1. EXECUTIVE SUMMARY

The Community-based Drug Substitution Therapy (DST) program is a service provided by FPMPAM/AMAM with the guidance from the Ministry of Health to offer addicts community-based medical treatment in settings such as private clinics, general practitioners, family doctors and specialist centers. The program mechanisms have shown to be successful in curbing abuse of medications and improving results of the treatment. The treatment program is monitored real-time by a specially dedicated integrated computerized system, the National Drug Substitution Register (NDST Register) which was set up in 2006.

This NDST Report 2011 will review the performance of this treatment program for the period 2006 to 2011.

This Report will show data to prove that Community-based DST programme for opiod addiction can work for Malaysia in a setting of self-regulation. The treatment environment must be stable and complete doctor-patient confidentiality is vital. The future success of such a program is dependent on proper administrative and legislative support from relevant government authorities to ensure that all parties from patient, healthcare professional and pharmaceutical industry must abide by the set rules and standard operating procedures.

This report is structured as follows:

- Introduction and background
- The NDST registry
- Compliance of DST guidelines
- Situational analysis of community-based DST programme as of 31 July 2011 (with updated data as of 20.10.2011)
- Conclusions and AMAM recommendations

2. INTRODUCTION AND BACKGROUND

Since the global acceptance that addiction to drugs is a medical disease that can be medically treated the capacity for medical management of this problem in Malaysia has been extremely encouraging.

Statistics from the AADK shows that there were at least 300,000 registered drug addicts in Malaysia, the majority of which were addicted to heroin and opium-like drugs. We believe that there still exists significant under-reporting as patients avoid detection due to the stigmatization and criminalization of the disease.

The program for Community-based drug substitution (DST) therapy for opoid addition was started by the Federation of Private Medical Practitioners' Associations Malaysia (FPMPAM) in 2002 as one of its community social responsibility project. This was in response to the call from the then Agensi Dadah Kebangsaan in 2001

Founded in 1989, the FPMPAM is the national medical body that supports doctors in private practice to provide high quality health care through continuing medical education, ethics advocacy and public outreach programs

The FPMPM initiated the setting up of the Addiction Medicine Association Malaysia (AMAM) on Aug 25, 2005 to help develop addiction medicine in Malaysia.

Since the year 2002, FPMPAM and subsequently AMAM have consistently increased and maintained its efforts to promote medical treatment for drug addiction in Malaysia.

As of 31.7.2011, AMAM has a nationwide network of 692 trained registered medical practitioners (483 with active DST facilities), comprising both GPs and specialists, 382 clinics, and 23573 registered patients.

ROLE OF FPMPAM/AMAM IN COMMUNITY-BASED DST

In 2002, Community-based DST was initiated as one of the continuing professional development and community social responsibility (CPD/CSR) initiative of the FPMPAM in its ongoing "Ask Your Doctor" programme.

The first community out-reach project, the "Helping Hand Help Line", was launched in 10 September 2002 with the support of the AADK. The Help Line aimed to increase awareness of the problem in the community and to urge patients to seek early treatment from their family doctor.

This was complemented by sustained public educational activities. A dedicated website www.no2drugs.org was launched in July 2003.

Since 2002, the FPMPAM had embarked on an intensive programme to train doctors in the field of addiction medicine and addiction counseling. The programme was well-received and by the year 2005, there were more than 300 registered medical practitioners actively treating patients with drug addiction. In 2004, the FPMPAM together with the Malaysian Psychiatric Association developed the first Clinical Guidelines for Buprenorphine Treatment. Together with the Ministry of Health, similar Clinical Practice Guidelines were also developed for methadone and suboxone (buprenorphine/naloxone combination) therapy.

In addition to regular CME/CPD training programmes , a yearly national conference, the National Conference on Addiction Medicine (NatCAM) was started in 2004 followed by the First International Conference on Addiction Medicine in 2007(ICAM). All these programmes were in collaboration with the Ministry of Health and other relevant professional NGOs. The FPMPAM sponsored participation from both governmental and non-governmental bodies.

ADDICTION MEDICINE ASSOCIATION OF MALAYSIA (AMAM)

The Association was inaugurated in 2005 at the 2ndNatCAM. It is a registered society under the Societies Act and its main objective is to promote and develop the specialty

of addiction medicine in Malaysia. To date it has more than 600 members consisting of family and general practitioners, psychiatrists and counselors.

THE NATIONAL DST POLICY AND NATIONAL DRUG SUBSTITUTION THERAPY GUIDELINES

By 2005, there was evidence that there was abuse of the system of community-based treatment by some unscrupulous practitioners and patients who were hopping from one doctor to another. Furthermore it was shown that there were patients who abused their DST medications by using it as an injection. Patients were also reporting that they were being harassed and arrested when they went for treatment. Thus an unstable treatment environment was endangering the viability of the programme.

Concomitant with the withdrawal of buprenorphine monotherapy (Subutex) and the introduction of combination buprenorphine/naloxone (Suboxone) and methadone in DST programme, a National Committee for DST was set up in the Ministry of Health to draw out the treatment guidelines and to formulate a National DST Policy. The FPMPAM/AMAM was represented in this Committee.

The Committee completed the final draft of the National DST Policy in 2007.

