

**Support.
DON'T
punish.**

Experiences of community advocacy and harm reduction programmes



Ministry of Foreign Affairs



www.supportdontpunish.org

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**COMMUNITY ACTION
ON HARM REDUCTION**



Introductory foreword

Eliot Albers, International Network of People who Use Drugs

Collectively, China, India, Indonesia, Kenya and Malaysia are home to over 3 million people who inject drugs. While the national contexts differ, challenges relating to punitive drug laws and poor access to essential harm reduction services are common to all. Common, too, is the desire among people who inject drugs to organise in order to claim their human rights and advocate for access to services. The International Network of People who Use Drugs (INPUD) is working actively to support and build capacity among communities of people who use drugs in Kenya and India as part of the Community Action on Harm Reduction (CAHR) project. While the same hunger to organise is apparent in both contexts, how these communities of people who use drugs are organising in the two countries looks very different.

In Kenya, one in every five people who inject drugs is living with HIV, and over half are living with hepatitis C. The majority do not have access to life-saving treatments, and epidemics are left to expand unchecked as needle and syringe programmes are limited to small pilots, and exorbitant prices preclude the limited opioid substitution programmes from the majority who would benefit from them. Despite Kenya's repressive legal environment, violent and abusive policing practices, and widespread stigma, discrimination and intolerance, there is a voracious appetite among the injecting community for knowledge, for access to harm reduction and legal services, and for an understanding of human rights and a will to organise. This has resulted in the Kenyan Network of People who Use Drugs (KeNPUD), a group that grew out of a workshop organised by members of the International Network of People who Use Drugs (INPUD). KeNPUD is now flourishing. The group has succeeded in electing office bearers, registering legally as a community-based organisation, and writing a bid for a small grant – all despite extremely limited financial and human resources.

India's drug using community has successfully organised a significant number of established statewide networks in Manipur, Mizoram, Meghalaya and Nagaland. These, and additional networks of people who use drugs currently developing across India, organise under the umbrella of the Indian Drug Users' Forum (IDUF), which has been technically and financially supported throughout the CAHR project via INPUD. IDUF's focus on the punishment

and extrajudicial killings occurring in the country's thousands of unregulated, privately-run drug treatment centres arose in response to widespread documentation of practices such as caging, tonsuring, torturing, beating and occasional killings of drug users consigned to these centres. The Indian drug-using community and its allies, most notably the Lawyers' Collective, responded by organising a public interest litigation calling for the regulation of drug treatment centres, together with sanctions against or closure of those in which human rights abuses have been reported, and scale up of evidence-based harm reduction services.

This report highlights these and other key harm reduction and drug policy issues that impact on the lives of people who use drugs in the five countries where the CAHR project is implemented. For instance, in Indonesia, local partners have identified the need to document best practice around diverting people arrested for minor drug offences to community-based treatment rather than prison. In Malaysia, local partners are working with police and law enforcement agencies to reduce barriers to accessing existing harm reduction services. And in China, community partners have documented structural obstacles that impede access to community methadone maintenance services, and are working toward innovative means of overcoming these.

The CAHR project has facilitated concrete changes on the ground by enabling the scale up of voluntary, human rights-based harm reduction and other health services, and by supporting drug user organising in a range of diverse and challenging environments. Much work remains for drug user networks and other advocates in calling for governments and donors to invest in harm reduction approaches, and to improve drug policies and laws so that these efforts are supported, not undermined, and the human rights of people who use drugs are protected, not violated. These are the central demands of the Support. Don't Punish. campaign, which has arisen from the CAHR project but makes these calls at national, regional and international levels. I am delighted to support the important work of the CAHR community and the Support. Don't Punish. campaign towards advancing humane and evidence-based drug policies and improving access to services for people who use drugs.



Eliot Ross Albers, PhD, Executive Director
International Network of People who Use Drugs

About this publication

This report provides a snapshot of the national context and experiences of the Dutch government-funded CAHR project partners in five countries: China, India, Indonesia, Kenya and Malaysia. These experiences reflect a broader programme of work that comprises CAHR and the European Union-funded Asia Action on Harm Reduction project (Asia Action).

This work is jointly supported and implemented by a consortium of international policy partners: Harm Reduction International (HRI), International Drug Policy Consortium (IDPC), International HIV/AIDS Alliance (the Alliance) and International Network of People who Use Drugs (INPUD), working in collaboration with national-level community-based organisations.

What is the Support. Don't Punish. campaign?

Support. Don't Punish. is a global advocacy campaign to raise awareness of the harms caused by the criminalisation of people who use drugs. Its aims to:

1. Change laws and policies which impede access to harm reduction interventions for people who use drugs.
2. Raise awareness about the need to stop criminalising ('punishing') people for using drugs.
3. Raise awareness about the need for greater funding and attention for essential health services and other 'support' for people who use drugs.
4. Promote respect for the human rights of people who use drugs.
5. Engender public support for drug reform.

Support. Don't Punish. has been conceived by the International HIV/AIDS Alliance, the International Drug Policy Consortium, Harm Reduction International, and the International Network of People Who Use Drugs. It comprises an independent campaign brand and website for people to support, an Interactive Photo Project via social media, events at key international conferences and policy meetings, reports and videos, and a Global Day of Action on the 26th June (the UN's International Day Against Drug Abuse and Illicit Trafficking). The campaign statement was released in March 2012 at the UN Commission on Narcotic Drugs, and can be found on page 3 of this report.

For more information about the campaign, the Interactive Photo Project and the Global Day of Action, please visit www.supportdontpunish.org.

What is Community Action on Harm Reduction (CAHR)?

CAHR is an ambitious project funded by the Dutch Ministry of Foreign Affairs spanning five countries (China, India, Indonesia, Kenya and Malaysia) that aims to significantly improve access to quality HIV prevention services for more than 180,000 people who inject drugs, their families and communities by 2014. In addition, CAHR aims to protect and promote the rights of these groups by fostering an enabling policy environment for HIV and harm reduction programming in the five countries.

The goal of the CAHR project is to empower people injecting drugs, their partners and families to be healthier, less marginalised and more engaged in social and

community life. This will be achieved through four pillars: increasing access to services, building capacity, promoting human rights, and brokering knowledge.

The programme is implemented by a consortium of Alliance Linking Organisations: AIDS Care China, India HIV/AIDS Alliance, Rumah Cemara (Indonesia), Kenya AIDS NGOs Consortium (KANCO) and Malaysian AIDS Council (MAC), in collaboration with four international policy partners: the Alliance, HRI, IDPC and INPUD.

The programme is structured around four objectives:

1. To improve access to HIV prevention, treatment and care, sexual and reproductive health, and other services for people who inject drugs in China, India, Indonesia, Kenya and Malaysia.
2. To increase the capacity of civil society and government stakeholders to deliver harm reduction and other health services to people who inject drugs and their partners in China, India, Indonesia, Kenya and Malaysia.
3. To promote and protect the human rights of people who inject drugs and their partners in China, India, Indonesia, Kenya and Malaysia, and advance their rights within global institutions.
4. To increase learning about effective and efficient harm reduction programmes in China, India, Indonesia, Kenya, Malaysia, and globally.

For more information on the CAHR project, please visit: www.cahrproject.org.

What is Asia Action on Harm Reduction (Asia Action)?

Asia Action is a 3-year project funded by the European Union. It aims to improve knowledge, increase the evidence base 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 Alliance Linking Organisations (AIDS Care China, KHANA (Cambodia), Supporting Community Development Initiatives (SCDI) (Vietnam), MAC (Malaysia), Rumah Cemara (Indonesia) and India HIV/AIDS Alliance) work together with international policy partners HRI and IDPC, and the Alliance secretariat in the UK and Brussels, to achieve three results:

- improved knowledge of evidence-based and rights-based approaches to HIV and drug use among national and local governments and their agencies
- increased political and social support for law reform and the implementation of existing laws to improve national responses to HIV and drug use
- increased evidence on effective rights-based approaches to HIV and drug use in Asia.

For more information on Asia Action, please visit: <http://www.aidsalliance.org/Pagedetails.aspx?id=543>

Additional resources:

- Harm Reduction International
- International Drug Policy Consortium
- International HIV/AIDS Alliance
- International Network of People who Use Drugs



A global advocacy campaign to raise awareness of the harms being caused by the criminalisation of people who use drugs.

CAMPAIGN STATEMENT

The HIV epidemic is fuelled by the criminalisation of people who use drugs. Governments must reform drug laws and policies that impose harsh penalties and law enforcement measures on people who use drugs, and hamper access to essential HIV prevention and health services. The heightened HIV risks faced by people who inject drugs can no longer be ignored. The SUPPORT. DON'T PUNISH campaign calls upon governments to put an end to drug policies that lead to poor health, social, economic and human rights outcomes.

An estimated 11-21 million people inject drugs worldwide, with HIV infection rates amongst this group as high as 37% in Russia, and 43% in Indonesia¹. People who inject drugs account for 30% of HIV infections outside of sub-Saharan Africa, and up to 80% of infections in Eastern Europe and Central Asia.

