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

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

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

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Abbreviations.

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

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Executive Summary.

In 2009, the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (UNRTF) commissioned Burnet Institute, Australia, to undertake a review of policies, resources and services for injecting drug users (IDUs), in order to update the baseline assessment conducted in 2006[1].

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

Methodology.

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

The review consisted of three outputs;

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

Identified gaps.

Comprehensive package of harm reduction services: None of the countries reported to be delivering all nine of the core interventions which make-up the comprehensive package of harm reduction services[2].

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations.

The review outcomes contribute a number of recommendations relating to;

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

Limitations with the activity, and moving forward.

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

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

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

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

Introduction.

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

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

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

The information collected and reported through this activity will provide a useful update to the UNRTF on the baseline information which was collected in 2006 for twelve of the fifteen countries reviewed during this activity[1]. An analysis of progress and ongoing gaps in harm reduction service delivery in the three years since the baseline was conducted will help to inform the Task Force of its effectiveness in driving the harm reduction response, and strategic direction for prioritizing its activities in the coming years.

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

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

Methodology.

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

During the 2006 Baseline Assessment activity[1], an analytical framework was developed and endorsed by UNRTF members, before being used as the tool for collection of country-specific information on harm reduction policies, programs and services, and the environment which facilitates or hinders the scale up of services.

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

In consultation with a Working Group consisting of members of the UNRTF, a team of experts from Burnet Institute revised the 2006 analytical framework tool to reflect the core services which make up the comprehensive package of harm reduction services[2]. The framework was reviewed by the Working Group in June 2009, and endorsed in August, 2009 (see Appendix A).

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

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

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

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

Information from available resources was fed into the country specific data matrices, before being provided to UNRTF country focal points for review of the presented information, and addition of further information available in-country. This process took place between September 2009 and January, 2010. For a complete list of contributors to country-specific data matrices, see Appendix B.

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

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

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

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

Identified Gaps, 2009.

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

Comprehensive package of harm reduction services.

None of the countries reported to be delivering all nine of the core interventions which make-up the comprehensive package of harm reduction services as outlined in the WHO, UNODC, UNAIDS Technical Guide[2].

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

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

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

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

In reviewing the extent to which South East and South Asian countries deliver the nine core interventions which make up the comprehensive package of harm reduction services as outlined in the WHO, UNODC, UNAIDS Technical Guide[2], it should be acknowledged that this resource was only released in 2009, and therefore it could be expected that services may be scaled-up to meet these over the coming years. It should be noted, however, that Bangladesh, Cambodia, Myanmar, Nepal and Viet Nam were the only countries to identify plans for scaling-up of IDU targeted diagnosis, treatment of and vaccination for viral hepatitis, and Nepal was the only country with identified plans for scale-up of tuberculosis prevention, diagnosis and treatment services for IDUs in the near future.

Political commitment to harm reduction.

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

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

Four countries indicated political commitment to harm reduction approaches to HIV prevention, treatment and care among IDUs, however in practice, this commitment is to particular interventions, rather than the comprehensive package of core services outlined in the WHO, UNODC, UNAIDS Technical Guide[2], and in some cases, it was indicated that these services are compulsory for IDUs, rather than voluntary. A number of countries expressed concern that despite documented commitment to harm reduction for IDUs, factions within the political system, or some sectors (such as law enforcement) openly oppose this approach.

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

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

Multi-sectoral and civil society involvement in the response.

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

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

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

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

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

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

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

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

Involvement of IDUs in the response.

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

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

Limited IDU involvement in the development of IDU-specific policies and strategies, or in the planning, monitoring and evaluation of harm reduction programs has the potential to further

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

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

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

National harm reduction strategies.

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

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

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

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

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

Legal and policy environment.

There exists throughout the region a continued conflict between progressive national and sub-national strategies and policies for the prevention, treatment and care of HIV and AIDS which are supportive of targeted interventions for IDUs, and firmly entrenched legal criteria which either explicitly or implicitly prohibit or inhibit the implementation of many of the core services which comprise the comprehensive harm reduction package[2].

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

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

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

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

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

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

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

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

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

Capacity and resourcing.

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

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

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

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

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

Surveillance and Monitoring and Evaluation.

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

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

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

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

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

Nepal is the only country that reported to be monitoring and evaluating harm reduction activities against the core harm reduction services of the comprehensive package as outlined in the WHO, UNODC, UNAIDS Technical Guide[2]. However, as this resource was only released in 2009, it would be expected that improvements to monitoring and evaluation systems in other countries would take place over the coming years.

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

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

Prisons and Compulsory Centres for Drug Users.

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

Due to high prevalence of injecting drug use that is known to take place in prison settings in the region[3-5], and the relatively short sentences of many inmates which contribute to large populations regularly moving into and out of prison, harm reduction services in these settings are integral to effective HIV prevention for IDU populations in the whole community.

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

Recommendations, 2009.

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

- Comprehensive package of harm reduction services:
  The core elements of the comprehensive package of harm reduction services as outlined in the WHO, UNODC, UNAIDS Technical Guide[2] have been derived through evidence-based analysis of what constitutes the most effective interventions for HIV prevention, treatment and care among IDUs. Scale-up of harm reduction services to include these core services constitutes the most promising opportunity to deliver an effective harm reduction response in the region. Technical capacity building, resourcing and legal and policy reform in many of the countries under review is necessary to enable scale-up of these services, both in the general community, and in closed settings.

- Greater political commitment to harm reduction for IDUs:
  Sustainability and effectiveness of IDU-targeted harm reduction programs are heavily reliant on ensuring harm reduction interventions are well-supported within national and sub-national political mechanisms. Donors, United Nations and technical agencies and civil society have a strong role to play in advocating for the harm reduction approach amongst political parties and factions.

- Greater multi-sectoral and civil society involvement:
  Multi-sectoral involvement of government agencies is essential to ensuring the harm reduction response is both comprehensive (incorporating aspects of law enforcement, health and social service delivery, judicial oversight etc), and in accordance with a human rights-based approach which values the welfare of IDUs, and their right to HIV prevention, treatment and care interventions. This multi-sectoral collaboration must exist not only at the national/central level, but between this and implementation levels, as cooperation between government agencies at the service delivery level is essential to ensuring both IDUs accessing services, and those providing these, are protected from stigma, discrimination and/or legal reprisals.

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

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

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

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

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

- Legal and policy reform to facilitate scale-up:
  In many of the countries reviewed, HIV and AIDS prevention, treatment and care strategies and policies are not compatible with laws and policies which could view harm reduction activities such as OST and NSP as unlawful, and liable to prosecution. Advocacy and technical support from donors, United Nations and technical agencies, civil society and national Bar associations should be directed to amending (or clarifying) laws which prohibit harm reduction approaches, stigmatise those who access or deliver services, or inhibit IDUs' human rights. Involvement of the judiciary as a multi-sectoral partner in national and sub-national HIV and AIDS policy/strategy development is an essential element to facilitating more informed legal reform to support harm reduction approaches.

- Greater commitment to building capacity and resourcing the response:
  Scale-up of harm reduction activities to meet the coverage needs of IDUs in all of the countries reviewed is heavily reliant on sufficient financial and commodity resources, and sound technical capacity of program implementers and service providers. Technical agencies must commit to developing capacity of those conducting data collection, reporting and analysis, while donors should prioritise the resourcing of same.

- Strengthening surveillance and monitoring and evaluation:
  National and sub-national surveillance systems require improvement to facilitate collection of IDU-specific data, preferably by gender, in order that population denominators can be more accurately determined, and harm reduction programs designed to more effectively meet the needs of IDUs. Technical agencies must commit to developing capacity of those conducting data collection, reporting and analysis, while donors should prioritise the resourcing of same.

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

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

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

Limitations of this activity, and moving forward.

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

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

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

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

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

References.

1. Burnet Institute. (2007). Baseline assessment of current status of resources, policies and services for injecting drug use and HIV/AIDS in South and South East Asia. Melbourne. Centre for Harm Reduction, Burnet Institute.

2. WHO, UNODC, UNAIDS (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

3. Jürgens, R. (2007). Effectiveness of interventions to address HIV in prisons: HIV care, treatment and support. Evidence for Action Technical Papers. Geneva, World Health organisation (WHO).

4. Bezziccheri, S. (2006). HIV/AIDS and custodial settings in South East Asia: an exploratory review into the issue of HIV/AIDS and custodial settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam, UNODC.

5. UNAIDS (1997). Prisons and AIDS. UNAIDS Best Practice Collection. Geneva, UNAIDS.

Appendix A:

Analytical framework tool for collection of country-specific data (Output 1).

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: ??

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place (List Relevant Items)	
		Existing	Gaps
Political Commitment			
Civil Society Engagement			
Donor Commitment			
Multi-sectoral Involvement			
Involvement of IDUs in the Response			
Costed National Harm Reduction Strategy		Yes/No	
Does the National Drug Strategy complement the National HIV strategy?		Yes/No	
Legal and Policy Environment		Enable/Restrict	

Surveillance Systems			

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				Yes/No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps

2. Program Implementation.

Estimated IDU Population: _____ (year and reference) *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs					Yes/No		Yes/No			Yes/No
Opioid Substitution Therapy (OST)					Yes/No					Yes/No
HIV Testing and Counselling (T&C)					Yes/No					Yes/No
Antiretroviral Therapy (ART)					Yes/No					Yes/No
Prevention and treatment of STIs					Yes/No					Yes/No
Condom programs					Yes/No					Yes/No
Targeted IEC					Yes/No					Yes/No
Primary Health Care (including treatment of opportunistic infections)					Yes/No					Yes/No
Diagnosis, treatment of and vaccination for viral hepatitis					Yes/No					Yes/No
Prevention, diagnosis and treatment of tuberculosis					Yes/No					Yes/No

Peer Education programs					Yes/No					Yes/No

2b. Services in Prisons.

