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Harm reduction in Asia: progress towards universal access to harm reduction services among people who inject drugs

Updating of the baseline assessment of status of policies, resources and services for people who inject drugs (2006) and analysis of gaps in the country responses to injecting drug use and HIV/AIDS

Commissioned on behalf of
The United Nations Regional Task Force on Injecting Drug Use
and HIV/AIDS in Asia and the Pacific

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Appendix B: List of contributors to the collection of country-specific data

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Abbreviations.

ACDHAP	Asian Consortium on Drug use, HIV, AIDS and Poverty
AIDS	Acquired Immunodeficiency Syndrome
ANPUD	Asian Network of People who Use Drugs
ART	Antiretroviral Therapy
AusAID	Australian Agency for International Development
CCDU	Compulsory Centres for Drug Users
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HAARP	HIV/AIDS Asia Regional Program
HIV	Human Immunodeficiency Virus
ICDDR-B	International Centre for Diarrhoeal Disease Research, Bangladesh
IDU	Injecting Drug User
IEC	Information, Education and Communication materials
OST	Opioid Substitution Therapy
MIPUD	Meaningful Involvement of People who Use Drugs
NSP	Needle and Syringe Programs
PWID	People Who Inject drugs
RBB	Response Beyond Borders
STI	Sexually Transmitted Infection
T&C	HIV testing and counselling
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UNRTF	United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific

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Executive Summary.

In 2009, the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (UNRTF) commissioned Burnet Institute, Australia, to undertake a review of policies, resources and services for injecting drug users (IDUs), in order to update the baseline assessment conducted in 2006¹.

This update was designed to collect specific information regarding existing activities and conditions which facilitate or hinder the implementation of harm reduction services in the selected countries, with which to augment the annual UNGASS Country Progress Reports. The information collected will also contribute to informing the UNRTF of its effectiveness in driving the harm reduction response, and its strategic activity planning for the coming years.

Methodology.

The review of fifteen countries across South and South East Asia identifies gaps in country level efforts towards achieving universal access to HIV prevention, treatment and care for IDUs, and makes recommendations for overcoming identified barriers to achieving scale-up.

The review consisted of three outputs;

- i) The development and endorsement of a analytical framework tool focusing on national harm reduction program support, monitoring and evaluation systems, harm reduction program and service implementation, harm reduction services in prisons and compulsory centres for drug users, and barriers to scale-up.
- ii) Review of country and regional level data from recent reports, peer-reviewed literature and through input from identified, United Nations and government, country focal points.
- iii) Development of a summary report of harm reduction policies, services and resources for IDUs across the region featuring common, identified gaps, recommendations and comparative analysis with 2006 data.

Identified gaps.

Comprehensive package of harm reduction services: None of the countries reported to be delivering all nine of the core interventions which make-up the comprehensive package of harm reduction services².

- Opioid substitution therapy and/or needle and syringe programs were either unavailable, or not reported in almost half of the countries reviewed.
- IDU-targeted antiretroviral therapy and HIV testing and counselling were either not available, or were not reported in approximately 35% of the countries reviewed.
- IDU-targeted services for vaccination, diagnosis and treatment of viral hepatitis and prevention, diagnosis and treatment of tuberculosis failed to be identified in any of the countries reviewed.

Political commitment to harm reduction: While all of the countries reviewed demonstrate political commitment to HIV and AIDS prevention, treatment and care, only eight explicitly support harm reduction interventions which target IDUs (in varying forms or to varying

degrees). Three countries identified limited political commitment to harm reduction interventions which target IDUs.

Multi-sectoral and civil society involvement in the response: Multi-sectoral government involvement in the harm reduction response was identified as a gap in nine of the countries reviewed, with the response directed to IDUs remaining the exclusive domain of law enforcement and the judiciary in a number of countries. Poor coordination between the central/national level and the implementation level is also reflected in a number of countries.

Despite fledgling civil societies and/or prohibitive laws and policies which inhibit civil society involvement in the response in some countries, civil society organisations (including those comprising or representing IDUs) lead the human rights-based response to HIV prevention amongst IDUs in the region.

Involvement of IDUs in the response: IDUs contribute to the response in approximately 65% of the countries reviewed, however this involvement is limited to service delivery in most of these (as opposed to contributing to the development of policies and strategies, or the planning, monitoring and evaluation of harm reduction programs).

National harm reduction strategies: Costed national harm reduction strategies and/or operational plans either exist or are being developed in over half of the countries reviewed. National drug strategies complement national HIV strategies in three countries, while eight others indicated that processes are underway to achieve this.

