

Community-based drug treatment models for people who use drugs

Six experiences on creating alternatives to compulsory detention centres in Asia

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Harm Reduction International is a leading non-governmental organisation working to promote and expand support for harm reduction. With over 8,000 members worldwide, Harm Reduction International is the largest membership-based global harm reduction association.

We work to reduce the negative health, social and human rights impacts of drug use and drug policy – such as the increased vulnerability to HIV and hepatitis infection among people who inject drugs – by promoting evidence-based public health policies and practices, and human rights based approaches to drug policy.

We are an influential global source of research, policy/legal analysis and advocacy on drug use, health and human rights issues.

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Introductory Remarks by Dr Adeeba Kamarulzaman

Over the last five decades, several countries in Asia have struggled with illicit drug use, initially with opiates and more recently with amphetamine-type stimulants. Largely, regional responses are punitive in nature, focus on the implementation of abstinence-based treatment models, and include detention in prisons or in compulsory detention centres for people who use drugs.

Faced with ever-increasing HIV and Hepatitis B and C epidemics amongst people who use drugs, several countries have begun to adopt harm reduction measures instead. These include opioid substitution therapy, needle syringe programmes, and provision of antiretroviral treatment for people living with HIV. As countries begin to transition from punitive treatment for people who use drugs to community-based harm reduction and drug treatment programmes, the publication of this report, which documents different treatment interventions and experiences from Cambodia, China, India, Indonesia, Malaysia, Vietnam is very much welcome.

Whilst services and intervention models differ from country to country, the researchers have identified common elements that make community-based drug treatment and support programmes effective and responsive to the diverse needs of people who use drugs. Voluntary access, client-centred approaches, meaningful involvement of people who use drugs and civil society, the provision of comprehensive health and psychosocial care services and medical guidelines and oversight are common key features in these programs. Additionally, collaborative engagement, particularly between public health law enforcement agencies, is crucial.

The countries highlighted in this report share similar challenges and experiences in responding to illicit drug use and related harms such as HIV and Hepatitis C. Each can learn from one another as they scale up community-based harm reduction programmes. Evidence from the region and elsewhere has shown that criminalisation of drug use does more harm than good to the individual and to society at large. This publication shows not only that it is possible to move away from these punitive responses, but also that these models of community-based treatment and support are effective and associated with positive health and social outcomes.

With evidence accumulating from the region showing that the adoption of harm reduction programmes has led to a reversal in the HIV and Hepatitis epidemics in some countries, a concerted effort towards scaling up such programmes is urgently needed. Ultimately, for this effort to succeed, countries in the region will need to review existing drug laws and policies that lead to adverse health, social and economic outcomes.

Professor Adeeba Kamarulzaman

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Objectives of this report

This report documents a range of models of community-based drug treatment interventions and experiences from Cambodia, China, India, Indonesia, Malaysia, Vietnam, based on which the authors identify the essential components and minimum requirements needed to define such services. The elements identified in this report are critical enablers that are likely to facilitate positive treatment outcomes and stimulate greater demand for such services. These elements can be used as guiding principles to support national transitions away from compulsory detention for people who use drugs, and inform the development of plans for service delivery and policy reform.

Between 2014-2015, Harm Reduction International (HRI) worked with local civil society researchers and partners in the six countries to document community-based harm reduction models employed by civil society as well as efforts toward the creation of alternatives to compulsory drug treatment centres for people who use drugs in the Asia region. This report, compiled by HRI, provides a snapshot of the national context and experiences in the six countries. It is hoped that the experiences from the six countries will inform and guide national level action. Based on the common findings from the six countries, the report also includes recommendations targeted at policymakers and government officials.

This report and many of the experiences captured within it, reflect a broader programme of work within the Asia Action project. The wider aim of Asia Action is to build the political and social momentum for change by empowering civil society, including people who use and inject drugs, to advocate for reform and to bring about social and political change.

Methodology

HRI worked with six individual consultants based on Cambodia, China, India, Indonesia, Malaysia and Vietnam to collect both primary and secondary data to inform this report.

Existing data sources consulted for this report include published and unpublished evaluation and operational research reports, research papers and reports from multilateral agencies, international non-governmental organisations, civil society and harm reduction networks, organisations of people who use drugs, and expert and academic positions from those working on HIV, drug use, drug dependence treatment, and harm reduction.

Primary data collection in each country included in-depth interviews with key informants including government representatives, health service providers, community-based organisations, organisations of people who use drugs, and where possible, national anti-drug agencies and law enforcement agencies, and focus group discussions with people who use drugs and programme beneficiaries. All data was anonymously coded and analysed at country-level before being compiled into this regional report.

Data analysis, further research on the regional situation and formulation of the report was conducted by HRI.

Limitations

Several limitations and considerations must be taken into account upon reading this report. First, information collected and presented in this report is linked to the Asia Action for Harm Reduction project and, therefore, the scope of the project predetermined which countries and organisations could contribute to this report. Second, the report is not intended or designed to be exhaustive but rather to provide a snapshot of possible interventions currently implemented in Asia. The authors recognise that other models and incarnations of community-based drug dependence treatment exist in Asia and beyond. Third, much of the data presented in this report is based on secondary sources with limited opportunities for verification and triangulation. Most of the data emerged from underfunded pilot projects and the authors recognise that additional research in assessing community-based drug dependence treatment modalities is urgently needed. Finally, the absence of a formal consensus around the definition of community-based drug dependence treatment also affected the Asia Action for Harm Reduction project team whose reports were significantly different from country to country.

Additional Resources

Harm Reduction International
(www.ihra.net)

International HIV/AIDS Alliance
(www.aidsalliance.org)

International Drug Policy Consortium
(www.idpc.net)

International Network of People Who Use Drugs
(www.inpud.net)

Asian Network of People Who Use Drugs
(www.anpud.org)

Abbreviations and Acronyms

AADK National Anti-Drug Agency	MMT Methadone Maintenance Therapy
AIDS Acquired Immune Deficiency Syndrome	MoH Ministry of Health
ATS Amphetamine-Type Simulants	MoHA Ministry of Home Affairs
AusAID Australian Agency for International Development	MOLISA Invalids and Social Affairs
CAHR Community Action for Harm Reduction	MoPS Ministry of Public Security
CATS Community Addiction Treatment Site	NACD National Authority for Combating Drugs
CBDDT Community-Based Drug Dependence Treatment	NFM New Funding Model
CBTx Community-Based Treatment Programme	NSP Needle Syringe Programme
CCC Cure & Care Clinics	OST Opioid Substitution Therapy
CCDU Compulsory Centres for the Treatment and Rehabilitation of People Who Use Drugs	PEKA Rumah Singgah PEKA
CCRC Cure & Care Rehabilitation Centres	PEPFAR President's Emergency Plan For AIDS Relief
CCSC Cure & Care Service Centres	PKNI National Network of People Who Use Drugs
CERiA Malaya's Centre of Excellence for Research in AIDS	RC Rumah Cemara
CSO Civil Society Organisation	REDA Rural Economic Development Association
CWPD Cambodian Women for Peace and Development	SAMHSA Substance Abuse and Mental Health Services Administration
FHI3600 Family Health International 360	SASO Social Awareness Service Organisation
FI Friends International	SCDI Centre for Supporting Development Initiatives
HBV Hepatitis B Virus	SEADO Social, Environment, Agricultural, Development Organisation
HCV Hepatitis C Virus	STI Sexually Transmitted Infection
HIV Human Immunodeficiency Virus	UNAIDS Joint United Nations Programme on HIV/AIDS
HRI Harm Reduction International	UNODC United Nations Office on Drugs and Crime
KBA Khmer Buddhist Association	USAID United States Agency for International Development
KHANA Khmer HIV/AIDS Alliance	WHO World Health Organisation
MHC Men's Health Cambodia	
MHSS Men Health Social Services	

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Executive summary

Countries across Asia are significantly affected by illicit drugs. Half of the world's opiate users and the greatest concentration of people who inject drugs live in the region, while the market for amphetamine-type stimulants is the largest in the world. Asian governments have invested significant resources in addressing drug-related issues within and beyond their borders, favouring prohibitionist models and punitive approaches grounded on a 'war on drugs' paradigm. Criminalisation and drug-related arrests lead to punishment by the state, usually in the form of incarceration in closed settings, including in compulsory detention centres in the name of drug treatment for people who use drugs. Corporal and capital punishment for drug-related crimes are used more frequently in Asia than any other region of the world.¹

The response to drug-related issues across the region has centred on developing an extensive public security infrastructure. Since the early 2000s, a key component of this response has been the opening of compulsory centres designed for the treatment and rehabilitation of people who use drugs (CCDUs). Implementation of CCDUs by governments spread rapidly across many countries in Asia. Indeed, the detention and coercive treatment of people who use or are dependent on illicit drugs is currently a dominant approach in 11 countries in the region,² including Cambodia, China, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand and Vietnam.³ In addition, while harm reduction approaches are becoming increasingly accepted across Asia, the largely punitive policy and legal environment continues to undermine access to life-saving services, including needle syringe programmes, opioid substitution therapy, and naloxone for overdose prevention.⁴

In 2012, United Nations agencies released a statement calling for the closure of compulsory centres. They cited a vast and growing body of evidence unequivocally finding such practices

to be ineffective, costly and out of line with international best practice guidelines and human rights obligations. The United Nations statement called on governments to deploy the necessary resources to scale-up voluntary, evidence-informed and rights-based drug dependence treatment and support services in the community.⁵ Formal regional consultations involving policy-makers from Asia, international experts, and multilateral agencies have since taken place in December 2010, October 2012, and September 2015 to encourage governments to accelerate the transition toward voluntary community-based treatment and support services.

While community-based harm reduction and drug dependence treatment options operate in the region, in many countries these are small programmes with limited reach that are facing diminishing international funds. The scale and reach of existing programmes varies between regions and across countries, and the successes and challenges faced are not well documented. Health service coverage for drug-related issues across Asia, as in other parts of the world, remains below levels required to control the transmission of blood-borne infections like HIV and hepatitis C. The financial resources supporting public health interventions have been infinitesimally small when compared to those invested in public security approaches.

However, there is growing recognition that CCDU are counter-productive instruments to achieving effective national health and social reintegration objectives. There is also growing motivation and interest across Asia to develop and pilot alternatives to CCDU. Some of these alternatives are documented in this report. The demand for voluntary, comprehensive evidence- and community-based drug treatment services is also growing among people who use and inject drugs in Asia.

This report represents a collective effort by international and national civil society organisations (CSOs) to document community-based drug treatment efforts in Asia. In the context of this report, community-based drug dependence treatment and support services refers to an integrated model of treatment in the community that facilitates access to a menu of evidence-based treatment options, including harm reduction services, from which clients can choose. This report details a range of models, interventions and experiences from Cambodia, China, India, Indonesia, Malaysia and Vietnam in developing community-based alternatives to CCDU. While these programmes differ within and across countries, several common elements have been identified as critical to effective community-based services that meet the needs of people who use drugs. These elements were reported to lead to positive health and treatment outcomes and stimulate greater demand for services and should be considered minimum requirements for community-based alternatives to CCDU. They include:

- > Voluntary access
- > Client-centred approach
- > Meaningful involvement of people who use drugs and civil society
- > Comprehensive health and psychosocial care services
- > Medical guidelines and oversight
- > Drug policy reform and leadership
- > Coordination with law enforcement.

The research also highlighted the importance of lessons learned from the HIV sector and national HIV responses, which, in all six countries, are intimately linked with the push for community-based drug dependence treatment. These lessons include CSO participation, meaningful involvement of people who use drugs, adherence to international human rights obligations and health systems integration. All have, to a

varying extent, informed and structured national efforts to develop alternatives to CCDU.

The support and involvement of agencies from a range of sectors, but in particular public health, has been essential to the programmes documented across all six countries. While space for public health agencies to influence the design, implementation and evaluation of drug dependence treatment services is growing, few countries have empowered public health sector agencies to lead on matters related to drug treatment and harm reduction. In contrast, it was found that public security agencies remain involved in virtually every emerging model of community-based drug services, often providing oversight and final authority. Meanwhile, there is growing recognition that collaboration and coordination with law enforcement facilitates the design, implementation and evaluation of effective community-based services for people who use drugs.

Despite the apparent successes across the six countries in developing alternatives to CCDU, a number of critical challenges are currently impeding progress in the transition to community-based drug dependence treatment. Firstly, all of the efforts documented in this report suggest that the insecure funding environment for harm reduction and community-based drug treatment models remains a key challenge for programme scale-up and endorsement of alternatives by policy-makers at the national level. All countries reported significant human resource challenges, both in terms of volume of available workers as well as in regards to the capacity and attitudes of drug treatment service providers. In addition, while virtually all models included in this report foster the official participation of CSOs and people who use and inject drugs, in practice many emerging models and efforts fail to effectively and meaningfully involve people who use drugs in their design, implementation, and evaluation.

Based on the findings of this report, HRI makes the following recommendations to support the development of community-based services:

- > Criminalisation of drug use and possession is a significant barrier to effective voluntary, comprehensive, and evidence- and community-based drug treatment and support services. ***It is therefore critical that laws and policies that compel the registration, random urine testing, arrest, detention and forced treatment of people who use and inject drugs be repealed and amended to facilitate diversion to voluntary, community-based harm reduction and drug treatment and other support services through health facilities.***
- > The models documented in this report represent promising alternatives to CCDU. However, data collection, documentation, monitoring and evaluation of these efforts have been consistently weak: many are emerging models that have recently initiated service delivery; many have donor-specific indicators against which to report; and most are facing financial and human resource gaps that restrict their expansion. ***Additional documentation and research is urgently required to assess emerging models across Asia.***
- > ***Emerging models should promote a client-centred approach whereby clients can choose from a menu of options including harm reduction services,*** and should develop clear guidelines for assessing clinical drug dependence while recognising that not all people who use and inject drugs require, are willing or ready to access drug treatment. Additionally, as voluntary drug treatment models are developed, those should promote evaluation against indicators of success that prioritise client outcomes such as improvement in quality of life, job retention, crime reduction, and reduction in risky injecting and sexual behaviours that lead to the transmission of blood-borne viruses.
- > The availability and coverage of harm reduction services, particularly needle syringe programmes (NSP) and opioid substitution therapy (OST), remains insufficient to make a significant dent in HIV and HCV epidemics among people who inject drugs in most countries across Asia. ***Harm reduction interventions should be urgently scaled up alongside other advocacy efforts toward community-based services with the goal of promoting an institutional shift away from criminalisation and punishment.***
- > CSOs involved in harm reduction service delivery across the region offer low-threshold opportunities for integration of community-based drug dependence treatment and support services. However, the meaningful participation of CSOs implies equal partnership in the design, implementation and evaluation of all responses that affect the lives of people who use and inject drugs. ***Additional efforts must be supported to facilitate meaningful involvement of CSOs, and to utilise and improve existing healthcare delivery infrastructure via CSOs to stimulate the development of community-based drug dependence treatment alternatives in Asia.***
- > ***Principles of harm reduction and key harm reduction interventions, such as methadone, should be at the centre of voluntary community-based drug treatment.***
- > ***The meaningful involvement of people who use and inject drugs must be strengthened across the region.*** As for

CSOs, meaningful participation implies equal partnership in the design, implementation and evaluation of all responses that affect the lives of people who use and inject drugs. ***Peers' contributions are significant and add considerable value when they are meaningfully integrated and respected.***

- > While public health representatives have increasing influence on drug treatment related matters, public security agencies remain largely in control of managing national drug treatment efforts. ***It is critical that responsibility and authority for drug treatment related matters be transferred from the public security to the public health sector.***
- > In line with the recommendation above, ***the role of public security representatives, particularly those of law enforcement agencies, must be reviewed and adapted to support effective diversion of people who use drugs away from the criminal justice system, away from CCDU and into community-based drug treatment and support services.***
- > Significant technical and financial gaps have been identified across the region related to planning, implementation and evaluation of the transition towards voluntary comprehensive evidence-informed and community-based drug dependence treatment and support services. ***It is critical that government agencies re-programme and redirect funds used to support CCDU as well as funds from national drug control budgets to support emerging models and scale-up effective alternatives to CCDU.*** In addition, it is urgent that international donors and technical support providers earmark resources to support the retooling of national drug treatment infrastructures across Asia.

