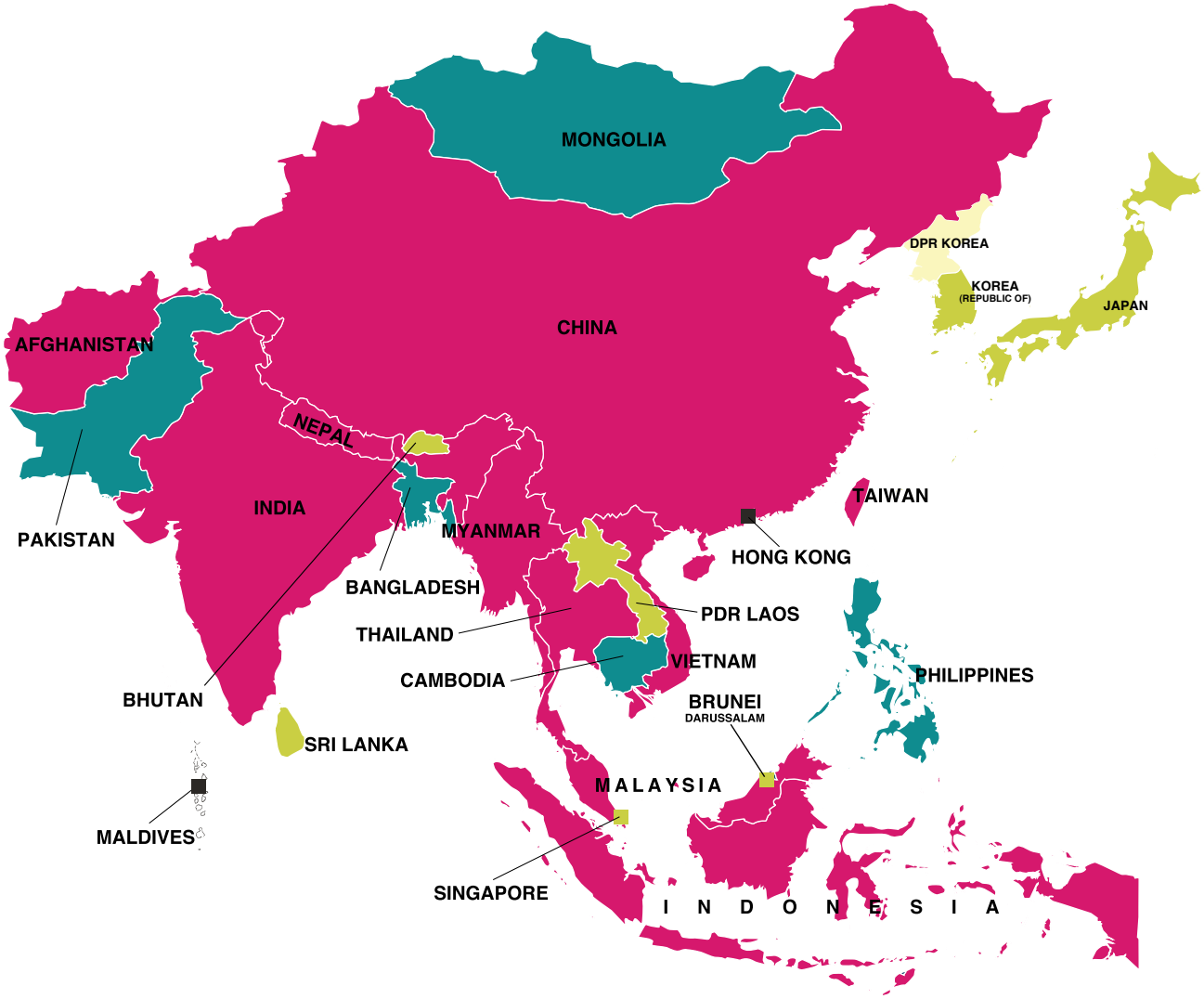
2.1 Regional Update: Asia



Map 2.1.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

Table 2.1.1: Harm reduction in Asia

Country/territory with reported injecting drug use[a]	People who inject drugs[1]	Adult HIV prevalence amongst people who inject drugs[1]	Harm reduction response[2]	
			NSP[b]	OST[c]
Afghanistan	6,900	3.4%	✓(18–28) (NP)	✓(1) (M)[3]
Bangladesh	30,000	1.35%	✓93 (P)	x
Bhutan	nk	nk	x	x
Brunei Darussalam	nk	nk	x	x
Cambodia	1,750	22.8%	✓(2)	x
China	2,350,000	12.3%	✓(897–901)	✓(600–675) (B,M)
Hong Kong	30,000 [4]	nk	x [5]	✓[1]
India	164,820	11.15%	✓(200–219)	✓(61–63) (B,O)
Indonesia	219,130	42.5%	✓(182–323)	✓(35–46) (B,M)
Japan	400,000	nk	x	x
Korea (Republic of)	nk	nk	x	x
PDR Laos	nk	nk	x	x
Malaysia	205,000	10.3%	✓(117–130) (P)	✓(≥95) (B,M)
Maldives	nk	nk	x	✓(1) (M)
Mongolia	nk	nk	✓(1)	x
Myanmar	75,000	42.6%	✓(18–24) (P)	✓(7) (M)
Nepal	29,500[6]	41.39%	✓(43)	✓(2) (B,M)
Pakistan	141,000[6]	21%[6]	✓(81)	x
Philippines	15,500[6]	0.4%[6]	✓(3)	x
Singapore	nk	nk	x	x
Sri Lanka	nk	nk	x	x [e]
Taiwan	nk	13.8%	✓(1,103) (P)	✓(90) (B,M)
Thailand	160,528[f]	42.5%	✓(10) (P)	✓(147) (B,M)
Vietnam	135,305	33.85%	✓(382–2,023) (P)	✓(6) (M)

nk = not known

a. There is no reported injecting drug use in the Democratic People's Republic of Korea.
b. The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets; (NP) = needles and syringes not available for purchase; where this is not referred to it is not known.
c. The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone; (B) = buprenorphine; (O) = any other form (including morphine, codeine).
d. Estimated figure: 2002 (UN Reference Group).
e. It is reported that there are no official programmes in Sri Lanka, but some psychiatrists and general practitioners are prescribing methadone as substitution therapy.
f. Estimated figure: 2001 (UN Reference Group).

Harm Reduction in Asia

The large and diverse Asian region is home to significant numbers of people who inject drugs. They represent at least one-quarter of the total number of people injecting drugs around the world. HIV epidemics in many Asian countries are driven by injecting drug use. At the regional level, it is estimated that 16% of people who inject drugs are living with HIV.[1] Several Asian countries have reported much higher national HIV prevalence rates amongst people who inject drugs – most notably Indonesia, Myanmar, Nepal, Thailand and Viet Nam, where between one-third and one-half of all people injecting drugs are likely to be living with HIV.