Legal and policy environment: Conflict between national and sub-national strategies and policies which are supportive of harm reduction, and inhibitive or prohibitive legal criteria still exists throughout the region. Despite the fact that at least one of the core services which make up the comprehensive package of harm reduction services is prohibited under law in twelve of the countries reviewed, many national strategies and programs still support and resource activities such as needle and syringe programs, opioid substitution therapy and targeted education.

The judiciary and law enforcement agencies contribute to national HIV and AIDS coordinating mechanisms in half of the countries reviewed, and as a result, legal reform to enable harm reduction services have either been completed, or are underway in these countries.

Capacity and resourcing: Resourcing of harm reduction programs, and monitoring and evaluation systems in particular, were identified as being insubstantial for the effective scaling-up of harm reduction services to achieve appropriate coverage in most of the countries reviewed. Limited technical capacity amongst implementing agencies remains one of the most important barriers to scaling-up harm reduction activities in the region.

Surveillance and Monitoring and Evaluation: Many HIV surveillance systems in the region either do not disaggregate data for IDUs, or it is unclear whether they do this. Other methods of surveillance are limited in their ability to reach all IDU populations, while others are affected by bias.

Monitoring and evaluation is limited in many of the countries reviewed by poor resourcing and insufficient capacity at the data collection/entry and the analysis/reporting levels.

Prisons and Compulsory Centres for Drug Users: Very few harm reduction activities were reported to be taking place within formal prison systems, and little information was identified regarding possible services within CCDU.

Recommendations.

The review outcomes contribute a number of recommendations relating to;

- National commitments to the delivery of a comprehensive package of harm reduction services,
- Greater political commitment to harm reduction for IDUs,
- Greater multi-sectoral and civil society involvement in the harm reduction response,
- Greater involvement of IDUs in the response,
- Development of costed harm reduction strategies which complement HIV strategies,
- Legal and policy reform to facilitate scale-up of comprehensive harm reduction services,
- Greater commitment to building capacity and resourcing the response,
- Strengthening of HIV surveillance and harm reduction program monitoring and evaluation,
- Greater support for regional initiatives, particularly those led by groups comprising and/or representing IDUs.

Limitations with the activity, and moving forward.

This report and the country-specific data matrices (Appendix C) constitute a comprehensive review of available data and documents, which contribute an important snapshot of the regional and country-specific status of harm reduction activities, and the extent to which these are being delivered at appropriate scale to achieve universal access targets and to meet the needs of IDU populations.

While every effort was made to seek feedback and input from the country level in order to inform this review, the accuracy of data was contingent on the capacity and time availability of those countries to respond.

Furthermore, as the analytical framework tool used in this review is designed to collect country level data, it fails to identify regional initiatives which have proven effective in influencing policies, programs and services in the region in recent years.

It is recommended that a follow-up of this activity be conducted within the next three years. Some refinement of the analytical framework tool may be required in future to simplify and improve the process and timeliness of obtaining input and feedback from the country level.

Introduction.

In 2009, the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (UNRTF) commissioned the Centre for International Health, Burnet Institute, to develop an analytical framework tool, and to undertake an extensive review of the status of HIV and AIDS interventions for injecting drug users (IDUs)^φ in fifteen priority countries in South and South East Asia, namely;

South East Asia	South Asia
Cambodia	Afghanistan*
China (People's Republic of)	Bangladesh
Indonesia	India
Lao PDR	Maldives*
Myanmar	Nepal
Malaysia	Pakistan
Philippines*	
Thailand	* new countries not included in
Viet Nam	2006 Baseline Assessment

This activity was designed to collect specific information regarding existing activities and conditions which facilitate or hinder the implementation of harm reduction services in the selected countries, with which to augment the less-IDU specific information that is collected and reported through annual UNGASS Country Progress Reports.

The information collected and reported through this activity will provide a useful update to the UNRTF on the baseline information which was collected in 2006 for twelve of the fifteen countries reviewed during this activity¹. An analysis of progress and ongoing gaps in harm reduction service delivery in the three years since the baseline was conducted will help to inform the Task Force of its effectiveness in driving the harm reduction response, and strategic direction for prioritizing its activities in the coming years.

In addition, a considerable number of resources with which to guide and monitor harm reduction programs have become available in recent years, and these have been considered in reporting program gaps and barriers which hinder scale-up of activities to meet the needs of IDUs in the region.

^φ While the author acknowledges the recent step to ensure drug users are not further stigmatised through labels, the term 'injecting drug user' (IDU) has been selected for use in this report over the more recently-accepted term, 'people who inject drugs' (PWID) in order to remain consistent with the name of the organisation which has commissioned the report, namely the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (UNRTF).

Methodology.

Output 1: Review and development of revised analytical framework tool.