Introduction

In 2012, United Nations agencies released a statement calling for the closure of CCDU in favour of voluntary, evidence-informed and rights-based drug dependence treatment and support services in the community.⁶ The United Nations' position on compulsory drug dependence treatment is supported by a vast and growing body of evidence that unequivocally shows such practices to be ineffective, costly and out of line with international best practice guidelines and human rights obligations.⁷

The limited availability of academic publications and grey literature regarding community-based drug treatment is a major barrier to the scale-up of evidence-based alternatives to CCDU. With few documented operational models of community-based drug treatment and documentation of civil society advocacy efforts in this domain, many governments hesitate to initiate a transition away from CCDU in the name of treatment. And without a firm consensus regarding the operational definition of 'community-based drug treatment,' published materials offer little consistency and few opportunities for comparison.

Asia Action on Harm Reduction

Asia Action on Harm Reduction (Community alternatives to the war on drugs: community advocacy for harm reduction) is a three-year harm reduction advocacy project of the International HIV/AIDS Alliance, funded by the European Union. It aims to improve knowledge, generate evidence and build support for harm reduction and evidence-based drug policy among key policy-makers across six countries: Cambodia, China, India, Indonesia, Malaysia and Vietnam, over a period of three years (2013–16).

Asia Action is jointly implemented by AIDS Care China, KHANA (Cambodia), SCDI (Vietnam), the Malaysian AIDS Council, Rumah Cemara (Indonesia) and India HIV/AIDS Alliance, the International HIV/AIDS Alliance, Harm Reduction International and the International Drug Policy Consortium.

The project works on several key advocacy areas in the Asia region, including enhancing law enforcement engagement with rights-based harm reduction approaches in Malaysia; assessing the harm reduction advocacy capacity of state-level drug user forum members and mapping stakeholder support of harm reduction policies in India; advocating for access to treatment in pre-trial detention and other closed settings in Malaysia; and documenting the implementation of diversion policy to drug treatment as opposed to prison for people arrested for drug-related offences in Indonesia.

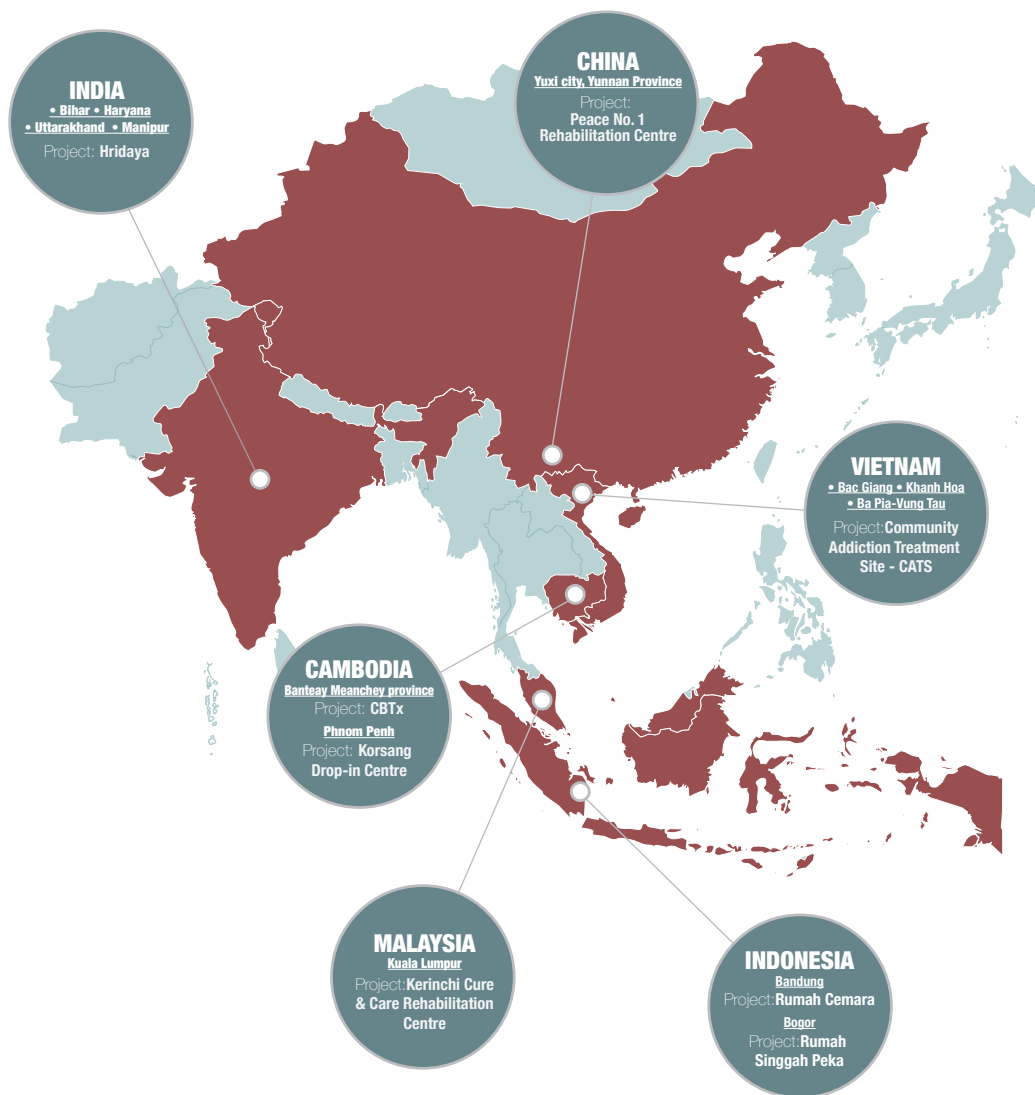
For more information on Asia Action, please visit:

<http://www.aidsalliance.org/our-priorities/current-projects/176-asia-action>

This report documents a range of models and experiences of community-based harm reduction and drug treatment from six Asian countries – Cambodia, China, India, Indonesia, Malaysia, Vietnam – based on which the authors identify the essential features and minimum requirements needed to define such services. HRI compiled the report in the context of the Asia Action on Harm Reduction project with financial support from the European Union.

The first section of the report reviews the regional context and policy frameworks related to illicit drugs and health services to meet the needs of people who use drugs. In the following section, six national level case studies are presented. Each case study reviews the evolution of health services and delivery models and civil society advocacy efforts that have been developed to meet the needs of people who use drugs. The third section identifies the critical elements of community-based drug treatment services through a comparative analysis based on the national level case studies. The report concludes with a set of recommendations targeting policymakers, to assist with advocacy to promote best practices and alternatives to CCDU at the regional and global levels.

Project documentation sites in Asia



Regional Context

Epidemiological and programmatic overview

There are no official estimates of the number of people living in Asia who use drugs, but data indicate that their numbers are significant. Amphetamine-type stimulants (ATS), the second most widely used drug in the region after cannabis, affect 3.5 to 20.9 million people;⁸ between 12 and 21 million people use opiates, half of the total global population of opiate users;⁹ and an estimated 4.5 million people inject drugs in Asia, the highest concentration in any region.¹⁰ Such high numbers of people who use drugs are not surprising given that Asia is also recognised as a major platform for drug production and trafficking. Opiate production in the Golden Crescent and the Golden Triangle has been on the rise since the 1980s¹¹ and since 2006¹² respectively and together “account for the vast majority of illicit opium poppy cultivation”¹³ worldwide while “East and South-East Asia and Oceania has (*sic*) the largest ATS market in the world.”¹⁴

The public health burden associated with illicit drug use is significant in Asia. Between 15,000 and 140,000 deaths per year are associated with drug use.¹⁵ Hepatitis C virus (HCV) prevalence rates among people who inject drugs are above 80% in Nepal and Thailand, 70% in Indonesia, Myanmar and Vietnam, 60% in China, Japan and Malaysia, and 40% in Bangladesh, Korea, India and Singapore.¹⁶ HIV rates among people who inject drugs are between 25 and 270 times higher than in the general population.¹⁷ Though drug overdoses are generally not recorded as cause of death, evidence shows that such incidents are not uncommon. Data from Thailand show that approximately 30% of people who inject drugs have survived at least one overdose while 68% have witnessed at least one overdose in their lifetimes.¹⁸

Table 1: Epidemiology of HIV and hepatitis C among people who inject drugs in Asia

Country/territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)
Afghanistan ¹⁹	20,000 (18,000–23,000) ⁽¹⁾	4.4 ⁽²⁾⁽²⁰⁾	31.2 ⁽²⁾
Bangladesh ²¹	21,800–23,800 ⁽⁴⁾⁽²²⁾	1.1 ⁽⁴⁾	39.6 ⁽⁵⁾⁽²³⁾
Bhutan	nk	nk	nk
Brunei Darussalam	nk	nk	nk
Cambodia ²⁴	1,300 (1,200–2,800) ⁽⁷⁾	24.8 ⁽⁷⁾	nk
China ²⁵	2,580,000 ⁽⁸⁾⁽²⁶⁾	6.3 ⁽⁹⁾	67 ⁽⁶⁾
Hong Kong	nk	nk	nk
India ²⁷	177,000–180,000 ⁽¹⁰⁾⁽²⁸⁾	7.14 ⁽¹¹⁾	41 ⁽⁶⁾⁽²⁹⁾
Indonesia ³⁰	74,326 (61,901–88,320) ⁽¹³⁾	36.4 ⁽¹⁴⁾	77.3 ⁽⁶⁾
Japan	nk	nk	64.8 (55–74.5) ⁽⁶⁾
Korea (Republic of)	nk	nk	54 ⁽⁶⁾
Laos PDR ³¹	1,700 ⁽¹⁵⁾	nk	nk
Macau ³²	238 ⁽¹⁶⁾	1.32 ⁽¹⁷⁾	80.4 ⁽¹⁸⁾
Malaysia ³³	170,000 ⁽¹⁹⁾	18.9 ⁽²⁰⁾	67.1 ⁽⁶⁾
Maldives ³⁴	793 (690–896) ⁽²¹⁾	0 ⁽²¹⁾	0.7 ⁽²²⁾
Mongolia ³⁵	nk	nk	nk
Myanmar ³⁶	75,000 ⁽²⁵⁾	18.7 ⁽²⁶⁾	79.2 ⁽⁶⁾
Nepal ³⁷	52,174 ⁽²⁷⁾	6.3 ⁽²⁸⁾	87.3 (80.5 –94) ⁽⁶⁾
Pakistan ³⁸	91,000 ⁽²⁹⁾ –423,000 ⁽³⁰⁾⁽³⁹⁾	27.2 ⁽²⁹⁾	85 (75–92.9) ⁽⁶⁾⁽⁴⁰⁾
Philippines ⁴¹	12,304–16,607 ⁽³²⁾⁽⁴²⁾	41.6 ⁽³³⁾	70 ⁽⁶⁾
Singapore	nk	nk	42.5 ⁽⁶⁾
Sri Lanka	nk	nk	nk
Taiwan ⁴³	60,000 ⁽³⁴⁾⁽⁴⁴⁾	17.7 ⁽³⁴⁾	41 ⁽⁶⁾⁽⁴⁵⁾
Thailand ⁴⁶	40,300 ⁽³⁵⁾	25.2 ⁽³⁶⁾	89.8 ⁽⁶⁾⁽⁴⁷⁾
Vietnam ⁴⁸	271,000 (100,000–335,000) ⁽³⁷⁾	10.3 ⁽³⁷⁾	74.1 ⁽⁶⁾⁽⁴⁹⁾

The emergence of public health approaches to drug-related issues has been intimately linked to the global HIV response, specifically to the endorsement by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Crime (UNODC) and the World Health Organisation (WHO) of a comprehensive package of health interventions to prevent HIV transmission among people who inject drugs, often referred to as the “comprehensive package.” For more than 10 years, an increasing number of stakeholders have promoted harm reduction measures to reduce the public health burden associated with illicit drugs.

The comprehensive package of harm reduction interventions for HIV prevention, treatment, care and support among people who inject drugs⁵⁰

Essential health sector interventions

1. Condom distribution and safe sex education
2. Harm reduction interventions including:
 - a. distribution of sterile injecting equipment,
 - b. opioid substitution therapy (OST), and
 - c. overdose prevention with naloxone
3. Behaviour change communication on risk reduction
4. Referrals to HIV testing and counselling
5. Referrals to HIV treatment and care
6. Referrals to STI diagnosis and treatment
7. Prevention, vaccination, diagnosis and treatment for viral hepatitis

8. Prevention, diagnosis and treatment of tuberculosis
9. Targeted information, education and communication for people who inject drugs and their sexual partners

Essential strategies for an enabling environment

1. Advocacy towards legal and policy reform
2. Stigma reduction and raising awareness
3. Community empowerment and meaningful participation
4. Addressing violence against people who use and inject drugs through partnerships with law enforcement

The policy response to drug use and injecting

Governments in the region have invested significant resources to address drug-related issues within and beyond their borders, favouring prohibitionist models and suppression approaches grounded on a 'war on drugs' paradigm. At the regional level, the Association of South East Asian Nations (ASEAN) has maintained a "drug-free ASEAN by 2015" vision reflected in the 1998 Joint Declaration for a Drug-Free ASEAN and later outlined in its Work Plan on Combating Illicit Drug Production, Trafficking and Use (2009-2015), which treats drug use primarily as a public security rather than a public health issue.⁵¹ It remains to be seen whether ASEAN's post-2015 drug strategy, which is set to be deployed in 2016,⁵² will consider broader public health concerns.