3. THE NDST REGISTRY

The FPMPAM/AMAM developed the NDST registry in the year 2006, following the directive of the Director-General of Health, to monitor and regulate DST in the private sector. It was launched on 26 November 2006 and became fully functional on 1.2.2007.

The DG directed that all medical practitioners providing DST and patients receiving DST should be registered on the Registry. This applied to all registered DST medications. To be a registered DST provider, doctors had to undergo a training module that was approved by the NDST Committee consisting of:

1. Training in the use of the particular DST medication
2. Training in the use of the DST Registry

Private practitioners offering community-based DST treatment were invited to be registered on the system free of charge. To remain on the Registry, FPMPAM/AMAM merely requires that the doctor shall:

3. Abide by all rules and guidelines on the use of the DST medication and the Registry and,
4. The number of patients allocated to each practitioner shall be in accordance to the guidelines provided by the National Committee on DST.

It was the intention of the MOH to start its own MyDST and that this would interface with this NDST Register to ensure that patients on the government MMT Harm Reduction Programme would not be able to abuse their treatment by hopping into the private sector and vice versa.

The NDST registry is a robust internet-based, real-time system and is fully secured against unauthorized entry. It has functioned 24/7 and 365 days per year since 2006.

The system is designed for the registration of individual clinics, doctors, patients and also for hospital-based practices via its upgraded pharmacist module. The system also documents, patients' clinical data, treatment records, clinical epidemiological information and tracks stock and flow of medications.

There are millions of records of daily transactions in the system and had kept in pace with the thousands of daily entries of doctors who actively use the system to perform the necessary prescription and dispensing activities.

The NDST register is a real-time system that has the capacity not only monitor DST but also expandable if needed to include the concomitant monitoring of psychotropic and other related dangerous drugs and to input data for clinical research.

The companies participating in the NDST community-based system are Reckit Benckisser for Suboxone, Hoe Pharmaceuticals and Sunward Pharmaceuticals for Methadone. It was the implied original objective of the DG of Health to have this system designed to handle all DST medications, supplying pharmaceuticals, participating doctors and patients. However there was no follow-up written administrative directive thereafter.

AMAM have constantly called to have this requirement implemented so that a truly integrated community-based DST programme can be fully developed.

As of 1.7.2011, Poison Act 1952 (Psychotropic Substances) (Amendment) Regulations 2011 now merely requires prescribing RMPs to apply and maintain tedious time-consuming written records for a specific permit for the storing, prescription and dispensing of methadone, buprenorphine and suboxone. Contravention of the provisions of these regulations is punishable by a heavy fine and or a jail term.

The new regulations have major defects namely;

1. It is a manually based system, tedious, time-consuming, user-unfriendly and is a disincentive for doctors genuinely wanting to help out in the community-based DST programme,
2. It has no real-time facility or provision to stop/monitor doctor-hopping and micro-manage prevention of abuse of treatment and illegal diversion of DST medications and
3. Registered pharmacist can store and dispense DST medications without a need for such a permit. This creates a two tier system that is open to abuse.

Despite our call, there was no provision in the amended regulations that either implicitly or explicitly requires RMPs to continue with the NDST register. This is a perverse incentive of the said amendment and is in total contradiction to what was required in 2006.

4. COMPLIANCE OF DST GUIDELINES

COMPLIANCE OF DST GUIDELINES BY MEDICAL PRACTITIONERS

Six clinics were removed from the NDST Registry up to 31.7.2011. In addition listing was refused five when their application was not approved by the DG of Health for various infringements.

No appeals for relisting have been entertained.

Including the above, there were a total of 68 inactive registered users. These were mainly doctors who had attended the training courses but subsequently had no further interest in the programme.

COMPLIANCE OF DST GUIDELINES BY PHARMACEUTICAL INDUSTRY

When the NDST registry was launched by the DG in 2006, it was the implicit requirement that all pharmaceutical companies shall not supply any DST medications to any doctor who is not on the NDST registry or has been removed from the Registry.

To date only three companies have voluntarily maintained this partnership with the NDST register. This system is unable to monitor the use of generic buprenorphine and methadone prescribed and dispenses by the government system or any party that has not voluntarily registered with it.

5. SITUATIONAL ANALYSIS OF COMMUNITY–BASED DST PROGRAMME AS OF 31.7. 2011

1: **Challenges in Capacity-building**

Total Number of Trained Doctors Registered on NDST Register

	No. RMPs	% increase
2006	300	-
2007	485	61.6%
2008	576	18.8%
2009	631	9.5%
2010	679	7.6%
2011	692	1.9%

The general practitioners and family practitioners continue to remain the most important frontline personnel in the community-based DST programme. After the initial exponential growth up to the year 2009, the NDST register has recorded a

steady fall of the rate of growth in the number of doctors trained in community-based addiction treatment.

We have noted that generally it is not easy to encourage doctors to take up this programme. Getting involved in DST brings unwanted attention of the enforcement officers and also creates an unwanted stigmatization of their practice.

Distribution of Clinic by Patient Load

No. of registered patients	1 to 50	51 to 100	101 to 200	210 to 300	➢ 300	Total:
No. of clinics	335	42	4	0	1	382

There are presently 382 clinics with 483 doctors actively logging on the NDST Register. It should be noted that a significant number of doctors trained in DST programme finally do not opt to participate in the program.