During the 2006 Baseline Assessment activity¹, an analytical framework was developed and endorsed by UNRTF members, before being used as the tool for collection of country-specific information on harm reduction policies, programs and services, and the environment which facilitates or hinders the scale up of services.

In planning for the 2009 update, it was acknowledged by the UNRTF that while this tool provided the basis for collecting country-specific data for harm reduction service planning, implementation, monitoring and evaluation, a number of recent technical guides and policy documents (most notably the *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*)² have influenced harm reduction program development and implementation, and have set new standards for more effective monitoring and evaluation in the region such that the existing tool would need to be altered prior to commencing data collection.

In consultation with a Working Group consisting of members of the UNRTF, a team of experts from Burnet Institute revised the 2006 analytical framework tool to reflect the core services which make up the comprehensive package of harm reduction services². The framework was reviewed by the Working Group in June 2009, and endorsed in August, 2009 (see Appendix A).

Output 2: Desk review and updating of country-specific data matrices.

Reflecting the large body of regional and country specific technical literature, resources and reports concerning the delivery of harm reduction services released in recent years, an extensive review of service availability and conditions which could act as enablers or barriers to the delivery of comprehensive harm reduction services in the fifteen priority countries, and across the Asia region was conducted. Specific areas addressed in this review included;

- Political and donor commitment to harm reduction activities,
- Civil Society engagement
- Multi-sectoral involvement in harm reduction activities,
- Involvement of IDUs in the harm reduction response (including policy development and planning, implementation and monitoring of service delivery),
- National drug and HIV strategies
- Resource allocation to harm reduction activities,
- Legal and policy environment,
- Surveillance systems for monitoring IDU numbers (denominators) and service needs,
- Harm reduction program monitoring and evaluation systems and processes,
- Coverage of comprehensive harm reduction services in the community, prisons and compulsory centres for drug users (CCDU)^φ.

Information from available resources was fed into the country specific data matrices, before being provided to UNRTF country focal points for review of the presented information, and

^φ The term 'Compulsory Centres for Drug Users' (CCDU) refers to any institution, centre or camp in which drug users are involuntarily detained on the basis of their drug-taking behaviour. While the name, period of detention and the extent to which these establishments offer treatment for drug dependence may differ across countries, their common attribute is that detention within them is involuntary.

addition of further information available in-country. This process took place between September 2009 and January, 2010. For a complete list of contributors to country-specific data matrices, see Appendix B.

Completion of data collection and finalisation of the fifteen country-specific data matrices took place in late January, 2010. See Appendix C for the finalised data matrices for each country, complete with identified gaps in the legal and political environment that affect delivery of comprehensive harm reduction services, and recommendations to address the identified barriers to the scale-up of harm reduction services in the region.

Output 3: Comparative analysis of policies, resources and services from 2006 to 2009.

The following section of this report outlines common gaps experienced across many of the countries reviewed in planning and delivering comprehensive harm reduction services to scale. Recommendations for addressing these have also been outlined where these are common across a number of countries.

Where appropriate, this section includes a comparative analysis of progress made in the twelve countries since the 2006 Baseline Assessment was conducted. This is presented with a view to informing the UNRTF's performance monitoring for the period, and to identify priority areas for activity planning over the coming years.

Identified Gaps, 2009.

For a complete list of identified gaps applicable to each individual country reviewed during this activity, see the appropriate section following the completed, country matrix in Appendix C.

Comprehensive package of harm reduction services.

None of the countries reported to be delivering all nine of the core interventions which make-up the comprehensive package of harm reduction services as outlined in the WHO, UNODC, UNAIDS Technical Guide².

Regarding the two interventions of the comprehensive package which are specific for IDUs, opioid substitution therapy (OST) and/or needle and syringe programs (NSPs) were either unavailable, or not reported in almost half of the countries reviewed.

Other elements of the comprehensive harm reduction services package which were lacking included IDU-targeted antiretroviral therapy (ART) and HIV testing and counselling (T&C), which were either not available, or were not reported in approximately 35% of the countries under review.

All countries failed to identify the availability of IDU-targeted services for vaccination, diagnosis and treatment of viral hepatitis and prevention, diagnosis and treatment of tuberculosis. A possible contributing factor for under identification of these services may be that IDUs are able to attend mainstream viral hepatitis and tuberculosis prevention, diagnosis and treatment services, however further investigation is required to confirm this.

Similarly, primary health care services and prevention and treatment of sexually transmitted infections (STIs), while not targeting IDUs specifically, may be accessible by IDUs, and were therefore under reported for most of the countries. Also under reported were condom promotion, peer education and targeted IEC services; however it appears that these activities often take place through NSPs, indicating there may be a need to develop capacity within the harm reduction community in each country to ensure these interventions are separated and reported accordingly.