The regional vision is reproduced at the national level across Asia. Laws are in place to criminalise drug possession, use, distribution, production, cultivation and trafficking in every country in the region and law enforcement agencies have played a leading role in implementing national, regional and global responses to illicit drugs. Globally, estimated government investments surpass \$100 billion per year to support drug law enforcement.⁵³

If arrested for drug-related crimes, convicted perpetrators are punished by the state, generally through incarceration in closed settings. Asia's prisons are overcrowded,⁵⁴ and a majority of Asian prisoners have been incarcerated for drug-related crimes.⁵⁵ For example, over two-thirds of total prison population in Thailand,⁵⁶ and up to 40% of the prison population in Indonesia⁵⁷ have been incarcerated for drug-related crimes. Evidence indicates that sentences for drug-related crimes in Asia are overwhelmingly disproportionate and among the most

severe in the world.⁵⁸ In addition to incarceration, reports indicate that state-sponsored corporeal punishment is also used in some Asian countries while 16 nations have the death penalty for drug offences in national legislation.⁵⁹

Drug laws and their enforcement have also been associated with significant negative unintended consequences.⁶⁰ Specifically, criminalisation of drug use exacerbates stigma and discrimination, amplifies the negative consequences of poverty and jeopardises people's access to employment, housing, education and health services.⁶¹ In addition, reports have documented abuses perpetrated by law enforcement including extortion and entrapment, violence, violations of privacy and confidentiality and a range of other human rights abuses.⁶² Such pervasive and frequent abuses of power against people who use drugs have further reduced health-seeking behaviours and driven people who use drugs further underground and away from health and social care services.

Implementation of national, regional and global responses to drug-related issues has led to the development of an extensive public security infrastructure. However, drug dependence is defined by the UN Office on Drugs and Crime and the World Health Organisation as a "multifactorial health disorder that often follows the course of a relapsing and remitting chronic disease". These agencies advise that it is best addressed through a biopsychosocial model and a multi-disciplinary approach centred on health.⁶³ In addition, the overarching international conventions and treaties that govern drug policy recognise that "the drug issue is first and foremost a matter of public and individual health and welfare."⁶⁴ In that context, the massive investments in public security have created significant barriers to public health approaches that seek to address drug-related issues.

Over the past ten years, an unprecedented number of drug laws and policies across Asia have been developed, amended, and deployed. While governments in the region continue to criminalise drug use and apply punitive approaches, many of the recent changes have promoted the integration of public health and human rights frameworks into emerging responses to drug use. Recent legal and policy changes have also facilitated the emergence of alternatives to established models. In a few countries like Cambodia, those changes have also contributed to the establishment of official national and sub-national structures to plan, guide and oversee the transition away from CCUD.

Resourcing for harm reduction approaches

UNAIDS estimated that US\$ 2.3 billion was required to fund HIV prevention among people who inject drugs in 2015. The majority of harm reduction funding in low and middle income countries to date has come from international donors. However, at last estimate this investment amounted to US\$ 160 million – approximately 7% of what is required.⁶⁵ Across Asia, financial support for harm reduction interventions has been almost exclusively sourced from international donors. With few notable exceptions, such as China and Malaysia, national governments have contributed an infinitesimally small proportion of the resources invested in harm reduction programmes.⁶⁶ Indeed, the difference between international and domestic investment for harm reduction in the Asia Pacific region is starker than for any other region of the world.⁶⁷

The situation is set to deteriorate further as countries in the region become ineligible for international donor support due to their middle income status. Funding for harm reduction from donors

such as the UK Department for International Development, AusAID and PEPFAR are set to decrease or be discontinued in several Asian countries, regardless of epidemiological need or the willingness of national governments to step in and cover the funding gaps.⁶⁸ In addition, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the leading source of financial support for harm reduction programming across the world in recent years,⁶⁹ has now introduced its New Funding Model (NFM). Through the NFM, allocation of funding is primarily calculated on the basis of country income status and epidemiological need, which in practice has meant that middle income countries with epidemics concentrated among key populations such as people who inject drugs, receive decreased funds. This has compromised the sustainability of national HIV prevention responses targeting people who inject drugs in an alarming number of countries.⁷⁰ While governments in the region are beginning to increase domestic resources for HIV responses, very few have directed such investments towards key population programming, such as harm reduction and community-based programming for people who use drugs.⁷¹

The path to community-based services for people who use and inject drugs

Virtually all governments in the region have reviewed their national laws and policies to identify barriers and challenges to harm reduction service delivery. Almost all have also developed and deployed legal and policy instruments to support and facilitate access to those services among people who use and inject drugs.⁷² While some countries like Vietnam have almost 10 years of national legal and policy experience in the context of harm reduction, others like Thailand enacted their policies more recently. It is worth noting that a significant proportion

of countries also have laws and policies that simultaneously consider people who use drugs as ‘patients’ and ‘criminals’.

Priority harm reduction services such as NSP and OST are generally endorsed by government agencies and commonly implemented across the region. However, harm reduction coverage among people who inject drugs remains very poor, well below levels to effectively prevent the spread of blood-borne infections,⁷³ and reports from the field indicate persistent implementation challenges that stem from conflicts in legal and policy objectives related to illicit drugs.⁷⁴

Since the early 2000s, governments in the region have also employed less evidence-based approaches to integrate public health objectives in drug control strategies. Specifically, the implementation of closed centres designed for the compulsory treatment and rehabilitation of people who use drugs has spread across many countries in Asia. Indeed, the detention and coercive treatment of people who use or are dependent on illicit drugs is currently the dominant approach in Cambodia, China, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand and Vietnam.⁷⁵

However, evidence suggests that CCDU are counter-productive instruments to achieving effective national health and social reintegration objectives. CCDU are not conducive to achieving abstinence from drug use or significant gains in health or quality of life; relapse rates after release are high, and so is criminal recidivism.⁷⁶ Detention in CCDU has been associated with a higher risk of HIV transmission,⁷⁷ increased risk behaviours,⁷⁸ higher risk of overdose⁷⁹ and reduced access to health care and health seeking behaviours.⁸⁰ In addition, many front-line project reports have documented human rights violations in CCDU, including arbitrary detention, denial of health care, forced

labour and physical and sexual violence.⁸¹ Such events represent significant deviations from the fundamental goals of any form of medical treatment and as well as from specific clinical and social support objectives targeting people who use drugs. Meanwhile, staff managing and implementing ‘drug rehabilitation’ interventions in CCDU lack basic medical and clinical capacity; national clinical guidelines and standards for treatment services and providers have often not been developed; where guidelines have been developed, they often omit key interventions that could significantly reduce harm and improve clients’ quality of life but rather promote interventions that are not aligned with evidence and good practice.⁸²

Evidence further suggests that a great number of people who use drugs detained in CCDU do not need clinical treatment for drug use and dependence.⁸³ Research indicates that a relatively small proportion of people who use drugs develop clinical dependence, and this varies depending on the substance consumed.⁸⁴ For instance, the need for clinical treatment as correlated with drug dependence rates develops in approximately 23% of people who use heroin, and 11% of those who use ATS.⁸⁵ Reports indicate that significant numbers of people who use drugs are sent to CCDU after simple urine tests, often performed by law enforcement representatives, in order to detect illicit drugs, while such tests are not designed to assess clinical dependence.⁸⁶ While assessment of clinical dependence using international guidelines is increasingly integrated in national drug treatment services, CCDU continue to be favoured by governments over harm reduction and community-based treatment and social support services.

In 2012, United Nations agencies released a statement calling for the closure of CCDU, for the release of all people detained in such

facilities, and for a moratorium on funding and technical support for any and all activities related to CCDU.⁸⁷ Yet despite the evidence and international pressure to abandon a clearly inappropriate approach, governments have blindly invested significant sums to scale-up and expand the national CCDU infrastructure. For example, the Thai government reported fewer than 20 CCDUs in 2000 and over 1,200 in 2012.⁸⁸ That same year, the national drug control agency reported that over 500,000 individuals received drug dependence treatment in Thailand, including those detained in CCDU.⁸⁹

The UN Statement also called on governments and donor agencies to support and expand voluntary, evidence- and community-based drug dependence treatment services. In parallel, UN agencies have convened a series of regional consultations on CCDU to facilitate national transitions away from CCDU, culminating in the endorsement of action-oriented recommendations focused on the establishment of national transition committees, drug law and policy reform, and systems integration across public health and public security sectors.⁹⁰

Civil society organisations (CSO) from a number of countries in the region have started delivering services that are examples of voluntary community-based drug treatment. This report highlights six models of voluntary community-based services for people who use and inject drugs currently being implemented in Asia. It sets out findings from Cambodia, China, India, Indonesia, Malaysia and Vietnam.

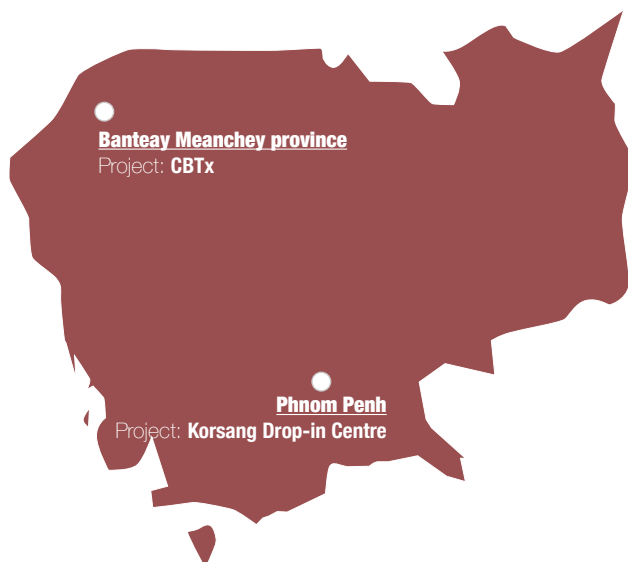
Country Case Studies

The following case studies document some emerging community-based treatment models targeting people who use and inject drugs in six Asian countries. For each country, background data on the epidemiological context, an overview of service provision, a summary of the country's legal and policy infrastructure as well as a brief review of the current drug dependence treatment mechanisms will first be presented.

The case studies will then review the components of specific models as well the results they generated following implementation. The case studies will focus on the service package and delivery modalities, involvement of people who use drugs and civil society, as well as challenges to scale-up.



Cambodia



Cambodia has a population of approximately 15 million people and remains one of the poorest countries in the region, with an estimated 30% of the population living below the poverty line.⁹¹ In 2007, a total of 5,797 people who use drugs came in contact with local authorities, and that same year, UNAIDS estimated the population size of people who use drugs at 46,300 across the country.⁹² Later estimates placed the number of people who use drugs at 13,086⁹³ with ATS being the most commonly used drugs. An estimated 1,300 people inject drugs in the country.⁹⁴

Government authorities have acknowledged the public health risks associated with injecting drug use, especially in the context of HIV: prevalence among people who inject drugs is estimated at 24.8%,⁹⁵ compared to less than 1% in the general population.⁹⁶ HCV prevalence among people who inject drugs is estimated at 74%.⁹⁷ Despite harm reduction services being included in the national HIV strategy and other policy documents, the scale-up of comprehensive services for people who use and inject drugs

has been slow. At present, only one methadone maintenance therapy (MMT) clinic operates in the country, covering 130 clients (down from 252 in 2012) and approximately 20 sites distribute free sterile injecting equipment.⁹⁸ Harm reduction service provision has been drastically reduced since 2012 due to budget cuts and increased policing of people who use drugs and other marginalised groups.

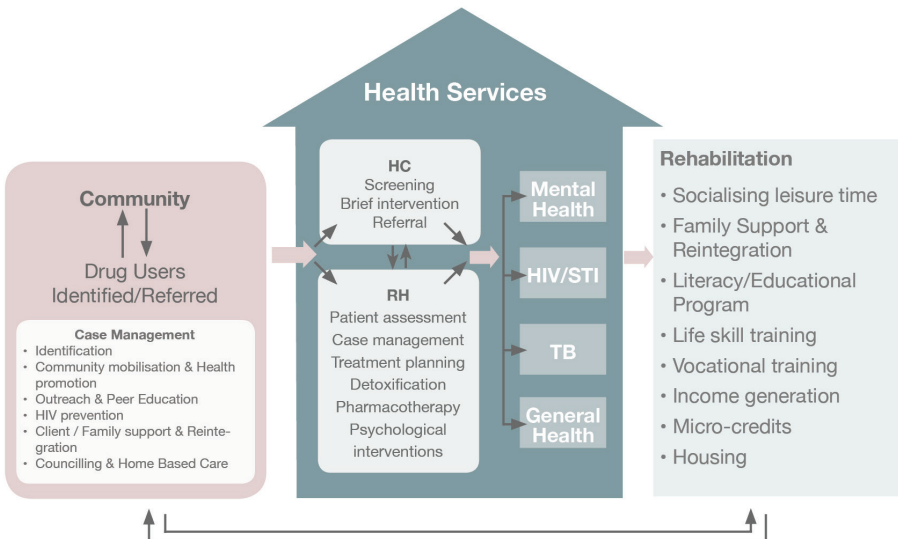
Drug-related crimes are punished with long prison sentences as mandated by the *Law on the Control of Drugs* (1996; a2005). Though the *Circular on Implementation of Education, Treatment and Rehabilitation Measures for Drug Addicts* (2006) and the *National Policy on Treatment and Rehabilitation of Drug Dependent People* (2008) include provisions to facilitate diversion of people who use and inject drugs towards CCDU. Landmark changes occurred in 2010 with the deployment of the *Sub-decree on Treatment and Rehabilitation* (2010) which compels relevant government agencies to develop mechanisms to provide a range of

health and social support services, from detoxification to rehabilitation and re-integration, targeting people who use and inject drugs in the community.

However, in practice, people arrested for using illicit drugs are coerced into choosing between incarceration for up to six months and detention in CCDU for up to two years, including a period of parole.⁹⁹ Before 2010, eight CCDU were operated by the Ministry of Interior, the Ministry of National Defense, the Ministry of Social Affairs, Veterans and Youth Rehabilitation, the Phnom Penh municipality and a number of CSOs. In total, those centres detained up to 1,500 people whose treatment consisted of physical exercise

and abstinence counselling.¹⁰⁰ Internal evaluations and external assessments have concluded that the compulsory rehabilitation infrastructure was compromised by a lack of medical staff, a lack of adherence to treatment guidelines, lack of referral mechanisms, and poor overall management of the centres in general.¹⁰¹ Health and human rights violations, including forced labour, sexual abuse, torture and cruel, inhuman, and degrading treatment in Cambodian CCDUs are well documented.¹⁰²

Figure 1: Structure of Cambodia's CBTx project



CASE STUDY: Banteay Meanchey

Banteay Meanchey is a province located in the northwest region of the country along the Thai border, and is home to over 800,000 people. The number of people who use drugs in the province is estimated to be 2,245. Official provincial records show 1,207 people to be registered as people who use drugs and 284 people are enrolled in drug treatment services.