Since the implementation of the said amendments to the Poisons Act as of 31.7.2011, there has been a noticeable drop in interest among doctors in the programme. Some doctors have already called in to return their stock of medications and to opt out of the programme.

Among the other feedback received recently are:

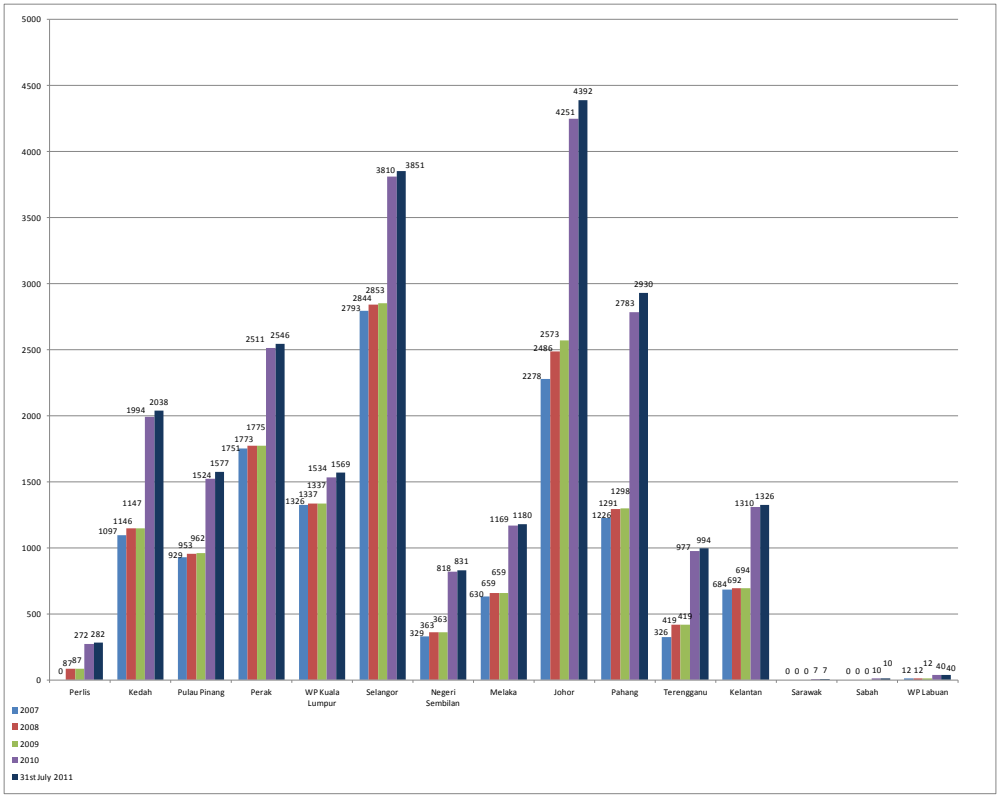
1. Reports of abusive and harassing inspection of clinics by PSD enforcement officers (4 cases)
2. Applications for permit is too cumbersome, too much red tape and its daily input is impractical for clinical use
3. Delay in approval, misplacement of permit during re-application process, incomplete paper-work puts doctor in real risk of criminal prosecution for a failure of an administrative process
4. A catch-22 situation has developed whereby new doctors cannot apply for a permit unless they have particulars of patients and new patients would not want to register with these new doctors as they will have to wait weeks for their first dose of medications. We have noted that when patients have move from a phase of contemplation to commitment to treat their addiction, unnecessary delay has an adverse effect on their decision for treatment.

In the light of this new scenario, we do expect to be able to maintain the projected 10% yearly increase in the number of trained new doctors participating in the programme. The AMAM/FPMPAM had in 2009 targeted critical mass of trained doctors is 1000 for the entire nation to be achieved by the year 2013.We are now forecasting an eventual decrease in the number of RMPs in the community-based programme as more and more doctors will give up under this constant fear of criminal prosecution for administrative failure and increasing paperwork.

The move away from a previously successful computerized real-time self-regulated monitoring system back to an archaic manual, hard-copy, time-and labor consuming system is a disincentive and will not synchronize well with the present overall policy of up scaling DST programme.

It was our observation and our proposal that the provisions of the said amended regulations could have been easily micromanaged by the computerized capability of the NDST register thereby relieving the RMP of the burden of enormous paper work and minimizing administrative failure. Had this been accepted, it would clearly have been a major step forward and would enormously increased the capacity and scope of work that can be undertaken by the NDST register.

2. Distribution of registered patient by States



DISTRIBUTION OF PATIENTS BY STATES					
State	2007	2008	2009	2010	31st July 2011
Perlis	0	87	87	272	282
Kedah	1097	1146	1147	1994	2038
Pulau Pinang	929	953	962	1524	1577
Perak	1751	1773	1775	2511	2546
WP Kuala Lumpur	1326	1337	1337	1534	1569
Selangor	2793	2844	2853	3810	3851
Negeri Sembilan	329	363	363	818	831
Melaka	630	659	659	1169	1180
Johor	2278	2486	2573	4251	4392
Pahang	1226	1291	1298	2783	2930
Terengganu	326	419	419	977	994
Kelantan	684	692	694	1310	1326
Sarawak	0	0	0	7	7
Sabah	0	0	0	10	10
WP Labuan	12	12	12	40	40

Since 2007, the majority of reported cases continue to be in West Malaysia, with a predominant skewing of the cases in the west coast with Selangor and Johor topping the list. The distribution indicates that in most states there has been an improvement of case registration for treatment in 2009 and 2010. This coincided well with the sustained two-year public awareness and education programme, "Jiwa Baru".