The HIV epidemic is being driven by laws, policies and practices that impose harsh penalties and law enforcement measures on people who use drugs. Initially based on the belief that tough enforcement would stifle drug markets, this punitive approach has failed to reduce levels of drug use.² It has also led to the discrimination and stigmatisation of people who use drugs, impeding their access to HIV prevention, treatment and care services that are essential to saving lives and curbing the spread of HIV.

The criminalisation of drug use creates an environment that condones imprisonment for minor offences along with a range of human rights violations by law enforcement agencies, including torture, executions, extrajudicial killings, bribery, imprisonment as a form of treatment, and other abuses that result from overcrowded prisons.³ The imprisonment of people who use drugs increases their HIV vulnerability because of unsafe injecting and sexual practices, and worsens HIV treatment outcomes because of inadequate treatment access.⁴

Evidence-based interventions that are effective at halting or reversing the HIV epidemic among people who inject drugs are already endorsed by international agencies such as the WHO, UNAIDS and UNODC⁵. But their full implementation is blocked by policy and legislative barriers, inadequate resources, lack of capacity and political or ideological objections. Eminent groups of experts and policy makers, such as the Global Commission on HIV and the Law and the Global Commission on Drug Policy, have recently published reports⁶ calling for reform of drug policies based on available evidence and human rights in order to prevent HIV amongst people who inject drugs. The body of evidence and the momentum for change is growing.

As part of this momentum, the SUPPORT. DON'T PUNISH campaign calls on governments to confront these political, legislative and ideological barriers, and ensure the health and human rights of people who use drugs, their families and the wider community.

Support:

Invest in effective HIV responses for people who use drugs.

- ▶ We call on countries to scale up evidence-based HIV prevention measures for people who inject drugs, including programmes that prevent the sharing of injecting equipment (needle and syringe programmes), and effective programmes for those with drug dependency problems (opioid substitution therapy).
- ▶ We call on donors, UN agencies and governments to direct resources to close the gap between the scale of need, and current levels of investment, for targeted harm reduction and HIV programmes for people who use drugs.
- ▶ We call on international donors to fully fund the Global Fund to Fight AIDS, Tuberculosis and Malaria, so that programmes essential for tackling HIV transmission amongst people who use drugs can achieve the required scale.

Don't punish:

Improve policies and reform laws that undermine effective HIV responses for people who use drugs.

- ▶ We call on governments to bring an end to the criminalisation and punishment of people who use drugs, and to the prohibition of needle and syringe programmes and opioid substitution therapy.
- ▶ We call on governments to ensure the provision of voluntary, evidence-based and human rights compliant drug treatment programmes and put an end to imprisonment as a form of treatment.
- ▶ We call on governments to work with civil society and most-at-risk populations to gain a better understanding of the harmful impacts of drug laws and policies, and to develop programmes that are proven to be effective at stopping HIV transmission.

Country profile

China

Although China's national HIV prevalence remains low, HIV rates vary widely both geographically and among different key affected population groups. In 2011, there were an estimated 780,000 people living with HIV in China, of which nearly a third (28.5%) acquired the virus via injecting drug use.²

Of the 2,350,000 people who inject drugs that reside in China, 6.4% live with HIV.⁴ People who inject drugs in the provinces of Yunnan, Xinjiang, Sichuan, Guangxi, Guizhou and Guangdong have the highest HIV prevalence rates in the country – in some areas exceeding 50%.² China is also home to more than half (1.6 million) of all people worldwide who inject drugs and also have hepatitis C.³ Co-infection with HIV and viral hepatitis (hepatitis C and/or hepatitis B) is particularly prevalent among people who inject drugs in border areas with Myanmar, Bangladesh and Laos.⁵

China's efforts to address HIV among people who inject drugs have been concentrated on the provision and scale up of opioid substitution therapy (OST) in the form of MMT programmes. In accordance with the stipulations of the Law of Narcotic Control and the Drug Rehabilitation Regulations, which were updated in 2008 to support a public health approach to drug treatment, China's Health, Public Security and Food and Drug Administration has moved towards integrating community MMT into drug

EPIDEMIOLOGICAL AND PROGRAMMATIC PROFILE:

Harm reduction explicit in national policy documents	Yes
Number of people who inject drugs	2,350,000 ¹
HIV prevalence among people who inject drugs	6.4% ²
Hepatitis C prevalence among people who inject drugs	67 (60.9–73.1)% ³
Needle and syringe programmes (NSP)	>900 ²
Opioid substitution therapy (OST)	738 sites (buprenorphine, methadone) ²
OST in prison	No
NSP in prison	No

treatment services for people in need who inject drugs. This represents an important shift towards more accessible, evidence-based harm reduction services, in contrast to the compulsory and punitive treatment centres widely used across China to address drug use.⁶

In recent years, OST was scaled up from 600–675 MMT sites in 2010 to 738 sites across 28 provinces in 2012, with a total of 140,000 people who inject drugs receiving treatment.² But despite improvements in the availability of MMT, constraints to coverage and accessibility remain to be addressed. These include the need for individuals to obtain official identity cards registered in police databases identifying them as "drug users", which may drive those



in need away from services due to fear of exposure, additional subsequent restrictions,⁷ and potential police harassment. Other obstacles include inflexible opening hours, geographical distance, and the cost of both the health assessment required to confirm MMT eligibility and the daily cost of MMT itself.

Coverage of NSPs has now reached medium levels by the international targets of the Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization and the United Nations Office on Drugs and Crime,⁸ with 180 needles and syringes distributed per person per year through approximately 900 sites across 19 provinces.²

Although China has scaled up provision of essential harm reduction programmes and broadened the range of available services in recent years, significant challenges to service accessibility and quality remain. For instance, access to health care in China, including to MMT programmes, examination to access antiretroviral treatment and drug rehabilitation, are available only at a cost to the client. Coverage remains low, and recruitment and retention are ongoing challenges. In addition, drop-out rates are high, particularly where outreach, psychosocial support and community engagement are lacking.⁹ An absence of cooperation among government departments at the local level, combined with increasing demand for care, support and treatment access, also limit the effective implementation of harm reduction programmes.

Despite attempts by central government to integrate NSP provision as an HIV prevention strategy as part of the five-year action plan, the provision of sterile injecting equipment is not fully supported by all governmental agencies, particularly local law enforcement authorities. Findings from a recent review of NSPs highlighted a number of barriers to NSP access, including long distances to NSP sites and fear of being arrested when receiving and if carrying sterile needles.

Despite a government commitment to expand provision of evidence-based programmes, those remanded to

compulsory treatment in punitive “drug-free centres” continue to exceed exponentially the number accessing evidence-based services.¹⁰

Community based organisations (CBOs) that implement harm reduction services in China face significant restrictions to programme delivery. In order to receive funding and be granted permission to deliver programmes, CBOs are required to register with the government and are often restricted to operating in certain geographic areas. The current service delivery model severely limits the independence of some CBOs to implement low-threshold and effective harm reduction services.

Resourcing for harm reduction

Domestic financing for the HIV response in China has increased steadily in recent years. China’s latest report to UNAIDS in March 2012 states that central and local government investment in HIV totalled approximately 7.8 billion yuan RMB (US\$1.25 billion), of which 970 million yuan RMB (US\$155 million) came from international donors.² It is unclear what proportion of this funding supports harm reduction. Harm reduction programmes receive assistance from a variety of sources, such as foundations, civil society groups, corporations and international organisations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States Agency for International Development/President’s Emergency Plan for AIDS Relief.¹¹

The Global Fund in particular has been a long-term supporter of harm reduction interventions in China through HIV grants in Round 3 (2003), Round 4 (2004) and Round 6 (2006). In total, the Fund has approved more than US\$369 million for HIV efforts in the country,¹² of which approximately US\$23 million (6%) has been targeted at people who inject drugs.¹³ This funding has helped support a range of HIV prevention services including NSPs, OST and HIV voluntary counselling and testing.

Legal and policy profile

The Chinese government has enacted various regulations and policies that have implications for harm reduction. These are some of the key developments.

2006 China launches its Action Plan for HIV/AIDS Prevention and Containment (2006–2010), which defines the responsibilities of the government and civil society in the national response to HIV and AIDS. This is the first policy in China to emphasise the human rights of people living with HIV and AIDS, and to provide a legal basis for the provision of methadone maintenance treatment (MMT) and needle and syringe programmes (NSPs).

2008 The Anti-Drug Law of the People’s Republic of China is the first drug policy to introduce public health approaches to HIV and injecting drug use.

2010 New measures focusing on expanding coverage of harm reduction interventions are set out in China’s State Council Notice on Further Strengthening the AIDS Response.

2011 China issues the Law of Narcotic Control and the Drug Rehabilitation Regulations; a set of policies on drug rehabilitation that supplement the Anti-Drug Law of the People’s Republic of China (2008).

2012 The State Council issues China’s Five-Year Action Plan for Reducing and Preventing the Spread of HIV/AIDS, which sets out targets for reducing new HIV infections by 25% and reducing mortality from AIDS by 30% by 2015. The Action Plan adopts MMT and NSP as harm reduction models as part of the national response to HIV and AIDS among people who inject drugs.