In 2010, the Sub-Committee on Treatment and Rehabilitation was established in Banteay Meanchey province under the leadership of the Chair of the National Authority for Combating Drugs (NACD). The committee was tasked with intensifying and harmonizing drug treatment and rehabilitation activities in the province. UN agencies supported the development and scale-up of comprehensive community-based drug dependence treatment and rehabilitation services, building on the successes and lessons learned generated under UNODC's H83 Project operating in Banteay Meanchey province since 2007.¹⁰³

In 2011, the Community-Based Treatment (CBTx) programme was formally initiated in Banteay Meanchey province. The project model relies on multi-sectoral collaboration to ensure that people who use drugs are redirected towards community-based drug dependence treatment services: the existing national public health infrastructure is used to deliver services; CSOs and law enforcement agencies actively refer people who use drugs to the CBTx project. The project benefits from high level political support and international partners provide technical and financial support (see Figure 1). In 2012, the CBTx project was expanded to cover Battambang and Stung Treng provinces.¹⁰⁴

The CBTx treatment journey: Following an initial assessment, a treatment plan is designed for clients of the CBTx project and they may be assigned to the four-week "intensive" outpatient

detoxification programme or the four-week inpatient "recovery" program. During the intensive stage, clients are provided with medically-assisted symptomatic treatment. Following the initial four-week stage, all clients are subjected to regular follow-up over a four-week period and a six to eight-month aftercare period. Throughout treatment, clients have access to regular counselling, as well as on-site testing and screening for HIV, sexually transmitted infections and tuberculosis. MMT is not considered a priority given that the vast majority of clients primarily use ATS. Cambodia's CBTx model theoretically provides an extensive menu of services to support clients' reintegration (see services under rehabilitation box in Figure 1). However, the research that informed the development of this report found that, in practice, most of the listed activities are not presently operational. Cuts in financial and technical support to the programme, and cadres of overworked staff have compromised the quality of care as well as access to the programme.

Drug dependence treatment services under the CBTx project are delivered through the existing national public health infrastructure. Specifically, staff have been trained on a range of drug dependence treatment topics at four out of the provinces' five referral hospitals as well as at 21 out of the province's 56 community health centres. In 2012, the CBTx project provided services to 1,400 clients, with this number dropping drastically to 284 in 2013 due to severe cuts to financial and technical support.

Provision of care through existing health centres has led to less client friendly services in the Cambodian context, presenting a major challenge to the country's nascent CBTx programme. Clients hesitate accessing the programme directly via health centres that are open to the general public. CSOs have played a critical role in supporting and implementing

the CBTx project in this regard. While clinical staff provide medical services, clients are also encouraged and referred to local CSO partners who provide a range of social support services, from vocational training to family support and social reintegration activities, and CSOs reciprocally refer clients who use drugs to the CBTx project. In addition, and most importantly, the involvement of CSOs has facilitated the recruitment of new clients who use drugs in the community. Peer support has been highlighted as a critical enabler for service access among Cambodians who use and inject drugs, particularly in ensuring that client contacts with health service providers are appropriate and friendly. People who use drugs play a critical role in follow-up through home-visits to their peers, especially when clients drop out of the program.

The CBTx project is operated by National Authority for Combating Drugs (NACD) with support from UNODC and the World Health Organisation in partnership with CSOs including the Khmer HIV/AIDS Alliance (KHANA), Family Health International 360 (FHI360), Friends International (FI), Mith Samlanh, the Social, Environment, Agricultural, Development Organisation (SEADO), the Khmer Buddhist Association (KBA), the Cambodian Women for Peace and Development (CWPD), Men's Health Cambodia (MHC), Men Health Social Services (MHSS), Poor Family Development and the Rural Economic Development Association (REDA).

"I will not go to the health centre to access services unless there is someone from an NGO to accompany."

– CBTx project client

Korsang Drop-in Centre

Established in Phnom Penh in 2004, Korsang is a local CSO working in partnership with the Department of Mental Health and Substance Abuse to deliver low-threshold harm reduction services to people who use and inject drugs. Twelve employees, including a drop-in centre manager, a medical doctor and a counsellor, offer a range of drop-in services complemented by outreach services delivered by 15 volunteer peer workers. The centre is open Monday to Friday from 8am to 5pm.

All of Korsang's services are offered on a voluntary basis using a client-centred approach where clients are free to choose services they need without conditions or legal repercussions. Many of Korsang's employees and volunteers have personal experience with drugs, and the meaningful involvement of people who use drugs has been a grounding principle guiding the organisation's work. Korsang's package of services is aligned with the recommended comprehensive package of HIV prevention interventions targeting people who inject drugs. While MMT and services related to viral hepatitis are not provided on-site, Korsang regularly refer clients to public health service providers.

Korsang distributes sterile injecting kits which contain four sterile needles and syringes, four vials of sterile water, four alcohol swipes, two condoms, a toothbrush, and soap packets. In 2014, approximately 250 clients used Korsang's needle and syringe distribution services. Korsang also provides clients access to counselling, harm reduction education, primary health care, basic medical services, rapid HIV testing, as well as referrals to nearby government health facilities for treatment. A transportation service has been setup by Korsang to facilitate daily access to methadone. Temporary shelter, washing facilities, food and a playground for children are also available from Korsang.

"The [drop-in centre] is a stepping stone to get clients tested and treated because over time, our workers build a relationship of trust with the clients and that trust allows our workers to convincingly underline the importance for them to know their status and initiate early treatment."

- Korsang Executive Director

Korsang currently receives financial support from the Flagship programme, funded by the United States Agency for International Development (USAID), through KHANA. Annual operating costs are estimated at \$42,000.

Implications

The Cambodian government has acknowledged the need to transition away from compulsory approaches to drug treatment despite the fact that the country still operates a wide network of CCDU.¹⁰⁵ The government developed policies and structural measures that culminated in an official pilot project offering community-based drug dependence treatment to people who use and inject drugs in Banteay Meanchey. The CBTx model is unique in the region in that drug dependence treatment services are integrated into the existing national health infrastructure across a significant geographical region. Several features have supported its development:

- > *Comprehensive health and psychosocial care services:* a range of health and social care services are offered through the CBTx project in Cambodia, from primary health and clinical drug dependence treatment services to social reintegration and support services.
- > *Effective collaboration with law enforcement:* local law enforcement officers have been sensitised and trained to support diversion to the CBTx project sites.
- > *Engagement of people who use drugs in some aspects of programme operation:* CSOs and peers play important supportive roles in the CBTx project by facilitating outreach and home visits and providing counselling support.
- > *Engagement of medical professionals:* full and official responsibility for treatment and rehabilitation services was transferred from the National Authority for Combating Drugs (NACD) to the Ministry of Health in 2012.

A number of challenges need to be addressed in order to ensure the positive development of the CBTx programme in Cambodia:

- > Community-based drug treatment services are emerging alongside an extensive national CCDU infrastructure;
- > Developing a client-centred approach that allows people who use drugs to determine the content of treatment plans;
- > Supporting the empowerment for people who use drugs to actively engage in the design, implementation, monitoring and evaluation of community-based drug dependence treatment and support services;
- > Ensuring additional flexibility for clients to pursue goals related to reducing drug-related harms rather than abstinence-oriented treatment services only;
- > Developing client friendly services, including adequately trained and motivated staff, that encourage people who use drugs to access programmes without fear of arrest, stigma or discrimination.

China



Out of the 1.3 billion people living in China, almost three million individuals were officially registered with authorities as people who use drugs in 2014. However, the Chinese National Narcotics Control Commission indicates that the actual number could reach over 14 million.¹⁰⁶ Almost two million people inject drugs across China.¹⁰⁷ HIV rates among people who inject drugs reached a peak of 10.6% in 2002,¹⁰⁸ and have decreased to 6.3% in recent years,¹⁰⁹ while HCV prevalence is estimated at 67%¹¹⁰ compared to 1.9% in the general population.¹¹¹ Drug-related crimes are punished with long prison sentences, including provisions for capital punishment.¹¹²

The Chinese government and CSOs community-based organisations responded to the spread of HIV among people who use drugs by establishing NSP and MMT in the nation's most affected regions. By 2008, over 700 sites distributed sterile injecting equipment across China,¹¹³ reaching an estimated 2% of the total

population in need.¹¹⁴ As of August 2014, 765 MMT clinics were operating across China as well as more than 300 smaller MMT extension sites based in community healthcare centres in urban areas and township hospitals in rural areas. China's government-endorsed MMT program is the largest in the world, serving more than 410,000 cumulative clients since the first clinic opened in March 2004.¹¹⁵ Whereas MMT is fully financed and supported through national government mechanisms, international donors cover 57% of the costs associated with needle and syringe distribution.¹¹⁶

The significant increase in drug use and HIV transmission also prompted the establishment in the early 2000s of a national system of CCDU. The Chinese government developed a three-tiered structure, under the 2008 *Chinese Narcotics Control Law*, to facilitate alternatives to incarceration for people who use drugs: in addition to compulsory detoxification, options are available for voluntary detoxification and

community drug treatment and rehabilitation. In lieu of incarceration, community drug treatment offers drug dependence education, occupational skills training, and other measures to promote detoxification and abstinence from drug use without forced isolation. However, in practice, alternatives to incarceration and detention in compulsory centres are rarely employed.

In 2006, 95,000 people were detained across 700 compulsory centres, and by 2011 the number of detainees had exceeded 171,000.¹¹⁷ Re-education through labour camps also detain large numbers of people arrested for drug possession, and thus these figures significantly underestimate the true number of people detained in the name of drug dependence treatment in China. Meanwhile, studies show that the majority of people in compulsory centres have already been detained at least two or more times,¹¹⁸ and that more than 60% of detainees resume drug use within three days of release.¹¹⁹ Relapse rates one year after finishing compulsory detoxification likely exceed 95%.¹²⁰

CASE STUDY: Peace No. 1 Rehabilitation Centre

Yuxi city is located in Yunnan Province, and is home to 5,027 officially registered people who use drugs, among whom 1,905 reside in Hongta District. Over 80% of people registered for drug use were arrested for heroin use. The city also operates a regional CCDU, with more than 2,300 detainees as of June 2014.

In late 2013, representatives from Yuxi's Hongta district government, from the Centre for Disease Control, from the Public Security Bureau, from the Department of Justice, from the Drug Control Office, agreed to support AIDS Care China in the development and implementation of a comprehensive community-based drug treatment program. The Peace No. 1 Rehabilitation Centre represents the first community-based drug treatment effort in China that seeks to offer comprehensive harm reduction and drug dependence treatment services on a voluntary basis, while facilitating linkages with local law enforcement and ensuring that clients' decisions related to treatment are supported and respected.

The long-term goals of this community-based drug treatment programme are to improve the physical and psychological health of people who use drugs; decrease re-incarceration in compulsory detoxification centres; increase the removal of former drug users from the government surveillance system; strengthen social and familial support for people who use drugs; and improve reintegration of people who use drugs in the community and into society.

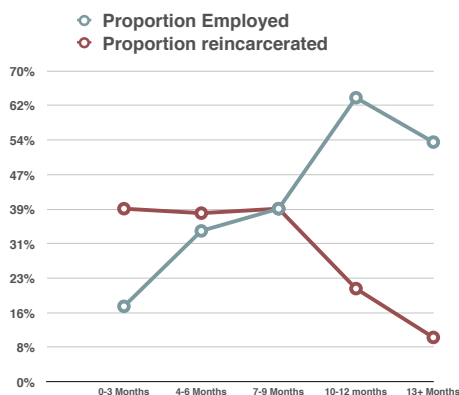
The Peace No. 1 programme has two distinct but equally important components: services provided directly to clients to address the medical, economic, and social issues; and active involvement of relevant government stakeholders, particularly local police, in the implementation of these services.

Peace No. 1 clients have access to a comprehensive package of health and social care services to address drug use and dependence. A client-centred approach ensures that clients are the architects of their own treatment plans. Peace No. 1 clients have access to the following services: on-site rapid testing counselling for HIV, HCV, HBV, and syphilis; direct distribution of naloxone to prevent overdose; individual and group counselling; MMT; outreach and home-visits; job placement; social and community activities; as well as referrals to HIV, HCV, HBV and STI treatment as well as for treatment of other illnesses. An incentive mechanism was also developed and deployed to encourage conformity to the Centre's rules and regulations while offering rewards and benefits to clients.

Cooperation and collaboration between a range of public security agencies were instrumental components to the design and implementation of the Peace No. 1 model. Specifically, at the design stage, a study visit to Seattle, USA was organized by AIDS Care China to observe how the Seattle Police Department and a community-run program (Law Enforcement Assisted Diversion) cooperate to refer people arrested for low-level drug crime to social services to support the design of the Peace No. 1 model. Discussions following this visit led to a consensus that local police would refer all people who use drugs, including those newly released from CCDU, to Peace No. 1 and avoid making arrests for low-level drug crimes in the immediate vicinity of the centre. Finally, a consensus was established to facilitate harm reduction and drug addiction training as a standard practice for all police stations across the district in order to support community-based rehabilitation models like the one in place at Peace No. 1.

Between 30 April 2014 and 18 June 2015, the Peace No. 1 centre enrolled 190 clients among which 171 were referred by law enforcement; three were referred via MMT clinics; one was referred by a family member; and 15 spontaneously enrolled without a referral. Approximately 8% of the centre's clients are female; and less than 3% identified as ethnic minorities. Data collected for this report also showed that the proportion of clients who were able to secure employment increased and the proportion of clients who were re-incarcerated decreased with the length of time enrolled at Peace No. 1 (see Figure 2).

Figure 2: Association between length of enrolment at Peace No. 1 and proportion of clients employed and re-incarcerated



Similarly, the proportion of clients who secured employment increased and the proportion of clients re-incarcerated decreased with the number of times clients had accessed services through Peace No. 1. In addition, over 250 doses of naloxone were distributed to a total of 127 clients, achieving a coverage level of 66.8%. A total of 1,740 contacts with people who use

drugs were made through Peace No. 1 centre's activities.

Five full-time employees, including a director, a consulting psychologist and three peer educators manage the daily operations at Peace No.1. All three peer educators have a drug use background and have been recruited because of their close ties with the local community of people who use drugs that live in the area, as well as their professional skills in HIV prevention outreach. People who use drugs at the Peace No. 1 Centre are involved in programme design, implementation and data collection, and their contributions are especially valued in building strong relationships with clients, families and community representatives.

Implications

Chinese national policy is gradually shifting towards community-based drug treatment programmes, and a greater proportion of national government funding is reportedly being invested to support these models. However, because of significant restrictions on participation of civil society groups in national mechanisms, the majority of community-based rehabilitation and detoxification programmes, along with associated funding, end up being managed by local law enforcement.