[1] At a more local level, extremely high prevalence rates can be found within this region. For example, in Yunnan Province, China, HIV prevalence is reported to be 54% amongst people who inject drugs.[7] In addition, there are anecdotal reports of emerging HIV epidemics among people who inject drugs in Punjab in Pakistan[8] and in the Philippines.[9]

Significant developments in policy and practice in parts of Asia have signalled a shift towards harm reduction in recent years. Fifteen countries in the region now have some form of needle and syringe programme (NSP) and twelve prescribe opioid substitution therapy (OST) to some extent (see Table 2.1.1). Since 2008 the majority of countries in the region have increased the number of sites providing key harm reduction services, and new interventions have been established in Mongolia and the Philippines (NSPs) and the Maldives and Afghanistan (OST). However, across the region, coverage still remains far below the levels necessary to have an impact on HIV epidemics. Throughout Asia, there is a need for further monitoring and evaluation to demonstrate the effectiveness of programmes, to track progress towards national and global targets and to inform strong advocacy for harm reduction in the region.

The investment of funds into harm reduction in Asia is poor, with estimates suggesting that currently available funding for the region amounts to only 10% of actual need.[10] A lack of supportive legal and policy frameworks in many countries continues to impede harm reduction responses, with several states prohibiting possession and/or provision of needles and syringes, methadone and/or buprenorphine. Imprisonment or detention in compulsory centres for drug users remains the dominant response to drug use in many Asian countries. Over half the countries in the region retain the death penalty for drug offences, and in the past three years, eight countries carried out executions for drug offences.[g] [11]

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Of the twenty-four Asian countries where injecting drug use has been reported, fifteen have needle and syringe exchange services available to varying degrees (see Table 2.1.1). In Cambodia, Mongolia, the Philippines and Thailand, this is very small-scale provision. Programmes in Cambodia and Thailand are NGO-led and continue to face difficulties with police 'crackdowns' and threats of closure.