However, in 2011 the Global Fund board took the decision that upper middle-income countries that form part of the G20 group were ineligible for new or renewed funding if they have a “less than extreme” disease burden. China had been expecting to access more than US\$800 million in grant renewals in 2012–13, but instead now receives nothing. The Chinese government was quick to declare that it would fill the funding gap left by this decision,¹⁴ but concerns remain about the long-term sustainability of community-orientated harm reduction services in the country.¹⁵

Although China is one of the countries that most frequently utilises capital punishment for drug offences, the country continues to receive drug enforcement assistance from international donors and the United Nations.¹⁶

The policy response to HIV and injecting drug use

China has made substantial progress in the development and implementation of public health approaches to HIV and injecting drug use. China’s narcotic control law, The Anti-Drug Law of the People’s Republic of China (2008) marked a milestone for evidence-based drug policy. However, although China’s Public Security Bureau

co-operates with the Centres for Disease Control and CBOs under the new regulations to implement MMT and pilot NSPs, punitive approaches and criminalisation continue to dominate the country’s policy response.

Human rights violations associated with government drug detention centres (sometimes euphemistically referred to as drug treatment centres, drug rehabilitation centres or re-education through labour centres) have been widely documented.¹⁶ More than 400,000 people in China and South East Asia are interned for months or years without due process rights such as proper medical evaluation, appearance before a judge or right of appeal.^{13,17} People who inject drugs in China face arrest and detention for possession of needles. They also experience publicly exposed registration lists and forced labour rehabilitation. It is illegal to purchase sterile needles in pharmacies.

The country also retains the death penalty for drug offences and frequently carries out executions. China is believed to execute more people than any other country in the world for drug offences.¹³ In May 2011, China reduced its list of crimes that are punishable by death sentence from 68 to 55.⁶ While this is a positive development, the 13 crimes that are no longer on the list are mainly financial and non-violent crimes, and do not include drug trafficking.

Story from the field

Documenting barriers and expanding access to methadone maintenance therapy

Faced with an expanding HIV epidemic among people who inject drugs, the Chinese government has gradually supported a harm reduction approach, and in 2004 invested in the piloting of eight OST clinics across five provinces. Beginning in 2000, the government extended its support for the broader implementation of MMT as an HIV prevention measure, subsequently scaling up provision as part of the national five-year plan to address HIV and AIDS in 2006. But despite the country’s remarkable progress in scaling up MMT, challenges to accessibility persist for the most marginalised groups of people who inject drugs.

Some of these challenges are illustrated by the experience of the Community Action on Harm Reduction (CAHR)-supported Clover Group, a peer group for people who use drugs in Jinniu district, Chengdu (the capital of Sichuan province). The Clover Group was originally established in 2008 by Médecins du Monde (an international medical organisation) and the local Centre for Disease Control and Prevention, with the mission of supporting communities of people who use drugs via outreach activities, information, education, peer education and counselling. Following the later withdrawal of Médecins du Monde, the Clover Group has been supported by CAHR and the Global Fund to develop its organisational capacity and continue its work in communities across Jinniu district.

The Clover Group has approximately 10 members who are enrolled in MMT. Yan Jing, a longstanding peer group leader, has been on MMT since 2007, following several years of injecting heroin. For Yan Jing, accessing MMT was a two-week process during which he was required to obtain a certificate from the police confirming his active drug-use status, a local residence permit, a personal identity card, and a full health assessment. As in Chengdu, waiting times across the country can range from one to several weeks, and administrative hurdles pose significant barriers to MMT access for many people

who use drugs. Once registered as a person using drugs with the authorities, the individual’s record remains in the possession of the police, even after they have discontinued drug use.

As Yan Jing’s life became increasingly stable, he found a new job in a construction company. But this opportunity was short-lived. In order to process Yan Jing’s formal employment card, his company visited the local government office. As police records are shared with employers and other government departments, Yan Jing’s former drug use status was revealed, leading to his immediate discharge without due pay.

Yan Jing’s experience reflects a significant barrier to accessing MMT among people who use drugs. Like Yan Jing, many want an opportunity to rebuild their lives and contribute as productive members of society. Yet the fear of being officially and indefinitely labelled a “drug user” by the state prevents many people who inject drugs from registering with the authorities and accessing state-provided MMT at a low cost. Instead, some procure illegally sourced methadone at much higher cost.

Although China’s 2008 drug law states that people who use drugs should have the same rights as other Chinese citizens in relation to education, employment and social support, community experiences reveal that people who use drugs continue to be discriminated against.

Yan Jing has continued to actively engage with the Clover Group, where his peers support him in continuing to navigate the bureaucracy and seek employment. With CAHR assistance, Yan Jing is currently working with his peers towards officially registering the group as an independent community organisation. This will enable them to further expand their peer education and outreach activities, and provide people who use drugs in Chengdu with a forum to advocate for their rights.

Country profile

India

Approximately 2.13–2.4 million people are living with HIV in India, most of whom represent key affected populations at higher risk, such as sex workers, men who have sex with men, transgender people and people who inject drugs.⁵ Although adult HIV prevalence in the general population remains low at 0.31% as of 2009, government estimates of prevalence in key affected populations are 15–30 times higher: 4.9% among sex workers, 7.3% among men who have sex with men, and 7.2% among people who inject drugs.⁶

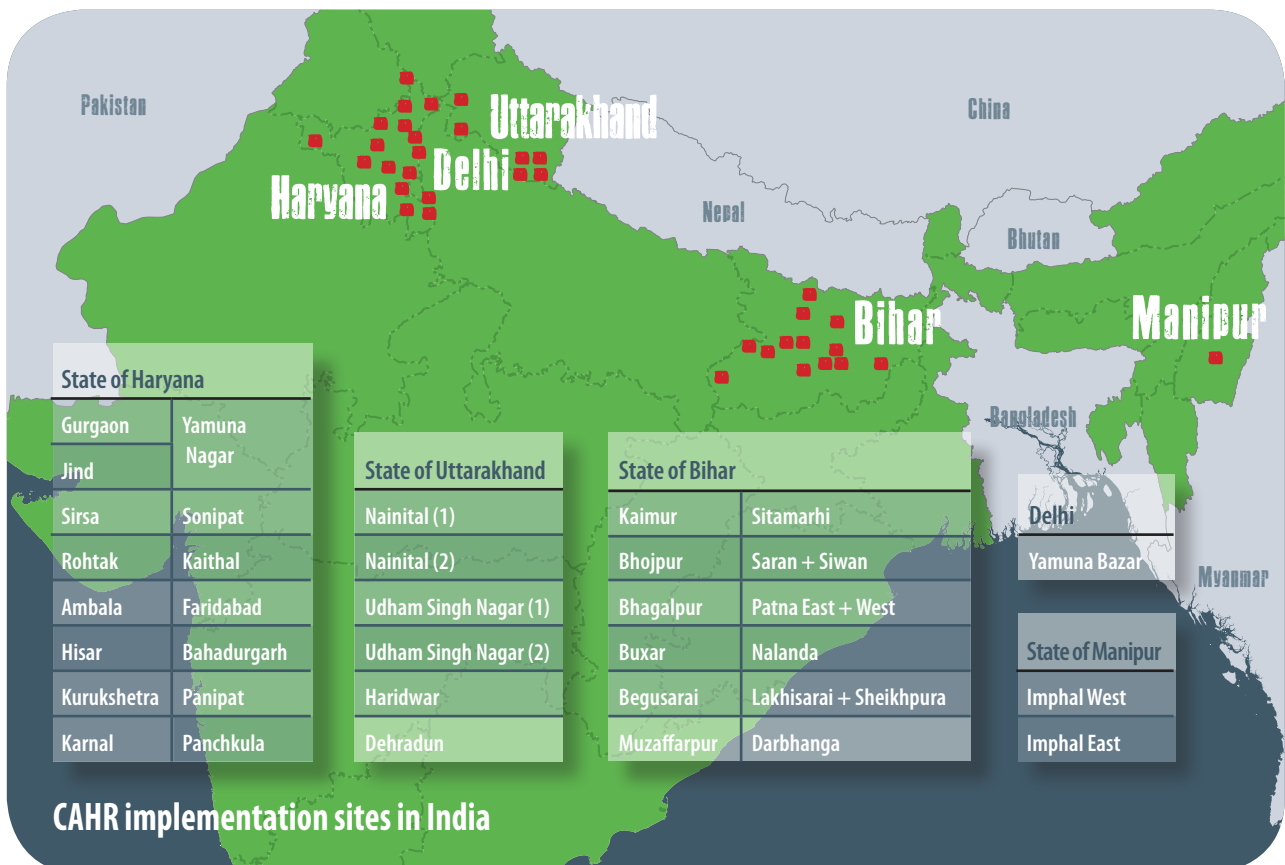
Transmission through injecting drug use is a major driver of India's HIV epidemic, particularly in north-eastern states, including Manipur, Mizoram and Nagaland, and features increasingly in the epidemics of major cities elsewhere, including in Chennai, Mumbai and New Delhi.⁶ For example, HIV rates among people who inject drugs range from 23% to 32% across different areas within Manipur,⁷ and are increasing in the northern state of Punjab, where HIV prevalence among people who inject drugs ranges from 26% in Jalandhar to 54% in Amritsar.⁸ Rates of hepatitis C among this group are even higher: almost half of all people who inject drugs (40%) in India are living with hepatitis C virus.²