However, the establishment of the Peace No. 1 centre represents a significant effort to operationalise policy provisions that endorse and promote community-based drug dependence treatment in China. In that respect, the Peace No. 1 centre has provided a model for implementation and potential scale-up of essential services targeting people who use drugs. Several components of the Peace No. 1 centre have contributed to its success, including:

- > *Voluntary access:* though a significant proportion of Peace No. 1 centre clients were referred by law enforcement agencies, all services are accessed on a voluntary basis.
 - > *Client-centred approach:* Treatment plans are designed in close consultation with clients who decide which services to access.
 - > *Comprehensive health and psychosocial care services:* a wide range of health and psychosocial care services are offered to clients. The majority of services recommended by UN agencies to prevent HIV among people who inject drugs are available or accessible from the Peace No. 1 centre (except sterile injecting equipment). Additional social support services complement the availability of health services.
 - > *Effective collaboration with law enforcement:* agreements are in place to divert and refer people who use drugs to the Peace No. 1 centre without legal consequences. Law enforcement agencies actively participated in the design and implementation of the project to date and over 200 local police officers have been trained.
 - > *Meaningful involvement of peers:* developed by AIDS Care China and a number of other civil society organisations, the Peace No. 1 centre has involved people who use drugs in the design, implementation and monitoring of service delivery and their contributions through outreach are especially valued and appreciated locally.
 - > *Engagement of medical professionals:* since the design phase, health professionals have been involved in the design, implementation and documentation of the activities rolled-out in the Peace No. 1 centre.
- However, authorities continue to rely on CCDU and local arrest quotas for drug offences lead to significant numbers of people in such centres. These arrest quotas have become one of the largest impediments to the success of community-based rehabilitation in China because they actively encourage local law enforcement to detain clients. Much of Peace No. 1's current advocacy work is directed towards this issue in order to pave the way for more comprehensive and successful community-based drug treatment programmes by piloting an alternative model for implementation and potential scale-up of essential services targeting people who use drugs.
- A number of challenges need to be addressed regarding the operation of the Peace No. 1 centre including:
- > Community-based drug treatment services are emerging alongside an extensive national CCDU infrastructure;
 - > Incorporating post-arrest referrals to Peace No. 1 in addition to post-release referrals;
 - > Improving job placement services to provide clients with stable, long-term, well-paid employment;
 - > Increasing peer participation in programme design and operations;
 - > Facilitating better linkages to long-term medical care for clients with complex health needs;
 - > Improving collection and analysis of programme data to objectively evaluate programme effectiveness.

More information about Peace No. 1 Rehabilitation Centre and take home methadone service delivery is available in films recently produced by AIDS Care China, which can be accessed at:

<https://www.youtube.com/watch?v=c39ZvLYcTA0>
and <https://www.youtube.com/watch?v=yIrlMnvvR5nw>

India



India ranks second in the world in terms of population size, counting over 1.2 billion people. There are an estimated 1.8 million people who inject drugs in India, but in reality this number is likely much higher. Among people who inject drugs, HIV prevalence has been recorded at 7.1%,¹²¹ and HCV prevalence at 41%.¹²² Opioids (heroin, buprenorphine, dextropropoxyphene) are the most commonly injected drugs. Drug-related crimes are punished with long prison sentences, including provisions for capital punishment, although India's drug law contains an exemption from prosecution for people charged

with drug use for personal consumption if they are enrolled in a drug treatment programme.¹²³

Harm reduction services have been pioneered by community-based organisations in India in the 1990s. OST was incorporated into the national response to HIV in 2007-2008 and free OST services have been available in 107 centres reaching 11,500 clients as of December 2012. Comparatively, by 2010, there were 261 sites distributing an average of 228 needles and syringes to 135,000 clients in a 12-month period.¹²⁴ Harm reduction services are part of

the national HIV response both at policy and program levels although significant coverage gaps exist. There are 263 targeted harm reduction interventions being implemented to meet the objectives of the Fourth National AIDS Control Programme (2012-2017).

Drug dependence treatment services are available through both voluntary organisations and government-operated ‘de-addiction’ centres which offer a wide range of models and approaches across India: 122 government hospitals provide both in- and outpatient detoxification services; 346 locally and nationally funded CSOs operate integrated abstinence-focused rehabilitation centres; a number of licensed private-sector medical professionals offer fee-based clinical services; and an indeterminate number of unaccredited and unlicensed ‘de-addiction’ centres.¹²⁵

In 2009, legal action in the wake of documented human rights violations in de-addiction centres¹²⁶ led to amendments in the *Narcotic Drugs and Psychotropic Substances Act* (1985) that compelled the development of the *Haryana De-addiction Centres Rules* (2010) and the *Punjab Substance Use Disorder Treatment, Counselling and Rehabilitation Centres Rules* (2011). The legal amendments compelled licensing and inspection of all drug treatment facilities in a number of states across the country.¹²⁷ The *Rules* promote voluntary admission into treatment and include provisions for closure and legal action against those that operate unlicensed centres. In addition, the development of minimum standards for drug dependence treatment in India remains an important tool to ensure that services are aligned with scientific evidence and best practice that should be further reviewed, analysed and promoted.

Table 2: Overview of Hridaya's geographical scope

States	Bihar	Haryana	Uttarakhand	Manipur
Total population	104 million [52% male/48% female]	25 million (53% male/47% female)	10 million (51% male/49% female)	2.5 million (51% male/49% female)
Number of districts	38 districts	9 districts	13 districts	9 districts
Number of registered people who inject drugs	3,849	4,699	1,833	704
Hridaya support	12 peer counsellors	11 peer counsellors	12 peer counsellors	2 peer counsellors

CASE STUDY: The Hridaya project of the India HIV/AIDS Alliance

The Hridaya (a name given to the Community Action for Harm Reduction project¹²⁸ in India) project, managed by India HIV/AIDS Alliance, was designed to complement and strengthen the national harm reduction response in the states of Bihar, Haryana, Uttarakhand and Manipur. Table 2 below summarizes the scope of the project in each state. Specifically, the project aims to increase access to health and social care services among people who inject drugs and their families.

Alliance India provided technical support provided to existing CSOs working with people who use and inject drugs to improve their peer-based methods. This led to changes in the way services were provided and to the development of tools and methods that are shaped by drug users. In that sense, the Hridaya project is a unique effort to increase access to health services through the direct meaningful involvement of peers in service delivery in existing government health services. For example, each CSO was provided with at least two female peer counsellors to deliver behaviour change communication sessions on viral hepatitis, HIV, vein care through safer injecting practices, condom promotion and safer sexual practices.

Organisations involved in the implementation of targeted interventions to prevent HIV transmission among people who inject drugs offer a comprehensive package of health and social care services. Table 3 below includes a detailed list of services offered in project partners across the four states.

The contributions of peers were regularly monitored and evaluated in order to document results and assess the value of this approach. Peers were mobilised at each site to implement interventions such delivering psychosocial support services and enhancing referral to external services.

“The inclusion of peers in the service-delivery mechanism has opened a gateway not only to service access but also to empower PWID community in order to establish and maintain regular contacts with services matching their individual needs. Peer counsellors made essential referrals to primary services such as OST, antiretroviral treatment, screening and treatment of tuberculosis and sexually transmitted infections.” – Hridaya project management team representative

Many clients who accessed peer support were able to reduce the frequency of their drug use; many felt that peers had facilitated their greater acceptance in the community, particularly with local law enforcement, and contributed to reducing stigma and discrimination. In addition, project reports underline the critical importance of female outreach workers, especially reaching out to the partners and families of people who inject drugs, as well as recruiting new clients for enrolment in regular services. Meanwhile, project reports also highlight that peer interventions have been cost-effective.

Finally, the Hridaya project facilitated the establishment and official endorsement of a number of state-level forums that support the meaningful participation of people who use and inject drugs in state-level decision making.

Table 3: Services offered through targeted interventions under Hridaya

Mechanism	Description of Services
Direct Services	<ul style="list-style-type: none"> > Medical support (emergencies) > Emergency support for people living with HIV > Peer progression support > Crisis response teams – support for people experiencing arrests, violence, discrimination, overdose > Overdose prevention and management with naloxone
Prevention and Education Services	<ul style="list-style-type: none"> > Outreach services focusing client partners and families > Prevention of viral hepatitis > Prevention & management of overdose > Legal assistance and rights empowerment > Sexual and reproductive health support > Formation of peer support groups & network meetings > Home-based care
Specialist Services through Referrals	<ul style="list-style-type: none"> > Drug treatment support (e.g. OST detoxification, rehabilitation, etc.) > Nutrition for people living with HIV > Social entitlements program – advocacy for access to existing entitlements > Diagnosis and treatment of viral hepatitis > Sexual and reproductive health services > CD4 testing > OST follow-up
Services for Spouses/Partners	<ul style="list-style-type: none"> > HIV testing and counseling / pre & post ART > Management of sexually transmitted infections > Diagnosis and treatment of tuberculosis

Implications

The Hridaya model is a unique initiative that provides community-based service delivery to people who use drugs. This is achieved through the development and reinforcement of peer-based interventions in civil society organisations already targeting people who use and inject drugs. The positive results achieved under the Hridaya project show that peer involvement has generated important benefits for the project as well as for clients.

The Hridaya project was able to successfully facilitate delivery of community-based health and support services for people who use and inject drugs. The following enabling factors have been identified:

- > *Voluntary access:* all Hridaya clients accessed services on a voluntary basis
- > *Meaningful involvement of peers:* as the central component of the project, peers were critical and cost-effective enablers in recruitment and retention of clients as well as in facilitating service delivery
- > *Comprehensive health and psychosocial care services:* a wide range of health and psychosocial care services are offered to clients to add to the basic health services provided by government services, responding to the many health and social care needs of people who use drugs in India

It is worth underlining that the minimum standards for drug dependence treatment in India are significant and important tools that should be further reviewed, analysed and promoted. These were generated based on rich experiences in drug dependence treatment, and many opportunities to pilot a range of models of drug dependence treatment services exist in India.

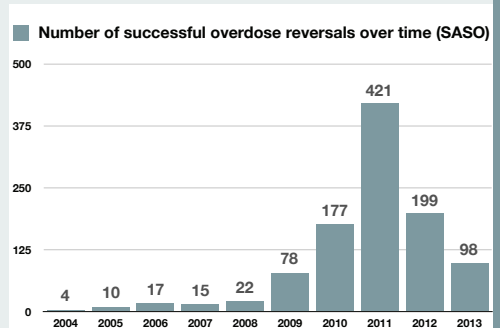
Responding to drug-related crises in Manipur

Social Awareness Service Organisation (SASO), a CSO based in Manipur, has been providing peer-based harm reduction and drug dependence treatment services, including community-based rehabilitation, since 1990. More recently, SASO's comprehensive package of health and social care interventions targeting people who use and inject drugs has been expanded to include overdose prevention and management with naloxone. SASO's overdose response is one component of a comprehensive crisis response mechanism.

The overdose management efforts supported under the Hridaya project have increased awareness of the risks and responses to drug overdoses among people who use and inject drugs as well as among their families and communities in Manipur. Specifically, the administration of naloxone by outreach workers and health service providers

has contributed to reversing 83 overdoses between January 2014 and March 2015. Data from previous years is presented in Figure 3.

Figure 3: Number of successful overdose reversals over time (SASO)



Indonesia



Out of Indonesia's total population of 240 million, between 60,000 and 80,000 people inject drugs.¹²⁹ Over a third of people who inject drugs in Indonesia are living with HIV, compared to 52% in 2007,¹³⁰ while over 77% are living with HCV.¹³¹ Drug-related crimes are punished severely, with long prison sentences and capital punishment.¹³²

Out of a total of 274 government-operated service outlets targeting people who use and inject drugs, 194 community health clinics offer sterile injecting equipment and 24 also provide MMT.¹³³ A total of 77 sites offer MMT across the country – including in prison settings.¹³⁴ As of July 2014, 9,302 people who inject drugs were provided with sterile injecting equipment and 2,512 clients were enrolled in.¹³⁵ Data shows that fewer than a quarter of Indonesians who inject drugs access sterile injecting equipment each year,¹³⁶ with CSOs being the primary source of sterile injecting equipment.¹³⁷

Drug treatment practices and policies have changed significantly since the 1990s and two tracks – medical or social rehabilitation – each with several treatment options, are available for people who use and inject drugs. Services under the first track are managed by government agencies whereas those offered under

the second track are operated by private sector organisations. All services managed by government agencies seek to achieve total abstinence from drugs.

Medical rehabilitation services are managed and overseen by the Ministry of Health and integrate harm reduction interventions, drug dependence counselling as well as other clinical and psychosocial interventions. Social rehabilitation services are managed and overseen by the Ministry of Social Affairs to offer a wide range of interventions, including case management, aftercare programmes, self-help groups, religious and spiritual counselling, and vocational programmes. However, many facilities offer components of both medical and social rehabilitation. The National Narcotics Board also operates an estimated 20 facilities that employ therapeutic community methods. The National AIDS Commission's Community-Based Drug Treatment project cultivates alternatives to existing drug dependence approaches by offering client-centred options that meet the needs of clients and contribute to reducing harms and improving quality of life.

In total, over 450 facilities offer drug treatment and rehabilitation across Indonesia, including in drug dependence hospitals, within CSOs,

government-operated centres and privately-operated facilities.¹³⁸ The majority of services operating in Indonesia seek to achieve total abstinence from drugs, which remains the dominant approach nationally. The exception is The National AIDS Commission's Community-Based Drug Dependence Treatment (CBDDT) programme, which is governed by standardised guidelines and monitoring and evaluation tools that seek to focus on reducing harms associated with drug-use and improving clients' quality of life.¹³⁹

Several national legal and policy instruments have influenced health services among people who use drugs and particularly drug dependence treatment. Notably, the Narcotics Law #35/2009 was designed to facilitate access to treatment among people who use and inject drugs by diverting them away from the criminal justice system.¹⁴⁰ However, the Narcotics Law #35/2009 together with Regulation #25/2011, compelled the reporting of all adults dependent on drugs to authorities.¹⁴¹ In 2013, the National AIDS Commission published the *National Guidelines on Community-based Drug Dependency Treatment*. However, laws and policies in Indonesia still compel law enforcement to arrest people who use drugs.

Meanwhile, starting with the Sentani Commitment in 2004, significant policy and legal instruments have been deployed to support the implementation of harm reduction services to prevent HIV. Regulation on Harm Reduction #2/2007 was endorsed and legitimised the delivery of such services while Regulation on HIV and AIDS Prevention #21/2013 further compelled the expansion of such services.

CASE STUDIES: Rumah Singgah PEKA & Rumah Cemara

Rumah Singga (PEKA) and Rumah Cemara (RC) are both located in West Java province. An estimated 13,000 people who inject drugs live in West Java, as do over 9,000 people living with HIV. HIV prevalence among people who inject drugs in West Java province decreased from 67% in 2008 to 13% in 2012.¹⁴² Harm reduction services are available in 16 out of 26 districts in the province, with 56 community health centres offering sterile injecting equipment and 13 sites where MMT is offered. Across the province, 25 NGO are involved in the delivery of health and social care services for people who use and inject drugs.