Estimated Prisoner Population:		(*reference, year*)
Estimated # and % of Drug Offenders:		(*reference, year*)
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	Yes/No	
Opioid Substitution Therapy (OST)	Yes/No	
HIV Testing and Counselling (T&C)	Yes/No	
Antiretroviral Therapy (ART)	Yes/No	
Prevention and treatment of STIs	Yes/No	
Condom programs	Yes/No	
Targeted IEC	Yes/No	
Primary Health Care (including treatment of opportunistic infections)	Yes/No	
Diagnosis, treatment of and vaccination for viral hepatitis	Yes/No	
Prevention, diagnosis and treatment of tuberculosis	Yes/No	
Peer Education programs	Yes/No	
Post-release Follow-up	Yes/No	
Total		

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		(*reference, year*)
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Yes/No	
Opioid Substitution Therapy (OST)	Yes/No	
Medically Assisted Detoxification	Yes/No	
HIV Testing and Counselling (T&C)	Yes/No	
Antiretroviral Therapy (ART)	Yes/No	
Prevention and treatment of STIs	Yes/No	
Condom programs	Yes/No	
Targeted IEC	Yes/No	
Primary Health Care (including treatment of opportunistic infections)	Yes/No	
Diagnosis, treatment of and vaccination for viral hepatitis	Yes/No	
Prevention, diagnosis and treatment of tuberculosis	Yes/No	
Peer Education programs	Yes/No	
Post-release Follow-up	Yes/No	
Total		

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	1.		
	2.		
	3.		
	4.		
Civil Society Engagement			
Legal and Policy Environment	1.		
	2.		
	3.		
	4.		
	5.		
Law Enforcement			
Comprehensive Services			
Resources (Financial, human and data)			
Involvement of IDUs in the Response			
Availability of Commodities			
3. Needle and Syringe programs			
ii. Opioid Substitution Therapy (OST)			
iii. HIV Testing and Counselling (T&C)			
iv. Antiretroviral Therapy (ART)			
v. Prevention and treatment of STIs			

vi. Condom programs			
vii. Targeted IEC materials			
viii. Primary Health Care (including treatment of opportunistic infections)			
ix. Diagnosis, treatment of and vaccination for viral hepatitis			
x. Prevention, diagnosis and treatment of tuberculosis			
xi. Peer Education programs			
Scaling Up Plans			
Capacity Building			
Monitoring and Evaluation			

4. Gap Analysis

As required to provide insight and clarification, summary of gaps identified and further detail where necessary.

5. Recommendations

Recommendations stemming from analysis of data collected

6. References

Include annotations for tables and data, references for data collected (mapping exercises, reports, statistics) etc

NOTES FOR TABLES

1a. National Program Support	
Political Commitment	Identifies the degree to which governments support harm reduction approaches (including statements of commitment and budgetary allocations).
Civil Society Engagement	Identifies the degree to which civil society is involved in the response. If less than 10 organisations, list the names of those whose core activities directly address the needs of injecting drug users. If greater than 10 organisations, an estimate should only be provided.
Donor Commitment	Identifies the degree to which donors support harm reduction approaches (including budgetary allocations) and the extent to which donor harmonization is occurring.
Multi-sectoral Involvement	Identifies networks, collaborations, agreements and mechanisms for multi-sectoral involvement in program development and implementation. Should also include media involvement, and type (TV, newspapers, radio).
Involvement of IDUs in the Response	Identifies activities, such as the creation of a drug user networks and other avenues for the inclusion of IDUs.
Costed National Harm Reduction Strategy	Assesses existence of a comprehensive and costed national strategy. This could include costed operational and activity plans. Describes the amount of funding available, and the month/year that the funds expire (if available).
Does the National Drug Strategy complement the National HIV Strategy?	Identifies the presence of national strategies, and whether these are inter-related (ie: whether activities and directions of one contribute to, or restrict the other).
Legal and Policy Environment	Assessment of relevant drug laws and existence of enabling or restrictive legislation or policy: legal status and availability of substitution drugs, needle and syringe; legal/judicial practices and punishment of drug use.
Surveillance Systems	Summarises existence, appropriateness and effectiveness of existing surveillance systems.

1b. Monitoring and Evaluation Systems	
Description of Systems / Frameworks	Lists specific documents, commitments, strategies, legislation, policies, systems, frameworks or mechanisms that contribute to the support of a national program of harm reduction activities.

2. Program Implementation	
Estimated IDU Population *(a)*	Estimation of total IDU population based on common agreed statistical measure (eg government reported figures as per last detailed analysis).
2a. Service Coverage: Available data	Examines the provision of services and the extent to which they effectively reach the IDU population. Considers separately for each component of a comprehensive package of services for IDUs.
Provincial Coverage	Name the provinces which have a recognised, consistent population of IDUs. Name the provinces with services which either directly target IDUs, or which are accessed by IDUs.
INGOs / NGOs	Number of INGOs / NGOs engaged in the provision of harm reduction services.
Govt Health Services	Number of government health services (hospitals, health clinics etc) engaged in the provision of harm reduction services.
Clients Accessing Services *(b)*	Numbers of registered or recorded clients accessing harm reduction services. These must be unique clients (not number of contacts) – each client can be counted only once.
Cost to user	State Yes/No for whether services targeting IDUs require the user to pay for them.
Distributed	Estimate of total number of needles and syringe, condoms or IEC distributed. Numbers of needles and syringes may be reported separately, or together according to practices in country.
Outreach provided	Outreach services offered for the intervention type (Yes/No), and number of services provided by Govt and both INGOs and NGOs.
Services Coverage *(b/a)*	Numbers of registered or recorded clients accessing harm reduction services *(b)* / estimated IDU Population *(a)*.

	This is a crude estimate of coverage for interventions.
2b. Services in Prisons	Examines the provision of services and the extent to which they effectively reach the IDU population in prison settings. Considers separately each component of a comprehensive harm reduction package.
2c. Services in Compulsory Centres for Drug Users	Examines the provision of services and the extent to which they effectively reach the IDU population in Compulsory Centres for Drug Users, such as 05/06 centres, re-education through labour centres and treatment centres across the Region. Considers separately each component of a comprehensive harm reduction package.
Medically Assisted Detoxification	Medical relief provided for physical withdrawal symptoms.

3. Barriers to Scale Up	
Completion of the tables enables analysis and identification of barriers to implementing comprehensive harm reduction approaches. These can be listed here and detailed further in the narrative report	
Political Commitment	Assessment of key influences and issues limiting government support to/of harm reduction approaches.
Civil Society Engagement	Assessment of key influences and issues limiting INGO / NGO engagement.
Legal and Policy Environment	Review of key concerns and attitudes preventing enabling legislation and policy being implemented.
Law enforcement	Assessment and identifications of practices and policies which may prevent effective implementation of harm reduction approaches.
Comprehensive services	Assessment of critical factors which could discourage effective implementation of outreach services.
Resources (Financial, human and data)	Assessment of insufficient resources, workforce capacity and data availability for effective planning and implementation of harm reduction approaches.
Involvement of IDUs in the Response	Factors which prevent involvement /participation of IDUs, eg. Stigma and discrimination, low literacy.
Availability of Commodities	Factors limiting the availability, accessible and quality of essential commodities for harm reduction.

Scaling-Up Plans	Factors limiting scale-up of activities.
Capacity Building	Factors limiting the development of a well-trained workforce.
Monitoring and Evaluation	Factors limiting implementation of appropriate monitoring processes.

Appendix B:

List of contributors to the collection of country-specific data.

The author would like to acknowledge the following individuals and organisations for their assistance in reviewing and providing input to the development of the analytical framework tool and/or country-specific data.

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Dr Anne Bergenstrom	UNRTF and Working Group to finalise analytical framework tool

Appendix C:

Competed country-specific data matrices; in alphabetical order (Output 2).

Afghanistan Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Afghanistan

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	NGO	Non Government Organisation
ART	Antiretroviral Therapy	NSP	Needle and syringe program
C&T	HIV Testing and Counselling	OST	Opioid Substitution Therapy
CCDU	Compulsory Centres for Drug Users	STI	Sexually Transmitted Infection
HIV	Human Immunodeficiency Virus	UNESCO	United Nations Educational, Scientific and Cultural Organisation
IDUs	People who inject drugs		

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	HIV/AIDS Unit, Ministry of Public Health, Demand Reduction Section, Ministry of Counter Narcotics[1].	HIV/AIDS Unit, and Demand Reduction Section developed the Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan[1]. Mental Health Institute, Ministry of Public Health delivers rehabilitation and counselling to IDUs[2].	
Civil Society Engagement	Nejat (Kabul) SHRO (Herat) Wadan (Paktiya & Kandahar) KOR (Kabul & Faizabad)[2]. Medecins du Monde	NGOs providing peer education through outreach and drop-in centres. Medecins du Monde implementing/supporting NSPs. World Bank HIV/AIDS Prevention Project allows for NGOs to work with identified groups, such as IDUs and their partners in selected sites[3].	Negative community attitudes towards IDUs contribute a level of stigma and discrimination which has the potential to disrupt or inhibit harm reduction activities. Lack of community support for OST exists; “drug use is always unacceptable, even for intoxicants used to treat pain”[4].
Donor Commitment	GTZ UNESCO World Bank	GTZ supporting some NGOs[2]. UNESCO funding civil society working on harm reduction[5].	