In much of Asia, the number of NSP sites has increased; for example, in Afghanistan (from 1 in 2008 to 18–28 in 2010), China (from 92 in early 2006 to 775 in 2007 and 897–901 in 2010) and Taiwan (from 427 in 2008 to 1,103 in 2010).[5] [12] Despite these increases, most countries with NSPs still have only one site (or less) per 1,000 people who inject drugs (exceptions to this being Afghanistan, Bangladesh, India, Indonesia, Nepal and Viet Nam).[2] Where data are available, estimates suggest that the percentage of people who inject drugs accessing NSPs in a year varies widely, from 0.2% in Thailand to over 90% reported in Bangladesh and Viet Nam. In India, over three-quarters of people who inject drugs are reported to be reached by NSPs.[2] Estimates suggest that NSP coverage reaches 'medium' levels in Viet Nam (189 needles per person per year) and Bangladesh (118 needles per person per year).[h] Most countries, however, have extremely low levels of distribution, including Indonesia, the Philippines, Thailand and Malaysia, where NSPs provide less than ten needles and syringes per person per year.[i] [2]

In nine Asian countries with reported injecting drug use there are no NSP sites operating.[j] Laws that are prohibitive of needle and syringe exchange are a barrier to effective service provision in several countries, including Bhutan, Bangladesh, Hong Kong, Japan, Malaysia, Myanmar, PDR Laos, the Philippines, Sri Lanka and Thailand.[13] Support for harm reduction measures remains an issue in many countries. For example, government delegates from Singapore and Sri Lanka expressed their lack of support for these measures at the 2009 Commission on Narcotic Drugs in Vienna.[14]

Opioid substitution therapy (OST)

Many Asian countries have also scaled up provision of OST since last reported in 2008.[5] For example, the number of sites providing OST has increased in China (from 503 to 600–675), India (from 35 to 61–63), Malaysia (from very small-scale provision to 95 sites) and Taiwan (from 63 to 90).[5] [2] In 2009 the Maldivian government established a pilot methadone project with support from the UNODC Regional Office for South Asia (ROSA).[15] In Thailand, where methadone provision has been integrated into the National Healthcare Scheme, further expansion of OST services is planned through the Global Fund Round 8.[16] Furthermore, agreements have been reached in Bangladesh, Cambodia and India to pilot OST with methadone, as well as in Pakistan with methadone and buprenorphine. However, programmes starting up face issues of service provider capacity, procurement and safe storage of supplies, as well as difficulties in forming effective partnerships with key stakeholders, before OST can begin to reach people who need it.[8]

Despite recent increases, coverage levels in the region are still insufficient to have an impact on HIV epidemics. It is estimated that the highest numbers of clients in OST (including both injecting and non-injecting drug users) are in China (94,973) and Taiwan (12,598).[2] Current measures of OST coverage are inexact, using people who inject drugs as a denominator, even though not all will be injecting opiates or in need of OST. However, the available data indicate that no more than five in every 100 people who inject drugs are currently receiving OST in Asia.[2]

g China, Democratic People's Republic of Korea, Indonesia, Malaysia, Pakistan, Thailand, Singapore and Viet Nam.

h However, the % IDUs accessing NSPs in a year for Viet Nam, India and Bangladesh ranged from 73%, 58% and 54% respectively to over 100%, which suggests that the mid-point estimates may be exaggerated.

i The WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises NSP coverage as follows: low (<100 needles/syringes per injector per year), medium (>100 to <200 needles/syringes per injector per year) and high (>200 needles/syringes per injector per year).

j Bhutan, Brunei Darussalam, Hong Kong, Japan, Korea (Republic of), PDR Laos, Maldives, Singapore and Sri Lanka.

Commonly cited reasons for drop-out and lack of retention in OST programmes across the region include the poor quality of services and fear of arrest by law enforcement agencies.[8]

In twelve countries in the region where injecting drug use has been reported, OST remains unavailable.[k] The legal availability of substitution therapies in Asia remains a serious obstacle to OST introduction and scale up.[13]

The expansion of harm reduction services has occurred against a backdrop of continued government over-reliance on detention in compulsory centres for drug users. Expansion of centres has continued without evidence to demonstrate their effectiveness. It is estimated that more than 350,000 people were detained in these centres in Asia in the past twelve months.[17] There are reported to be 1,043 such centres across the region,[l] the majority in China.[17] These centres vary in their approach, but tend to be characterised by arbitrary detention without due process of law and some form of forced 'treatment', which is often detoxification focused. In many cases, detainees are also subjected to forced labour. Reports from numerous countries document a range of human rights concerns related to inadequate health care in compulsory centres for drug users.[18 19] For example, lack of access to anti-retroviral treatment (ART) for detainees has been reported in centres in China, Malaysia, Cambodia and Viet Nam. Forced or involuntary testing for HIV of persons in centres has been reported in China, Malaysia and Viet Nam. In some countries, entry into OST programmes is dependent on having spent a number of months in such a facility. Of even greater concern are the reports of torture, physical and sexual violence and other forms of cruel punishment within these centres.[18] Indeed, several key regional stakeholders have taken up the issue of drug treatment as a priority based on: the need for more evidence, increased HIV transmission risks, limited access to comprehensive services, human rights violations and high relapse rates. UNODC's TreatNet II was recently initiated to develop evidence-based models and build capacity in Cambodia, China, Laos, Malaysia, Myanmar, Thailand and Viet Nam.[20]