In reviewing the extent to which South East and South Asian countries deliver the nine core interventions which make up the comprehensive package of harm reduction services as outlined in the WHO, UNODC, UNAIDS Technical Guide², it should be acknowledged that this resource was only released in 2009, and therefore it could be expected that services may be scaled-up to meet these over the coming years. It should be noted, however, that Bangladesh, Cambodia, Myanmar, Nepal and Viet Nam were the only countries to identify plans for scaling-up of IDU targeted diagnosis, treatment of and vaccination for viral hepatitis, and Nepal was the only country with identified plans for scale-up of tuberculosis prevention, diagnosis and treatment services for IDUs in the near future.

Political commitment to harm reduction.

All of the fifteen countries in the review demonstrate political commitment to HIV and AIDS prevention, treatment and care, and in many cases, vulnerable populations (including IDUs) are implicit within these interventions.

Eight countries demonstrate documented, political commitment to harm reduction interventions which target IDUs. However some of these countries are unable to support this commitment with appropriate resourcing, or it was indicated that commitment at the national/central level was not reflected at the implementation/service level.

Four countries indicated political commitment to harm reduction approaches to HIV prevention, treatment and care among IDUs, however in practice, this commitment is to particular interventions, rather than the comprehensive package of core services outlined in the WHO, UNODC, UNAIDS Technical Guide², and in some cases, it was indicated that these services are compulsory for IDUs, rather than voluntary. A number of countries expressed concern that despite documented commitment to harm reduction for IDUs, factions within the political system, or some sectors (such as law enforcement) openly oppose this approach.

Three countries were identified as having limited political commitment to harm reduction interventions which target IDUs. Two of these attributed the limited commitment to the low prevalence of injecting drug use in their countries, while the third country's response to HIV and drug use is strongly led by an intolerant law enforcement sector.

Comparative analysis, 2006 – 2009: A greater, documented political commitment to IDU-targeted, harm reduction interventions currently exists as compared with 2006, however the challenge of ensuring this commitment is reflected in the provision of appropriate services for IDUs remains to be addressed in some countries.

Multi-sectoral and civil society involvement in the response.

Meaningful, effective multi-sectoral government involvement in the harm reduction and HIV response was identified as a gap in nine of the countries reviewed, while two others did not adequately report the extent of multi-sectoral collaboration for the development of policies and strategies and the planning and delivery of harm reduction programs. Some countries reported this deficit despite documented statements of multi-sectoral coordination within national fora.

In a number of countries, while reasonable multi-sectoral involvement exists for coordination of the national HIV and AIDS response, the response directed to drug users was either recognised as exclusively the domain of law enforcement and the judiciary, or was strongly led by these government ministries and/or departments, leaving little opportunity for the health, social and other sectors to play a meaningful and effective role.

Multi-sectoral, government involvement in the development of supportive policies and strategies and the planning and delivery of harm reduction program policy and strategies is essential to ensuring the harm reduction response is one which is built around the maintenance of human rights for all those who are living with HIV and AIDS, or who are at increased vulnerability to this.

A number of countries in both South East and South Asia identified poor multi-sectoral, government coordination between the central/national level and the implementation level within provinces/states/districts or communities. This was identified as a major impediment to the effective delivery of harm reduction services.

In terms of a human rights-based approach to HIV prevention amongst IDUs, civil society organisations (including those comprising or representing IDUs) appear to be leading the harm reduction response through the delivery of services in many of the countries reviewed. In a number of countries, however, fledgling civil societies and/or prohibitive laws and policies inhibit civil society involvement in the response, which is reflected in these countries' limited progress to scaling-up harm reduction services.

Comparative analysis, 2006 – 2009: There has been a natural progression during the period to moving towards greater multi-sectoral collaboration on, and civil society engagement in harm reduction programming in most of the countries reviewed. Those countries which had a predominantly law enforcement and the judiciary-led response in 2006 have increased the involvement of other ministries and/or departments (at least on paper, if not in practice) through the enactment of national committees to coordinate HIV and AIDS prevention, treatment and care targeted to IDUs. Likewise, those countries with very limited multi-sectoral collaboration in 2006, have expanded upon this, and are moving towards greater involvement of these expanded coordination mechanisms.

The same progression is reflected in civil society engagement in the response, where many countries with little civil society engagement in 2006 have taken steps to amend prohibitive policies in this regard, while others have moved from civil society organisations represented only at the service delivery level, to being included in national planning and coordination fora.

There still exists a necessity to formalise and activate more effective and diverse involvement of government ministries and/or departments in most of the countries reviewed, and to ensure that civil society involvement in planning and decision making is meaningful, rather than merely tokenistic.

