Regional Overview

2.1 Asia

ASIA

Table 2.1.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Asia

Country/territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response	
					NSP[a]	OST[b]
Afghanistan	40,900[1] (13,500–80,000)	4.4[2]	31.2[2]	6.6[2]	✓18[3]	✓1[3]
Bangladesh	21,800–23,800[4][c]	1.1 (5.3 in Dhaka[5])	39.6[6]	9.4[7]	✓88[6]	✓3[6] (M)
Bhutan	nk	nk	nk	nk	✗	✗
Brunei Darussalam	nk	nk	nk	nk	✗	✗
Cambodia	1,300 (1,200–2,800)[8]	24.8[8]	nk	nk	✓5[9]	✓1[9]
China	2,580,000[10][d]	6[11]	67 (60.9–73.1)[7]	9.6 (3.8–15.4)[7]	✓814[11]	✓767[11] (B, M)
Hong Kong	nk	nk	nk	nk	✗	✓20[12]
India	1,700,000[13]	9.9[13]	41[7][e]	10.2 (2.7–17.8)[7]	✓277[14]	✓145[15] (M, B, 0)
Indonesia	74,326 (61,901–88,320)[16][f]	36.4[17]	63.5[18][g]	2.9[7]	✓194[17]	✓87[19] (B, M)
Japan	nk	nk	64.8 (55–74.5)[7]	3.2 (2–4.3)[7]	✗	✗
Korea (Republic of)	nk	nk	54[7]	4[7]	✗	✗
Lao PDR	1,317[20]	0.1[21]	nk	nk	✓4[22]	✗
Macau	238[23]	1.3[24]	80.4[25]	10.7[25]	✓4[25] (P)	✓4[25] (B, M)
Malaysia	170,000[26]	16.3[26]	67.1[7]	nk	✓662[26]	✓838[26] (B, M)
Maldives	793 (690–896)[27]	0[28]	0.7[29]	0.8[29]	✗	✓1[30] (M)
Mongolia	570	nk	nk	nk	✓1[31]	
Myanmar	83,000[32]	23.1[32]	79.2[7]	9.1[7]	✓40[33] (P)	✓35[32] (B, M)
Nepal	52,174[34]	6.3[35]	87.3 (80.5–94)[7]	5.8 (5.5–6)[7]	✓60[36]	✓15[36] (B, M)
Pakistan	104,804[37]	37.8[38]	93[38]	6.8 (6–7.5)[7]	✓34[39]	✗(B)[38]
Philippines	20,000 (17,000–23,000)[40]	41.6[41]	70[7]	nk	✓[h]	✗
Singapore	nk	2[42]	42.5[7]	8.5[7]	✗	✗
Sri Lanka	nk	nk	nk	nk	✗	✗
Taiwan	60,000[43][i]	17.7[43]	41[7]	16.7[7]	✓1,254[44]	✓162[44] (B, M)
Thailand	71,000[40, 45]	21[40]	89.8[7]	nk	✓14[46]	✓147[j] (M)
Vietnam	271,000 (100,000–335,000)[47]	40[47]	74.1[7][k]	19.5[7]	✓297(P)	✓145[48] (M)

nk = not known

[a] All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.
[b] Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
[c] Data from 2009, and only for men who inject drugs.
[d] Figure indicates the number of registered people who use drugs who have been recorded by the police. There are an estimated 10 million people who use drugs thought to exist in China.
[e] HCV prevalence rates vary greatly, from 90% in Manipur to 1% in Bihar; no national figure is available.
[f] The Indonesian Ministry of Health is working on new population size estimates which have yet to be released at the time of writing.
[g] Based on sub-national data from three cities: Tangerang, Denpasar, Makassar.
[h] Needles and syringes are distributed regularly to people who inject drugs but only at a health facility, thus limiting coverage.
[i] Based on longitudinal data from two prison cohorts.
[j] Civil society and experts in the region suggest that this estimate is too high and may not represent the actual level of OST provision in Thailand. It may include clinics that require periodic detoxification and re-enrolment.
[k] Figure from 2003.

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

Harm reduction in Asia

Overview

Asia is the region with the second highest number of people living with HIV in the world (approximately 5.1 million). living with HIV in the world.[49] Of the estimated 300,000 new HIV infections in the region in 2015, 96% were in just nine countries: China, India, Indonesia, Malaysia, Myanmar, Pakistan, Philippines, Thailand and Vietnam; and were concentrated within three key population groups: people who inject drugs, men who have sex with men (MSM) and (male, female and transgender) sex workers.[49] According to a 2011 report, between 12 and 21 million people use opiates across Asia, representing half of the total global population of opiate users.[50] An estimated four million people inject drugs, the highest concentration in any region.[40] A disproportionate number of new HIV infections in Asia are found among the population of people who inject drugs.[49] Table 2.1.1 also illustrates very high levels of hepatitis C prevalence among this population. These figures clearly demonstrate the vital need for increased harm reduction service provision in Asia.