Both PEKA and RC are recipients of the National AIDS Commission's CBDDT initiative. Established in 2009 in close cooperation with 11 community-based organisations, the project now supports 15 community-based drug dependence treatment facilities across 11 cities. The CBDDT project was designed to promote a client-centred approach with informed and voluntary participation in treatment; integration of harm reduction approaches within its programming; engagement of the community within which it operates; and active involvement of beneficiaries and people who use drugs in programme planning, implementation, monitoring and evaluation.¹⁴³

Rumah Singga PEKA

Rumah Singga PEKA (PEKA) is a local CSO established in August 2010 in Bogor to provide treatment options for people who inject drugs and improve their quality of life, in response to the closure of several treatment facilities for people who use and inject drugs in the surrounding area. PEKA relies on client-centred approaches to deliver tailored health services to meet the needs of people who use and inject drugs. Clients access all of PEKA's services on a voluntary basis and can withdraw from the program at any time without negative repercussions.

"In other treatment centres, relapse means the end of the story [suspension of treatment]. That creates more feelings of guilt for us... and we go deeper and deeper down the cycle of addiction. Here at PEKA, the staff really appreciate our efforts to stop using or to reduce our consumption. When we relapse, we're not forced to stop treatment are re-start from zero again. This is not happening in other treatment centres." – PEKA client

PEKA offers both inpatient facility-based treatment, as well as community-based outreach services. Clients enrolling in treatment services can select the intensive two-month program – involving detoxification, peer addiction counselling, psychosocial support, life skills training, relapse prevention and management as well as social and vocational activities – or the non-intensive four-month program – involving counselling, life skills training, relapse prevention and management, as well as social and vocational activities.

Outreach services were designed to facilitate client referrals to external health services – given that PEKA does not have clinical staff to directly provide medical services. An extensive network of hospitals, community health centres, health laboratories and private psychiatrists has been mobilised to support PEKA and facilitate effective health referrals for clients. PEKA's clients are regularly referred to OST (MMT and suboxone), primary and reproductive health care, HIV counselling and testing, antiretroviral therapy, as well as diagnosis and treatment for viral hepatitis, tuberculosis and sexually transmitted infections.

Sterile injecting equipment is available to both inpatient and outreach clients. In addition to health service delivery, PEKA mobilises people who use drugs to participate in national- and community-level advocacy interventions and campaigns as well as social activities and celebrations. PEKA regularly contributes to research and documentation activities as well as in supporting capacity building of a range of key stakeholders on drug-related issues, including in closed settings.

In 2013, PEKA reached a total of 786 people who use and inject drugs. Among those, 95 received inpatient drug dependence treatment services; and 691 were reached via outreach. During the same period, a total of 5,085 people accessed NSP; 670 people who use and inject drugs were referred to HIV counseling and testing; 62 were referred to basic health care; 13 were referred to MMT; 49 were referred for screening and treatment of sexually transmitted infections; and six were referred for screening and treatment of tuberculosis. An additional 250 inmates received training and education sessions in four prisons in 2014.

PEKA's clients are people who use and inject drugs though the vast majority of clients inject, and heroin remains the drug of choice for over 90% of all clients. Two-thirds of clients have completed high school and approximately half are currently employed. Women account for 14% of PEKA's total clients. Female staff and counsellors are available on site to tailor drug treatment plans to the needs of female clients.

PEKA currently hires 12 full-time employees, including four peer outreach workers, as well as 10 volunteers, including three psychologists and one nurse. PEKA was founded by people with experience using drugs and the majority of workers also have experience using drugs. PEKA values the contributions of people who

use drugs and facilitates meaningful participation of its clients in program development, implementation and evaluation.

Between 2010 and 2015, PEKA received support from the Australian Agency for International Development (AusAID), from the Global Fund, from the International HIV/AIDS Alliance, and from UNODC. During this period, the organisation's annual budget was \$120,000 with Global Fund contributing the largest share. Additional funding from national sources – including from the Ministry of Social Affairs, from the National AIDS Commission and from the National Narcotics Board – represented 30% of the average annual budget.¹⁴⁴

Rumah Cemara

Rumah Cemara (RC) was established in 2003 in Bandung to provide treatment options for people who inject drugs and improve their quality of life. RC is a Linking Organisation of the International HIV/AIDS Alliance. In 2006 and 2014, RC established new offices in Sukabumi and Jakarta respectively. While the offices in Bandung and Sukabumi are designed for health service delivery, the Jakarta office was opened to focus on policy development, advocacy and coordination with national agencies, including the national network of people who use drugs (PKNI).

RC uses client-centred approaches to deliver tailored health services to meet the needs of people who use and inject drugs. Clients access all of RC's services on a voluntary basis and can withdraw from the program at any time without negative repercussions. Originally designed and intended as a drug rehabilitation centre, RC quickly expanded to incorporate harm reduction services. RC's drug treatment program combines 12-step, therapeutic community and peer-led approaches in a six-month inpatient program

with three additional months of post-treatment aftercare. RC's clients set their own objectives – from abstinence to a reduction in drug use – and obtain the support they need.

RC offers a comprehensive package of health and support services to its clients including: residential drug dependence treatment; peer outreach, distribution of sterile injecting equipment and condoms; psycho-social support for MMT clients; individual and group counselling and support activities; as well as education and information related to HIV, drugs and public health.

Given the absence of a full-time on-site doctor, an extensive referral network was cultivated to facilitate RC's clients' access to additional health services from partner organisations. For example, RC regularly refers significant numbers of clients to MMT, HIV counselling and testing, HIV treatment with antiretroviral therapy, as well as screening and treatment of tuberculosis, viral hepatitis, and sexually transmitted infections.

RC has been widely recognised for its community sports programme designed to facilitate social inclusion of people who use drugs and live with HIV in the community. The programme offers a range of sports activities – football, boxing, running, rugby, and skateboarding – through which people who use drugs and living with HIV can safely engage with members of the community. RC's clients participated in the Homeless World Cup, an international tournament for disadvantaged people which attracted significant national and international media attention in 2011.

Though RC initially targeted people who use and inject drugs, the services offered now reach people living with HIV; partners and families of people who inject drugs and people living with HIV. In 2013, RC reached a total of 9,737 clients

with health services. Out of this total, 1,247 clients received a total of 20,000 sterile needles and syringes; 57 clients received intensive psychosocial support in the context of MMT; and 30 clients were enrolled in the residential drug dependence treatment program, compared to a cumulative total of 625 since 2003. In addition, 2,775 clients were referred to legal aid services; 1,129 clients were referred to HIV testing and counselling; and 150 clients were referred for screening and treatment of sexually transmitted infections. RC's clients are overwhelmingly male (21% female); 72.7% have completed high school; and 25% are unemployed.

In 2013, RC's total budget was \$490,895 with three quarters of the total funds sourced from international donors including the Australian Agency for International Development, the United States Agency for International Development, the Global Fund, the International HIV/AIDS Alliance, the International Drug Policy Consortium, the Australian and Dutch Embassies in Jakarta, the European Commission and UNODC. National sources of funding included the National Narcotics Board, the National AIDS Commission, the Ministry of Health and Pertamina, a local oil and gas company. Rumah Cemara hires 12 administration staff, 43 programme staff and seven volunteers across its three offices. In addition, a part-time doctor, nurse and psychologist volunteer to support the services in Bandung office and additional interns from local schools and universities frequently contribute to RC's projects.

RC is recognised and acknowledged for the peer-based nature of the services it offers. The organisation was founded and has been operated by people with a drug user background, and the majority of workers continue to be overwhelmingly from the community of people who use drugs. RC workers and their clients consider peer involvement as a critical approach

to increase the effectiveness of health services. RC currently covers 80% of the total population of people who inject drugs in Bandung and Sukabumi.¹⁴⁵

“I can be myself at Rumah Cemara because of the friendly and sympathetic atmosphere. In all of my treatment experience, I’ve never seen such an enabling treatment environment. In the past, the treatment I received was irrelevant to my current needs. [...] I’m here is not just because I want to stay off drugs but because I want to be a productive member of society. Back home, I have a child to raise and Rumah Cemara is helping me find a job so I can take care of my family.” – RC client

- > *Comprehensive health and psychosocial care services:* a wide range of health and psychosocial care services are offered to clients. The majority of services recommended by UN agencies to prevent HIV among people who inject drugs are available or accessible from PEKA and RC. Additional social support services complement the availability of health services
- > *Meaningful involvement of peers:* peer-to-peer contact among criminalised and marginalised populations greatly enhances receptivity of clients
- > *Engagement of medical professionals:* though neither PEKA or RC have been able to secure full-time clinical staff, both organisations have established partnerships with a number of medical agencies and have mobilised medical professionals who volunteer on a part-time basis

Implications

The CBTx project launched in 2009 by the National AIDS Commission is a landmark effort to address critical gaps in health programming by building on important lessons learned and successes achieved and documented in the response to HIV among people who use and inject drugs. PEKA and RC are among a number of civil society groups that have contributed to the success of the project. The following have been identified as enabling components:

- > *Voluntary access:* all of PEKA and RC’s services are accessed voluntarily
- > *Absence of legal consequences:* clients who do continue to use drugs do not suffer legal penalties or threats of legal penalties. Instead, a client-centred approach is prioritised, focusing on improving the health of clients and ensuring they are not deterred from accessing health services

Despite the success of this model, additional efforts must be deployed to facilitate broader acceptance and further integrate this approach in practice at the national level. Specifically, the majority of drug treatment services remain abstinence-based, and harm reduction approaches to drug use and dependence continue to be officially rejected by the national anti-drug agency. Law enforcement endorsements and sustainable state funding will be critical if this model is to be replicated and scaled-up.

Malaysia



Among the 30 million people living in Malaysia,¹⁴⁷ an estimated 170,000 inject drugs.¹⁴⁸ While HIV prevalence rates among people who inject drugs remain well above that of the general population, those rates have been decreasing steadily – from 39% in 2011, to 21.5% in 2013 down to 18.9% in 2014.¹⁴⁹ In contrast, HCV prevalence rates among Malaysians who inject drugs are estimated at 67.1%.¹⁵⁰ Drug-related crimes are punished severely, with a combination of long prison sentences and corporal¹⁵¹ and capital punishment.¹⁵²

Across Malaysia, 728 sites distribute sterile injecting equipment, over one fifth of which are located in government health clinics and many services are provided by community-based organisations. Since initiation of needle distribution, 72,686 people who inject drugs have been reached and received an average 522 needle and syringes per person per year.¹⁵³ In comparison, 811 sites have provided MMT to a cumulative total of 65,249 clients while an additional estimated 10,000 clients received buprenorphine.¹⁵⁴ Just a little over half of MMT sites are operated by government agencies – in both community and closed settings – while the remainder are managed by private sector health providers, all reporting to the Ministry of Health.¹⁵⁵

By the end of 2011, the Malaysian government had invested \$16.6 million of the national budget to support the implementation of harm reduction programmes through partnerships with CSOs. The impact of these services has been quantifiably measured by government agencies and confirmed by community representatives. Evaluation results demonstrate a reduction in HIV prevalence, an increase in the use of sterile injecting equipment, and an increase in frequency of condom use among Malaysians who inject drugs.¹⁵⁶ WHO has recognized Malaysia's national response to HIV among people who inject drugs as an example of good practice.¹⁵⁷

The 1983 *Drug Dependents (Treatment and Rehabilitation) Act* compelled the government to set up CCDU and delegate operational control of such institutions to the National Anti-Drug Agency (AADK) under supervision of the Ministry of Home Affairs (MoHA).¹⁵⁸ In 2010, 6,658 people were detained in Malaysia's 28 CDDCs.¹⁵⁹ That same year, AADK developed a progressive plan to gradually phase out CCDUs and replace them with Cure & Care Centres (CCC). The CCDUs were rebranded as Cure & Care Rehabilitation Centres (CCRCs) while voluntary inpatient (CCC) and voluntary outpatient centres (Cure & Care Service Centres or CCSC) were introduced. Methadone maintenance therapy was introduced in the CCRCs. CCC and

CCSC were designed to offer free, voluntary, comprehensive health services to people who use drugs through a holistic treatment strategy without legal repercussions if abstinence from drugs is not achieved.¹⁶⁰ At present, there are 19 CCDU and 59 CCC and CCSCs operating in Malaysia, all managed by the AADK under supervision of MoHA.

Malaysia's transition to CCC has been very positive. Importantly, preliminary data provides clear evidence of the beneficial impact of CCC on a number of outcomes for clients. Assessments have shown that clients reported to be satisfied with treatment outcomes, reported experiencing fewer withdrawal symptoms and cravings for drugs compared to those in CCDU, and felt that their interaction with CCC staff had greatly improved their overall health.¹⁶¹ Clients also considered CCC services helpful in securing employment, accessing welfare and government services, accessing formal education, improving relationships with family and friends, finding a place to live, assisting with drug problems, staying out of prisons and CCDU, accessing health services including HIV prevention and OST, and accessing legal aid. In addition, a study has shown relapse rates of those leaving CCDU and those leaving CCC to be vastly different, with 50% of clients coming out of CCDU relapsing within 32 days of release compared to 429 days after leaving CCC.¹⁶² These studies convincingly support the country's transition away from compulsory detention towards community-based, comprehensive drug treatment services.

CASE STUDY: Kerinchi CCSC

The Kerinchi CCSC initiated its operations in a drug use hotspot in Kuala Lumpur, in September 2011. As of September 2014, the CCSC had registered 479 clients of which 266 were considered 'active' clients. Between 80 and 90 clients visit the CCSC every day despite limited opening hours (9am-1pm, four days per week). Of the 266 active clients, 78% are employed, 40% are living with HIV, 28% are living with HCV, 27% are co-infected with both HIV and HCV, and 8% are living with tuberculosis. All clients of the Kerinchi CCSC accessed its services on voluntary basis.

Day-to-day operations of the CCSC are managed by seven full-time staff and two peer educators. Full-time staff positions include at least one medical officer, one methadone clinic manager, one administrative coordinator and one CCSC manager though several positions were vacant during the data collection phase of this project. CCSC peer educators are responsible for facilitating peer support activities, implementing outreach as well as advocacy activities, and coordinating the residential programme. The important role and contributions of peer educators was repeatedly acknowledged in interviews with AADK representatives and CCSC team members.

Like other drug treatment and rehabilitation facilities in Malaysia, the Kerinchi CCSC is under the supervision of AADK, which oversees implementation of the residential programme, of outreach activities and of psychosocial interventions. The unique partnership between AADK and the University of Malaya's Centre of Excellence for Research in AIDS (CERiA), in which operational responsibilities are shared and CERiA representatives manage the delivery of medical services, distinguishes the Kerinchi CCSC from other CCSC in Malaysia and allows the rapid integration of evidence-based lessons into practice.

