-growing regions of northern Laos takes the form of alternative development projects that are implemented by foreign aid agencies and that comprise both supply and demand reduction. These projects are based on somewhat contradictory models of development. Alternative development is a top-down, state controlled form of development that relies on 'carrot and stick' policies, with the potential for resort to punitive sanctions (including law enforcement and the use of force. By contrast, community-based drug abuse control is a bottom-up model that has its philosophical roots in participatory action research and emphasises, amongst other things, community participation and the development of social capital through village-level organisations, networks, and sanctions.

In this paper I have argued that the benefits derived from the development of social capital comprise largely the 'common pool of resources' provided by the aid agencies. These vital resources have become the focus of the 'politics of the commons' that govern the strategic interaction between highland communities, on the one hand, and foreign agencies and local government officials, on the other.

The control of these resources by the agencies, given the contractual nature of alternative development, serves as a powerful force of compliance to the requirements of opium demand reduction. An additional, critical factor is the development of effective systems of community social control, which is closely connected to village headmen and 'model' villages with low rates of relapse for detoxified addicts. The concern of village headmen with their reputation (or 'face'), vis a vis fellow headmen and local agency and government officials, is enhanced by new forms of social capital derived from 'shared experience' and 'networking'. The rigorous system of social control that has emerged in Phase 2 villages in Long district also reflects a process whereby headmen have become crucial intermediaries and surrogates for the policing of communities; this has allowed both foreign agencies and local government to so far adopt relatively non-coercive, hands-off policies. However, this could soon change as the 2005 deadline draws nearer and pressures grow to meet opium supply and demand reduction targets.

I have emphasised the relationship between the development of social capital, effective community social sanctions against relapse and the economic benefits for rehabilitated addicts. I have also identified the attendant social costs in terms of the creation of an 'addict identity' and increasing stigmatisation and marginalisation of relapsed addicts. This is inconsistent with the humane principles of community-based drug control and also with UNDCP programme pronouncements that addiction is a 'chronic relapsing order' and that neither addiction nor relapse should be subject to punishment (UNDCP 2002:25,26). Furthermore, there is a realistic prospect that relapsed opium addicts will turn to the furtive use of more easily concealed and more harmful illicit drugs. Indeed there are already reports of the spread of methamphetamine (*ya ba*) use in the highland communities of both districts.

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