Since *The Global State of Harm Reduction 2014*, revised population estimates for people who inject drugs have been proposed and approved in India (ten times the size of previous estimates), Afghanistan (double previous estimates), Myanmar (approximately 10% more) and Thailand (approximately 65% more). A situational analysis of drug use in Mongolia, which was conducted in 2015 as a precursor to the implementation of a rapid assessment and response programme, revealed up to 2,300 people who use drugs, and 570 people who inject drugs, mostly concentrated in the capital city of Ulaanbaatar.[51] While such revised estimates may lend support to the perception that the number of people who use and inject drugs is increasing, sometimes new figures can be the result of differences in the research methodologies used.

In 2015, based on *Global State 2014*, it was reported that the average HIV prevalence among people who inject drugs in Asia was 15.4%.[52] New data (see Table 2.1.1) suggest that this figure has risen to 17%, with increases in prevalence reported in Myanmar, Pakistan and Vietnam. Overlaps between people who inject drugs and other key population groups, including sex workers and MSM, have also been reported in several countries in the region, and require increased attention in the form of data gathering and integrated service delivery.[40, 53] Four Asian countries have been prioritised by UN agencies and other development partners due to the continued rapid expansion of their national HIV epidemics: Bangladesh, Indonesia, Philippines and Sri Lanka.[54] Meanwhile, several countries in the region continue to produce evidence that supports the effectiveness and cost-effectiveness of harm reduction interventions in the context of HIV and HCV transmission.[55–57]

Although the need for harm reduction is increasingly accepted across the region, a largely punitive policy and legal environment continues to undermine access to life-saving harm reduction programmes. Eleven countries in the region still operate compulsory detention centres,[54] incarcerating over 455,000 people who use drugs in 2014.[40] Although UN agencies and member states increasingly advocate an end to the death penalty for drug offences,[58] some Asian states continue to execute people in high numbers, in violation of international law and contrary to the global trend towards death penalty abolition. China, Singapore, Malaysia, Indonesia and Vietnam are all considered 'high application states', prescribing the death penalty for drugs as common practice.[59] While the Philippines abolished the death penalty for all crimes in 2006, President Rodrigo Duterte promised to restore capital punishment following his election in 2016 and has instigated thousands of extrajudicial killings of alleged drug suspects by police and armed vigilante groups.[60, 61]

Amphetamine-type stimulants remain the dominant drugs of choice in Asia, with between 3.5 and 20.9 million people using amphetamines.[50] HIV incidence rates are notably high among this group,[6] yet tailored harm reduction and HIV prevention services for people who use amphetamines are lacking within the region.

Compulsory drug detention and rehabilitation centres in Southeast Asia

Detention and coercive treatment of people who use drugs remain the dominant approaches in 11 countries in the region,[54] including Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Vietnam.[62, 63] UN agencies released a statement in 2012 calling for the closure of compulsory drug detention and

rehabilitation centres.[64] They also hosted formal regional inter-governmental consultations involving policy-makers from Asia, international experts and multilateral agencies in 2010, 2012 and 2015 to encourage governments to accelerate the transition towards voluntary community-based treatment and support services.

The Third Regional Consultation on compulsory centres for drug users (CCDUs) was held in September 2015 in Manila, the Philippines. It generated a commitment to transition away from compulsory models and towards evidence-informed and community-based approaches to address drug dependence. An expert paper produced by leaders from the region outlines key elements and principles that are important for a successful transition to voluntary community-based treatment and support services. It also proposes a model for initiating an effective transition at national level, and highlights recent examples of good practice from Cambodia, China, Indonesia, Malaysia and Thailand.[62]

Harm Reduction International also documented six models in developing community-based alternatives to CCDUs from Cambodia, China, India, Indonesia, Malaysia and Vietnam. While these programmes naturally differ within and across countries, several common elements have been identified as critical to effective community-based services that meet the needs of people who use drugs.[65]

The Malaysian government initiated the conversion of compulsory detention centres into Cure and Care (CNC) centres in 2010. These centres offer voluntary access to a comprehensive package of health and support services for people who use drugs, which has been identified as a good practice model.[62] In recent evaluations of CNC centres, clients expressed satisfaction with treatment outcomes and identified diminished withdrawal symptoms and fewer cravings for drugs as important personal successes.[66] Analyses of participant interviews identified four CNC services that contributed the most to these positive results: methadone treatment, psychological counselling, religious instruction and recreation. The open environment, with strong and trusting relationships among peers and staff, contributed to improved programme adherence. Participants felt that their access to healthcare greatly benefited their overall health. Another study, comparing CNC centres and CCDUs in Malaysia, found that 50% of clients coming out of CCDUs relapsed within 32 days of release compared with 429 days for those attending CNC centres.[66]

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

A total of 17 countries implement NSPs across Asia, a figure that has remained stable since the publication of the *Global State 2012*. Service-delivery modalities remain varied across the region, but implementation is concentrated largely in the civil society sector. As reported in 2012[29] and 2014,[67] no NSP sites are operating in Bhutan, Brunei-Darussalam, Hong Kong, Japan, Republic of Korea, Maldives, Singapore or Sri Lanka.