The Indian government's response to drug injecting and HIV has largely been based on punitive law enforcement. Evidence-based approaches to HIV prevention did not

EPIDEMIOLOGICAL AND PROGRAMMATIC PROFILE:

Harm reduction explicit in national policy documents	Yes
Number of people who inject drugs	177,000–180,000 ¹
HIV prevalence among people who inject drugs	7.2% ²
Hepatitis C prevalence among people who inject drugs	41% ³
Needle and syringe programmes (NSP)	268 ²
Opioid substitution therapy (OST)	107 sites (4 methadone, 103 buprenorphine) ²
OST in prison	No ^b
NSP in prison	No

feature prominently in India's HIV response among people who inject drugs until 2008, when the government adopted its first harm reduction strategy as part of the National AIDS Control Programme for the period 2007–2012.⁵ During this time, the number of sites providing sterile needles and syringes increased from 200–219 in 2010 to 268 in January 2013, while the number of sites providing opioid substitution therapy was scaled up from 61 to 63 sites in 2010 to at least 107 in January 2013.⁹ But despite the scale up of essential harm reduction programmes, the quality and coverage of existing services remains fragmented, and varies widely among different states.¹⁰ As part of the Community Action on Harm Reduction (CAHR) project, Hridaya, the consortium of CAHR partners in India, has



worked to build more effective community responses for people who inject drugs and to support expansion of harm reduction activities to reach them, their spouses, partners and families. Hridaya aims to provide services to 10,250 people who inject drugs across 39 sites in the states of Bihar, Haryana, Jammu, and Uttarakhand, Imphal, Manipur and Sharan in Delhi.

The provision of harm reduction services in prisons across India is very limited. In 2008, OST was piloted in Tihar prison, the largest prison complex in South Asia, reaching approximately 120 inmates.⁹ Despite substantial overall improvement in the quality of life and productivity of many prisoners, the government failed to endorse this essential programme. The pilot ended in October 2012, with no plans to expand provision. Indian law continues to prohibit the provision of harm reduction services to people who use drugs while they are in prison or awaiting trial, which may increase the risk of sharing needles and syringes during confinement.¹¹

Large numbers of people who inject drugs in India also experience forced detention in unauthorised “de-addiction” centres that do not employ public health principles or evidence to address drug dependence. There is well-established evidence that human rights violations and abuses, including torture, corporal punishment, chaining, caging, forced detention and even death, are commonly practiced in such centres.¹² The lack of guidelines for the establishment and regulation of treatment centres, and the lack of monitoring from central and state governments, continue to aid the proliferation of such abuses, despite increasing community action.

Women who inject drugs in India are particularly vulnerable, as they experience high levels of risk due to both sexual risk-taking and to unsafe injecting practices. These women are also likely to engage in paid sex or selling drugs as a source of income to support their drug habit. However, despite the increasing visibility and documentation of a sizeable number of women who inject drugs across several states in India, the national HIV programme does not address the specific needs of this group.¹³ Presently, the only existing services are being implemented on a small scale by a few non-governmental organisations with support from international donor agencies.¹⁴

Resourcing for harm reduction

India receives funding support towards its HIV response from a variety of multilateral and bilateral donors. The implementation of India’s NACP III 2007–2012 was jointly supported by national funds via India’s National AIDS Control Organization and international donors like the UK Department for International Development and the World Bank.¹⁵ Additional donors supporting programming for key affected populations include The Bill and Melinda Gates Foundation through their Avahan programme targeting sex workers, Clinton Health Access Initiative, the UK Department for International Development, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the United States Government (United States Agency for International Development, Centers for Disease Control and Prevention, and the President’s Emergency Plan for AIDS Relief), the Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, UNICEF, United Nations Development Programme and the World Health Organization.⁷

Legal and policy profile.

The Indian government has enacted various regulations and policies that have implications for harm reduction. These are some of the key developments.

1985 The Narcotic Drugs and Psychotropic Substances Act is the first legislation to criminalise and regulate both illicit and traditional forms of drug use.

The legislation focuses largely on demand reduction through drug prevention and treatment, and supply reduction through law enforcement activities. The Act classifies individuals in possession of more than a quarter of a gram of a given drug as traffickers. The law contains a provision stating that those arrested under Section 27 for possession of small quantities of drugs for personal use should be offered treatment rather than being imprisoned, but this provision is rarely used in practice.

1988 The Indian government passes the Prevention of Illicit Trafficking in Narcotic Drugs and Psychotropic Substances Act, which largely supports the full implementation of the Narcotic Drugs and Psychotropic Substances Act (1985). India’s approach to controlling narcotic drugs and other psychotropic substances is enshrined in Article 47 of its Constitution and based on a prohibitive, punitive approach.

2001–2012 A review of the Narcotic Drugs and Psychotropic Substances Act (1985) leads to amendments relating to the length of prison sentence depending on the quantity and type of drug seized. A further reassessment in 2002 results in two categories of quantities of drugs seized: small quantities and commercial quantities, which in turn vary depending on the drug. The penalty for trafficking in commercial quantities is imprisonment for at least 20 years, along with severe fines.

2007 The third phase of the government’s National AIDS Control Programme (NACP III) 2007–2012 sets ambitious objectives for the HIV and AIDS response in India, and adopts a harm reduction strategy to reducing HIV transmission among people who inject drugs. NACP prioritises targeted HIV prevention interventions and increasing coverage to 80% among high-risk groups, including sex workers, men who have sex with men, and people who inject drugs.⁴

Although needle and syringe programmes (NSPs) and opioid substitution therapy (OST) are introduced as part of HIV prevention under NACP III, the legality of these harm reduction services under the Narcotic Drugs and Psychotropic Substances Act (1985) remains an open question, as the provision of drug paraphernalia can be seen as facilitating the offence of drug consumption.

More than US\$820 million has been approved by the Global Fund for HIV programmes in India,¹⁶ with just US\$20 million estimated to be targeted at people who inject drugs.¹⁷ Grants from Rounds 2 (2003), 7 (2007) and 9 (2010) included services for this population, such as HIV testing and counselling, condom distribution, information, education and communication, and the development of supportive environments. So far the Global Fund has not directly supported the provision of NSPs, nor OST.

India has been selected as one of the “interim applicant” countries for the Global Fund’s transition to a new funding model, and has been given an indicative funding envelope of US\$19 million (to “cover activities managed by a civil society organization for a Round 7 grant that will come to an end on 31 August 2013”).¹⁸ This indicates that there is an opportunity to advocate for the inclusion of the full harm reduction package¹⁹ in the country’s proposal for new HIV funding.

The policy response to HIV and injecting drug use

India’s harsh drug policy, centred on punitive approaches guided by its Narcotic Drugs and Psychotropic Substances Act (1985), remains the major obstacle to the implementation of harm reduction programmes in many states.¹⁰ India’s Ministry of Social Justice and Empowerment and its Narcotics and Drug Control Board both claim to endorse humane and public health-based approaches to

drug use, while simultaneously implementing punitive approaches to address drug demand and supply. Although NACP endorses harm reduction services such as NSPs and OST as part of a comprehensive HIV and AIDS response in India, the Narcotic Drugs and Psychotropic Substances Act criminalises the provision of drug paraphernalia. This legal ambiguity poses challenges to the implementation and scale up of NSPs in India, and especially to outreach work and peer education, and leads to mixed understandings of harm reduction among policy-makers.

An assessment carried out by the CAHR project in three states in India in 2012 found that people who inject drugs face widespread discrimination, physical violence, hostility and harassment from law enforcement agencies, as well as from the local community and pressure groups, particularly in the north-eastern states of the country.¹⁰

India continues to uphold the death penalty for drug offences. In a landmark decision in June 2011, the Bombay High Court declared the mandatory death penalty for drug offences unconstitutional, becoming the first court anywhere in the world to do so.¹⁸ The ruling described mandatory capital punishment as harsh, “unjust and unfair”²¹ for the crime of dealing in drugs.²² However, instead of striking down the law, it rather informed the courts that imposing capital punishment on repeated drug offenders was now optional.

Story from the field

Punishment in the name of treatment

In India, the CAHR-supported programme Hridaya has collaborated with the Indian Drug Users’ Forum (IDUF), the Indian Harm Reduction Network (IHRN), the Lawyers Collective (a forum of lawyers working on health and human rights issues) and community representatives to advocate against human rights abuses against people who use drugs held in unregulated “de-addiction” centres.

Hridaya is implemented by India HIV/AIDS Alliance in partnership with Social Awareness Service Organization (SASO), Sharan, and a number of community-based harm reduction organisations and networks. Both IDUF and IHRN represent people who use and are dependent on drugs in India. The principal role of IDUF is to advance the human rights and social well-being of people who use and are dependent on drugs. IHRN is a network of organisations that collaborates with the National AIDS Control Organization and the Ministry of Health and Family Welfare in providing harm reduction services to people who use drugs.