In all the states, the optimum numbers of patients per practitioner have being achieved early in the programme. The average ratio ranged from 30 to 50 patients per doctor. To further increase capacity for treatment will require more trained doctors and expansion of counseling facilities in existing clinics to cater for increased number of patients per RMP.

The data indicates that more active awareness and public education programmes together with continuing capacity building of treatment facilities does work and will be required in the next phase of the programme to sustain the momentum generated by the first five years of this community-based DST programme.

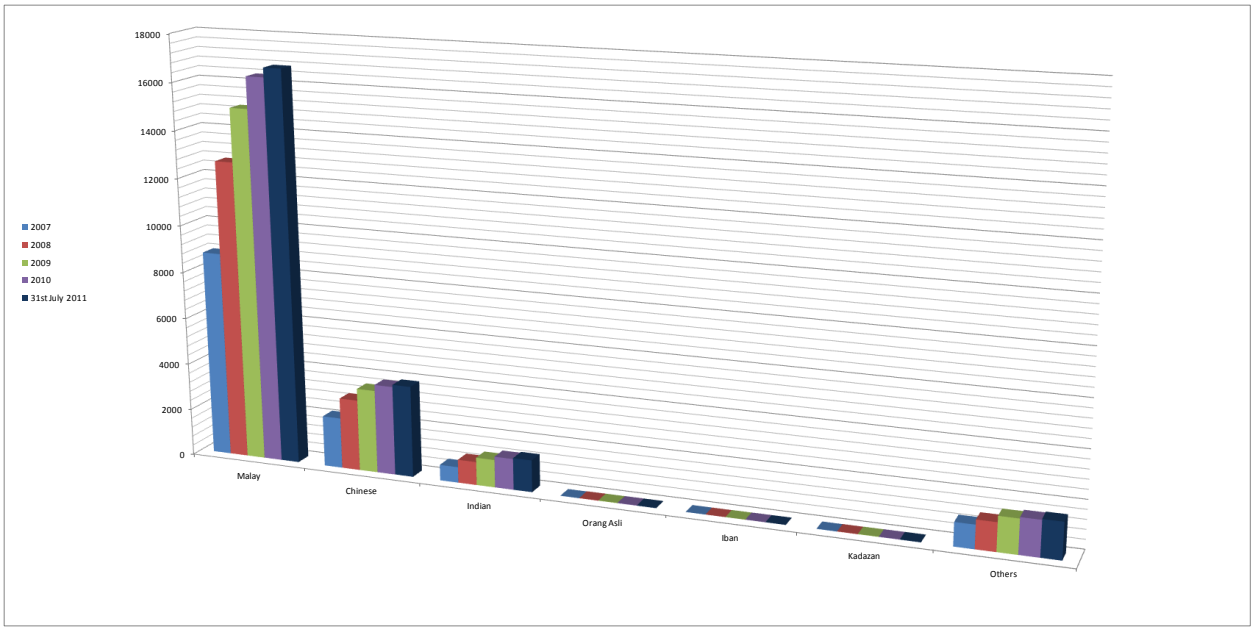
The absence of any cases registered in East Malaysia except for Labuan should not be taken as indicative of the absence of opiate addiction in these two states. As stated in the 2009 NDST Report, we see no inherent reason why the population of East Malaysia would be immune to this disease. The possibility of lack of awareness and failure of patients to seek medical treatment are more likely reasons. The breakdown of the patients by race and ethnic group (appended below) shows twenty four indigenous patients originating from East Malaysia.

3. Distribution by Race/Ethnic Group

Distribution by race of patients

Race	2007	2008	2009	2010	31st July 2011
Malay	8771	12717	14987	16329	16728
Chinese	2169	3038	3547	3806	3898
Indian	672	993	1181	1323	1362
Orang Asli	8	15	15	17	17
Iban	3	3	6	8	8
Kadazan	9	11	13	16	16
Others	993	1199	1454	1511	1544