	UNODC GFATM	World Bank HIV/AIDS Prevention Project (2008-2012) focuses on behaviour change among vulnerable groups and improving knowledge of HIV prevention and reducing stigma related to HIV and AIDS in the general population[3]. Also works on strengthening HIV surveillance. Targets 2,000 IDUs in the community and 100 in prisons[6]. The project's targeted intervention for HIV prevention among IDUs provides a comprehensive harm reduction package, including NSPs, peer counselling and education, and condom promotion, delivered at drop in centers and through outreach services[3]. UNODC has 1 international HIV/AIDS Advisor and 1 National Programme Officer working on harm reduction for IDUs as a core focus. Particularly targets female IDUs in the community and prisons[6]. GFATM supports targeted interventions (2008-2012) for 3,520 IDUs in provinces[6].	
Multi-sectoral Involvement	HIV/AIDS Unit, Ministry of Public Health, Demand Reduction Section, Ministry of Counter Narcotics[1].	HIV/AIDS Unit, and Demand Reduction Section developed the Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan[1].	
Involvement of IDUs in the Response	Information not available.		
Costed National Harm Reduction Strategy	Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan. 2005 and OST policy[6].	It is unclear if this is a costed strategy.	
Does the National Drug Strategy complement the National HIV strategy?	Harm Reduction Strategy for IDU and HIV/AIDS Prevention in Afghanistan. Afghanistan National Strategic Framework for HIV/AIDS 2006-2010. Ministry of Public Health, Afghanistan. 2006[6]. National drug control strategy[6].	Main components: Information, Education and Communication (IEC) and Behaviour Change Communication, Stigma reduction associated with drug use and HIV, Needle/ Syringe exchange, Condom promotion and distribution, Drug substitution therapy[1].	National Drug Strategies are moving towards a state of synergy with National HIV strategies.
Legal and Policy Environment	Documents not specified.	Enables harm reduction programs: Unspecified, but explicit, supportive reference to harm reduction in national policy documents[5].	Restricts harm reduction programs: Decrees exist banning cultivation, production, drug abuse and trafficking of narcotic drugs, and the use of opium

			products is illegal in Afghanistan[2]. Has the potential to attract stigma, discrimination and disruption from law enforcement agencies to harm reduction activities.
Surveillance Systems	HIV/AIDS Prevention Project (World Bank)	Surveillance of knowledge and attitudes conducted in 2007, and planned again for early 2009[4]. HIV/AIDS Prevention Project focuses on strengthening HIV surveillance through biological and behavioural surveys and knowledge attitudes and practice studies[3].	

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
HIV/AIDS Prevention Project (World Bank)	HIV surveillance through biological and behavioural surveys and knowledge attitudes and practice studies[3,6].	Surveillance of knowledge and attitudes conducted in 2007, and planned again for early 2009[4].		

2. Program Implementation.

Estimated IDU Population: 6,900 (6,870<n<6,930); (estimates from 2005)[6] *(a)*
34,080; (estimates from 2006)[5] *(a)*
19,000; (estimates from 2010)[6] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage	Plans for Scale-up
							NGO	Govt		

				Services (#) (*b*)					*(b/a)*	
Needle and Syringe programs (NSPs)	1 site, Kabul[5]. Pharmacies a common source, but cost prohibitive for some[2].	Medecins du Monde			Unknown Yes (pharmacies)		Unknown	Unknown	No client data available.	Unknown
Opioid Substitution Therapy (OST)	Methadone and buprenorphine not available[2,5]. Govt may have recently imported methadone for OST.				Unknown					Yes. Govt committed to making methadone available
HIV Testing and Counselling (T&C)	Unknown				Unknown					Unknown
Antiretroviral Therapy (ART)	Unknown				Unknown					Unknown
Prevention and treatment of STIs	Unknown				Unknown					Unknown
Condom programs	Unknown				Unknown					Unknown
Targeted IEC	Unknown				Unknown					Unknown
Primary Health Care (including treatment of opportunistic infections)	Yes, but not specifically for IDUs.	2x NGO in-pt services[2].	Govt Mental Health Institute has out-patient services[2].		Unknown		Yes			Unknown
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown				Unknown					Unknown
Prevention, diagnosis and treatment of tuberculosis	Unknown				Unknown					Unknown
Peer Education programs	NGO services.	Nejat (Kabul) SHRO (Herat) Wadan (Gardez & Kandahar) KOR (Kabul & Faizabad)[2].			Unknown		Yes			Unknown

2b. Services in Prisons.

Estimated Prisoner Population:		12,500 in 35 prisons[6] (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Nov 08; sourced 30/7/09)
Estimated # and % of Drug Offenders:		(*reference, year*)
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	
Additional info: World Bank HIV/AIDS Prevention Project (2008-2012) targets 100 IDUs in prisons, however it is not clear what this intervention includes[6]. UNODC implements interventions which target female IDUs in the community and prisons, however it is not clear what this intervention includes[6].		

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		No data available.
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	

Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	450 (across prisons and CCDU)
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Little multi-sectoral collaboration on harm reduction issues.	HIV/AIDS Unit, Ministry of Public Health, Demand Reduction Section, Ministry of Counter Narcotics[1].	
Civil Society Engagement	None identified.		
Legal and Policy Environment	Ambiguity within legal documents have the potential to attract stigma, discrimination and disruption from law enforcement agencies to harm reduction activities.		
Law Enforcement	Lack of sensitization and commitment on the issue regarding the harm reduction.	Ministry of Justice, police	
Comprehensive Services	IDUs face stigma and discrimination at the service provision, legal and community levels.	Government: HIV/AIDS Unit, Ministry of Public Health. Donors and technical agencies: GTZ, World Bank, WHO, UNESCO, UNODC, GFATM. Civil society organisations.	World Bank HIV/AIDS Prevention Project focuses on reducing stigma related to HIV and AIDS in the general population[3]
Resources (Financial, human and data)	Human resources for harm reduction scarce; lack of trained staff. Severe shortage of female health workers and counsellors[2].	Government: HIV/AIDS Unit, Ministry of Public Health. Donors and technical agencies: GTZ, World Bank, WHO, UNESCO, UNODC, GFATM.	Advocacy for sufficient resource mobilization (both financial and technical). This being attempted by UNODC, UNESCO.
Involvement of IDUs in the Response	No information is available to ascertain IDU involvement.		
Availability of Commodities			

i. Needle and Syringe programs	None identified.		
ii. Opioid Substitution Therapy (OST)	Methadone and buprenorphine not available		Govt may have recently imported methadone for OST.
iii. HIV Testing and Counselling (T&C)	None identified.		
iv. Antiretroviral Therapy (ART)	None identified.		
v. Prevention and treatment of STIs	None identified.		
vi. Condom programs	None identified.		
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		
Scaling Up Plans			
Capacity Building	Limited capacity identified at all levels of the harm reduction response: legal reform, policy development, law enforcement, service provision, M&E.	All levels of the harm reduction response	
Monitoring and Evaluation	Limited capacity to implement effective M&E.	Government: HIV/AIDS Unit, Ministry of Public Health. Donors and technical agencies: GTZ, World Bank, WHO, UNESCO, UNODC, GFATM.	HIV/AIDS Prevention Project (World Bank) focuses on strengthening HIV surveillance through biological and behavioural surveys and knowledge attitudes and practice studies[3].

4. Gap Analysis

Gap analysis for this country is hampered by little available data regarding the harm reduction response. However the following points are noted;

- There is little multi-sectoral involvement from government in the harm reduction response.
- Very few harm reduction services have been identified as being delivered to IDUs; complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[8]) are far from being met.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[8].
- It is unclear whether IDUs contribute to either policy development, service delivery or M&E of harm reduction services, however it is assumed that involvement of IDUs would be minimal, given the relatively recent initiation of the harm reduction response. Limited IDU involvement has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable harm reduction services (especially OST).
- There is a significant time lag between endorsement of evolving policies which support harm reduction activities, and systematic implementation at the service provision, legal and law enforcement levels.
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Very little information is available regarding harm reduction services for prisons and CCDU, however it is assumed that these would be minimal and insufficient.

5. Recommendations

- Further input into the completion of the matrix will enable a more accurate picture of harm reduction needs with which to plan and implement programs for IDUs in Afghanistan.
- Greater multi-sectoral, government involvement is required to view harm reduction as being other than simply a health-related issue, and is essential to facilitate scale-up to deliver comprehensive services.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Greater involvement of IDUs in policy development and both implementation and M&E of harm reduction programs.

- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[8].
- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. HIV/AIDS Unit. (2005). Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan, HIV/AIDS Unit, Ministry of Public Health, Demand Reduction Section, Ministry of Counter Narcotics.
2. Todd, C., N. Safi, et al. (2005). "Drug use and harm reduction in Afghanistan." Harm reduction Journal 2: 13.
3. World Bank Afghanistan. (2007). Technical Annex for a proposed grant in the amount of SDR 6.60 million (US$IO.O million equivalent) to the Islamic Republic of Afghanistan for a HIV/AIDS Prevention Project, World Bank Afghanistan.
4. Stanekzai, M. R., C. S. Todd, et al. (2007). Baseline Assessment of Community Knowledge and Attitudes Towards Drug Use and Harm Reduction in Kabul, Afghanistan: Baseline Assessment.
5. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
6. Samaruddin. (2010). HIV situation and response in Afghanistan, National AIDS Control Program, presentation at the 7th Meeting of United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, Bangkok, March 2010.
7. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
8. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Bangladesh Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Bangladesh

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	MOHA	Ministry of Home Affairs
ART	Antiretroviral Therapy	MOHFW	Ministry of Health and Family Welfare
AusAID	Australian Agency for International Development	NGO	Non Government Organisation
BAP	Bangladesh AIDS Program (FHI)	NNCB	National Narcotics Control Board
C&T	HIV Testing and Counselling	NAC	Bangladesh National AIDS Committee
CCDU	Compulsory Centres for Drug Users	NASP	National AIDS/STD Programme
CTC	Central Drug Treatment Centre	NSP	Needle and Syringe program
DNC	Department of Narcotics Control	OST	Opioid Substitution Therapy
FHI	Family Health International	PLHIV	People Living with HIV and AIDS
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	RAB	Rapid Action Battalion
HAPP	HIV/AIDS Prevention Programme (MOHFW)	RCC	Rolling Continuation Channel
HRP	Harm Reduction Programme	SAC	Surveillance Advisory Committee
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
IA	Implementing Agency	UNAIDS	Joint United Nations Programme on HIV/AIDS
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh	UNICEF	United Nations Children's Fund
IDUs	People who inject drugs	UNODC	United Nations Office on Drugs and Crime
IEDCR	Institute of Epidemiology, Disease Control and Research	USAID	United States Agency for International Development
MA	Management Agency	WHO	World Health Organization

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Drug-related: DNC (under Ministry of Home Affairs)[1] NNCB comprising; Ministries of Home Affairs (lead), Health and Family Welfare, Education, Law and Justice,	NNCB is responsible for policy formulation on drug related issues[2]. DNC responsible for policy-implementation on drug abuse, prevention, education, treatment, rehabilitation and after care	Demand reduction policies of the government have not critically looked at concerns of drug injecting and HIV; programs limited to awareness creation. [1]

	Foreign Affairs, Social Welfare, Finance, Local Government and Youth and Sports and Member of civil society organization.[1,2] For HIV and AIDS: NAC established 1985. MOHFW lead. [1] Ministries of Home Affairs, Education, Law and Justice, Social Welfare, Finance, Local Government and Youth and Sports.[1] Religious Affairs, parliamentarians, Member of civil society organization[2]. National AIDS/STD Programme (NASP), MOHFW[2].	of users. NAC responsible for policy formulation related to HIV and AIDS. NASP responsible for implementing the HIV policies including HIV related to drugs. It also coordinates the harm reduction programmes conducted by different organizations[2].	
Civil Society Engagement	NNCB CARE Bangladesh[3]. Padakhep[4]. Mukto Akash[3]. Family Health International (FHI)[3]. Marie Stopes[1].	Representation of a social worker, journalist, physician/psychiatrist on NNCB[1]. 162 NGOs/private clinics (in 2008) providing or contributing to a range of activities for IDUs, including needle/syringe and condom distribution through peer outreach, and drop-in centres that provide abscess and STI management, counselling and education, and recreational facilities. Some offer drug rehabilitation and vocational training[3]. Total 21 NGOs are engaged in harm reduction programmes for drug users under the coordination of NASP[2].	Services provided by NGOs not available in sufficient scale to meet IDU populations.
Donor Commitment	World Bank, GFATM, USAID, UNODC, UNICEF, Save the Children – USA, AusAID.	World Bank provides financial support to MOHFW, who then provides the funds to MA (UNICEF until 2008), who then provides the funds to the NGOs/CBOs through bidding process for IDU harm reduction[2,5]. GFATM provides financial support to the Principal Recipient (MOHFW), who then provides funds to MA (Save the Children-USA). MA provides the funds to the NGOs/CBOs through bidding process for previously-unserved IDU populations[2,6]. USAID funds FHI to support NGOs working with homeless and marginalized IDUs through its Bangladesh AIDS Programme (BAP) [3].	Funds and personnel capacity not sufficient to enable appropriate service coverage to scale. Inadequate funds flow, with frequent interruption[2].

		AusAID supports UNODC and WHO to implement interventions such as OST, outreach, NSP, condom promotion, VCT, STI treatment and ART[7].	
Multi-sectoral Involvement	Ministries of Home Affairs, Health and Family Welfare, Education, Law and Justice, Foreign Affairs on NNCB[1].	NNCB Fund contributes resources to awareness, prevention, treatment and rehabilitation interventions[1].	Firm commitment to multi-sectoral approach to HIV and AIDS, and to drug use prevention and rehabilitation, however commitment to harm reduction not articulated in the Narcotics Control Act.
Involvement of IDUs in the Response	No representation of IDU self help groups in policy forum	Prochesta and BODAR, two self help group were formed respectively with current and ex injecting drug users. There are some other self help groups but not active now[2].	There is no representation of IDU self help groups in policy forum. In addition the participation of the self help group in the implementation level also negligible[2].
Costed National Harm Reduction Strategy	National Harm Reduction Strategy for Drug Use and HIV, 2004-2010. National HIV/AIDS strategy, 2004-2010	It is not clear if these are costed strategies.	
Does the National Drug Strategy complement the National HIV strategy?	Five Year Master Plan for drug abuse, prevention and control, 1991. National Drug Demand Strategy, 1995. National Strategic Plan on HIV/AIDS II, 2004-2010: National Policy on HIV/AIDS, 1997: National Harm Reduction Strategy for Drug Use and HIV, 2004-2010.	These focus on i) drug abuse prevention and education, and ii) treatment and rehabilitation of those already dependent on drugs[4]. National Policy on HIV/AIDS makes reference to vulnerable groups such as IDUs, and endorses interventions that 'empower' rather than impede rights. Recommends interventions that include outreach, NSP, STI treatment. Further reference is made to peer education, condom distribution, substitution of injections with oral drugs, health education and counselling, support groups and recovery programs as other components of IDU projects[1].	National Drug Strategies do not complement the National HIV strategies. Policy directives remain abstinence-focused, however in practice, authorities have not significantly hindered harm reduction measures, including NSPs. National Harm Reduction Strategy for Drug Use and HIV, 2004-2010: Endorsed by government but not systematically implemented[4].
Legal and Policy Environment	Narcotic Control Act 1990. Penal code.	Enables harm reduction programs: Possession of needles, syringes and other paraphernalia is not a legal offence, however provision of needles and syringes is prohibited[5].	Restricts harm reduction programs: Under the Narcotic Control Act 1990 "methadone…is expressly prohibited". Also prohibited are the carrying, purchase, sale and use of opiates and other narcotics[1]. Penal code could restrict STI/HIV prevention IEC materials and demonstrations of condom use if material found to be "morally objectionable" [1]. Possession of needles, syringes and other paraphernalia is not a legal offence, however provision of needles and syringes is prohibited, and may amount to abetment of drug use. While few NGOs implementing NSPs have been prosecuted for this, the ambiguity surrounding NSPs poses

			issues for the scaling-up and sustainability of such measures[5].
Surveillance Systems	MOHFW, NAC, HIV/AIDS Prevention Programme (HAPP), NGOs.	IEDCR and ICDDR,B collaboratively conduct HIV Serological Surveillance with the financial support from NASP, MOHFW. Behavioural Surveillance is conducted with the financial support from USAID through FHI. MOHFW and NAC develops national size estimations of the population of IDUs. MOHFW's HAPP and FHI's BAP contribute to this[4].	In 2008 and 2009 Surveillance was not conducted. Some NGOs providing services to IDUs have limited capacity through which to contribute to surveillance.

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
NASP of MOHFW and NAC develops national size estimations of the population of IDUs with the support from FHI, UNAIDS, WHO, ICDDR,B, UNICEF and some I/NGOs[2,4].	Enables development of accurate denominators against which to measure service coverage.	Field level monitoring is done by IAs. Individual and joint monitoring also conducted by MA and NASP. IAs send reports to MA and NASP, usually on a quarterly basis.	Reported to the Country Coordination Mechanism (CCM) and NAC however not on a regular basis)	National monitoring framework has been developed, however there is lack of capacity to implement it.
IEDCR and ICDDR,B collaboratively conduct HIV Serological Surveillance with the financial support from NASP, MOHFW.		Regular HIV serological and behavioural surveillance system in place.		

2. Program Implementation.

Estimated IDU Population: 30,000 (20,000<n<40,000); (estimates from 2005[8]) *(a)*
95,000; (estimates from 2006[5]) *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs	93 sites (Drop-in centres) [4-5]. 14 NGOs are conducting NSP through 93 sites[2-6].	14	Also available in pharmacies[5]	23,684[4]	Unknown Yes (pharmacies)		Yes	Unknown	25-79% (b/a) 31-61%[9].	Yes
Opioid Substitution Therapy (OST)	No services [1,9] Methadone and buprenorphine not available [5] (Pilot has been approved but not implemented)								23,684 (all IDU services)[9]	Yes. GFATM Rnd 2 (RCC); after 2010[2].
HIV Testing and Counselling (T&C)	91 sites in total; 9 for IDUs specifically[4]		6 services exist[1].	1,724[4]	No.					Yes
Antiretroviral Therapy (ART)	1 site, Dhaka	ICDDR,B		5	No		yes	no	31.3%[4]	Yes
Prevention and treatment of STIs	On-site services exist[1,3] throughout the country	Included in all NGO harm red'n programs.	Yes (or all STI patients, not only IDUs))	Not available	No[2].					Yes
Condom programs	Social marketing and free distribution by NGOs (not targeting IDUs only)[1] Among IDUs in 93 sites[2].	CARE Bangladesh, Padakhep, UNODC & partners[2].	HNPSP and GFATM are Govt. projects.	Not available	No (HRP)[2].	27,75,950 (HRP 2008)[2].	Yes	Yes		Yes
Targeted IEC	Distributed through HRP[1]			Not available	No					Yes
Primary Health Care	Through HRP	On-site care	Yes (these are	Not available	No					Unknown