Across India, people who use drugs report neglect, mistreatment and death in “de-addiction” centres. Physical isolation, chaining, thrashing and other violence, forced labour, denial of meals, interception of communication and other inhumane acts are commonly practiced in the name of drug treatment across several states in India.⁹ While some incidents are recorded, most go unreported and few are investigated or prosecuted. A majority of drug treatment centres in India function without official approval and in contravention of legal provisions for the establishment and management of such centres. Despite serious violations of the law and the rights of people who use drugs, these centres continue to

operate as there is no monitoring undertaken by the government.

In addition, most drug treatment centres operate without standards for clinical care, and many follow outdated, non-scientific methods and non-standard protocols. For instance, several drug detoxification centres in the state of Manipur administer Lobain – a combination of dextro-propoxyphene and ibuprofen – even though its use has been discontinued in Europe due to adverse effects. Centres supported by India’s Ministry of Social Justice and Empowerment provide only psychosocial interventions such as yoga, spiritual guidance or group counselling. While such activities may aid recovery, they should not replace pharmacotherapy as the primary method of managing drug dependence.

In response, IDUF, IHRN, the Lawyers Collective, community representatives and staff from Hridaya met to discuss the issue of drug treatment and to strategise on how to improve the situation. As a result of the meeting, the partners filed a request to expand regulation and monitoring of drug treatment centres. They also urged the Ministry of Social Justice and Empowerment and Ministry of Health and Family Welfare to convene a joint meeting with non-governmental organisations, health care providers, drug policy experts and, above all, people who use drugs to discuss concerns related to drug treatment practices in India. The request asked the government to collaborate with IDUF and IHRN to develop a regulatory framework that provides for human rights-compliant and evidence-based treatment and care in all centres in India working on drug dependence. The government has yet to act on this request.

Country profile

Indonesia

Indonesia is experiencing one of the fastest growing HIV epidemics in South East Asia. Between 2006 and 2011, there was a ten-fold increase in the cumulative number of reported HIV cases.² HIV is concentrated among key affected populations, such as people who inject drugs and their sexual partners, sex workers, and men who have sex with men. More than a third of people who inject drugs in the country are living with HIV.² Elevated HIV prevalence rates, largely attributed to unsafe injecting practices, are also reported among Indonesian prisoners, particularly among women.²

While the HIV response among people who inject drugs has increased in scale in recent years,¹ the availability and coverage of key harm reduction interventions is still too limited to have a major impact on the HIV and viral hepatitis epidemics. For instance, although the number of sites distributing sterile needles and syringes has increased steadily and coverage varies widely across different geographic areas, figures for 2011 indicated that national-level coverage equated to only seven needles and syringes per year per person injecting drugs.² According to revised technical guidance and to Global AIDS Response progress reporting in 2012, coverage levels equal to or more than 200 syringes per person injecting drugs per year are needed to impact on the HIV epidemic among this population.⁶ For the prevention of hepatitis C virus, coverage levels are likely to be much higher.

Similarly, the availability and scope of opioid substitution therapy (OST), such as methadone and buprenorphine, are limited by poor programme quality, including lack of proper follow-up among those who drop out and inappropriate dosing levels.¹ A significant proportion of people enrolled in this programme (39%) continue to inject, particularly in the early months following the start of treatment.²

EPIDEMIOLOGICAL AND PROGRAMMATIC PROFILE:

Harm reduction explicit in national policy documents	Yes
Number of people who inject drugs	105,784 (73,663 – 201,131) ¹
HIV prevalence among people who inject drugs	36% ²
Hepatitis C prevalence among people who inject drugs	77.3% ³
Needle and syringe programmes (NSP)	194 sites ²
Opioid substitution therapy (OST)	85 sites (Methadone) ⁴
OST in prison	Yes (in 9 prisons) ⁵
NSP in prison	No

Access to antiretroviral treatment for people who inject drugs is similarly limited. Despite high rates of HIV testing and counselling among people who inject drugs, only 6% of people injecting drugs and living with HIV were receiving antiretroviral treatment in 2010.⁷

The provision of harm reduction services in Indonesian prisons is even more limited than provision in the community. There are 429 prisons across the country, including 13 prisons designed specifically for drug offences, yet only four prisons provide OST.² There is no provision of sterile injecting equipment within Indonesian prisons or detention centres, despite the evidence in support of this intervention.

Resourcing for harm reduction

Investment in the HIV response from the Indonesian government has been increasing steadily since 2010. Although disaggregated information on harm reduction spending is not available for Indonesia, resourcing support for harm reduction programmes in the country has



CAHR implementation sites in Indonesia

largely come from external donors, such as the Australian Government Overseas Aid Program, the United States Agency for International Development, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

An estimated 50–60% of funding for key harm reduction services, such as NSPs and MMT, is provided by the Global Fund, with government sources accounting for roughly a third of harm reduction financing.⁸ Indonesia has had HIV grants worth more than US\$130 million approved by the Global Fund,⁹ of which an estimated US\$14 million has been budgeted for programmes for people who inject drugs, through grants in Rounds 1 (2002), 4 (2004), 8 (2008) and 9 (2009).¹⁰ This funding has helped support NSPs, OST, condom distribution and information, education and communication services. The existing HIV grants (two managed by governmental organisations, and two by non-governmental organisations) were recently approved for Phase 2 and are due to run until 2015, meaning that there were no proposals planned or submitted for the cancelled Round 11. It remains to be seen how the ongoing changes at the Global Fund will impact on Indonesia's programmes beyond 2015.

Anecdotal evidence has shown that local HIV and AIDS budget allocations in Indonesia often depend on the personal commitment of local and district officials.² However, 2015 will mark the end of Indonesia's eligibility for Global Fund monies due to its revised classification as a middle-income country. There will be an urgent need for increased government commitment to fill the funding gap and to ensure the continued scale up of harm reduction programmes.

The policy response to HIV and injecting drug use

The policy response to drugs in Indonesia has been dominated by punitive law enforcement measures. In 2009, Indonesia launched a new law on narcotic drugs (Narcotics Law no. 35), which introduced mechanisms for diverting people who use drugs away from prison and towards drug treatment programmes.¹¹ The new regulations provide judges with discretionary powers to impose drug dependence treatment as an alternative to imprisonment.

However, despite provisions to divert people into drug treatment, the ongoing criminalisation of drug use has resulted in high rates of imprisonment of people who use drugs and severe overcrowding in existing facilities.¹² The number of prisoners incarcerated for drug-related offences had grown significantly from 7,122 (10% of prisoners in Indonesia) in 2002 to 37,295 (26% of prisoners) by the end of September 2009.¹³ Injecting drug use has been widely documented in Indonesian prisons, as has high HIV prevalence associated with unsafe injecting practices.² Between 2009 and 2011, 108,414 people were arrested for drug offences in the country. However, no information is available on the proportion diverted to treatment instead of prison.¹⁴

The Narcotics Law no. 35 (2009) and the related Government Regulation no. 25 (2011) also introduced requirements for the compulsory reporting of all people who use drugs over the age of 18.¹⁵ People who use drugs are required to report themselves to designated

Legal and policy profile

The Indonesian government has enacted various regulations and policies that have implications for harm reduction. These are some of the key developments.

2003 The National AIDS Commission and National Narcotics Board sign a Memorandum of Understanding that establishes a political and institutional foundation for a national harm reduction programme.

2004–05 The Sentani Commitment is signed by the National AIDS Commission and several other authorities in Indonesia in January 2004, and revised in June 2005 to specify needle and syringe programmes (NSPs) and methadone maintenance treatment (MMT) programmes. It becomes the first official document supporting the implementation of harm reduction activities across the country.

2005 Indonesia launches its first National Strategy on AIDS, which includes harm reduction. During the same year, the Ministry of Justice and Human Rights launches the National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres (2005–09). The document provides a basis for the development of guidelines on prevention, care, support and treatment of HIV and AIDS in prisons, but stops short of including harm reduction interventions such as NSPs and MMT within prison settings.

2006 The Ministry of Health launches the first national policy (Ministry of Health Regulation no. 567) setting out guidelines for harm reduction programme implementation.

2007 The Coordinating Minister of People's Welfare issues Regulation no. 2 on addressing HIV and AIDS among people who inject drugs through harm reduction interventions.

2009 The Indonesian state passes a new law on the use and supply of drugs, Narcotics Law no. 35, which introduces measures to divert people who use drugs to treatment rather than prison.

2010 The National AIDS Commission launches their National Strategic Plan 2010–2014, which sets targets for HIV prevention programme coverage among key affected populations, including people who inject drugs, up to 2014.

2011 The Indonesian state introduces Government Regulation no. 25 that, together with Narcotics Law no. 35, establishes requirements for the compulsory reporting of all people using drugs over the age of 18.