Involvement of IDUs in the response.

It is encouraging to note that almost two thirds of the fifteen countries identified involvement of groups comprising and/or representing IDUs in the delivery of harm reduction services (predominantly NSPs consisting of both drop-in centres and outreach, in conjunction with condom promotion, peer education and development and dissemination of targeted, IEC materials).

It should be noted, however, that involvement of IDUs in the development of policies and strategies, or in the planning, monitoring and evaluation of harm reduction programs is not nearly as well represented amongst the priority countries under review. In twelve countries, it was either explicitly indicated that IDUs do not contribute to these processes, or available information was not able to confirm their involvement.

Limited IDU involvement in the development of IDU-specific policies and strategies, or in the planning, monitoring and evaluation of harm reduction programs has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in

inappropriate and inadequate planning and delivery of services. Involvement of IDUs in all aspects of national commitments to HIV prevention, treatment and care is an essential element to the effective implementation of comprehensive harm reduction services for IDUs.

Comparative analysis, 2006 – 2009: Amongst the South East Asian countries reviewed, there has been some encouraging, increased involvement of IDUs in the HIV response, with IDUs from a number of countries moving from an exclusively service delivery role in 2006, to advocating for and contributing to policy development, legal reform and program planning. Most notably, Indonesia has made a number of commitments to IDU involvement at many levels, such as contributing to the National AIDS Commission's Working Group on Harm Reduction and National Strategy on Drug Use, and amendments to the Anti-Discrimination and Narcotics and Psychotropics Bills presented to Parliament. IDUs also contribute to planning, coordination, monitoring and evaluation within Indonesia's National Aids Commission.

It should be noted, however, that the majority of involvement of IDUs in the response in South East Asia remains focused on service delivery, which in many cases is limited in terms of its geographical coverage. This is also true for the South Asian countries reviewed, most of who reported no IDU involvement in the HIV response in 2006.

National harm reduction strategies.

Seven of the priority countries under review indicated that costed national strategies and/or operational plans exist for the implementation of IDU-targeted harm reduction interventions, while one country indicated that the process of developing a costed strategy is currently underway.

The remaining seven countries either do not have costed national strategies and/or operational plans for these activities, or it was unclear from the information provided whether or not these exist.

While only three of the fifteen priority countries indicated that their national drug strategies complement national HIV strategies, eight additional countries articulated actions currently in process in order to address this inequity. Four countries indicated that national drug strategies did not complement national HIV strategies, although in practice, harm reduction services were being systematically implemented in three of these.

Comparative analysis, 2006 – 2009: The strong commitment to developing costed, national harm reduction strategies/operational plans in the priority countries since 2006 is an encouraging development through which to ensure resources are allocated to harm reduction programs. Five of the twelve countries under review in 2006 are either yet to have developed documented commitment of resources to harm reduction activities, or have not identified that these exist.

Amongst the twelve priority countries reviewed in 2006, a strong movement currently exists to ensure that national drug strategies complement national HIV strategies. A number of the countries have either achieved this, or are currently working towards this.

Legal and policy environment.

There exists throughout the region a continued conflict between progressive national and sub-national strategies and policies for the prevention, treatment and care of HIV and AIDS which are supportive of targeted interventions for IDUs, and firmly entrenched legal criteria which either explicitly or implicitly prohibit or inhibit the implementation of many of the core services which comprise the comprehensive harm reduction package².

In many of the countries reviewed, national HIV and AIDS strategies and programs support and resource harm reduction activities targeted towards IDUs, despite laws which prohibit or inhibit NSPs, OST or targeted education. Such laws regularly result in law enforcement agencies finding themselves conflicted between following poorly understood national directives which support a human rights based approach to HIV prevention, and fulfilling their legal obligation to apprehend known or suspected drug users, and those in possession of injecting paraphernalia, "obscene" educational material or prohibited narcotic substances such as methadone and buprenorphine.

In the following countries, at least one of the core services which make up the comprehensive package of harm reduction services is prohibited under law; Cambodia, China, Lao PDR, Myanmar, Malaysia, Philippines, Afghanistan, Bangladesh, India, Maldives, Nepal and Pakistan. It should be noted, however, that in some of these countries, harm reduction services are tolerated, yet service providers remain under threat of legal reprisals should the political commitment to harm reduction for IDUs change at any given time.

Sluggish legal and judicial systems rooted in decades old laws and decrees are slow to respond to the comparatively new burden that HIV and AIDS (and in particular, the associated link with injecting drug use) places on their communities. This slow response is due in part to the judiciaries' limited understanding of their role in tackling what is often viewed as a response required from the health or social sectors, as well as the protracted consultation and political processes that are involved in re-drafting and amending legal statutes.