(including treatment of opportunistic infections)	(treatment of opportunistic infections only from 2 sites, Dhaka)[2].		for all patients)							
Diagnosis, treatment of and vaccination for viral hepatitis	Not available									Unknown
Prevention, diagnosis and treatment of tuberculosis	Not available (however small scale referral mechanism available into HRP)[2].				Unknown					Yes
Peer Education programs	Reported to exist[1].	CARE Bangladesh, Padakhep, UNODC & partners[2].			Unlikely		Yest[2].			Yes
Additional info: NGOs and private practitioners provide over 100 drug detoxification and rehabilitation centres[1]										

2b. Services in Prisons.		
Estimated Prisoner Population:	83,000 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Sep 08; sourced 30/7/09)	
Estimated # and % of Drug Offenders:	(*reference, year*)	
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	No	
HIV Testing and Counselling (T&C)	No	
Antiretroviral Therapy (ART)	No	
Prevention and treatment of STIs	No	No harm reduction services for IDUs in prisons[1,5]
Condom programs	No	
Targeted IEC	No	
Primary Health Care (including treatment of opportunistic infections)	Yes	For all prisoners[2].
Diagnosis, treatment of and vaccination for viral hepatitis	No	
Prevention, diagnosis and treatment of tuberculosis	No	
Peer Education programs	No	
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		5,865, but these not explicitly CCDU[4]. Includes: 2,583 (in 4 centres operated by DNC); 2,073 in 4 centres operated by Directorate of Prisons; 1,209 in centres supported by FHI.
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Yes	450 (across prisons and CCDU)
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Although National HIV/AIDS policy and strategies support HRP, Narcotic Control Act does not permit NSPs[2]. 2. Lack of commitment from law enforcement to support HRP (e,g NSP, condom promotion etc.) [2].	MOHA, DNC, MOHFW, NASP, Ministry of Law, Justice and Parliamentary Affairs (MOLJPA) NNCB, NAC and UN agencies Research organizations (to generate evidence) [2].	MOHFW could play important role in advocating for changes to laws. A national level drug HIV forum has been initiated to advocate with policy makers to remove legal and policy barriers to harm reduction. UNODC, UNICEF, UNAIDS, NGOs and community organisations enhance advocacy efforts with the policy makers to implement harm reduction programme[2].
Civil Society Engagement	Interruption of funds flow to implement HRP[2] limits civil society engagement. This could be associated with limited capacity of MAs	Donors (GFATM, World Bank, USAID). Government (MOHFW, MOHA). MAs (Save the Children – USA, UNICEF, FHI).	
Legal and Policy Environment	Ambiguity regarding possession and distribution of needles, syringes and other paraphernalia cited as a barrier to scale-up of NSPs[1] Owners who let premises to NGOs or other organisations to run NSPs are liable for prosecution[1] OST not allowable under existing laws[1]. Morphine and Burpenorhine are illegal[5].	NNCB.	Approval for OST pilot now exists[9], however this has not yet commenced.
Law Enforcement	Lack of sensitization and commitment on the issue regarding the harm reduction[2].	Police, RAB, DNC, MOHA, MOHFW.	UNODC, UNICEF, UNAIDS, NGOs and community organisations enhance advocacy efforts with the policy makers to implement harm reduction programme[2].
Comprehensive Services	Mobility of IDUs hamper regular reach/contact[6]. Resource gaps in program design limit delivery of comprehensive services[2].	Donor, Govt. and implementing agencies	Advocacy for sufficient resource mobilization (both financial and technical). This being attempted by UNODC, UNICEF, UNAIDS, NGOs and community organisations[2]. Improved design of the program based on the needs of drug users being facilitated by improved mechanisms for calculating IDU denominator[2].
Resources (Financial, human and data)	Funds and personnel capacity not sufficient to enable appropriate service coverage to scale[6].	Donors (GFATM, World Bank, USAID). Government (MOHFW, MOHA). MAs (Save the Children – USA, UNICEF,	Advocacy for sufficient resource mobilization (both financial and technical). This being attempted by UNODC, UNICEF, UNAIDS, NGOs and community organisations[2].

	Inadequate funds flow, with frequent interruption[2].	FHI).	It is unclear if the MA mechanisms help to increase flow of funds, or whether these complex systems inhibit this.
Involvement of IDUs in the Response	Mobility of IDU hampers regular reach/contact[6].	Donor, Govt. and implementing agencies	
	Violence against target communities affecting IDUs[6] contributed to ongoing stigma and discrimination.	Ministry of Law, Justice and Parliamentary Affairs (MOLJPA), Police, RAB, DNC, MOHA, MOHFW.	
Availability of Commodities			
i. Needle and Syringe programs	Legal restrictions on possession or provision of needles and syringes.	Donors (GFATM, World Bank, USAID). Government (MOHFW, MOHA). MAs (Save the Children – USA, UNICEF, FHI). Implementing agencies.	Although community is supportive, ongoing sensitization will lead to increase acceptance by all, and should therefore remain a part of regular HRP activity[2].
ii. Opioid Substitution Therapy (OST)	Morphine and Burpenorhine are illegal[5].		Approval for OST pilot now exists[9], however this has not yet commenced.
iii. HIV Testing and Counselling (T&C)	Coverage is not adequate[2].		
iv. Antiretroviral Therapy (ART)	Available but not adequate.		
v. Prevention and treatment of STIs	Partner treatment is neglected[2].		
vi. Condom programs	Available but not adequate.		
vii. Targeted IEC materials	Available but not adequate.		
viii. Primary Health Care (including treatment of opportunistic infections)	General health is overlooked by the intervention programme.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	No services available.		
x. Prevention, diagnosis and treatment of tuberculosis	Very poor coordination with existing, non-IDU specific services.		
xi. Peer Education programs	None identified.		
Scaling Up Plans	None identified. Plans exist for many activities (see above).	Donors (GFATM, World Bank, USAID). Government (MOHFW, MOHA). MAs (Save the Children – USA, UNICEF, FHI).	Planned
Capacity Building			Planned under HRP plans.
Monitoring and Evaluation	Lack of capacity to implement M&E activities across the country. National monitoring framework has been developed, however there is lack of	National monitoring framework. NASP of MOHFW. NAC.	FHI, UNAIDS, WHO, UNODC, ICDDR,B, UNICEF and some I/NGOs provide technical support to improve M&E.

	capacity to implement it.		

4. Gap Analysis

- Good multi-sectoral contribution to IDU services exists, however these not equally distributed across IDU populations throughout Bangladesh.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[10]) not currently being delivered to IDUs consistently, particularly OST, ART, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- IDUs not currently contributing to either policy development, service delivery or M&E of harm reduction services. This has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable harm reduction services (especially OST and NSPs), so while there is a firm commitment to a multi-sectoral approach to HIV and AIDS, and to drug use prevention and rehabilitation, commitment to harm reduction is not articulated in the Narcotics Control Act.
- There is a significant time lag between endorsement of evolving policies which support harm reduction activities, and systematic implementation at the service provision, legal and law enforcement levels.
- Financial resources (both in absolute terms, and in terms of dispersal) and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Harm reduction services for prisons and CCDU inadequate and pose an HIV and STI transmission threat throughout Bangladesh. Little is known regarding services available in CCDU, as data is rarely disaggregated for these.

5. Recommendations

- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs in all areas of Bangladesh through improved coordination and planning between donors, government and technical agencies.
- Improved (more rapid, accountable) processes for dispersal of funds from donors to implementing agencies with which to deliver harm reduction services to IDUs.

- Greater involvement of IDUs in policy development and both implementation and M&E of harm reduction programs.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit. UNODC ROSA.
2. Personal communication with UNAIDS Bangladesh and Ezazul Islam Chowdhury, 25th November, 2009.
3. Reddy, A., M. M. Hoque, et al. (2008). Article in press. "HIV transmission in Bangladesh: An analysis of IDU programme coverage. "International Journal of Drug Policy"; doi:10.1016/j.drugpo.2007.11.015.
4. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. (2009). Bangladesh Country Advocacy Brief Injecting Drug Use and HIV.
5. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
6. Rabbani, S. (2009). Harm Reduction Program in Bangladesh: Progress, Opportunity and Challenges. 9th International Congress on AIDS in Asia and the pacific (ICAAP IX). Bali, Indonesia.
7. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
8. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
9. Sharma, M., E. Oppenheimerb, et al. (2009). "A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region." AIDS 23.
10. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Cambodia Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Cambodia

Abbreviations			
ADB	Asian Development Bank	NAA	National AIDS Authority
AIDS	Acquired Immunodeficiency Syndrome	NACD	National Authority for Combating Drugs
ART	Antiretroviral Therapy	NCHADS	National Centre for HIV/AIDS Dermatology and STI
AusAID	Australian Agency for International Development	NGO	Non Government Organisation
C&T	HIV Testing and Counselling	NSP	Needle and syringe program
CCDU	Compulsory Centres for Drug Users	NSP II	National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV and AIDS (2006-2010)
DHAWG	Drug and HIV/AIDS Working Group	OST	Opioid Substitution Therapy
DIC	Drug Information Centre	Sida	Swedish Government development agency
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	STI	Sexually Transmitted Infection
HAARP	HIV/AIDS Asia Regional Program	UNESCO	United Nations Educational, Scientific and Cultural Organisation
HIV	Human Immunodeficiency Virus	USAID	United States Agency for International Development
IDUs	People who inject drugs	WHO	World Health Organization
KHANA	Khmer HIV/AIDS NGO Alliance		

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	National Authority for Combating Drugs (NACD): Ministries of Interior, Health, Justice, Economy and Finance, Information, Social Affairs, Education, Tourism[1]. Drug and HIV/AIDS Working Group (DHAWG) and its Secretariat.	NACD determines drug control policy and supervises drug control operations[2]. NAA sets policy framework, coordinates and monitors national multi-sectoral response to HIV/AIDS (set out in the Law on HIV Prevention and Control of HIV/AIDS, 2002), including policy development and advocating for legislative support[1,3].	