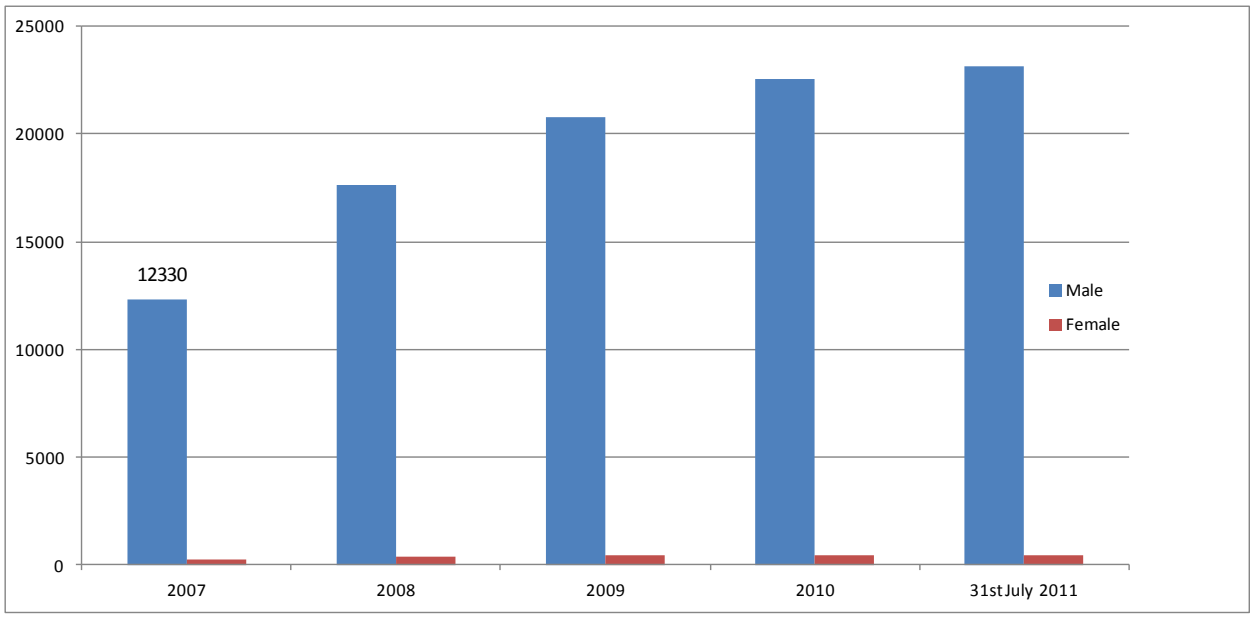
Total: 23573 patients



Malays continue to account for the predominant number of patients registered for treatment. All three major races show an increasing number presenting for treatment year by year. The rate of increase per year is also the highest amongst Malay patients indicating the continued acceptance of DST within the community.

4. Distribution by Gender

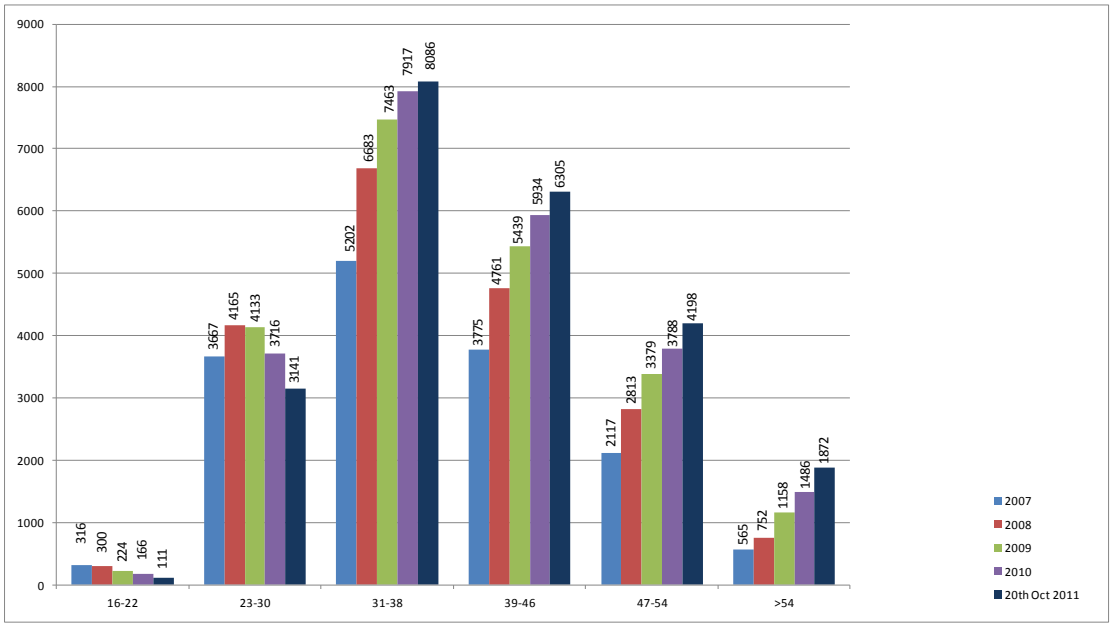
DISTRIBUTION OF PATIENTS BY GENDER					
Gender	**2007**	**2008**	**2009**	**2010**	**31st July 2011**
Male	12330	17602	20782	22567	23125
Female	236	374	421	443	448



Opiate addiction is still predominantly a male issue in Malaysia. This was noted since 2007. The early disturbing trend of a steady increase in the number of females has tapered off in 2009.

5. **Distribution by Age Group (Data updated to 20.10.2011)**

DISTRIBUTION OF PATIENTS BY AGE GROUP					
Age	**2007**	**2008**	**2009**	**2010**	**20th Oct 2011**
16-22	316	300	224	166	111
23-30	3667	4165	4133	3716	3141
31-38	5202	6683	7463	7917	8086
39-46	3775	4761	5439	5934	6305
47-54	2117	2813	3379	3788	4198
>54	565	752	1158	1486	1872
	15642	19474	21796	23007	23713



This is updated data since the preliminary analysis ending 31.7.2011. There has been a pickup of 140 new patients since 31.7.2011.