Antiretroviral therapy (ART)

New estimates gathered by the Reference Group to the UN on HIV and Injecting Drug Use indicate that only a small proportion of people living with HIV who inject drugs are receiving ART in Asia. Data were only available for eight Asian countries, and within these the numbers of people receiving ART ranged from five people in Bangladesh to 9,300 people in China. In Indonesia, the country with the highest coverage, only six in every 100 people who injected drugs living with HIV were receiving ART.[2]

Policy developments for harm reduction

Harm reduction forms a key component of HIV policies and strategic plans in Asia. In early 2009 IHRA reported that fourteen Asian countries included harm reduction in their national HIV and/or drug policies.[l 21] Since then, strategy and policy documents in the Philippines and Thailand have been developed that also include harm reduction.[13] Eighteen countries now have HIV policies and strategic plans that identify people who inject drugs as a target population for their HIV responses.[m 13] However, UNGASS reports have revealed that almost two-thirds of countries in the Asia-Pacific region still have laws, regulations or policies that are obstacles for effective HIV prevention, treatment, care and support for people who inject drugs.[13] In some countries, HIV policy or strategy documents directly conflict with national laws. For example, in PDR Laos, where needle and syringe exchange remains prohibited by law, the HIV strategy states that the national aim is for 70% of people who inject drugs to be using sterile injecting equipment by the end of 2010.[13] In Indonesia, despite strong efforts to scale up harm reduction, tensions between the aims of the national HIV office and the drug control agency have resulted in a review of drug laws towards a more repressive stance, in conflict with the scale-up of harm reduction services.[22]

Conversely, efforts have begun in some Asian countries to investigate improvements to policing strategies in order to increase access to harm reduction services and mitigate unintended health consequences for people who use drugs. The Royal Malaysian Police organised a national seminar in late 2009 to investigate mechanisms to change existing policing practice and to support harm reduction services and remove barriers to access. In February 2010, the Nossal Institute hosted a round-table meeting entitled 'Law Enforcement and Harm Reduction: Effective Partnerships' which aimed to facilitate discussion on these issues between key stakeholders in South-East Asia.[23] Similar discussions have been unofficially held in Thailand and Viet Nam as well as in a few local areas across China. Furthermore, in Thailand and Viet Nam, government requests have been lodged with key agencies to share international experiences of the decriminalisation of drug use.[8]

Civil society and advocacy developments for harm reduction

Harm reduction advocates continue to sensitise and inform parliamentarians in Asia on the need for harm reduction policies and enabling legislation. Response Beyond Borders has played a central role in this effort, not least through the organising of key events such as the second Asian consultation on the prevention of HIV related to drug use held in Bangkok in January 2010. Significantly, at this event, discussions within the Asian Forum of Parliamentarians on Population and Development (AFPPD) culminated in an agreement among members of parliament to form a standing committee to further advocate for harm reduction within the region.[24]

k Bangladesh, Bhutan, Brunei Darussalam, Cambodia, Japan, Korea (Republic of), PDR Laos, Mongolia, Pakistan, Philippines, Sri Lanka and Singapore.

l Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, PDR Laos, Malaysia, Myanmar, Nepal, Pakistan, Taiwan and Viet Nam.

m Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, PDR Laos, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Taiwan and Viet Nam.

Response Beyond Borders also played a part in generating momentum for the formation and establishment of the Asian Network of People Who Use Drugs (ANPUD). With support from the World AIDS Campaign (WAC), the Australian Injecting and Illicit Drug Users' League (AIVL), the UN Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, UNAIDS and WHO, ANPUD has now finalised its organisational constitution and is proceeding with official registration while governance structures are being formalised.[25] ANPUD has been established with the ultimate objective to further empower people who use drugs across Asia towards more effective engagement in decision-making processes that affect them.