The Kerinchi CCSC offers a comprehensive range of health and psychosocial services to support people who use and inject drugs. Specifically, the Kerinchi CCSC offers both inpatient and outpatient drug dependence treatment services, where the all-male inpatient residential programme allows for clients to stay for a maximum of three months. Methadone maintenance treatment (MMT) with flexible dosing and options for take-home doses (under strict conditions) is available to all. In addition, Kerinchi CCSC provides its clients with condoms, behaviour change communication and education about HIV and drugs. Psychosocial support activities, including individual and group counselling sessions as well as peer support group meetings, are regularly implemented for both in- and outpatient clients. Voluntary HIV and HCV tests are regularly offered and performed at the CCSC, always accompanied by pre- and post-test counselling sessions.

Kerinchi CCSC clients are also referred to external health service providers. For example, people living with HIV who have not initiated treatment are regularly referred to the Kuala Lumpur General Hospital or the Tanglin Hospital, which provides antiretroviral treatment and primary care services. Similarly, all clients showing symptoms of tuberculosis are rapidly referred to hospital facilities.

Finally, the Kerinchi CCSC also offers its clients day-care support for those with children, as well as a job placement program. The CCSC team members regularly conduct community advocacy activities targeting local religious leaders, local police representatives as well as neighbours living around the CCSC.

Implications

While some CCDU are still in operation, the emergence of the CCSC model represents a significant transition away from compulsory detention and brings drug treatment and psychosocial support services closer to the community. Linkages between Kerinchi CCSC and harm reduction service outlets operated by CSOs remain limited. However, it is clear that the evolution of the CCSC model has been supported by harm reduction advocacy efforts and by national commitments to improve the health and quality of life of people who use and inject drugs.

“The introduction of harm reduction programmes in Malaysia also opened the doors for the public health sector to be involved in providing treatment for people who use drugs in Malaysia. With the introduction of harm reduction in the country, NGOs who were previously providing services for drug users in an informal way began to play a more pivotal role in engaging with the government.”¹⁶³

Expanding the reach and maximizing the impact of the CCSC model will lead to closer collaboration with CSOs that are already involved in health service delivery for people who use and inject drugs. Many such CSOs have expressed an interest in participating in the design, implementation and evaluation of drug dependence treatment and psychosocial support services and these partnerships offer an opportunity to rapidly scale-up this model.

Several factors have contributed to attracting and retaining Kerinchi CCSC's clients, including:

- > *Voluntary access:* all of Kerinchi CCSC's services are exclusively accessible on a voluntary basis.
- > *Absence of legal consequences:* while abstinence remains the goal of the CCSC, clients who do continue to use drugs do not suffer legal penalties or threats of legal penalties. Instead, a client-centred approach is prioritised, focusing on improving the health of clients and ensuring they are not deterred from accessing health services.
- > *Comprehensive health and psychosocial care services:* a wide range of health, psychosocial care and social support services are offered to clients. The majority of UN recommended HIV prevention services for people who inject drugs are available from the CCSC. However, it is important to note that two essential services for people who inject drugs; sterile injecting equipment and naloxone for overdose management, are not available.
- > *Meaningful involvement of peers:* The important role and contributions of peer educators are recognised and greatly valued within the Kerinchi CCSC.
- > *Engagement of medical professionals:* Prior to the implementation of the CCSC model, medical professionals were obligated to report people who use and inject drugs to authorities. Within this model, medical professionals are engaged in daily operations of the CCSC and are not required to report drug use. This has improved the confidence of those using the services in practitioners providing drug dependence treatment and other health services.

Finally, it is worth highlighting the Malaysian government's high-level commitment to achieving the Millennium Development Goals as an incentive that also motivated a reform in drug treatment approaches and infrastructure. Malaysia stands out in the region for the political commitment and financial contribution made to harm reduction and for beginning to transition away from CCDU. However, the remaining CCDU must discontinue operating if there is to be a full commitment to move away from compulsory detention for people who use drugs.

Despite the impressive developments in regards to the transition away from CCDU in Malaysia, a number of gaps remain:

- > Community-based drug treatment services are emerging alongside an extensive national CCDU infrastructure;
- > More meaningful involvement of people who use and inject drugs is required in the design and evaluation of drug treatment services in order to ensure their continued relevance in the community;
- > CCC and CCSC models in Malaysia continue to prioritise abstinence-related objectives. Flexibility in the application of outcome indicators based on the reduction of harm and improvements in quality of life are needed;
- > Anecdotal evidence suggests that policy changes and legal reforms that paved the way for the transition to CCSC in Malaysia are in process of being overturned and that government agencies are once again promoting CCDU over CCSC.

Vietnam



Vietnam is home to approximately 90 million people, of whom 204,377 use drugs.¹⁶⁴ As this figure is based on those who are officially registered with the state, the actual number is estimated to be much higher. Injecting drug use is the leading contributor to the transmission of HIV in Vietnam, accounting for nearly 60% of all new infections. Heroin is the drug of choice for 85% people who inject drugs. Over 10% of people who inject drugs in Vietnam are HIV positive, compared to less than one percent of the general population.¹⁶⁵ In contrast, HCV prevalence among people who use drugs is estimated at 74%,¹⁶⁶ compared to less than 3% in the general population.¹⁶⁷

Since the mid-2000s, the Vietnamese response to HIV transmission has included significant provisions to scale-up comprehensive harm reduction services targeting people who inject drugs. Government agencies report that, by June 2015, methadone was being dispensed to over 29,278 clients in 43 provinces and cities throughout the country.¹⁶⁸ The President's Emergency Plan For AIDS Relief (PEPFAR) has been the primary provider of technical and financial support for MMT implementation. National plans include ambitious goals of reaching 80,000 heroin users with MMT by the end of 2015. There is reported to be a high demand for treatment services among people who use drugs and the number of provinces requesting support for MMT programmes continues to grow. By 2011, needle and syringe distribution programmes were operating in 60 of the 64 provinces in Vietnam.¹⁶⁹ Despite these important successes, coverage remains low, estimated at 29% and 15% for needle and syringe distribution and MMT programmes.¹⁷⁰

CASE STUDY: Drug policy reform facilitating a national transition to community-based drug dependence treatment

In 1995, the National Assembly issued the *Ordinance on Handling of Administrative Violations* that included provisions for ‘drug addicts’ to “... be sent to health institutions for treatment, education and manual labour for from (*sic*) three months to one year.” The Ordinance paved the way for the rapid expansion of the national compulsory detention infrastructure over the next decade. In 2000, Vietnam counted 56 CCDU with a capacity for 27,000 people, and by 2011, a total of 121 such centres were detaining 40,000 individuals over a total capacity to accommodate 70,000 individuals.¹⁷¹ In parallel, legal provisions have allowed the state to detain people who use drugs for an increasingly long period of time: between one and two years and up to four additional years with forced labour. Meanwhile, government data indicates that relapse rates have been consistently high – between 80% and 90% - after people leave the centres.¹⁷²

Implementation of drug policy is the responsibility of all government ministries and departments, however the Ministry of Public Security (MoPS), the Ministry of Labour, Invalids and Social Affairs (MOLISA) and the Ministry of Health (MoH) play lead roles. Under the current framework, methadone programmes are largely the responsibility of MoH, implementation of drug rehabilitation is under the supervision of MOLISA, and the MoPS retains leadership for the development and oversight of the national strategy. National coordination is the responsibility of the National Committee on AIDS, Drugs and Prostitution Control under the authority of the Deputy Prime Minister.

The *Law on Preventing and Combating Narcotic Drugs* (2000), mandating prison sentences for people who relapse after compulsory treatment, was amended in 2008 to provide support for harm reduction measures, as prescribed in the *Law on HIV/AIDS Prevention and Control* (2006).

In 2009, the Penal Code was amended to legally consider people who use drugs as patients rather than criminals.¹⁷³ In 2012, the *Ordinance on the Handling of Administrative Violations* (1995) was upgraded to a law. The new law abolished compulsory detention for sex workers, but maintained provisions for the compulsory detention of people who use drugs; however, it included provisions that recognised the right to legal representation for people facing drug charges.

In 2013, the Prime Minister approved the *Drug Rehabilitation Renovation Plan* that outlines a comprehensive strategy to increase evidence- and community-based drug dependence treatment programmes, and decrease State reliance on the compulsory system. The Renovation Plan provides a roadmap to reform and harmonise the various public health, public security and social welfare laws, policies and programmes related to drug dependence treatment under a coherent and integrated framework. The Renovation Plan deviates from other high level drug-related strategies by emphasising internationally recognized standards and principles for drug dependence treatment as well as the importance of evidence-based interventions designed to address the needs of clients. The document outlines a process for the development of integrated voluntary services designed to address the health and social needs of people who use drugs. Key elements of the plan focus on renovating the majority of compulsory centres and transforming them into voluntary community-based treatment sites by 2020.

Revisions to the national Constitution in 2014 led to the removal of clauses related to drug use and compulsory detention, elimination of language relating to “social evils”, as well as the addition of new articles prohibiting discrimination (Article 16) and guaranteeing the right to a trial. However, the revisions also include

conditions that allow the state to legally bypass diversion mechanisms and reforms to compel detention.¹⁷⁴

While there are clear indications that voluntary drug treatment is gaining high-level government support, elements of the national response fuelled by a vision of a drug-free Vietnam still exert a powerful influence on government strategies. The *Strategy On Preventing, Combating And Controlling Drug Abuse In Vietnam Till 2020 And Orientation Till 2030* acts as the national drug control framework overseen by the National Committee for AIDS Drugs and Prostitution Control, and positions the MoPS as the lead implementation agency. The Strategy acknowledges the importance of treatment and harm reduction, and supports community-based treatment. However, a number of targets remain aligned with elimination objectives favouring total abstinence. For example, targets include reducing the number of 'drug addicts in Vietnam by up to 40%'; and the 'identification, control and treatment of 100% of drug addicts in centres'.¹⁷⁵

Capitalising on the momentum created by significant policy change, the Advisory Group reporting to the Chairperson of the National Committee on AIDS, Drugs and Prostitution invited the Centre for Supporting Development Initiatives (SCDI) to develop a model for community-based drug dependence treatment aligned with the Renovation Plan, and initiate a pilot to deliver services to people who use drugs in Bac Giang province. The Asia Action for Harm Reduction project as well as the French Embassy in Vietnam, the Open Society Foundations and the Substance Abuse and Mental Health Services Administration (SAMHSA) provided technical and financial support. SCDI, the lead implementing agency, is a civil society organisation playing a critical role in advocacy for voluntary community-based drug dependence treatment

in Vietnam. SCDI has forged strong partnerships with local and national government agencies to support implementation of the Renovation Plan through training for staff and volunteers and development of guidelines to safeguard the rights of and empower people who use drugs.

“Many people who use drugs in Bac Giang, including myself, have been looking forward to the opening of the voluntary community treatment centre. Health workers here are extremely committed and very friendly. People who use drugs are not afraid to access services from this centre; they can be very open and frank with the type of support they need. People in the local community now also have better, friendlier, attitude towards people who use drugs.” – CATS client and head of Bac Giang group of people who use drugs

SCDI worked closely with the provincial Department of Social Vices Prevention, court officials, law enforcement representatives, the district and provincial People's Committee, and local groups of people who use drugs to design an effective and attractive intervention model. On 12 May 2015, the first community addiction treatment site (CATS) was launched in Bac Giang province, based in the commune health centre and operated by their staff with support from local government and mass organisations. Since initiation of the pilot, SCDI has been requested by MoLISA to support replication of CATS in two additional provinces.

The objectives of the CATS pilot, to be assessed at the end of 2015, include:

- > To develop, pilot, finalize and disseminate technical guidelines for voluntary evidence-based drug treatment. The guidelines should include: development of provincial drug treatment infrastructure, standard operating procedures for services, and training curriculums to build capacity of workers and key stakeholders;
- > To develop voluntary drug dependence treatment system and deliver comprehensive drug dependence treatment services to meet the needs of people who use drugs in at least one province; and
- > To support government agencies in re-affirming their commitment to voluntary evidence- and community-based drug dependence treatment.

CATS is a voluntary, open access service that requires no referral from a physician or local official. The clinic offers a range of services and clients work with staff to develop a treatment plan based on their needs. Clients are able to access a wider set of services via referral, including legal support, vocational training and MMT. Services are free of charge and all staff have been trained in drug dependence and treatment models, cognitive behavioural therapy, MMT and detoxification.

Implications

The information presented here provides an overview of the recent reforms in Vietnam's drug policies that have facilitated a transition away from compulsory detention centres for people who use drugs towards voluntary evidence- and community-based drug dependence treatment. The process has further been facilitated by a national Renovation Plan that defines roles and responsibilities and guides agencies from public health, public security and civil society sectors. In that respect, this case study differs significantly compared to others presented in this report given the focus on policy level changes rather than on modelling service delivery only.

In this context, policy changes mapped out in a national plan have enabled the establishment of a government-endorsed, civil society-led evidence- and community-based pilot drug dependence treatment project. The Vietnamese policy process is noteworthy given that it largely aligns with the recommendations from a recent publication prepared by experts in drug dependence from the Asian region in the context of the Regional Intergovernmental Consultation on CCDU organised by UN agencies in September 2015 in Manila, the Philippines.¹⁷⁶

While a shared consensus regarding the failure of the compulsory system is clearly emerging among key government stakeholders responsible for drug control and treatment, there is less clarity regarding the vision for community-based treatment or its relationship to compulsory approaches. Without an overall guiding vision, there will be less certainty about what constitutes voluntary community-based treatment. The model supported by SCDI provides an important example and a template for developing a national set of guidelines based on a clear understanding of the aims of the community model, including the centrality of the role of people who use drugs.

CATS services

- > Detoxification
- > Addiction counselling
- > Legal support and referral
- > Residential and outpatient
- > Peer outreach
- > Peer support
- > MMT access (prescription, dispensary, referral)
- > Referrals to treatment (ie. HIV treatment)
- > Employment support
- > Overdose prevention and management

Key Findings

Table 4: Summary of projects documented

Cambodia	Community-based Treatment project (CBTx)
	Korsang
China	Peace No. 1 Centre
India	Hridaya project (2 components focused on in documentation: x and y)
	Social Awareness Service Organization (SASO)
Indonesia	Rumah Singgah PEKA
	Rumah Cemara
Malaysia	Kerinci Cure and Care Center (CCC)
Vietnam	Community Addicition Treatment Services (CATS)

The country case studies presented in the previous section provide snapshots of emerging models of services developed to effectively address drug use and dependence among people who use and inject drugs. The experiences from Cambodia, China, India, Indonesia, Malaysia and Vietnam summarised in this report (see Table 4) have highlighted several common critical elements that have contributed to the success of emerging community-based alternatives to CCDU.

The elements identified in this report are critical enablers that are likely to facilitate positive treatment outcomes and stimulate greater demand for services. These elements should be used as a guide to support efforts to transition drug treatment away from compulsory detention and forced rehabilitation. Further, these elements can inform the development of plans for service delivery, for policy reform and for the scale-up and strengthening of responses to drugs in Asia. The critical elements identified in this report are listed below.