Few countries have reported changes in the scale of NSP service delivery. However, important reductions have occurred since the *Global State 2014* in Afghanistan (from 31 to 18 sites), in India (from 295 to 277 sites) and in Thailand (from 38 to 14 sites). In Thailand, the dramatic decrease was precipitated by the sudden termination of the partnership with local pharmacists due to reduced funding.[68] Only Taiwan has recorded an increased number of NSP service-delivery sites, from 1,103 to 1,254.

Reports show that Bhutan may implement NSPs in the coming years through Global Fund support.[69] However, many countries in the region report dwindling support for harm reduction – both financially and politically – in the wake of the Global Fund's new funding model allocation. The decrease in NSP sites in the countries highlighted above is a direct consequence.

The temporary closure of an NSP has been reported at a methadone maintenance clinic in Cambodia, due to stigma and discrimination aimed at personnel running the service.[70] NSPs in Bangladesh, Indonesia and Lao PDR have also been impacted by reduced donor support, though the scale of the reduction of these services has yet to be officially reported.

Table 2.1.2: Overview of needle distribution per person who injects drugs per year[40]

Country	Needles distributed per person who injects drugs per year
Afghanistan	159
China	204
India	240
Indonesia	44
Malaysia	61
Myanmar	168
Pakistan	178
Philippines	0*
Thailand	14
Vietnam	62**

* Data from the Philippines show that among the 11,042 clients reached, an average coverage of 16 needles and syringes per client per month was achieved over a five-month period before the service was closed.
** NSP coverage in Vietnam has fallen from 180 in 2012,[29] to 98 in 2014,[67] to 62 in 2016.

A pilot peer-operated NSP was initiated in 2014 in Cebu, the Philippines, despite legal provisions making possession of needles and syringes a criminal offence. A temporary exemption negotiated with the Dangerous Drugs Board allowed the NSP to operate as a scientific study to assess effectiveness of such interventions among people who inject drugs.[71] Although the project ended in December 2015, arrangements are in place to sustain this programme with Global Fund support. However, needle and syringe distribution remains on hold as local stakeholders evaluate the unfolding political turmoil around the extrajudicial killings of people alleged to be in the drug trade, as encouraged by President Duterte.

In Vietnam, the introduction of low-dead-space syringes was piloted with success in three provinces. An assessment of the pilot determined that exposure to social marketing approaches led to increased sales of commodities as well as increases in reported use and consistent use of such commodities.[72] Securing sustainable funding for this intervention has been an important challenge; at the time of writing, the project will run until the end of 2016 with support from the private sector.

Opioid substitution therapy (OST)

Fifteen countries in the region provide OST to people who use opioids. The number of sites has remained relatively stable since the *Global State 2014*, with increases documented in Malaysia (from 811 to 838 sites), Taiwan (from 90 to 162 sites) and Vietnam (from 80 to 145 sites). In Vietnam, government representatives stated in June 2015 that methadone was being dispensed to over 27,278 people in 43 provinces and cities.[73] While this increase is welcome, OST service coverage in the country is still considered extremely low, meeting only 15% of need.[74] In Indonesia, OST sites providing methadone have increased marginally, from 85 sites in 2014[67] to 87 in 2015.[19] Although there has been an increase in provision, levels remain low according to UN guidelines.[75]

Official documents indicate that plans are being developed to initiate OST for people who inject drugs in Pakistan, with buprenorphine availability before 2020.[76] In Bhutan, a pilot OST programme was planned for 2015 with financial support from the Global Fund, but it has not yet begun.[69] According to the UNODC Country Office in Afghanistan, plans are in place to scale up OST provision to 320 sites within the community (in Kabul, Herat, Balkh, Nangarhar, Badakhshan, Kunuz,

Ghazni and Kandahar) and 180 sites in prisons over the course of 2016.[77] As of 2016, OST continues to remain unavailable in nine countries across the region.