A number of essential requirements to altering the policy and legal environment towards conditions which are more supportive of harm reduction include;

- Ensuring the judiciary and law enforcement are invited to contribute to national harm reduction and HIV and AIDS strategies, and that they understand their role in supporting policy and legal reform towards a human rights based approach to HIV prevention, treatment and care.
- Ensuring political commitment towards legal and policy reform exists through advocacy by donors, United Nations and technical agencies and civil society.
- Ensuring civil society organisations (particularly groups comprising and/or representing IDUs) are invited to contribute to the process of drafting policies and amending laws.

Currently many of the countries reviewed include the judiciary and law enforcement agencies in their national coordinating mechanisms for HIV and AIDS, and at least half of the countries have identified that legal reform to enable harm reduction services have either been completed, or are underway. Of those who have recently completed legal reform processes in this area (eg: Indonesia and Viet Nam), further work is required to build the capacity of law enforcement and other government agencies at the service implementation level to enact these new legal conditions through enabling harm reduction services.

With the exception of Indonesia (and to a limited extent, Malaysia, Cambodia, Viet Nam and India), the legal barriers which restrict or inhibit the harm reduction response targeted towards IDUs in the general community are reflected, or in some cases, are even more restrictive for IDUs in prison settings or in compulsory centres for drug users.

Comparative analysis, 2006 – 2009: The policy environment for many of the countries reviewed has improved considerably since 2006, reflected in the large majority of countries which now have documented support for IDU-targeted harm reduction approaches, either through national HIV and AIDS policies/strategies or through specific harm reduction strategies.

The challenge of enabling policies/strategies to be enacted through legal reform which gives harm reduction service providers the right to deliver a range of core services, and IDUs the right to access these still exists in most of the countries reviewed. Some of these have made a commitment to legal reform in the near future, while others will require further advocacy and technical support from donors, United Nations and technical agencies, national Bar associations and civil society to ensure this reaches national agendas for HIV prevention, treatment and care.

Capacity and resourcing.

Resourcing of harm reduction programs, and monitoring and evaluation systems in particular, were identified as being insubstantial for the effective scaling-up of harm reduction services to achieve appropriate coverage in most of the countries reviewed. In many cases (Thailand, Cambodia, Viet Nam, Nepal, Myanmar, India, Bangladesh, Pakistan and China), national harm reduction responses are being/will be strengthened through existing/recently awarded GFATM grants, or with UNODC and HAARP support in some countries, though it is expected that resourcing gaps will still remain.

Limited technical capacity amongst implementing agencies remains a regularly identified gap for policy development, program planning, service delivery and monitoring and evaluation. Despite efforts by UNODC and HAARP to develop national and service implementation capacity in many of the countries under review, capacity development remains one of the most important barriers to scaling-up harm reduction activities.

Comparative analysis, 2006 – 2009: Resourcing of harm reduction activities in many countries has greatly improved, thanks largely to GFATM Round 9 grants awarded to Thailand, Cambodia, Viet Nam, Myanmar, Pakistan and India) and HAARP. Despite this, as in 2006, the resourcing gap to enable appropriate scale-up of service coverage is far from being met.

As in 2006, a number of countries identified the strong reliance on donors to support and resource national and sub-national harm reduction programs. There remain few examples of governments allocating their own resources to harm reduction initiatives, and the private sector is yet to be engaged in the region.

Lack of technical capacity remains a major barrier to scaling-up harm reduction activities.

Surveillance and Monitoring and Evaluation.

While advances have been made in developing stronger HIV surveillance systems in many of the countries reviewed, many of these either do not disaggregate data for IDUs, or it is unclear whether they do this.

Amongst the countries where some IDU data is collected (eg: Thailand, Myanmar, Nepal and Cambodia), this is either passive (and may not be effective if IDUs refuse to access some services), or collected through periodic (between one and five years) behavioural surveillance of vulnerable groups in program implementation areas (reflecting potential bias).

In each of the countries reviewed, there are recognised inadequacies in the current surveillance systems relating to this inability to disaggregate data for IDUs, which contributes to inaccurate IDU population estimates (denominators) upon which to plan and deliver services.

Furthermore, each country identified poor resourcing and limited capacity at the data collection/entry and the analysis/reporting levels. Mechanisms for communicating data analysis and findings were not clearly identified in most of the countries reviewed.

Likewise, monitoring and evaluation processes for harm reduction programs were not well identified and articulated in most of the countries under review, and capacity development of service providers (many of whom are non-government organisations) to more effectively collect and report reliable data was routinely identified as an urgent need.