The data shows that there has been a fall in the number of younger patients registering for treatment. Patients in all age groups 31 years and above indicated a steady increase in number of patients registered for treatment.

The bulk of all cases under treatment continue to be in the economically productive age group ranging from 23 to 54 years. Successful and sustained treatment for this group of patients is expected to be a positive economic factor for the community and a form of preventive harm-reduction.

Another interesting point to note is there is further increase in those in the older age-group seeking treatment. This is an indication that even in late-stage disease, there is still scope for long-term maintenance treatment.

6. Distribution of patients by treatment options(as on 31.7.2011)

Treatment Option	Number of Registered Patients	Average Dose per Treatment
Burpenorphine/Naloxone (Suboxone)	18,152	7.52 mg
Methadone	3,316	49.08 mg

The data indicated sustained proportion of patient remaining well on an average dose of 7.52 mg daily of Suboxone treatment. The 8mg: 2mg ratio inventory data has been consistent over the years. There has been no data to indicate any increase in under-dosing or over-dosing.

The average daily dose of methadone was 49.08 mg. Generally speaking, this average dose of methadone 49.08mg is low compared with the MOH MMT programme which has an average dose of around 70-80mg. The possible reasons are:

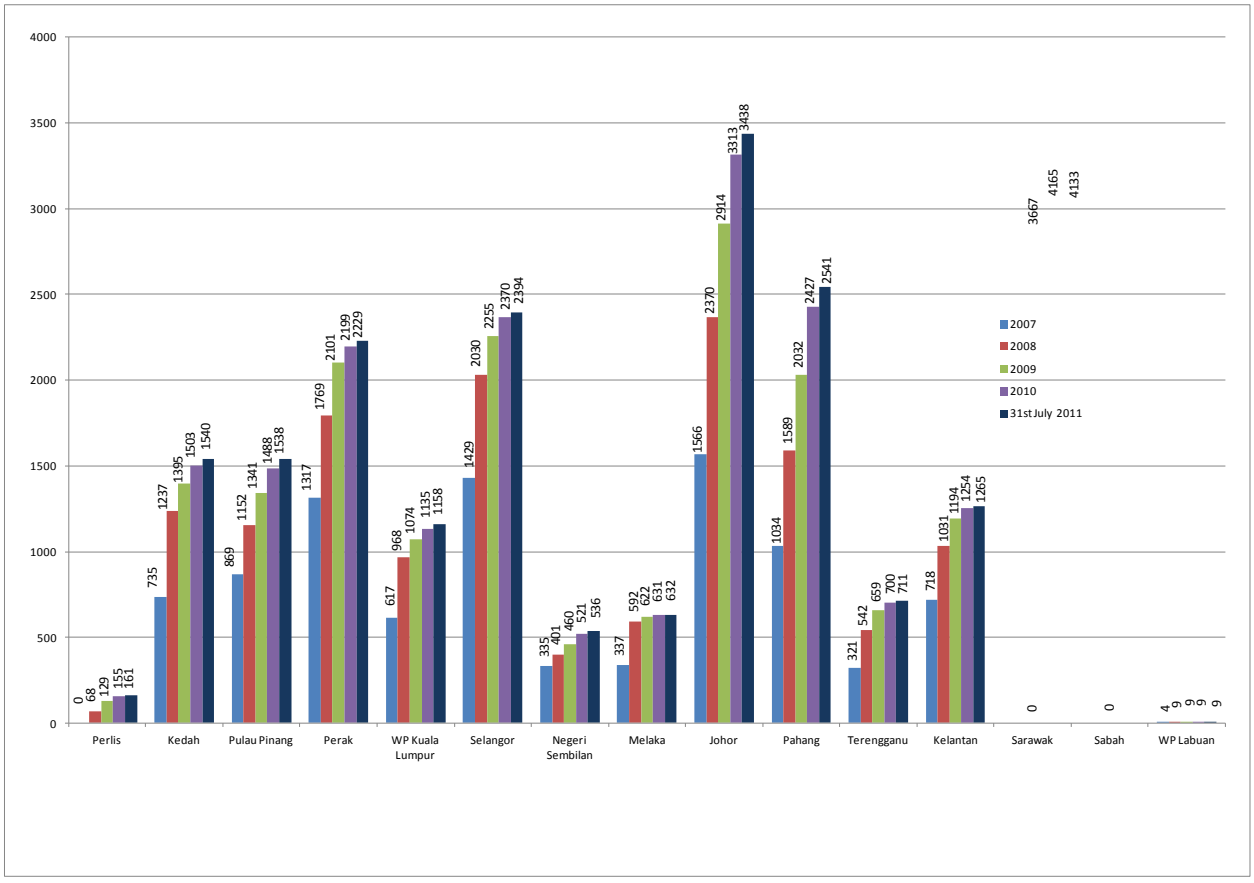
1. The need to pay for medication in the private sector which may also indicate that there may be some unnecessarily raising their dose in the MMT programme