Since the Chinese government first supported the piloting of eight OST clinics in five provinces in 2004,[7] the harm reduction programme in the country has expanded dramatically. There are currently 767 OST sites operating in 28 provinces, with 184,000 people receiving methadone maintenance therapy when UNAIDS last reported in 2015.[78] Between 2009 and 2013 in Yunnan, 63 new OST sites were established, with coverage reported to be 22.6%, equating to mid-level coverage according to UN targets.[75][i] Although harm reduction service providers illustrate promising results, it is important to note that NGOs delivering services operate in a difficult policy environment. China continues to support severe, punitive policies on drugs, with estimates of at least 600 people being executed for drug-related offences in 2014.[59]

In Thailand, detoxification and long-term maintenance with methadone has been provided for free since 2014, as it is included in the universal health insurance scheme as well as in the social security scheme.[79] Methadone treatment is currently available only in district-/province-level hospitals and at a few remote drug treatment centres, reaching no more than 10% of all people who require methadone in the country.[79] In order to increase access, O-zone, a Thai NGO aiming to improve the quality of life for people who use and inject drugs in Thailand, has been implementing a peer-led, community-based methadone delivery service in the mountain village of Santikhiri in Chiang Rai province, where peer outreach workers operate methadone delivery at a drop-in centre with supervision from Mae Chan Hospital.[79] Initiated in 2013, the initiative attracted media attention and support from government agencies and has been replicated in Huay Pung in Chiang Rai province.

Provision of vital harm reduction services is often hindered by legal and policy barriers that restrict or prohibit implementation and scale-up, and the limited financial commitment of governments and donors means there is still much work to be done to ensure an enabling environment.

Amphetamine-type stimulants (ATS)

It has been estimated that between 13.9 million and 54.8 million people use amphetamines worldwide,[80] with more than 60% of global ATS use thought to be concentrated in Southeast Asia.[81] The ATS market continues to expand, particularly in Southeast Asia, China and Australia.[82] For example, 74% of people who use drugs in one treatment centre in Cambodia were receiving treatment for crystal methamphetamine use,[83] and 58% of people in a treatment centre in Lao PDR were receiving treatment for methamphetamine use.[84]

A 2011 study conducted in three major urban areas in Malaysia found a rapid increase of ATS use in not-in-treatment opiate injectors after 1997, which was associated with an increased risk of HIV infection.[85] However, project data from Thailand indicate that patterns of drug use in Bangkok are changing, with approximately 50% of clients in the central region injecting ATS and pharmaceuticals in 2014, compared with 70% who were injecting heroin in 2009 in the same region.[86] Anecdotal evidence from Japan also suggests that up to 50% of ATS users may be injecting.[87]
In a 2016 study among 103 women who use drugs in Malaysia, ATS were the most commonly used drugs (45.6%).[88]

Very few interventions address ATS use in the region. The civil society organisation Health and Harm Reduction Tokyo has a 24/7 hotline in place to provide information to people who use and inject ATS drugs.[87] The Asia Pacific Coalition on Male Sexual Health (APCOM) is developing information, education and communication materials on chemsex for MSM in Thailand. It is worth noting that in the past two years an increasing number of harm reduction civil society organisations across the region have been calling for expanded HIV prevention interventions along with other harm reduction measures tailored to meet the needs of people who use but do not yet inject drugs. In light of the increasing trend of ATS use, Harm Reduction International produced an updated report in 2015 noting the ways in which harm reduction programmes can respond effectively to the harms associated with amphetamine use.[89]

Viral hepatitis

Asia is disproportionately affected by viral hepatitis: 67% of the world's people living with hepatitis C (HCV) are found in this region.[90] Viral hepatitis has caused more than one million deaths in Asia, approximately 20% of which are related to chronic HCV.[91] HCV prevalence rates among people who inject drugs are over 80% in Nepal, Thailand and Pakistan; above 70% in Myanmar and Vietnam; and over 60% in Indonesia, China, Japan and Malaysia.[7] Where treatment is said to be available, it is often inaccessible for people who inject drugs.

[i] According to the 2012 revised WHO, UNODC and UNAIDS target-setting guide, less than 100 syringes distributed per person who injects drugs per year is considered low coverage (100 to 200 is medium coverage and more than 200 is high coverage).