Nepal is the only country that reported to be monitoring and evaluating harm reduction activities against the core harm reduction services of the comprehensive package as outlined in the WHO, UNODC, UNAIDS Technical Guide². However, as this resource was only released in 2009, it would be expected that improvements to monitoring and evaluation systems in other countries would take place over the coming years.

Comparative analysis, 2006 – 2009: It would appear that only minimal improvements to HIV surveillance activities have been made since 2006, with only a small number of countries disaggregating data for IDUs. This is an urgent gap to be addressed in order to more effectively plan services to meet the needs of IDU populations. The opportunity should be taken during the development of new systems to disaggregate IDU data by gender, in order to ensure that female IDUs are not ignored in the delivery of targeted interventions.

Improvement to monitoring and evaluation systems is also an urgent need, in order to more effectively measure and manage the quality and effectiveness of harm reduction services. Commitment to increased resourcing and capacity development will be required to improve monitoring and evaluation systems.

Prisons and Compulsory Centres for Drug Users.

With the exception of Indonesia (and to a limited extent, Malaysia, Cambodia, Viet Nam and India), very few harm reduction activities were reported to be taking place within the formal prison system, and even less information about possible services was identified for CCDU. Certainly, these environments are far from being in a position to deliver the core interventions of the comprehensive harm reduction package.

Due to high prevalence of injecting drug use that is known to take place in prison settings in the region³⁻⁵, and the relatively short sentences of many inmates which contribute to large populations regularly moving into and out of prison, harm reduction services in these settings are integral to effective HIV prevention for IDU populations in the whole community.

Comparative analysis, 2006 – 2009: Some progress has been made since 2006 regarding scaling-up of harm reduction activities in prison settings. Indonesia has a comprehensive program in some prisons (consisting of needle and syringe bleaching, OST, T&C, ART, condom promotion and peer education), while Malaysia, Cambodia, Viet Nam and India have implemented a number of pilot activities which deliver some of the core harm reduction interventions. There is still much to be done in all of the countries to ensure IDU populations within and outside prisons are protected from HIV transmission.

Recommendations, 2009.

For a complete list of recommendations applicable to each individual country reviewed during this activity, see the completed country matrices in Appendix C.

- **Comprehensive package of harm reduction services:**
The core elements of the comprehensive package of harm reduction services as outlined in the WHO, UNODC, UNAIDS Technical Guide² have been derived through evidence-based analysis of what constitutes the most effective interventions for HIV prevention, treatment and care among IDUs. Scale-up of harm reduction services to include these core services constitutes the most promising opportunity to deliver an effective harm reduction response in the region. Technical capacity building, resourcing and legal and policy reform in many of the countries under review is necessary to enable scale-up of these services, both in the general community, and in closed settings.
- **Greater political commitment to harm reduction for IDUs:**
Sustainability and effectiveness of IDU-targeted harm reduction programs are heavily reliant on ensuring harm reduction interventions are well-supported within national and sub-national political mechanisms. Donors, United Nations and technical agencies and civil society have a strong role to play in advocating for the harm reduction approach amongst political parties and factions.
- **Greater multi-sectoral and civil society involvement:**
Multi-sectoral involvement of government agencies is essential to ensuring the harm reduction response is both comprehensive (incorporating aspects of law enforcement, health and social service delivery, judicial oversight etc), and in accordance with a human rights-based approach which values the welfare of IDUs, and their right to HIV prevention, treatment and care interventions. This multi-sectoral collaboration must exist not only at the national/central level, but between this and implementation levels, as cooperation between government agencies at the service delivery level is essential to ensuring both IDUs accessing services, and those providing these, are protected from stigma, discrimination and/or legal reprisals.

Greater civil society involvement (including groups comprising and/or representing IDUs), particularly in the policy/strategy development and program planning processes, is also an essential element to ensuring harm reduction approaches meet both the specific, identified needs of IDUs, as well as the elements of a rights-based approach. Prohibitive laws and policies which inhibit civil society involvement in the response in some countries should be replaced with enabling processes which directly encourage greater civil society engagement.

- **Greater involvement of IDUs in the response:**
While it is encouraging to note that only a small number of countries identify no involvement of IDUs in the harm reduction response, it is still concerning that in most cases, identified involvement of groups comprising and/or representing IDUs is limited to the delivery of harm reduction services. It is imperative to the long-term sustainability and effectiveness of national and sub-national harm reduction programs to ensure that IDUs are enabled and empowered to contribute meaningfully to the development of IDU-specific policies and strategies, as well as in the planning, implementation, monitoring and evaluation of harm reduction programs. Donors, United Nations and technical agencies

have a major role to play in advocating for the inclusion of IDUs in national planning and coordination processes.