2013 The Ministry of Health launches Regulation no. 21 on HIV prevention, which endorses harm reduction approaches for preventing HIV among people who inject drugs, including NSPs, MMT, and counselling and psychosocial support.

institutions for treatment and rehabilitation, including community health centres (puskesmas) operated by the Ministry of Health. The Ministry of Health has designated 181 health facilities (mental health hospitals, general hospitals and puskesmas) as reporting facilities, alongside two non-medical facilities operated by Badan Narkotika Nasional.¹² Usually such facilities lack harm reduction services, and at the most provide services such as counselling and referrals to drug treatment and rehabilitation. According to Article 134, failure to self-report can result in penalties ranging from a fine of Rp. 2 million (US\$200) to six months' imprisonment.¹⁶

Under the new legal regulations, families, parents and guardians of people who use drugs are also legally bound to report them. If they do not do so, relatives could face fines ranging from Rp. 1 million (US\$100) to six months' imprisonment.¹⁶

In practice, the content of Indonesia's Narcotics Law no. 35 (2009) is not implemented and applied uniformly, and law enforcement officers and courts continue to prosecute people who use drugs.¹⁵ Numerous human rights violations against people who use drugs have been reported in recent years, including physical and sexual violence, neglect of the right to health, and disproportionate punishment.¹⁴ Lack of clarity on penalties for possession of various amounts of illegal drugs, as well as on whether possession of needles and syringes is prohibited by law, means that prosecutors have broad scope to hand down heavy sentences. People charged under the 2009 law are then often required to bribe the police, the attorney general or the court to avoid heavier sentences – a practice known as the "peace way".¹⁶ Systemic corruption within the prison and justice system, together with lack of awareness about the new regulations and uneven implementation of the law, continue to pose obstacles to an effective HIV response among people who inject drugs.¹²

Story from the field

Supporting access to community-based treatment for people who use drugs

Community-based organisations have been instrumental in scaling up the national harm reduction response in Indonesia. The Community Action on Harm Reduction (CAHR) project works alongside Rumah Cemara, a community-based organisation set up in 2003 by five people who formerly used drugs to support each other and their peers. Rumah Cemara has since developed into a fully fledged organisation providing direct HIV prevention and harm reduction services, care and support programmes in the community and in prisons, and support to over 40 additional community-based organisations working with people who use drugs.

In early 2010, Rumah Cemara played a significant role in the diversion away from prison and towards community-based treatment for drug dependence of two people who had been convicted of non-violent drug offences under Indonesia's Narcotics Law no. 35 (2009). Rumah Cemara conducted a needs assessment for each client, released official statements recommending that both clients would benefit from community-based treatment rather than prison, and provided testimony as expert witnesses.

Ultimately, in accordance with the Narcotics Law no. 35 (2009) in Indonesia, both clients received nine-month sentences served through community-based drug treatment rather than in prison. At Rumah Cemara's treatment centre in Bandung, the clients received further in-depth individual assessments, as well

as detailed treatment plans that included both residential and outpatient treatment. Both individuals successfully completed their sentences with the support of their peers, and have now returned to work, college and their social lives.

Since 2011, the CAHR project has supported Rumah Cemara in developing a prison diversion programme for people who use drugs in West Java, a province with one of the highest levels of injecting drug use in the country. Rumah Cemara has since assisted in 25 additional cases of non-violent drug offences, by educating families on the legal procedure in accordance with the Narcotics Law no. 35 (2009) and documenting best legal practice.

As part of the CAHR project, Rumah Cemara plans to work together with national-level networks, such as the Indonesian Network of People Who Use Drugs, to extend its prison diversion programme. The organisation will do this by systematically documenting the implementation of the diversion clause in the Narcotics Law no. 35 (2009) and developing best legal practice examples in cases of non-violent drug offences. Rumah Cemara aims to use these tools to engage in local- and national-level advocacy with law enforcement, judges and prosecutors, and to raise awareness among people who use drugs in the community. The organisation will also support people who inject drugs who are preparing for release from prison in five cities across West Java province.

Country profile

Kenya

There have been dramatic reductions in HIV incidence and prevalence in Kenya since the early 1990s, attributed at least in part to national HIV prevention efforts. However, these efforts have not included a significant focus on key populations, who continue to experience high HIV prevalence rates. Around one-fifth of people who inject drugs in Nairobi and Mombasa are living with HIV, and sharing injecting equipment is reported to be widespread.² One study found that HIV prevalence was six times higher among those who reported ever having shared needles and syringes than among those who had never shared.² There is an urgent need for evidence-based interventions to prevent HIV transmission via injecting drug use in Kenya.

EPIDEMIOLOGICAL AND PROGRAMMATIC PROFILE:

Harm reduction explicit in national policy documents	Yes
Number of people who inject drugs	14,716 ¹
HIV prevalence among people who inject drugs	18.32 % ²
Hepatitis C prevalence among people who inject drugs	51.4 (42.2–60.6)% ³
Needle and syringe programmes (NSP)	4 civil society sites since November 2012
Opioid substitution therapy (OST)	Limited to 2 private clinics
OST in prison	No
NSP in prison	No



The response to HIV among people who inject drugs in Kenya has recently gathered some momentum. A pivotal moment in June 2012 saw the Kenyan government announce their intention to begin distributing sterile needles and syringes to people who inject drugs across the country. National operational guidelines for NSPs were drafted in consultation with national and international organisations, and informed by pilot NSP sites operating in coastal areas through the Community Action for Harm Reduction (CAHR) project.² These standard operating procedures will go some way towards protecting staff and clients from law enforcement, as current Kenyan drug law prohibits the possession and distribution of injecting equipment.⁸ Four non-governmental organisation sites began operating NSPs in November 2012 and were joined by a fifth in April 2013 – all supported by the CAHR programme. These sites are located in Nairobi, Ukunda, Mombasa, Kilifi and Mombasa, and others are set to join them following the official launch of the national guidelines on NSPs later in 2013. Sterile injecting equipment is also available to buy from pharmacies, but the cost is a deterrent. There are also anecdotal reports of inflated charges for people suspected of drug use.⁹

OST provision is currently limited to very small numbers receiving prescriptions from private clinics, at a significant cost. Current law prohibits OST provision in public health facilities, but with the recent development of national guidelines on OST provision, it is hoped that access to OST will increase.

In 2010, antiretroviral treatment for HIV was reaching less than 1% of the people in need who inject drugs.¹⁰

Currently, the scale of existing HIV services reaching people who inject drugs remains far below estimates needed to impact on the epidemic among this population.¹¹ Efforts are limited to Nairobi and Mombasa, despite anecdotal evidence of injecting drug use in rural areas and smaller towns.¹² The experience of the CAHR project suggests that there is significant demand for HIV and harm reduction services among people using drugs in Kenya. An initial CAHR baseline study among 186 people who inject drugs indicated that risky injecting behaviour was extremely common, with almost half of respondents reporting using someone else's syringe at last injection, and the majority reporting blood-filling (drawing blood back into the syringe after injecting to collect the remaining drug, before re-injecting into the vein) at some point in their lives. Almost three-quarters of those who had shared syringes stated that the main reason for this was the unavailability of sterile needles and syringes.¹³

Reports indicate that drugs are available in Kenyan prisons, as in those around the world, and that injecting drug use occurs. A recent study found that the majority of people who inject drugs in Nairobi and coastal provinces in Kenya have spent time in prison. Of those who injected drugs while incarcerated, most had shared needles or syringes.² More than 8% of the national prison population is living with HIV, and among female prisoners this figure is one in five.¹⁴ Kenyan prisons do not currently provide OST or NSP. While a majority of prisoners report ever receiving an HIV test,¹⁴ access to antiretroviral treatment in prisons is very limited, particularly among people who inject drugs.¹⁵

Legal and policy profile

The Kenyan government has enacted various regulations and policies that have implications for harm reduction. These are some of the key developments.

1994 The Narcotic Drugs and Psychotropic Substances Act (1994) states that drug possession for personal use will incur prison sentences of 10 years for cannabis and 20 years for any other illegal substance. It also states that it is illegal to possess drug paraphernalia such as syringes, and that this can lead to criminal prosecution and imprisonment. In effect, this means that needle and syringe programmes (NSPs) are not permitted by law in Kenya.

The Act also states that illicit possession of morphine and other opioids is punishable by life imprisonment and a heavy fine. There are exceptions for medical use, but no detailed guidelines about lawful possession by clients and health care workers exist. This law is interpreted very strictly, which means that current government policy does not permit opioid substitution therapy (OST) provision in public health facilities.

2006 The HIV and AIDS Prevention and Control Act prohibits HIV-related discrimination, but national legislation and policy fail to offer legal protection for key populations.⁴

2009 The National HIV and AIDS Strategic Plan for 2009/10–2012/13 (KNASP III) prioritises efforts to prevent HIV transmission, and states the intention to include a particular focus on interventions among most-at-risk populations. The supporting documentation explicitly mentions the development of supportive policies and legislation for the provision of NSPs and OST.

2012 The National Authority for the Campaign Against Alcohol and Drug Abuse Act creates a national agency of the same name with a wide-ranging mandate, including data collection, public education on drugs and alcohol, licensing and monitoring rehabilitation services, and supporting country-level drug control policy development and implementation. However, harm reduction does not feature in the document.

2013 Kenya's Ministry of Health launches its National Guidelines for the Comprehensive Management of Health Risks and Consequences of Drug Use,⁵ which aims to provide guidance on improving the effectiveness of NSPs and OST, and other HIV prevention measures. The document also includes guidance on vaccination, diagnosis and treatment of viral hepatitis, and management of co-occurring mental health issues among people who use drugs.