Significant advances have been made in improving the efficacy of HCV treatment over the last few years. The introduction of direct-acting antiviral (DAA) based treatment regimens has shortened treatment times, reduced side effects and greatly increased the likelihood of virus elimination. The extremely high prices set by pharmaceutical company Gilead meant that such treatments remained out of reach of the majority of people who use drugs. However, a combination of factors have favoured generic production and a consequent drop in prices for DAAs in many countries in Asia. Specifically, Gilead issued voluntary licences to 11 Indian generic producers, allowing them to produce and market generic sofosbuvir with a 7% royalty payment to Gilead.[92] These licences allow the export of generic sofosbuvir to 101 predefined countries, including Afghanistan, Bangladesh, Bhutan, Cambodia, Indonesia, India, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Sri Lanka, and Vietnam.[93] Generic sofosbuvir can be made available in the countries listed at a cost of approximately US$300 per month.[94] The licences exclude many large middle-income countries that are home to a significant proportion of people living with HCV in the region, including China and Thailand.[92]

While the availability of DAAs remains limited to some countries, generic companies are working to complete regulatory requirements for registration of the medicines prior to future marketing distribution.[95] The Thai government approved Gilead's application to register sofosbuvir in Thailand in August 2015, but the Chinese government rejected one of Gilead's patent requests for sofosbuvir in June 2015.[96] Malaysia plans to make treatment available to more than 1,000 people who inject drugs living with HCV in 2016, and more than 15,000 people by 2025.[97] In Manipur, India, the Community Network for Empowerment (CoNE), a local civil society network led by and delivering services to people who use drugs, established hepatitis B and C testing camps across nine districts over one month. The testing camps targeted people who use drugs and people living with HIV. This initiative won the innovative hepatitis testing contest initiated by the WHO at an award ceremony and symposium about hepatitis testing on 17 April 2015 during the International Liver Congress in Barcelona, Spain.[98] In Indonesia, PKNI (Persaudaraan Korban Napza Indonesia) is conducting a peer-driven study among 500 people who inject drugs to educate the community on HCV treatment access and literacy while assessing barriers to treatment uptake.[99]

Tuberculosis (TB)

Southeast Asia accounts for 38% of the global TB burden, with Bangladesh, India, Indonesia, Myanmar and Thailand among the highest TB-burden countries in the world.[100] Data on TB for people who inject drugs are sparse; however, individual studies indicate that there is a higher prevalence of TB among this population.[101, 102]

Although all eleven Member States of the United Nations within Southeast Asia have national TB control programmes, and TB mortality has decreased in the region by more than 50% since 1990,[100] the continuing high rates in some countries must be more robustly addressed. TB and HIV control programmes are improving,[100] but joined-up programmes need to be strengthened in countries with a high TB burden. In Bangladesh, for example, national TB/HIV operational guidelines were developed in 2009, and a national TB/HIV committee has been put in place, yet, despite these policy improvements, limited numbers of NGOs provide HIV counselling, prevention and care for TB/HIV co-infected individuals.[100]

The primary barriers to TB testing and treatment for people who inject drugs in Asia are a lack of integration into harm reduction programmes, stigma and discrimination against people who use drugs by service providers, a lack of awareness among criminal justice and healthcare providers, and limited testing and treatment opportunities at NSP and OST sites.[46, 97] Given the dearth of data on people who inject/use drugs and TB prevalence, it is clear that further research should be undertaken, and that greater integration of TB services into existing harm reduction initiatives is required.

Antiretroviral therapy (ART)

The Asia and Pacific region has the second highest number of people living with HIV in the world, estimated to be 5.1 million in 2015.[49] China, India, Indonesia, Malaysia, Myanmar, Pakistan, Philippines, Thailand and Vietnam account for around 96% of the 300,000 new infections each year.[49] Although reports indicate a 5% decline in new HIV infection rates between 2010 and 2015, testing rates remain suboptimal in many countries, with evidence suggesting that 1.9 million people living with HIV in Asia and the Pacific in 2015 did not know their status.[49]

While it is a fact that HIV in the region is concentrated among key populations, rates of HIV testing are extremely low among people who inject drugs. For example, fewer than one in three people who inject drugs in the region had tested for HIV in a 12-month period and knew their results.[49]

UNAIDS reported in 2013 that of the total number of people living with HIV in Asia who are eligible for ART, only 18% accessed treatment.[103] ART coverage among people who inject drugs continues to remain low: just 5% in Malaysia,[104] only 2% in Thailand,[105] 6% in Indonesia[106][m] and 4% in Vietnam.[106] There are very few ART sites in Afghanistan, and where they do exist, a lack of follow-up and a weak referral system hinder their success.[77] Similar to TB testing and treatment uptake, many barriers – including a lack of integration into harm reduction programmes such as NSPs and OST sites, fear of arrest and stigma and discrimination against people who use drugs by service providers – serve to further deter people who inject drugs into seeking either testing or treatment for HIV.[46, 77, 97]

Harm reduction in prisons

Over 3.89 million people are incarcerated in Asia,[107] and an additional 635,000 are being held in compulsory drug detention centres.[63] A large proportion of those in prison – for example, 20% in Japan,[108] 31% in Indonesia,[109] 50% in the Philippines[110] and 72% in Thailand[111] – are being held on drug-related charges. Across much of the region, incarceration rates have been on the rise since 2000, leading to overcrowding in many facilities. The increase has in large part been the result of repressive drug laws and policies implemented in pursuit of a 'drug free' Association of Southeast Asian Nations (ASEAN) by 2020.[112]