	National AIDS Authority (NAA)[2-3]. National Centre for HIV/AIDS Dermatology and STI (NCHADS).	NCHADS insures the implementation of policy frameworks through operation of its existing services provisions network throughout the country. A number of services have been complemented by NGOs[1].	
Civil Society Engagement	Korsang Mith Samlanh[3-5]. and shortly KHANA FHI[7].	UNESCO, Sida, HAARP, WHO, KHANA and FHI fund civil society working on harm reduction[1,6]. NGOs provide NSP and other harm reduction services in Phnom Penh and elsewhere[1].	
Donor Commitment	UNODC UNESCO WHO GFATM Round 7, GFATM Round 9, HIV/AIDS Asia Regional Program (HAARP), AusAID USAID, ADB, Sida[4].	NGO representation on Substance Abuse Working Group[2]. UNESCO funds civil society working on harm reduction[6], and also worked with WHO on drug services mapping survey[7]. UNODC provides technical support to the OST pilot, HIV response in prisons and other activities[7]. GFATM Round 9 recently approved (USD63,502,281 in first 2 years; USD165,087,396 over five years) to meet HIV prevention, treatment and care, and HIV-related health systems strengthening. As with Round 7, IDUs identified as a priority population for targeted prevention interventions[8]. HAARP (AusAID) supporting multisectoral approaches through direct engagement of non-health sectors in activities such as NSP, OST, condom promotion, primary health care, T&C and ART[9].	
Multi-sectoral Involvement	Substance Abuse Working Group. DHAWG. National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV and AIDS (2006-2010) (NSP II)[2-3]. National Strategic Plan for Illicit Drug Use Related HIV/AIDS 2008-2010[2]. Ministries of Health, National Defence, Interior, Education, Women Affairs,	Substance Abuse Working Group comprises a number of NGOs, and has input to policy and service planning[2]. DHAWG coordinates stakeholders to reduce HIV transmission that is related to drug misuse, and to enhance prevention, treatment and care services related to illicit drug and substance use[2]. NAA coordinates and monitors national multi-sectoral response to HIV/AIDS (set out in the Law on HIV Prevention and Control of HIV/AIDS, 2002)[2-3]. NSP II currently being implemented.	NSP II is the current plan, and will be replaced by NSP III in 2011[2]. Community and stakeholder consultation on policy development not optimal[2].

	Information, Rural Development, Tourism, Cult and Religions, Social Affairs, Planning and The Council for Development of Cambodia (CDC)[1].	National Strategic Plan for Illicit Drug Use Related HIV/AIDS 2008-2010, derived through consultations with all sectors to address policy issues, to develop a comprehensive approach to prevent HIV transmission associated with illicit drug use and to provide treatment, care and support for drug users at risk of infection and living with HIV[2-3].	
Involvement of IDUs in the Response	Drug user network not currently active[1].	A number of NGOs are working actively with IDUs (KORSANG, Friends, KHANA, FHI, Mith Samlanh)[1].	No mechanism for involvement of people who inject drugs in policy and service planning processes[2].
Costed National Harm Reduction Strategy	National Strategic Plan for Illicit Drug Use Related HIV/AIDS 2008-2010. National Drug Control Master Plan (2006-2010). Ministries of Health, Interior, Information, Planning, Economy and Finance[1].	Royal Government of Cambodia and UN agencies contribute to National Strategic Plan for Drug Use, related HIV and AIDS[4]. USD437,800 allocated to HIV prevention for IDUs. National Drug Control Master Plan (2006-2010) outlines drug control activities, principles, strategies and objectives, resource requirements and financing[2].	
Does the National Drug Strategy complement the National HIV strategy?	NSP II[2]. National Strategic Plan for Illicit Drug Use Related HIV/AIDS 2008-2010. Law on Drug Control (1997 as amended in 2009). Law on HIV Prevention and Control of HIV/AIDS (2002). National Drug Control Master Plan (2006-2010). Strategic Operational Plan for Demonstration sites for HIV testing and care treatment for IDUs[1].	A number of policy documents, committees and laws support comprehensive harm reduction through HIV prevention activities. The revised drug law is in favour of NSPs and other harm reduction activities targeting IDUs.	National Drug Strategies are moving towards a state of synergy with National HIV strategies.
Legal and Policy Environment	NSP II. National Strategic Plan for Illicit Drug Use Related HIV/AIDS 2008-2010. Law on Drug Control (1997 as amended in	Enables harm reduction programs: NSP II explicitly supports harm reduction. National Strategic Plan for Illicit Drug Use Related HIV/AIDS 2008-2010; comprehensive approach to prevent HIV transmission associated with illicit drug use and to provide	Restricts harm reduction programs: Public security agencies can limit proposed expansion to NSPs. Law on Drug Control (1997 as amended in 2009) renders consumption and use unlawful (except with medical

	2009). Law on HIV Prevention and Control of HIV/AIDS (2002). National Drug Control Master Plan (2006-2010).	treatment, care and support for drug users at risk of infection and living with HIV[2,6]. Law on HIV Prevention and Control of HIV/AIDS (2002) facilitates policy development and advocates for legislative support[2]. National Drug Control Master Plan (2006-2010) recognises comprehensive approach to HIV and AIDS. It also outlines drug control activities, principles, strategies and objectives, resource requirements and financing, and implementation for priority projects and cooperation. Focuses on demand reduction, supply reduction, drug law enforcement and expansion of international cooperation. Outlines activities for prevention of HIV including raising awareness, treatment and rehabilitation, outreach and peer education, risk reduction and primary prevention of drug use[4].	prescription)[4]. Illegality of drug use makes IDUs vulnerability to arrest when accessing harm reduction services (notably NSPs)[2]. Integration of harm reduction training within the curriculum of the Police Academy is required to promote understanding[2].
Surveillance Systems	No systematic, national surveillance system in place. Currently relies on local authorities and police[1].		

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
The Drug Information Centre (DIC) of the National Authority for Combating Drugs (NACD)[1].	DIC is responsible for data collection, monitoring and reporting on the number of drug users including IDU.	Data is sent from DIC's provincial networks and from NGO partners on a quarterly basis to DIC.	Data will be disseminated through DHAWG quarterly meetings.	The system is still in its premature stage and is being improved.

2. Program Implementation.

Estimated IDU Population: 1,750 (1,000<n<7,000); (estimates from 2004)[10] *(a)*
625; (estimates from 2006)[6] *(a)*
2,025 (1,250<n<7,500); (estimates from 2009)[4] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	2 sites in Phnom Penh. Available in pharmacies.	Mith Samlanh. Korsang[4-5].	Not Available[1].	980[4].	NGOs: No. Pharmacies: Yes.	267,271 in 2007[4]. NGOs: 91,617 in 2009[5].	Unknown.		48-56% (b/a)	Yes: Govt committed to comprehensive services[3].
Opioid Substitution Therapy (OST)	Methadone and buprenorphine not available[4,6].		Pilot soon to commence in National Hospital, Phnom Penh[4].		No					
HIV Testing and Counselling (T&C)	Currently only available for IDUs specifically through pilot project[4].		VCCT and ART/OI network of NCHADS[1].	~100 IDUs[4].	Unknown					
Antiretroviral Therapy (ART)	No services. It is believed there is not a high need for IDU-specific services[4].				Unknown					
Prevention and treatment of STIs	Some NGOs providing this to IDUs	Mith Samlanh Korsang[5].			Unknown					Unknown
Condom programs	Some NGOs providing this to IDU	Mith Samlanh Korsang[5].			No	61,928[5].	Unknown			Unknown
Targeted IEC		Mith Samlanh Korsang[5].			Unknown	39,152 ed sessions[5].	Unknown			Unknown
Primary Health Care (including treatment of opportunistic	Some NGOs providing this to IDU	Mith Samlanh Korsang[5].			Unknown	14,017 service events[5].	Unknown			Yes: Govt committed to comprehensive

infections)									services[3].
Diagnosis, treatment of and vaccination for viral hepatitis	Not available unless willing to pay[1].				Yes		Unknown		Unknown
Prevention, diagnosis and treatment of tuberculosis	Not identified.				Unknown		Unknown		Yes: Govt committed to comprehensive services[3].
Peer Education programs		Mith Samlanh Korsang[5].		~300[4].	No	56,398 ed sessions[5].	Unknown		Unknown

2b. Services in Prisons.