2. Possible differences in the supplier as there are definitely differences in pharmaco-availability

3. The MOH MMT programme may be receiving those on Rx with HAART thus requiring higher doses of methadone

7. Suboxone DST

TOTAL NUMBER OF PATIENTS FOR SUBOXONE ACROSS THE STATES					
State	**2007**	**2008**	**2009**	**2010**	**31st July 2011**
Perlis	0	68	129	155	161
Kedah	735	1237	1395	1503	1540
Pulau Pinang	869	1152	1341	1488	1538
Perak	1317	1796	2101	2199	2229
WP Kuala Lumpur	617	968	1074	1135	1158
Selangor	1429	2030	2255	2370	2394
Negeri Sembilan	335	401	460	521	536
Melaka	337	592	622	631	632
Johor	1566	2370	2914	3313	3438
Pahang	1034	1589	2032	2427	2541
Terengganu	321	542	659	700	711
Kelantan	718	1031	1194	1254	1265
Sarawak	0	0	0	0	0
Sabah	0	0	0	0	0
WP Labuan	4	9	9	9	9
	9282	**13785**	**16185**	**17705**	**18152**
% Increase		**48.5**	**17.4**	**9.4**	**2.5**



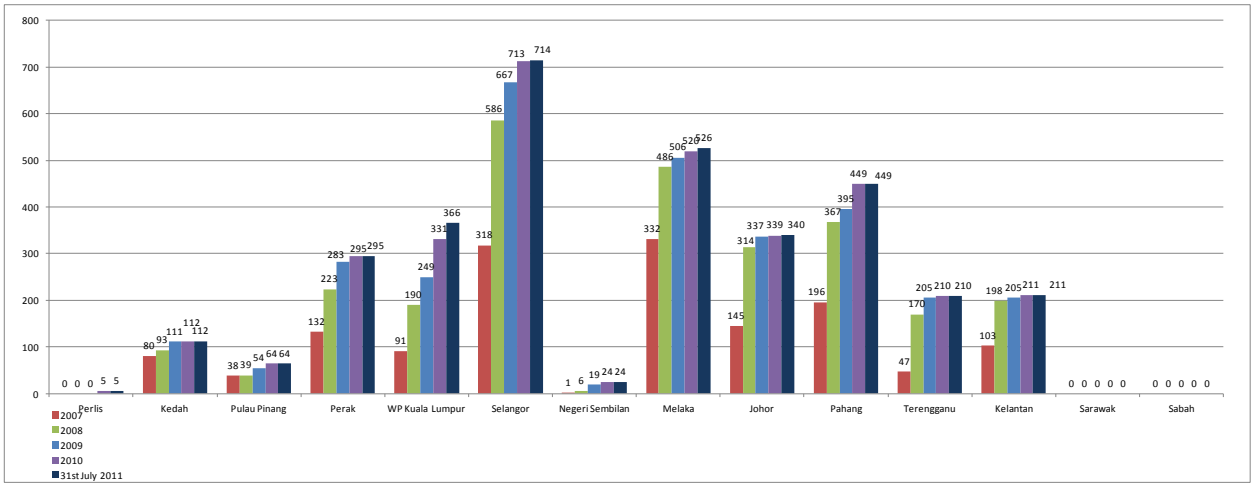
Since its introduction in November 2006, Suboxone DST have successfully replaced buprenorphine monotherapy. The treatment pick-up rate have decreased since 2009 following the reintroduction of generic monotherapy into the market together with the expansion of the government MMT program.

In community-based DST for the private sector, the combination medication of buprenorphine and naloxone (Suboxone) is by far the preferred treatment of choice for this group of patients. This trend has been consistent ever since the introduction of DST and is indicative of its effectiveness and patient's acceptance in the private sector.

8. Methadone DST

TOTAL NUMBER OF PATIENTS FOR METHADONE ACROSS THE STATES

State	2007	2008	2009	2010	31st July 2011
Perlis	0	0	0	5	5
Kedah	80	93	111	112	112
Pulau Pinang	38	39	54	64	64
Perak	132	223	283	295	295
WP Kuala Lumpur	91	190	249	331	366
Selangor	318	586	667	713	714
Negeri Sembilan	1	6	19	24	24
Melaka	332	486	506	520	526
Johor	145	314	337	339	340
Pahang	196	367	395	449	449
Terengganu	47	170	205	210	210
Kelantan	103	198	205	211	211
Sarawak	0	0	0	0	0
Sabah	0	0	0	0	0
WP Labuan	0	0	0	0	0
	1483	**2672**	**3031**	**3273**	**3316**
% Increase		**80.1**	**13.4**	**7.9**	**1.3**



Methadone usage has also shown steady acceptance albeit among a smaller group of patients. Methadone data reflected in this report are only from two companies namely Sunward Pharmaceutical and Hoe Pharmaceutical. It must be appreciated the NDST Register does not capture the data of methadone purchase and dispensing by doctors and pharmaceutical companies who are not on the Register.

The NDST Register also does not capture data of patients treated with methadone who are on the government sponsored harm-reduction/needle exchange treatment programme. Likewise we are also unable to monitor the re-introduction into the market of plain generic buprenorphine.

The early phenomenal rates of uptake of patients on treatment with both these modalities have since tapered down since 2009.

9. Treatment Retention

The NDST register actively tracks patient's treatment progress and automatically transfers registered patients who are not on active treatment to a "floating list" when these patients have either completed treatment (discharged by their doctors) or have defaulted from the programme

Subuxone "Floating List"

Year	2007	2008	2009	2010	2011(as on 20.10.2011
No. patients registered for treatment(cumulative)	9282	13785	16185	17705	18152
No. patients on active treatment	4176	7299	9699	10534	10738
No. of patients off treatment(Foating List)	(5106)*	1380	685	243	57

There was a massive deluge to the floating list during the first two years following the switch-over from Subutex(buprenorphine monotherapy) to Suboxone in end 2006. This has since settled down and data indicates majority of existing patient continue to remain active on treatment. A similar pattern was also noted for methadone DST.