Injecting drug use continues to be common in the region's prisons. A recent study in Indonesia, for example, found that more than half of a sample of 100 prisoners had injected drugs while incarcerated.[113] Pakistan's national anti-narcotics policy acknowledges that up to 40% of the prison population may be using drugs.[76] In the Maldives, more than two-thirds of incarcerated people who inject drugs have used drugs in prison, and almost one-third have injected while in prison.[114]

Data on HIV, HCV and TB prevalence in prison settings in Asia continue to be very scarce. In Malaysia, it has been reported that approximately 4.8% of sentenced prisoners are living with HIV.[112] Despite the known risks of HIV, HCV and TB transmission associated with injecting drug use and overcrowding in prison, few prisons offer comprehensive harm reduction services.

NSPs continue to remain unavailable to prisoners across the region. In 2015, however, government authorities in Nepal, in cooperation with national and international partners, developed standard operating procedures to scale up HIV prevention, treatment and care services in prison settings, which involved officially adopting the 15 key interventions of the comprehensive package, including NSPs, OST and condoms.[115] In practice, at the time of reporting, prevention messages continue to be the only intervention available in prisons in Nepal.[116]

OST is available in only some prisons in India (Tihar prisons, the largest prison complex in South Asia),[117] Indonesia (11 prisons),[118] Macau,[119] Malaysia (18 prisons)[26] and Vietnam (1 prison).[120] UNODC reports that a second prison-based OST programme will soon be launched in Vietnam (Ha Noi), and plans are reportedly in place to continue expanding the programme into other prisons.[120]

In Indonesia, prison-based OST and ART programmes are run by the Ministry of Health. Kerobokan prison in Bali, which has been used as a model, provides prisoners with condoms, OST, ART and bleach to sterilise injecting equipment (in the absence of sterile needles and syringes). It is important to note, however, that bleaching has proven ineffective at preventing HIV transmission.[121] Currently, up to 11 prisons in the country are providing OST to 248 prisoners, and an estimated 40 prisons are delivering ART to people living with HIV.[118]

Since *Global State 2014*, Cambodia's Ministry of the Interior has publicly acknowledged the issue of drug use in prisons and reports indicate that there is some interest in piloting harm reduction interventions in these settings;[70] while in Myanmar, UNODC has reportedly voiced its support for initiating OST in prisons.

Where harm reduction and HIV treatment and care services are available in the region's prisons, they can be difficult to access for various reasons (including stigma and discrimination) or not provided in accordance with international prison and human rights standards. A recent study on the factors affecting opioid dependence during incarceration in India, for example, found that 74% of those surveyed chose to access OST while incarcerated. The majority of the remaining 26% did not access the service for fear of physical violence at the hands of other prisoners.[122] Similar barriers to access have been documented in Indonesia and Malaysia.[112]

In Malaysia, HIV testing continues to be mandatory upon entry to prison and those found to be living with the virus are segregated into special housing units. Not only is this a clear violation of international human rights law and minimum standards on the treatment of prisoners, but also it increases the risk of TB outbreaks and reinforces the stigmatisation of HIV in prison settings.[112]

[m] 2010 data.

Due to the punitive environment that prevails in Asia, prisons remain one of the main sources of primary care for people who use drugs.[112] Given all of the above, harm reduction must urgently be prioritised in these settings and adequate resources allocated. That way, the region's criminal justice systems can play a role in reaching global targets on HIV, HCV and TB.

Overdose

As in many other regions, data on the extent of drug-related overdose prevention and management remain extremely limited across Asia. No country in the region collects and routinely monitors drug-related overdose deaths.

However, an opioid overdose prevention and management project – Servicing Communities with Opioid Overdose Prevention (SCOOP) – was integrated into the civil society response to HIV among people who inject drugs in Thailand in 2013 to address the growing needs of this community.[123] Civil society organisations facilitated access to naloxone across 19 provinces over a two-year period. Important legal, policy and procurement barriers were addressed and, within 18 months of the project beginning, 1,575 vials of naloxone were distributed across implementation sites. At least 148 field workers and clients were trained to recognise an opioid overdose and to respond with emergency care and the injection of naloxone, with field workers successfully reversing 21 opioid overdoses using naloxone. Between January 2013 and June 2014, overdose prevention was discussed with each of the 74,852 people entering the service, and the SCOOP project empowered and motivated both field workers and people who use drugs.[123] Overdose management is also part of the harm reduction package in Afghanistan, with naloxone distributed by outreach workers.[77]