Great concern has been raised in Cambodia with regard to the introduction of '*bong sen*' – a herbal formula manufactured by a Vietnamese company that is purported to 'cure' drug dependence, although there is currently no evidence to suggest so and the formula remains unapproved by the national ministries of health. A drug trial took place in which local non-governmental organisations (NGOs) were coerced into providing clients, which attracted the attention of human rights agencies and raised critical ethical questions regarding the process.[26] At the same time, local NGOs in Cambodia are under pressure and face potential service closures for voicing concerns and delivering essential health and social care services to people who use drugs.[27]

The Asian Harm Reduction Network (AHRN) has recently announced important changes to its organisational and governance structures, separating its networking and advocacy activities from its technical and implementation work and strengthening these streams of work.[28]

The Harm Reduction 2009 Conference held in Bangkok (April 2009) and the Ninth International Congress on AIDS in Asia and the Pacific (ICAAP) held in Bali (August 2009) were key events for harm reduction in Asia. At the national level, Thailand's civil society groups joined together to form a loose advocacy coalition called 12D, which was instrumental in the preparations for Harm Reduction 2009. Similarly, civil society groups mobilised around ICAAP. These events included a significant focus on decriminalisation, both in terms of drug use and harm reduction, as well as in the context of vulnerable populations and HIV transmission.[29] Decriminalisation of drug use is also an increasingly visible feature of advocacy by Indian civil society, following on from the decriminalisation of same-sex intercourse in Delhi.[30]

As in 2008, government-imposed restrictions on NGO functioning continue to limit civil society responses in several Asian countries.[31] Funding for civil society organisations involved in much-needed harm reduction advocacy within the region remains scarce, which poses difficulties for coordinated and sustained campaigning. In preparation of this report, for example, key stakeholders interviewed reflected on the lack of coordination, even tensions, within Indonesia's civil society response to drugs. Likewise, Nepal's vibrant civil society developments[n] have come at the cost of a lack of unity and much debate among local groups over the best avenue for progress.

Multilaterals and donors: Developments for harm reduction

Despite the international economic crisis, existing donor commitments to harm reduction in the region have so far been maintained. However, a general shift to programme- over project-based funding is restricting the access of many NGOs to much-needed funds. Global Fund support for harm reduction in Asia is increasing markedly to fill in the identified resource gap,[32] and there are expectations that the change in US policy towards NSP and OST will soon contribute to the harm reduction response in Asia. Governments in China, India, Malaysia and Taiwan have recently begun to invest in sustainable harm reduction service delivery within their own borders.

The Australian government's overseas aid programme's (AusAID) HIV/AIDS Asia Regional Program (HAARP), in particular, represents a large foreign investment in development of harm reduction over eight years (2007–2015) in Cambodia, China, Laos, Myanmar, Philippines and Viet Nam. Over the past few years, HAARP has contributed to harm reduction awareness among law enforcement agencies as well as community and local government agencies through multisectoral country programmes. Since its inception, HAARP has been able to establish needle and syringe exchange programmes in forty-two sites and reached over 10,000 men and women who inject drugs, along with a few thousand non-injecting drug users and their partners, with HIV prevention services, educational messages, primary health care and referrals in 2009.[8]

In December 2009 WHO, UNAIDS and UNODC consulted with key stakeholders on the Regional Strategy for Harm Reduction in Asia and the Pacific for the period 2010 to 2015, developed under the auspices of the UN Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, scheduled to be released in 2010.[33] Highlighted within the strategy are the need for increased coverage of NSP, OST and ART for people who use drugs, as well the importance of responding to challenges such as increasing HIV/hepatitis C co-infection and harms associated with methamphetamine use in the region.

UNAIDS is increasing its focus on addressing drug use in Asia, as directed by the recommendations from the Programme Coordinating Board (PCB),[34] and UNESCO's regional HIV strategy will concentrate on most-at-risk populations.[8] Also in 2009, the Association of South East Asian Nations (ASEAN) established an Intergovernmental Commission on Human Rights.[35]

The UN Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific[o] has provided an important forum for regional-level advocacy and discussion over the past two years. The Task Force has also delivered a number of important resources for the harm reduction response in the region. These include resource needs estimates for scaling up harm reduction in Asia,[10] advocacy briefs on injecting drug use and HIV and an assessment of policies, resources and services in fifteen countries.[36]

n Hundreds of active and recovering users have a strong desire to participate in decisions that affect their lives and are organising around NGOs and community projects to influence funding flows, policy design and service delivery.

o The Task Force is made up of twenty-nine members from government, civil society, technical advisors, donor partners and the UN agencies.

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