Voluntary access

All models presented in this report provide access to services on a voluntary basis, although in cases where diversion programmes exist, people who use drugs are also referred to services through law enforcement. The majority of the voluntary models have been specifically developed as alternatives to compulsory detention of people who use drugs. Voluntary access to services implies that enrolment is not coerced, compelled or conditional, that individuals are free to leave, and that no legal repercussions will follow from discontinuation of treatment or lack of adherence to treatment plans. Voluntary access to drug treatment draws on individual agency and motivation, and as such, is more likely to lead to success. For example, the Indonesian models specifically tailor their services to fit the needs of clients, whether the ultimate objective is abstinence or a reduction in drug use.

Voluntary access also implies the need for policy reforms aimed at decriminalisation and diversion of drug-related cases away from the criminal justice system and toward health services, as is most effectively achieved when people who use drugs are free from the threat of arrest for drug use or possession and purchase for personal use.

Client-centred approach

A client-centred approach empowers clients to take an active role in the design and content of their own treatment plans. Except for Cambodia's CBTx project and the Kerinchi CCSC in Malaysia, all models presented in this report have developed a client-centred approach where people who use drug are, to a large extent, in control of the design and implementation of their own treatment plans. For example, the Indonesian models specifically tailor their services to fit the needs of clients, whether the ultimate objective is abstinence or reducing harms associated with drug use.

Meaningful involvement of people who use drugs and civil society

All models presented in this report include strategies to facilitate the participation of people who use drugs as well as civil society representatives in the delivery of services. This represents a significant achievement given the reported limited opportunities for these groups to meaningfully engage in drug policy dialogues in the region. In practice, however, the engagement of people who use and inject drugs is not fully realised at all of the relevant levels due to persisting stigma and discrimination against this group. In addition, the space allocated by authorities for the involvement of CSOs and peers in these models and in the national response varies from country to country.

In the Chinese, Indian, Indonesian and Vietnamese models as well as in Korsang in Cambodia, CSOs have led the design and implementation of services targeting people who use and inject drugs. In contrast, CSOs remain involved in a supportive role, providing complimentary services, recruiting clients, and conducting follow-up, in Cambodia's CBTx and Malaysia's CCSC models.

Meaningful involvement of people who use drugs is a central guiding principle in the two Indonesian models, in Korsang (Cambodia), SASO (India), and Alliance India's approaches. In contrast, the contributions of peers in Cambodia's CBTx, in China's Peace No. 1 centre, and in Malaysia's Kreinchi CCSC are much more modest and often limited to peer outreach, facilitating peer counselling sessions and delivery of other services. The number of peer workers is considerably lower in the CBTx, the Peace No. 1, and the CCSC models compared to the others presented in this report.

Comprehensive health and psychosocial care services

The complex needs of people who use and inject drugs combined with the significant disease burden associated with illicit drug use requires a comprehensive package of health and psychosocial care services. Indeed, there are an impressive number of specific drug dependence treatment services that can be offered to people who use and inject drugs. The models underpinning the CBTx project, the Peace No. 1 centre, PEKA, RC, the Kerinchi CCSC and the CATS all include specific provisions for drug dependence treatment. In contrast, Korsang and Alliance India provide support services that complement drug dependence treatment.

All countries also integrated the comprehensive package of services to prevent HIV transmission among people who inject drugs in their implementation plans. While no country implemented all UN recommended services, the vast majority were providing access to the majority of those services through drug treatment service outlets. In addition, many models offered their clients additional social support services to facilitate social re-integration, from job placement and skills trainings to legal aid and support, and a range of social reintegration activities such as, in Indonesia's case, competing in regular community football matches and international tournaments.

Though most of the models presented in this report are considered comprehensive, none of the lead implementing agencies have the necessary infrastructure, capacity or resources to deliver all services from one site or on their own. Instead, all models rely on local and national networks of government and community health and social services in order to provide comprehensive care.

Medical guidelines and oversight

While the responsibility for implementing and overseeing drug treatment related activities has traditionally been that of public security agencies, the models presented in this report show that medical professionals are increasingly recognised as playing a critical role and are invited to contribute to planning and delivery of drug treatment services. In Cambodia for example, overall responsibility for drug treatment activities shifted from the NACD to the Ministry of Health.

In the Peace No. 1 centre, the Kerinchi CCSC, and the CATS, overall responsibility for drug treatment remains with public security authorities while public health representatives play an active role in both implementation and monitoring service delivery. In contrast, the PEKA, RC and Korsang models do include provisions for medical staff and linkages have been forged with public health authorities though the delivery of on-site medical services is limited by funding.

Alliance India's services provides no mechanism for facilitating medicalisation of services, but the project was never intended to do so. However, it is worth noting that Indian as well as Indonesian government agencies have developed and published minimum standards and guidelines for drug dependence treatment.

Drug policy reform and leadership

The transition away from compulsory detention and rehabilitation of people who use and inject drugs involves significant drug policy reform. While all countries covered in this report except India have relied on CCDU and continue to detain people who use drugs in such centres, changes in national drug policies have encouraged and facilitated diversion away from the criminal justice system and into effective treatment.

In Cambodia and Vietnam, policies have been deployed to support the establishment of formal mechanisms for planning, execution and oversight of the national transition away from CCDU. Drug policy reform in China, India and Indonesia has been slower and less transformative on a national scale. That said, laws and policies related to illicit drugs have been extensively reviewed in all countries and important changes have taken place across the region. However, despite high-level government endorsements and commitments have invited rapid action in alignment with global calls for reform towards humane drug treatment services, it is important to note that CCDU are still operational in East and South East Asia.

Coordination with law enforcement

Operating harm reduction and drug treatment services in community settings often experience challenges with local law enforcement agencies, particularly in a regional context where contradictory policies that both criminalise people who use drugs and promote a move toward public health approaches co-exist simultaneously. Partnerships with law enforcement are especially critical for the referral of clients to health services as well as for smooth outreach and other community-based operations. In that respect, the Cambodian CBTx project, the Peace No. 1 centre, the Kerinchi CCSC and the CATS all coordinated with local law enforcement

representatives in the project to avoid potential conflicts and challenges. In Cambodia and China, law enforcement personnel were trained to divert people who use drugs into community-based drug treatment.

Lessons learned

The findings of this report align with the definition of community-based drug dependence treatment and support services as outlined by an international expert group at the Third Regional Consultation on CCDU in September 2015:

A comprehensive system of voluntary evidence- and community-based treatment and complementary health, harm reduction and social support services that are aligned with international guidelines and principles regarding drug dependence treatment, drug use and human rights.¹⁷⁷

The elements highlighted in this report reinforce the definition above and offer additional dimensions for consideration and discussion. First, the meaningful involvement and participation of both CSOs and people who use and inject drugs in the design, implementation and evaluation of such services is a critical requirement to defining community-based drug treatment services. Second, a client-centred approach has been identified as an essential component to attract, retain and empower individuals. And third, there is a growing expectation that drug treatment services will be led by public health representatives, with support from law enforcement agencies, rather than the other way around.

Strict application of this broader definition implies that none of the models documented in the six country case studies qualify as community-based drug treatment services. It is useful to recognise that countries' progress towards full integration and implementation of the critical elements of community-based drug dependence treatment is best understood as existing along a continuum. For example, although people who use drugs are involved in almost all of the models documented, their level of involvement varies among models and countries. Accepting that the definition of community-based drug dependence treatment is tied to degrees of success also facilitates recognition of incremental progress at local, national, regional and global levels.

A number of lessons can be drawn from the Asian experiences in developing and implementing alternatives to CCDU documented in this report:

- > There is growing recognition and acknowledgement that CCDU are counter-productive mechanisms to address drug-related issues. There is also growing motivation and interest across Asia to develop and pilot alternatives to CCDU. In addition to those documented in this report, other models are being piloted across the region. The national research that informed this report shows that demand for voluntary, comprehensive, evidence- and community-based drug treatment services is also growing among people who use and inject drugs in Asia.
- > In many countries the push for community-based drug treatment is intimately linked to the national HIV response as an extension of harm reduction programming. Indeed, many of the CSOs involved in the provision of drug treatment services in the six countries have been directly and

indirectly involved in harm reduction service delivery to prevent HIV transmission. Other CSOs across Asia have manifested interest in playing a more meaningful role in the design, delivery and evaluation of drug treatment services. Lessons learned from the field of HIV related to CSO participation, meaningful involvement of people who use drugs, adherence to human rights requirements, and health systems integration, have to a varying extent informed and structured national efforts to find alternatives to CCDU.

- > The experiences from the six countries in this report suggest that effective delivery of community-based drug treatment services requires a combination of support and involvement of agencies from a range of sectors, high level political support, and extensive civil society advocacy targeted toward securing political allies to better influence policy. The case studies show that there is growing space for public health agencies to influence the design, implementation and evaluation of drug dependence treatment services, although only few countries have empowered public health sector agencies that can lead on the response to drug use. In contrast, the case studies point to the involvement of public security agencies in virtually every emerging model of community-based drug treatment, often providing oversight and final authority. Meanwhile, there is growing recognition that coordination with law enforcement in order to promote a move away from criminalisation and less interference from law enforcement in field operations facilitates the design, implementation and evaluation of effective community-based services.
- > Over the past ten years, an unprecedented number of drug laws and policies across Asia have been developed, amended, and deployed. While governments in the region

continue to criminalise drug use, many of the recent changes have promoted the integration of public health and human rights frameworks. Recent legal and policy changes have facilitated the emergence of alternatives to established models. In a few countries, those changes have also contributed to the establishment of official national and sub-national structures to plan, guide and oversee the transition away from CCDU. Continuing reforms to drug laws and policies, including at national, regional and international levels, are instrumental to the development and sustainability of community-based alternatives.

Challenges to the development and scale up of community-based alternatives

Despite the apparent successes across the six countries in developing alternatives to CCDU in Asia, a number of critical challenges are currently impeding progress in the transition to community-based drug treatment:

- > All countries report significant financial challenges to complete the national transition away from CCDU, despite the significant amount of funds spent on CCDU. Community-based efforts documented in this report highlighted financial limitations that prevent the full operationalisation of the transition and implementation plans.
- > Not all people who use drugs require or are willing or ready to access drug treatment, and among those who are, not all choose to pursue total abstinence. However, unclear standards for clinical drug dependence assessment and screening, and the application of abstinence-oriented treatment goals remain persisting challenges in the development of a majority of the emerging models documented in this report. A majority of the models documented here apply abstinence from drug use as a main treatment success

indicator. Evidence-based assessments of clinical drug dependence are unevenly applied, and in many cases, the standards applied are not based on sound scientific evidence.

- > All countries report significant human resource challenges, both in terms of volume of available workers as well as in regards to the capacity and attitudes of drug treatment service providers. There is an urgent need for expanded national investments in evidence-based drug dependence treatment as a discipline that promotes a new cadre of drug dependence professionals with adequate training and knowledge.
- > While virtually all models included in this report facilitate the official engagement of CSOs and peers, barriers including limited financing to support peer empowerment and participation, persisting stigma and discrimination against people who use drugs, and the lack of institutionalisation of peer involvement in policy processes, thwart the scope and level of their meaningful participation in practice in most countries in the region.

Recommendations

Based on the models and processes documented in this report, HRI makes the following recommendations intended to promote the scale up of community-based efforts and models in the context of transitioning away from punitive, compulsory approaches to drug use in Asia:

- > Criminalisation of drug use and possession is a significant barrier to effective voluntary, comprehensive, and evidence- and community-based drug treatment and support services. ***It is therefore critical that laws and policies that compel the registration, random urine testing, arrest, detention and forced treatment of people who use and inject drugs be repealed and amended to facilitate diversion to voluntary, community-based harm reduction and drug treatment services through health facilities.***
- > The models documented in this report represent promising alternatives to CCDU. However, data collection, documentation, monitoring and evaluation of these efforts have been consistently weak: many are emerging models that have recently initiated service delivery; many have donor-specific indicators against which to report; and most are facing financial and human resource gaps that restrict their expansion. ***Additional documentation and research is urgently required to assess emerging models across Asia.***
- > ***Emerging models should promote a client-centred approach whereby clients can choose from a menu of options including harm reduction services,*** and should develop clear guidelines for assessing clinical drug dependence while recognising that not all people who use and inject drugs require, are willing or ready to access drug treatment. Additionally, as voluntary drug treatment models develop, they should promote success indicators that prioritise client outcomes such as improvement in quality of life, job retention, crime reduction, and reduction in risky injecting and sexual behaviour that leads to the transmission of blood borne viruses.
- > The availability and coverage of harm reduction services, particularly NSP and OST, remains insufficient to make a significant dent in HIV and HCV epidemics among people who inject drugs in most countries across Asia. ***Harm reduction interventions should be urgently scaled up alongside other advocacy efforts toward community-based services with the goal of promoting a paradigm shift away from criminalisation and punishment.***
- > Related to the recommendation above, CSOs already involved in harm reduction service delivery across the region offer low-threshold opportunities for integration of community-based drug dependence treatment and support services. However, the meaningful participation of CSOs implies equal partnership in the design, implementation and evaluation of all responses that affect the lives of people who use and inject drugs. ***Additional efforts must be supported to facilitate meaningful involvement of CSOs, and to utilise and improve existing health-care delivery infrastructure via CSOs to stimulate the development of community-based drug dependence treatment alternatives in Asia.***
- > ***The meaningful involvement of people who use and inject drugs must be strengthened across the region.*** As for CSOs, meaningful participation implies equal partnership in the design, implementation and evaluation of all responses that affect the lives of people who use and inject drugs. ***Peers' contributions are significant and add considerable value when***

they are meaningfully integrated and respected.

- > While public health representatives have increasing influence on drug treatment-related matters, public security agencies remain largely in control of managing national drug treatment efforts. ***It is critical that responsibility and authority for drug treatment related matters be transferred from the public security to public health sector.***
- > In line with the recommendation above, ***the role of public security representatives, particularly those of law enforcement agencies, must be reviewed and adapted to support effective diversion of people who use drugs away from the criminal justice system, away from CCDU and into community-based drug treatment and support services.***
- > Significant technical and financial gaps have been identified across the region related to planning, implementation and evaluation of the transition towards voluntary comprehensive evidence-informed and community-based drug dependence treatment and support services. ***It is critical that government agencies re-programme and redirect funds used to support CCDU as well as funds from national drug control budgets to support emerging models and scale-up effective alternatives to CCDU.*** In addition, it is urgent that international donors and technical support providers earmark resources to support the retooling of national drug treatment infrastructures across Asia.

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This report documents a range of models of community-based drug treatment interventions and experiences from Cambodia, China, India, Indonesia, Malaysia, Vietnam, based on which the authors identify the essential components and minimum requirements needed to define such services. These elements can be used as guiding principles to support national transitions away from compulsory detention for people who use drugs, and inform the development of plans for service delivery and policy reform.