- **Costed harm reduction strategies which complement HIV strategies:**
Sustainable and effective IDU-targeted harm reduction programs are reliant on appropriate resource allocation through national coordinating mechanisms. Development of costed national strategies and/or operational plans which clearly articulate resource allocation for harm reduction activities are essential for facilitating service planning and delivery.

Costed harm reduction strategies and/or operational plans which are part of national HIV strategies should be encouraged to facilitate better coordination of services. Where this is not appropriate, strategies should be developed so that outlined interventions complement service coverage, rather than waste resources through duplication of services.

- **Legal and policy reform to facilitate scale-up:**
In many of the countries reviewed, HIV and AIDS prevention, treatment and care strategies and policies are not compatible with laws and policies which could view harm reduction activities such as OST and NSP as unlawful, and liable to prosecution. Advocacy and technical support from donors, United Nations and technical agencies, civil society and national Bar associations should be directed to amending (or clarifying) laws which prohibit harm reduction approaches, stigmatise those who access or deliver services, or inhibit IDUs' human rights. Involvement of the judiciary as a multi-sectoral partner in national and sub-national HIV and AIDS policy/strategy development is an essential element to facilitating more informed legal reform to support harm reduction approaches.
- **Greater commitment to building capacity and resourcing the response:**
Scale-up of harm reduction activities to meet the coverage needs of IDUs in all of the countries reviewed is heavily reliant on sufficient financial and commodity resources, and sound technical capacity of program implementers and service providers. Technical agencies must commit to developing capacity of those conducting data collection, reporting and analysis, while donors should prioritise the resourcing of same.
- **Strengthening surveillance and monitoring and evaluation:**
National and sub-national surveillance systems require improvement to facilitate collection of IDU-specific data, preferably by gender, in order that population denominators can be more accurately determined, and harm reduction programs designed to more effectively meet the needs of IDUs. Technical agencies must commit to developing capacity of those conducting data collection, reporting and analysis, while donors should prioritise the resourcing of same.

Increased resourcing and capacity support is also essential for program implementers and those delivering services to improve monitoring and evaluation mechanisms, in order to more effectively measure program performance in meeting the HIV and AIDS prevention, treatment and care needs of IDUs.

- **Greater support for regional initiatives:**
Civil society and drug user engagement in regional initiatives have proven instrumental in drawing attention to gaps in responses and efforts to scale-up harm reduction services, and continue to play a key advocacy role to regional bodies and governments.

Regional initiatives have the potential to effectively advocate for conditions and resources which facilitate the delivery of a comprehensive package of harm reduction services, and should not be overlooked by donors and United Nations agencies looking to support scale-up of harm reduction across the region.

Limitations of this activity, and moving forward.

This report and the country-specific data matrices (Appendix C) constitute a comprehensive review of available data and documents, which contribute an important snapshot of the regional and country-specific status of harm reduction activities, and the extent to which these are being delivered at appropriate scale to achieve universal access targets and to meet the needs of IDU populations.

The information and recommendations presented are intended to serve as a guide to progress of the UNRTF and country programs since the completion of the 2006 Baseline Assessment activity, and to inform planning for the next period.

It should be acknowledged that in collecting information to inform the country-specific data matrices, while every effort was made to seek feedback and input from the country levels, this process was contingent on the capacity and time availability of those countries to respond. Where information presented may be incomplete or inaccurate, it is hoped the release and dissemination of this report may prompt further input from country-level stakeholders to more accurately report service coverage in their countries.

A further limitation is that the analytical framework matrix is designed to collect country level data and does not take into account regional initiatives which have the potential to influence policies, programs and services in the region. A mechanism to capture regional, civil society and drug user led initiatives needs to be considered in any follow-up of this activity. In the past two and a half years, civil society and drug user engagement in regional (in addition to country-level) initiatives have drawn attention to the gaps in responses and the role different stakeholders can play in scaling-up harm reduction services. For example, the Asian Consortium on Drug Use, HIV, AIDS and Poverty (ACDHAP) initiated the Response Beyond Borders (RBB) Consultations and Sub Regional Workshops which gave rise to the Parliamentarians Forum for Harm Reduction. This, and the recently formalized Asian Network of People who Use Drugs (ANPUD) which has MIPUD (Meaningful Involvement of People who Use Drugs) as its guiding principle, are two important regional initiatives that are not identified through the data collection tools which inform this report.

A follow-up of this activity should be conducted at an appropriate time in the near future; the timing for this reflecting both the increasing momentum of the harm reduction response in the Asia region, and the available human and financial resources in many of the priority countries with which to provide appropriate input to the process. Ideally, this review should be conducted within the next three years. Some refinement of the analytical framework tool may be required to simplify and improve the process and timeliness of obtaining input and feedback from the country level.

References.

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