2013 Standard operating procedures for NSPs⁶ and OST programmes⁷ are published by Kenya's Ministry of Health. The standard operating procedures for OST also include guidance on overdose prevention and management, including the administration of naloxone, a safe, short-acting opioid antagonist that reverses the effects of overdose caused by opiates such as heroin.

As in other countries, there are fewer women who inject drugs than men, but women experience disproportionately higher levels of negative health outcomes, including HIV infection. A recent study found that women who inject drugs were three times more likely to test HIV positive than men who inject drugs.⁴ Similarly, in prisons women are significantly more impacted by HIV than men.

Resourcing for harm reduction

Unlike in most African countries, there is a wide range of international donors in Kenya supporting programmes with a focus on people who inject drugs. In 2012, the Kenya AIDS NGOs Consortium (KANCO) organised a meeting of all donors and partners to share plans and ensure the coordination of efforts. Current funding for these efforts comes solely from international sources, including the Dutch Ministry of Foreign Affairs, the French Agency for Development, the Open Society Foundations, the German Overseas Aid Agency, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the President's Emergency Plan for AIDS Relief and the Joint United Nations Programme on HIV/AIDS. To date, the Kenyan government has not provided funds to support NSP or OST provision, but it is hoped that this will soon change.

Kenya has had HIV grants worth nearly US\$460 million approved by the Global Fund since 2002,¹⁶ of which an estimated US\$1.9 million has been budgeted for programmes for people who inject drugs.¹⁷ Although some information,

education and communication services were included in the Round 7 (2007) grant, it was not until Round 10 (2010) that specialist services were included. The Round 10 grant includes new pilot NSP programmes across the country (with five sites proposed), as well as capacity-building, peer education, antiretroviral treatment and advocacy campaigns to build a supportive policy environment.

The policy response to HIV and injecting drug use

The Kenyan government's response to drugs has been overwhelmingly focused on supply reduction. Penalties for possession of drugs for personal use are among the harshest in the world. However, there is increasing recognition of the need for a public health response to HIV and injecting drug use by the National AIDS Control Council, the National AIDS and STI Control Programme (NAS COP) and the Ministry of Health. Intentions laid out in KNASP III, and the recent development of standard operating procedures for NSP and OST, suggest the emergence of a nascent harm reduction approach.

It remains unclear how existing restrictive legislation relating to the possession of needles and syringes, and the provision of OST, will impact on the further development of a harm reduction response. Agreements may be required with law enforcement for example, to ensure that those operating and accessing services are not subjected to police harassment and arrest. A recent study found that a third of people who inject drugs had been confronted or had injecting equipment confiscated by police in the past six months.²

Story from the field

People who use drugs are organising in Kenya

People who use drugs are severely stigmatised and marginalised within Kenyan society. Opportunities for meaningful involvement in decision-making on HIV and/or drug policy and programmes are extremely limited. One of the objectives of the CAHR programme in Kenya has been to catalyse people who use drugs into organising and getting involved in policy and decision-making by facilitating the establishment of a national network of people who use drugs.

Through the CAHR programme, the International Network of People who Use Drugs (INPUD) ran a training workshop on the employment of people who use drugs within HIV prevention services. Following this workshop, the Kenyan Network of People who Use Drugs (KeNPUD) was formed in June 2012. The group's membership is diverse: mainly people who inject drugs, sex workers who use drugs, and men who use drugs from the community of men who have sex with men. KeNPUD represents communities most affected by HIV and a number of other health conditions, and as such it speaks for key stakeholders in public health, drug treatment, drug policy and human rights. KeNPUD was registered as a community-based organisation in Kenya in November 2012, and currently has 42 members. Their mission is to contribute to a society that does not discriminate against or stigmatise people who use drugs. KeNPUD wants their community to have open access to quality and comprehensive health care services, and to be considered equal partners in the development of drug policy and harm reduction services.

The CAHR programme has provided opportunities for KeNPUD to obtain technical support from the KANCO – CAHR's Kenyan implementing partner. The support focuses on proposal

development to engage in capacity-building on behaviour change communication, to participate in training workshops run by the International Drug Policy Consortium on policy and advocacy, and to obtain ongoing capacity-building support through INPUD.

Since its conception, KeNPUD has been consulted in a number of forums where the meaningful involvement of people who use drugs is critical. For instance, in December 2012 Kenya Red Cross convened a meeting where partners shared their experience of NSPs in the Kenyan context. KeNPUD played an instrumental role in discussions on what should constitute an NSP starter kit as part of the standard operating procedures. The group has recently met with NAS COP, Médecins du Monde, KANCO and the United Nations Office on Drugs and Crime in order to enlist support for a community conference of people who use drugs in November 2013 in Mombasa.

The positive and empowering effects of involving drug-using communities in the services and policies that affect them are already being experienced in the region. Recently, KeNPUD has joined the Eastern Africa Harm Reduction Network launched in March 2013, and has continued to provide leadership to other nascent networks of people who use drugs in the region. Together with INPUD, KeNPUD members visited Tanzania and supported the establishment of the Tanzania Network of People who Use Drugs (TaNPUD). KeNPUD and TaNPUD plan to visit Uganda to support efforts to organise the Ugandan community of people who use drugs later in 2013.

There is significant momentum around expanding harm reduction programmes in Kenya, and KeNPUD, with CAHR support, has been at the forefront of shaping programming for the most affected members of the community.

Country profile

Malaysia.

Malaysia is experiencing a concentrated HIV epidemic, with a low HIV rate of 0.4% among the general population and much higher prevalence among key populations at higher risk, such as sex workers, people who inject drugs and prisoners. Over the past few years, the Malaysian government has gradually shifted from a repressive, punitive approach based on law enforcement towards one that recognises public health evidence and human rights imperatives.

Injecting drug use is a major driving factor in Malaysia's HIV epidemic. In 2011, approximately 39% of all HIV cases were attributed to injecting drug use, and out of a total of 170,000 people who inject drugs in Malaysia, 55,891 are living with HIV.² An even higher proportion (over 67%) live with hepatitis C, and more than half are co-infected with both HIV and hepatitis C.² There is also an overlap between sex work and drug use, with nearly a third of sex workers in one national study reporting that they also inject drugs and share needles with their partners and peers.

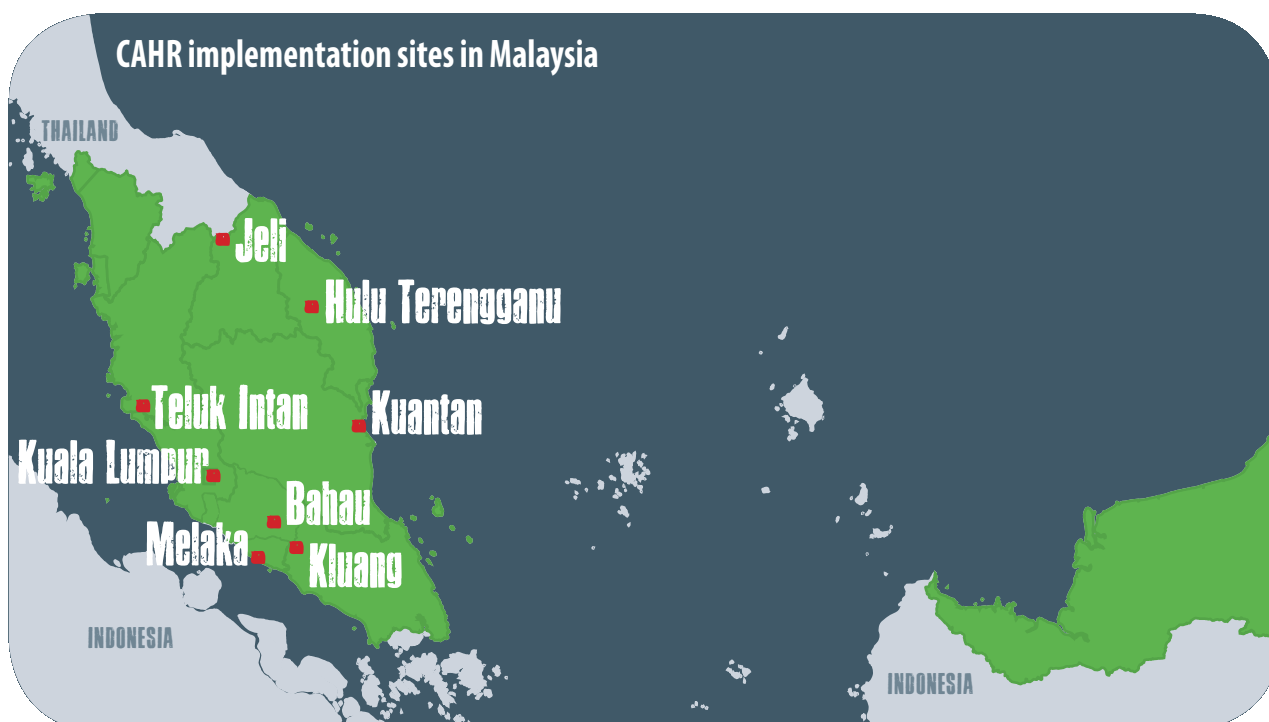
Since Malaysia introduced methadone maintenance therapy (MMT) and needle and syringe programmes (NSPs) in 2005 and 2006 respectively, its harm reduction programme has been significantly scaled up, and has been cited by the World Health Organisation as an example of best practice in Asia.⁶ The Malaysian National Strategy on HIV and AIDS 2011-2015 recognises the need to sustain and scale up existing programmes like MMT and NSPs, which are implemented by the government in partnership

EPIDEMIOLOGICAL AND PROGRAMMATIC PROFILE:

Harm reduction explicit in national policy documents	Yes
Number of people who inject drugs	170,000 ¹
HIV prevalence among people who inject drugs	8.7% ²
Hepatitis C prevalence among people who inject drugs	67.1% ³
Needle and syringe programmes (NSP)	297 ^{2, a}
Opioid substitution therapy (OST)	674 sites (buprenorphine, methadone) ^{2, b}
OST in prison	Yes (18 prisons)
NSP in prison	No

with NGOs, community-based organisations (CBOs) and private health practitioners. As part of the Community Action on Harm Reduction (CAHR) project, 2,369 people who inject drugs accessed harm reduction services in 2011, and new sites were opened in the northern states of Terengganu and Kelantan, and the southern states of Negeri Sembilan and Johor.