Estimated Prisoner Population:	11,688 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Jan 09; sourced 30/7/09) 11,207 (2008, 28th Asia and Pacific Conference of Correctional Administrators, Langkawi, Malaysia)	
Estimated # and % of Drug Offenders:	Information not available	
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs (NSP)	No	
Opioid Substitution Therapy (OST)	No	
HIV Testing and Counselling (T&C)	Yes but not systematically done[1].	NGO (Cambodian People Living with HIV/AIDS Network) provides, voluntary T&C in 12 provinces[6]. Referral available in 6 prisons[4].
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	No	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Yes	6 prisons[4].
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	No	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		No information available
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	No	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	No	
Antiretroviral Therapy (ART)	No	
Prevention and treatment of STIs	Unknown	
Condom programs	No	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	No	
Diagnosis, treatment of and vaccination for viral hepatitis	No	
Prevention, diagnosis and treatment of tuberculosis	Possibly	Possibly through referral only[1].
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Low level of political commitment[1]. High level officials are uncertain about the benefit of harm reduction[1]. Limited acceptance of harm reduction at the level of local authorities.	Government: NACD and Ministry of Interior UN: WHO, UNODC and UNAIDS	WHO, HAARP of AusAID, KHANA and UNAIDS have been working to convince government to support this issue[1].
Civil Society Engagement	Limited Civil Society Engagement as the community does not accept that this is its own problem. Community and stakeholder consultation on policy development not optimal[2].	NACD, NAA, NGOs, donors and technical agencies.	WHO, HAARP of AusAID, KHANA and UNAIDS have been working to convince government to support this issue[1]. UNESCO funds civil society working on harm reduction[6]. HAARP supporting multisectoral approaches through direct engagement of non-health sectors in harm reduction activities[9].
Legal and Policy Environment	Morphine and Burpenorhine are controlled drugs[6]. The drug law is still being approved. High level government officials are still unclear about the impact of harm reduction despite exposures to numerous workshops and study tours.	NACD. NAA.	Advocacy underway to amend the Law on Drug Control to enable health services to IDUs[3].
Law Enforcement	Public security agencies have power to limit proposed expansions of NSPs[2]. Majority of law enforcement officers have little appreciation of, or support for harm reduction[1]. Insufficient awareness and training to promote harm reduction in closed settings.	Ministry of Interior, NACD, NAA, Law enforcement authorities.	UNODC provides technical support to HIV response in prisons and other activities[7]. HAARP supporting multisectoral approaches through direct engagement of non-health sectors, including law enforcement authorities[9].
Comprehensive Services	It is believed that low prevalence of IDUs is cause for limited government support for comprehensive services[4].	NACD, NAA, civil society, donors and technical agencies.	Advocacy from donors and technical agencies required to ensure injecting drug use remains a focus within the national response to HIV and AIDS.
Resources (Financial, human and data)	Very limited from both the government and the UN[1]. Lack of capable human resources.	NACD, NAA, civil society, donors and technical agencies.	UNODC, HAARP and GFATM supporting capacity building activities.

Involvement of IDUs in the Response	No mechanism for involvement of people who inject drugs in policy and service planning processes[2]. Illegality of drug use – and the vulnerability ofIDUs to arrest when accessing harm reduction services is a key constraint to supporting effective and sustainable involvement[2].	Civil society, donors and technical agencies.	Advocacy from civil society (including IDU groups), donors and technical agencies required to facilitate greater involvement of IDUs in the response.
Availability of Commodities			
i. Needle and Syringe programs	Available in areas covered by KORSANG and Mith Samlanh. Also widely available in pharmacies in Phnom Penh and provincial towns[1].		UNODC, HAARP and GFATM supporting scale-up.
ii. Opioid Substitution Therapy (OST)	Methadone only in pilot stage – will be available early 2010.		Intention for methadone to be available by early 2010[1].
iii. HIV Testing and Counselling (T&C)	Available in capital cites and provincial towns[1].		UNODC, HAARP and GFATM supporting scale-up.
iv. Antiretroviral Therapy (ART)	Available for IDU if requested. Largely available for all people living with HIV in need of ART[1].		UNODC, HAARP and GFATM supporting scale-up.
v. Prevention and treatment of STIs	Not systematically available[1].		
vi. Condom programs	Available[7].		UNODC, HAARP and GFATM supporting scale-up.
vii. Targeted IEC materials	None identified.		UNODC, HAARP and GFATM supporting scale-up.
viii. Primary Health Care (including treatment of opportunistic infections)	Not available[1].		UNODC, HAARP and GFATM supporting scale-up.
ix. Diagnosis, treatment of and vaccination for viral hepatitis	Not available[1].		
x. Prevention, diagnosis and treatment of tuberculosis	Possibly available through referral only[1].		
xi. Peer Education programs	Not available[1].		UNODC, HAARP and GFATM supporting scale-up.
Scaling Up Plans		WHO, HAARP, UNODC, KHANA and UNAIDS.	WHO, HAARP, and UNAIDS are working with KORSANG, Mith Samlanh, KHANA and FHI to scale up NSP program. UNODC supporting procurement component of the OST pilot
Capacity Building	Lack of capable human resources[1].	WHO, HAARP, UNODC, KHANA and UNAIDS.	WHO, HAARP, and UNAIDS are working with KORSANG, Mith Samlanh, KHANA and FHI to scale up capacity building.

Monitoring and Evaluation	IDU data collection systems still in their premature stage and are being improved[1].	NACD (DIC) WHO, HAARP, UNODC, KHANA and UNAIDS.	WHO, HAARP, and UNAIDS are working with NACD (DIC) and relevant NGOs to improve M&E.

4. Gap Analysis

- Good multi-sectoral collaboration exists on paper, however high-level government commitment to harm reduction appears lacking, possibly as a result of low prevalence of visible injecting drug use.
- Less than optimal community and stakeholder consultation on policy development and implementation of harm reduction programs, especially amongst IDUs, for whom no mechanism for inclusion exists. This has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable harm reduction services (especially OST and NSPs), and to encourage wider civil society involvement (especially from IDU groups).
- Wide-ranging powers of law enforcement authorities over IDUs are incompatible with the provision of effective harm reduction services.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[11]) not currently being delivered to IDUs consistently, particularly OST, T&C, ART, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators by total IDUs and by gender) upon which to plan and deliver targeted services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Despite UNODC programs in this area, little information is available regarding harm reduction services for prisons and CCDU, reflecting the likelihood that such existing services would not be sufficient to address harm reduction needs to scale.

5. Recommendations

- Advocacy from donors and technical agencies to ensure injecting drug use remains a focus within the national response to HIV and AIDS.
- Greater involvement of civil society (including IDUs) in policy development and both implementation and M&E of harm reduction programs.

- Greater coordination between central and implementation levels of government is essential to ensuring effective harm reduction services, and this should be strengthened through technical and mentoring support to the latter.
- Legal and policy reform to facilitate delivery of harm reduction services (especially OST and NSPs), without fear of harassment from law enforcement for implementers or IDUs accessing the services.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Legal and policy reform to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Personal communication, Phauly Tea, Most-at-Risk-Populations Adviser, UNAIDS Cambodia. 18th October, 2009.
2. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit. UNODC ROSA.
3. Asian Consortium on Drug Use, HIV, AIDS and Poverty. (2008). Response beyond borders: the South East Asia regional workshop on the prevention of HIV related to drug use, Asian Consortium on Drug Use, HIV, AIDS and Poverty.
4. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific and HIV/AIDS Asia Regional Program (HAARP). (2009). Cambodia Country Advocacy Brief Injecting Drug Use and HIV.
5. Mith Samlanh and Korsang (2009). Routine Analysis of NSP Data: January– September 2009, eport provided by Graham Shaw, WHO WPRO (Cambodia), 17th November, 2009.
6. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
7. Personal communication, Anne Bergenstrom, United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific 9th November, 2009.
8. Global Fund for AIDS, TB and Malaria. (2009). "Proposal Form Round 9: Cambodia" Retrieved 15th November, 2009, from http://www.theglobalfund.org/programs/country/?countryID=CAM=en

9. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
10. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
11. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

China Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: People's Republic of China (China)

Abbreviations			
ADB	Asian Development Bank	IDUs	People who inject drugs
AIDS	Acquired Immunodeficiency Syndrome	NGO	Non Government Organisation
ART	Antiretroviral Therapy	NSP	Needle and syringe program
AusAID	Australian Agency for International Development	OST	Opioid Substitution Therapy
C&T	HIV Testing and Counselling	PSI	Population Services International
CCDU	Compulsory Centres for Drug Users	RTL	Re-education through labour
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	STI	Sexually Transmitted Infection
HAARP	HIV/AIDS Asia Regional Program	UNODC	United Nations Office on Drugs and Crime
HIV	Human Immunodeficiency Virus		

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	State Council AIDS Working Committee. National and State Narcotic Control Commissions. National guidelines on the operation of MMT enacted by: Ministry of Health Ministry of Public Security National Food and Drug Administration[1]. Ministry of Justice	Government of China has taken action to address the public health threat of HIV with the introduction of community based harm reduction services[2]. Ministry of Justice is responsible for prisons and re-education through labour (RTL) centres, and has (with the Ministry of Health) developed an HIV/AIDS prevention and care strategy for the correctional system[2]. Ministry of Public Security manages CCDU[2]. National Narcotics Control Commission formulates drug policy[1].	Commitment to harm reduction strategies in the community is not reflected in prisons and CCDU, and there is little coordination of pre- and post-release OST services[2]. Despite HIV/AIDS prevention and care strategy for the correctional system, this has not been widely implemented[2].