Although China has no national programme for overdose prevention, AIDS Care China, with support from the European Commission-funded Asia Action project, started to operate naloxone peer-distribution programmes in Yunnan and Sichuan provinces. By the end of May 2014, 4,361 naloxone kits had been distributed by AIDS Care China to 1,900 people who inject drugs, and 119 people had been saved from fatal overdose.[10]

Policy developments for harm reduction

In late 2014 Thailand announced the establishment of an ASEAN Narcotics Cooperation Centre.[86] In 2015 the ASEAN Economic Community was officially established. That same year, ASEAN ratified the new ASEAN Post-2015 Health Development Agenda, which maintains commitments to HIV through prioritisation of health-related Millennium Development Goals (MDGs) as well as of prevention and control of communicable diseases. The ASEAN Task Force on AIDS is finalising a working paper on HIV prevention among people who inject drugs in order to generate better system-wide coherence within ASEAN's various departments. A coalition of 12 civil society organisations from Southeast Asia was formed in 2015 to advocate for improved support for harm reduction interventions in ASEAN countries.

In Afghanistan, new national harm reduction guidelines were approved by the Counter Narcotics High Commission in December 2014.[124] In parallel, a new national strategic plan on HIV was designed to improve results from investments in the response to HIV for the period 2016 to 2020.[124]

In Cambodia, a national strategic plan on harm reduction related to drug use was launched in March 2016. However, following a request from the Cambodian police to amend drug laws, high-level government officials reported that current policies were too lenient, but any formal amendments would need careful consideration.[125]

In Malaysia, the Ministry of Health developed a new national strategic plan on ending AIDS for the period 2016 to 2030. However, leadership changes in Malaysia's national anti-drugs agency have weakened support for harm reduction and other effective approaches to address drug-related issues.[97]

In Myanmar, a workshop involving a broad range of stakeholders, including senior representatives of the government, parliamentarians, international health and legal experts, international and national NGOs, drug user networks, and development agencies, recommended an amendment to the drug law to include harm reduction.[126]

Thailand's national harm reduction policy, formally approved in 2014, expired in October 2015. Despite this important setback, a national drug law reform process was initiated in 2015, which should conclude by the end of 2016 with formal recommendations for adjustments

for several drug-related statutes that could facilitate harm reduction service delivery in the future.

Several Asian nations were represented at the 2016 UNGASS on the drugs. Unfortunately, few lent their support to harm reduction. Singapore's intervention was notable as the nation's representatives firmly opposed harm reduction.[127] China echoed Singapore's statement, underlining that harm reduction is acceptable only if it is aimed at reducing drug use. Malaysia spoke on behalf of ASEAN countries, outlining positions similar to that taken by Singapore and reiterating the vision of a drug-free region. Just Vietnam stated that harm reduction programmes are being implemented.[128]

Civil society and advocacy developments for harm reduction

Civil society organisations in Asia continue to play an important role in harm reduction, at both regional and national levels. The Asian Network of People who Use Drugs (ANPUD) is now well established. However, after several years of inactivity, the Asian Harm Reduction Network (AHRN) is no longer functioning. Similarly, the Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific, co-chaired by UNODC and UNAIDS, completed its operations in 2012.

National drug user networks are in place in Cambodia (Cambodian Network of People who Use Drugs – CNPUD), India (Indian Drug User Forum – IDUF), Indonesia (Persaudaraan Korban Napza Indonesia – PKNI), Myanmar (National Drug User Network Myanmar – NDNM), Thailand (Thai Drug User Network – TDN)[46] and Vietnam (Vietnam Network of People who Use Drugs – VNPUD). The Malaysian Network of People who Use Drugs (MANPUD) has been established[97] and the Malaysian Welfare Association of Recovering Drug Users (WARDU) is in the process of registering as an official network. Nepal also has several drug user networks, including one specifically for women; and a small group of people who use drugs established a network under the national People Living with HIV (PLHIV) network but this is yet to be officially recognised.

Although ANPUD has grown significantly since its inception, and the number of drug user networks continues to grow, albeit slowly, there remain important barriers – such as declining funding, repressive government regimes and stigma and discrimination – that hinder meaningful civil society engagement and overall coordination across the region. Regional sources of technical support on harm reduction include the Alliance Technical Hubs in Cambodia and India as well as the UNAIDS Technical Support Facility (TSF).

Across Asia, the 'Support Don't Punish' campaign[n] has provided an opportunity for people who use drugs to have their voices heard and call for the end of their criminalisation and stigmatisation. The campaign's 'global day of action', which occurs on 26 June every year, has been an important tool to change the messaging around drugs and people who use drugs, with media outreach sometimes involving local/national celebrities (for example, the punk band Jeruji in June 2015 and rock band The Changcuters in June 2014 in Indonesia). The global day of action in Asia has also been an opportunity to bring NGOs together to discuss critical drug policy reform issues, and to open and build dialogue with government agencies, UN agencies, law enforcement officers, networks of people who use drugs, local civil society groups and harm reduction service providers.