The latest estimates indicate that NSP coverage in Malaysia has improved from 117-130 sites in 2010 to 297 sites in 2012, reaching a total of 34,244 people who inject drugs.¹ Similarly, the number of opioid substitution therapy (OST) sites increased from 95 in 2010 to 674 in 2012, reaching 44,428 people who inject drugs. However, despite these positive improvements in availability and coverage, programmes remain difficult to access for some individuals in the community. Police harassment at harm reduction



sites continues to pose challenges to service accessibility, although the frequency of reported cases has decreased in recent years.

Importantly, Malaysia has quickly expanded OST coverage in closed settings such as prisons, starting with one prison in 2008 and expanding to 18 prisons by 2011.² In addition, the National Antidrug Agency has gradually moved away from supporting compulsory detention since 2010 by committing to convert drug detention centres known as Pusat Serenti or Puspens to “Cure and Care” voluntary treatment options. But despite this positive step forward, people who use drugs continue to be sent to compulsory drug detention centres, where detainees are held for six months without evidence-based drug dependence treatment. Those who relapse and are subsequently re-arrested for drug use, face lengthy prison terms and caning. This cycle of drug detention–relapse–imprisonment pushes people who use drugs to the margins, further preventing them from accessing existing prevention and treatment services for fear of detention and arrest.

Financing for harm reduction

Financing for harm reduction in Malaysia, specifically for MMT and NSP programmes, has largely been shouldered by the government. According to Malaysia’s AIDS progress report to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2012, the majority of domestic funding for HIV and AIDS in 2010 and 2011 was spent on care and treatment; mostly antiretroviral treatment procurement (52.6% in 2010 and 54.3% in 2011) followed by prevention programmes (25% in 2010 and 24.8% in 2011), of which more than half was spent on harm reduction programming.² Overall, international donors and the private sector supported 2% of the total HIV and AIDS expenditure in Malaysia in 2010 (USD\$31.9 million), and 8% in 2011 (USD\$39.9 million), but it is unclear what proportion of these funds directly supported HIV prevention and care services for people who inject drugs.²

The CAHR project works closely with the Malaysian AIDS Council, an umbrella, not-for-profit organisation that unites 48 NGOs, CBOs and professional associations, with an annual budget of approximately US\$4 million.

The Malaysian AIDS Council has received support from government ministries and international donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Open Society Foundations, the European Union and the International HIV/AIDS Alliance.

Up until the creation of the “MARPs Reserve” in Round 10 in 2010, Malaysia was ineligible for Global Fund grants due to its national income level. Through this Reserve, the Malaysian AIDS Council has now received a US\$6 million grant that focuses primarily on harm reduction services. The five-year programme started in 2011 and aims to increase coverage of NGO-led harm reduction services such as NSP, peer outreach, information, education and communication and legal support from 10% to 22% of the country’s injecting population. The grant is due for renewal and renegotiation in late 2013 to early 2014.

Drug policy environment

Malaysian drug policy stands in direct contrast to the important progress that the country has made in implementing and scaling up evidence-based harm reduction services, often undermining the efficiency of existing programmes. Malaysia’s national drug policy is based primarily on the Dangerous Drugs Act (1952), which criminalises drug possession for personal use, trafficking and production. Under this law, the possession of needles and syringes, especially if they have been used, can be employed as evidence for prosecuting people who use drugs in court.⁹

In 1983, the Malaysian government introduced the Drug Dependents Act, which promotes a zero tolerance approach to drug use, including a two-year mandatory treatment and rehabilitation in Puspens for those considered drug dependent. Malaysia’s response to drug use became increasingly punitive after 2000, once the country committed to achieving a drug-free society by 2015 as part of the Bangkok Political Declaration in Pursuit of a Drug Free ASEAN. Since then, police key performance indicators for drug arrests have continued to increase every year, and deaths in police custody have occurred on a frequent basis (approximately once a month), many among people who use drugs.

Legal and policy profile

The Malaysian government has enacted various regulations and policies that have implications for harm reduction. These are some of the key developments.

1983 The Malaysian government introduces the Drug Dependents Act, which promotes a policy of zero tolerance towards drug use, including two-year mandatory treatment and rehabilitation for anyone who is considered drug dependent. Primarily based on the Dangerous Drugs Act (1952), this law can enable the possession of needles and syringes, especially if they have been used, when they are to be employed as evidence in courts.

2008 Malaysia commits to achieving a drug-free society by 2015 by becoming a signatory of the Bangkok Political Declaration in Pursuit of a Drug Free ASEAN. This action results in an even more punitive approach.

2006 New measures focusing on expanding coverage of harm reduction interventions are set out in China’s State Council Notice on Further Strengthening the AIDS Response.

2011 The implementation and scale up of harm reduction interventions are carried forward in the National Strategy on HIV/AIDS 2011–2015. The strategy includes specific objectives to reduce by 50% the number of new HIV infections by scaling up evidence-based interventions targeted at key populations at higher risk, including people who inject drugs.

Malaysia also retains the death penalty for drug offences. Between January and August 2012, at least 44 people were sentenced to death, with at least 21 foreigners among them.¹² Although Malaysia continues to apply the death penalty for drug offences, as of October 2012

it was considering applying a moratorium on executions for those on death row for drug offences pending a review of the mandatory death penalty for drugs. Although the official moratorium has not yet been issued, no executions have been carried out since 2010.

Story from the field

Law enforcement and harm reduction accessibility in Malaysia

Malaysia has officially adopted harm reduction since 2006, and began the transition from compulsory treatment centres to voluntary outpatient treatment centres in 2011. Despite these positive developments, conflicts remain with police and law enforcement under the Dangerous Drugs Act (1952). In order to meet key performance indicators based on the numbers of arrests of people who use drugs, police continue to arrest people who use drugs, even when these hold official identification as clients of NSPs or MMT programmes.

The Malaysian AIDS Council, the CAHR partner in Malaysia, is an NGO with 48 partner organisations that works to improve sexual health education, promote evidence-based drug policy, and mitigate human rights violations faced by key populations at higher risk of HIV transmission. With CAHR support, the Malaysian AIDS Council has worked closely with the International Drug Policy Consortium and the Open Society Foundations to improve knowledge of harm reduction among low- to mid-level police officers, and with communities of people who use drugs around managing contact with law enforcement.

Beginning in 2011, the CAHR project team at the Malaysian AIDS Council met with police at district level to inform them about government-endorsed NSPs. A paralegal workshop was also held at the community level to address legal challenges faced by outreach workers, and to improve their knowledge of human rights and drug policies when in contact with police, religious authorities and other relevant bodies. Later that year, with support from the Open Society Foundations, three training sessions were held with rank-and-file police officers in Langkawi, north

peninsular Malaysia, Kuala Kubu Bahru in central Malaysia, and Muar in the southern region of the country. The training sessions covered basic information about HIV transmission, a description of harm reduction services in Malaysia, and a session on drug policy and decriminalisation models in Switzerland, Germany and Portugal.

They also emphasised how the police can support street crime reduction and health improvement among people who use drugs. Although police officers in the northern region have continued to display significant resistance to harm reduction, the other two sessions demonstrated that knowledge and acceptance of harm reduction was increasing. However, throughout the three sessions police officers reiterated that until their internal key performance indicators were amended, arrests of people who use drugs would not decline.

In October 2012, the CAHR project supported an event on police drug diversion with attendees from the Malaysian AIDS Council, the International Drug Policy Consortium, the Headquarters of the Royal Malaysian Police, and police officers from Dang Wangi, an area in Kuala Lumpur with high visibility of people who use drugs and high rates of drug-related arrests. The meeting centred around the police taking steps to divert people who use drugs to health and social services rather than prison or compulsory detention. Other attendees included members of parliament, private physicians and drug user representatives. The Malaysian AIDS Council aims to continue interacting with government stakeholders, and increasingly to target politicians with advocacy on policy change.

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