Methadone "Floating List"

Year	2007	2008	2009	2010	2011 (as on 20.10.2011)
No. patients registered for treatment (Cumulative)	1483	2672	3031	3273	3316
No. of patients on active treatment	629	1757	2116	2056	2038
No. of patients off treatment(Floating List)	854	286	77	61	84

Treatment Modality	No. registered on treatment	No. on "Floating List"	No. still on active treatment	Treatment Retention Rate
Suboxone	18152	7471	10681	58.8%
Methadone	3316	1301	2015	60.8%

The **gross treatment retention** rate for both treatment modalities for the period 2007 to 2011 is around 60%.

However when calculated on a year to year basis, it was >80% for both treatment modalities for the year 2009,2010 and 2011. The main reason for this is the artifact effect created by the massive initial default of treatment during the switch-over from Subutex to Suboxone in 2006/2007.

This initial defaulter rate was also made worst by:

i) the reintroduction of generic plain buprenorphine back into the market and
ii) the ready availability of methadone from alternate non-NDST sources

It should be noted that the NDST Register is unable to monitor data from these two sources of treatment. In the DST Guidelines, plain buprenorphine is supposed to be reserved for specialized centers only. Doctors in the programme have now confirmed that some of their patients have reported that they have been able to get plain buprenorphine in the market thus indicating that diversions have taken place.

If unchecked this will throw the entire treatment programme into disarray.

There has been a decrease in reports of enforcement officers harassing and detaining patients when they turn up in clinics for medications. This was a rampant problem in the early years of the programme and had an adverse effect on continuity of patient care. This was a major destabilizing factor in the treatment environment. There should now be a concerted move to decriminalize drug use in defined situations, allow medical treatment as a legal option and to reduce the stigma of addiction. The experience of Portugal in this aspect is a relevant case in mind.

6. CONCLUSIONS AND AMAM RECOMMENDATIONS

Our key observations based on our analysis of usage data from the NDST Register and feedback from the healthcare professional community are:

1. Community-based DST is a viable and sustainable treatment option for those afflicted with addiction to opiate drugs.
2. In the period of 2002 to 2011, the DST programme have initiated treatment for 23,713 active heroin addicts, taken them off the streets and into a sustainable community-based treatment programme.

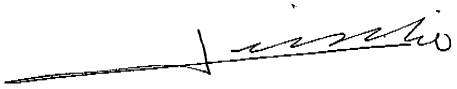
3. Drug-related arrests and HIV infection rates have fallen significantly during the period of the community-based DST programme.
4. The excellent acceptance of community-based DST and its overall retention rate of around 60% shows that it is a preferred alternative to institution-based treatment.
5. Further administrative and legislative measures to decriminalize drug use in selected situations are necessary to establish a stable treatment environment to encourage more patients to seek this form of treatment.
6. Patient confidentiality must be preserved in community-based DST programme as treatment is delivered in the context of a doctor-patient relationship.
7. All forms of DST treatment must be monitored closely real-time to prevent system failure. Failure to do so will result in the earlier situation of doctor-hopping and illegal diversion of DST medications.
8. The NDST Register has proven that it is effective and capable of providing this function. It can also be extended to cover all psychotropic drugs, all doctors and all pharmaceutical companies supplying DST medications
9. The programme should be consolidated with institutional backing before moving ahead.
10. We forecast that the plan for a 10% growth per year in treatment capacity and patient registration cannot be sustained in the current scenario and will be adversely affected by perverse incentive of the Poison Act 1952 (Psychotropic Substances) (Amendment) Regulations 2011.
11. The original directive and incentive for self-regulation with the NDST Register is now explicitly and implicitly made irrelevant by the said amendment.

Based on the above observations, we strongly recommend that the following measures be undertaken:

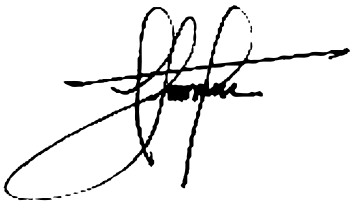
1. Urgent reform of existing laws and regulations to allow individuals suffering from addiction to voluntarily seek proper medical treatment. This will facilitate community-based DST to become more widely accepted and should reduce the incidences of patient harassment, incarceration and stigmatization;
2. The Government should formally adopt the NDST registry as the benchmark for monitoring DST for both private and public sector treatment programmes
3. The scope of the NDST registry should be extended to include:
    - The monitoring of all forms of DST treatment
    - All medical practitioners and pharmaceutical companies dealing with DST medications

Without implementation of the above recommendations, AMAM recommends the discontinuation of the NDST Register as we strongly believe that effective monitoring of community-based DST is not possible without the implicit and explicit backing of the Pharmaceutical Services Division and the Ministry of Health and all relevant enforcement authorities.

STEVEN K W CHOW
President
AMAM / FPMPAM



LIM BOON SHO
Deputy-President
AMAM



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