On the first 'Support Don't Punish' global day of action in Asia in 2013, 22 cities in five countries became involved in the campaign. In 2014, 33 cities in ten countries gathered under the 'Support Don't Punish' banner – including representatives from Cambodia, India, Indonesia, Malaysia, Nepal, Philippines, Thailand and Vietnam. This number rose to 38 participating cities in the region in 2015, making Asia the region with the highest level of engagement in the campaign.

The NGO Bridge Hope and Health, together with Coact (an international peer-led support agency), with a small grant of US$15,000 from the Czech government and technical support funding from Open Society Foundations, delivered a two-day capacity-building event and trained an Afghan community team in overdose management and peer interventions for people who use drugs. The peer outreach team is in the process of documenting 16 active drug scenes identified around the Kabul area, and Coact is assisting in translating a community needs assessment into a formal needs assessment and outreach plan. The Bridge Hope and Health team received language training in Dari and English and support with social media to support their engagement with the international community. Due to the limited funding, only four months of operations for the staff team are covered and no harm reduction commodities such as NSP, OST or naloxone distribution are included. However, Bridge Hope and Health is mobilising resources and has launched a crowd-sourced fundraising campaign through social media to increase the harm reduction response in Afghanistan.

[n] See http://supportdontpunish.org/.

The 24th International Harm Reduction Conference was held in Kuala Lumpur, Malaysia in October 2015. Malaysia's leadership in introducing harm reduction measures ten years ago and the need to continue to scale up similar interventions globally featured prominently during the three-day conference. Over 900 health workers, UN representatives, politicians, bureaucrats, researchers, medical professionals and community workers, representing over 70 countries, were in attendance at this biennial event. A civil society organisation coalition on the ASEAN drugs strategy was launched in the margins of the conference. This coalition, consisting of 12 civil society organisations from Southeast Asia, will seek to be a unifying voice and a platform for the engagement of harm reduction at the regional level.[97]

Funding developments for harm reduction

The funding landscape for harm reduction in Asia since *Global State 2014* has been scarred by political constraints in terms of support for the approach, international donor withdrawal and transitions from donor funding to government funding for services.

Community Action on Harm Reduction (CAHR) – a project that aimed to expand harm reduction services to more than 180,000 people who inject drugs, their partners and children in China, India, Indonesia, Kenya and Malaysia – ended in 2014. The Asia Action on Harm Reduction project – funded by the European Union to empower civil society organisations and to increase the evidence and build political support for harm reduction among key policy-makers in Cambodia, China, India, Indonesia, Malaysia and Vietnam – ended in 2016.

The Australian government's international assistance programme was revamped following cuts to foreign aid, with the result being that previous beneficiaries lost its support for harm reduction interventions across the region. For example, the HIV Cooperation Programme in Indonesia (HCPI) ended in December 2015, with no provisions to mend the funding gap.[129] Meanwhile, financial support for harm reduction from the World Bank, Open Society Foundations, UNODC and USAID has also decreased across the region.

Decisions on how to prioritise allocations under its new funding model have negatively impacted several Global Fund-supported programmes targeting people who inject drugs in Asia. However, the Global Fund approved a regional harm reduction advocacy grant covering seven countries in the region: Cambodia, India, Indonesia, Nepal, Philippines, Thailand and Vietnam. With a total budget of US$5 million over a three-year period, implementation is expected to begin in early 2017.

Other sources of funding have been approved. A multi-country grant awarded by the Dutch government to support HIV prevention among people who inject drugs also covers three countries in the region: Indonesia, Myanmar and Vietnam. PEPFAR has mobilised over US$20 million to support HIV prevention among key populations, including people who inject drugs. The United Nations Development Programme (UNDP) and the Global Fund have agreed a grant of US$8.7 million to scale up HIV prevention measures and treatment for people most at risk of contracting the virus in Afghanistan, including people who inject drugs and prisoners.[130]

By the end of 2011 the Malaysian government had invested approximately UIS$17.3 million of the national budget to support the implementation of harm reduction programmes through partnerships with civil society organisations.[65] For example, financial contributions for NSPs between 2006 and 2015 show that 69% of funds came from national donors (and 31% from external sources).[131] A recent assessment of returns on investments and cost-effectiveness of harm reduction programming in Malaysia shows conclusively that priority harm reduction services such as the distribution of sterile injecting equipment and OST, even with the present moderately low coverage, are effective and cost-effective interventions for averting HIV infections.[132]

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