		State Narcotic Control Commission responsible for organising, coordinating and guiding narcotic control within the jurisdiction of the respective administrative region[2]. State Council AIDS Working Committee has established national coordinating mechanism for the HIV response[1].	
Civil Society Engagement	Government restrictions limit this[3]. Some activities do take place, including: Daytop China in Yunnan Medicins du Monde in Sichuan PSI in Yunnan[4].	Narcotics Control Law outlines roles of trade union groups, communist youth leagues, women's federations etc in conducting community education about narcotics control[2]. The Regulations on AIDS Prevention and Treatment identifies strong societal participation towards delivery of comprehensive measures for the prevention and treatment of AIDS, through strengthened education and behavioural interventions together with care and support. Mass media campaigns involving a broad range of media are encouraged, and government institutions at all levels, associations, both profit and non-profit groups as well as individuals are identified as being required to participate[2].	Civil society engagement under the Narcotics Control Law does not extend to community harm reduction activities. While the Regulations on AIDS Prevention and Treatment identify high risk groups, regarding IDUs, governments from county level and above are directed to establish coordinated mechanisms with Health, Public Security and Drug Administration agencies for "dealing with drug abuse" and HIV. The only harm reduction aspect of this is in the implementation of OST. Anti-drug abuse measures take precedence over HIV prevention approaches for IDUs. Once identified as IDUs, HIV positive people will fall outside the Regulations on AIDS Prevention and Treatment and will fall under the narcotic control.
Donor Commitment	GFATM HIV/AIDS Asia Regional Program (HAARP), AusAID UNODC	GFATM supporting harm reduction[3]. Round 6 "Mobilizing Civil Society to Scale Up HIV/AIDS Control Efforts in China" program now complete, and Round 8 currently being finalised with The Chinese Centre for Disease Control and Prevention (approx. US$58.3m). Program aims to "Scale up and increase impact of prevention services to hard-to-reach populations, including most vulnerable SW and their clients, IDU, MSM, and out-of-school youth"[5]. HAARP/AusAID; AUD7.4 million (2008-2013) to bolster Chinese Government efforts to implement harm reduction for IDUs in Yunnan and Guangxi Provinces[6]. UNODC supporting Ministry of Justice towards implementing harm reduction strategies.	Donors unwilling/unable to be more active in working with counterparts to scale-up harm reduction policy development and activities. Currently these efforts are passive, relying on government agencies to request support, and to dictate the terms of this support.
Multi-sectoral Involvement	Health, Public Security and Drug Administration agencies. Ministry of Health. Ministry of Justice.	The Regulations on AIDS Prevention and Treatment identifies comprehensive measures to be implemented in the prevention and treatment of AIDS, with a focus on government led, multi-sectoral responses and cooperation.	While the Regulations on AIDS Prevention and Treatment identify high risk groups, regarding IDUs, governments from county level and above are directed to establish coordinated mechanisms with Health, Public Security and Drug

		Strong societal participation is encouraged with strengthened education and behavioural interventions together with care and support[2]. Ministry of Justice and Ministry of Health have developed an HIV/AIDS prevention and care strategy for the correctional system[2].	Administration agencies for "dealing with drug abuse" and HIV. The only harm reduction aspect of this is in the implementation of OST. Anti-drug abuse measures take precedence over HIV prevention approaches for IDUs. Despite HIV/AIDS prevention and care strategy for the correctional system, this has not been widely implemented[2].
Involvement of IDUs in the Response	Provincial network, Yunnan Province[4].	Provincial network in Yunnan, supported by Beijing AIZHIXING Institute of Health Education[4].	
Costed National Harm Reduction Strategy	Not currently available.	A costed harm reduction strategy is under development within the framework of China's Rolling Continuation Channel application to GFATM[4]. Next strategy from 2011-2015.	
Does the National Drug Strategy complement the National HIV strategy?	HIV/AIDS control legislation – Regulations on AIDS Prevention and Treatment. Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2006-2010). Narcotics Control Law. Regulations on AIDS Prevention and Treatment (issued by the State Council on 1 March 2006). Strategic Program of the Ministry of Justice for HIV/AIDS Prevention and Control (2003-2007). Decree of the State Council of the People's Republic of China, No. 457: Regulations on AIDS Prevention and Treatment[4].	HIV/AIDS control legislation – Regulations on AIDS Prevention and Treatment calls for prevention measures for vulnerable groups, peer education, OST and condom promotion, but not explicitly NSPs[1]. Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2006-2010) sets goals for implementing and scaling up NSPs, OST, condom use and antiretroviral treatment[1]. Narcotics Control Law requires drug users to undergo community based detoxification, and to be provided with vocational training and employment assistance. Public security departments to enact 'direct forced isolation treatment' for those deemed to be in non-compliance with community detoxification[1]. Strategic Program of the Ministry of Justice for HIV/AIDS Prevention and Control (2003-2007) issued by the Ministry of Justice on 20th March 2003 The Regulations on AIDS Prevention and Treatment provides instruments for the prevention, treatment and control of AIDS in China[2]. Ministry of Justice and Ministry of Health have developed an HIV/AIDS prevention and care strategy for the correctional system. It stipulates that correctional systems across the	National Drug Strategies are moving towards a state of synergy with National HIV strategies. Strategic Program of the Ministry of Justice for HIV/AIDS Prevention and Control (2003-2007) applies to the control and prevention of HIV/AIDS within prisons and RTL institutions that fall under the control of the Ministry of Justice. It outlines specific, targeted education conducted for high risk groups including the use of peer educators in behaviour change programs which target risk-reduction strategies. While this is referred to as a harm reduction approach, it is unclear if this includes such activities specific to IDUs[2].

		country should conduct HIV testing for all inmates in every correctional institution in China, and that testing be compulsory[2].	
Legal and Policy Environment	Narcotics Control Law (adopted by the Standing Committee of the People's Congress on 29 December 2007). Regulations on AIDS Prevention and Treatment (issued by the State Council on 1 March 2006). Implementation Measures on AIDS Prevention and Control at RTL Institutions in China (Trial) (issued jointly by the Ministry of Justice and the Ministry of Health 0n 22 October, 2004, and enacted in the same year). Regulations on Drug Rehabilitation through Labour (issued by the Ministry of Justice in 2 June, 2003 and effective on 1 August, 2003).	Enables harm reduction programs: Recent introduction of policy documents to guide scale-up for harm reduction[3]. At central government level, numerous laws, regulations and strategic plans relating to the prison system have been developed[2]. Narcotics Control Law requires drug users to undergo community based detoxification, and to be provided with vocational training and employment assistance, however public security departments to enact 'direct forced isolation treatment' for those deemed to be in non-compliance with community detoxification[1]. Narcotics Control Law directs the framework towards a supportive legal environment for the prevention of, and punishment for illegal and criminal acts involving narcotic drugs. The law stresses the need for control of narcotics cultivation, manufacturing, trafficking and ingestion[2]. While there is no specific mention of OST within the Narcotics Control Law, in practice, methadone (and possibly buprenorphine) are permitted[2]. Under the Regulations on AIDS Prevention and Treatment, HIV prevention programs are permitted within closed settings. However, this does not elaborate on what services are permitted[2].	Restricts harm reduction programs: Legal environment is conducive to increasing access to some harm reduction services, however link between policy and implementation not sufficient with regard NSPs[2]. Needles and syringes not specifically addressed in law, resulting in reluctance from within government to accept these approaches NSPs[2]. A lack of a clear policy and legal framework for the introduction of effective harm reduction responses in closed settings[2]. Establishing a 'drug free society' is a key Government of China strategy, with the legal and policy environment reflecting a strong approach against illicit drug use[7]. Central government directives regarding HIV prevention in prisons have not been adopted at provincial or district levels[2]. Some items within the Narcotics Control Law relating to "addiction quitting measures", which outline approaches to help addicts quit addiction, educate and "rescue" addicts could contribute to IDUs being unwilling to disclose their drug use. These include; Wide ranging powers of police, health and administrative departments to detain IDUs in closed settings in order to be "cured" of their addiction. Directions for "treatment of addiction quitting", allowing public security agencies to conduct inspection and testing of suspected IDUs. Enforcement of compulsory testing of IDUs should they refuse to comply with law enforcement authorities (this undefined). Registration of positive IDUs by public security officials[2]. Implementation Measures on AIDS Prevention and Control at

			RTL Institutions in China (Trial) Regulations on Drug Rehabilitation through Labour These two documents provide guidelines for implementing a range of measures within RTL centres that focus on testing, notification and confidentiality and management of persons infected with HIV within these centres. They do not outline harm reduction measures for IDUs, but rather articulate "severe punishment" for inmates found using drugs[2].
Surveillance Systems	Ministry of Health Ministry of Justice	National sentinel surveillance system exists.	HIV testing activities are oriented towards monitoring HIV/AIDS in correctional settings rather than providing care and support for those who are HIV positive[2].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used	No

Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
National HIV/AIDS sentinel surveillance system[2].	Commenced in correctional system in 1996.	Provincial Bureau of RTL Administration reports quarterly to the Bureau of RTL Administration within the Ministry of Justice.	National Bureau of RTL and Prison collects, manages and reports the national surveillance information, but it is not clear what happens to this information.	HIV testing activities are oriented towards monitoring HIV/AIDS in correctional settings rather than providing care and support for those who are HIV positive[2].
Integrated AIDS Information System	Established in 2008. Includes web-based elements for OST, C&T and "High risk interventions"	Web-based elements are "real time".		Other elements, such as ART, not yet web-based.

2. Program Implementation.

Estimated IDU Population: 2,350,000 (1,800,000<n<2,900,000); (estimates from 2005)[8] *(a)*
1,928,200; (estimates from 2006)[3] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	775 sites in 17 provinces[3]. 800 sites[2].	Medecins du Monde	Mostly gov't services.	Unknown	Unknown	110/client /yr[3].	Unknown	Unknown		Yes
Opioid Substitution Therapy (OST)	654 sites in 25 provinces + 26 mobile vans in 10 provinces[9].		Mostly gov't services.	109,523[9]. Cumulative total: 231,596[9]..	Yes and No (site dependent)		Yes	Yes	6-12% (b/a)-	Yes: increase to 1000 sites by the end 2009[2-3].
HIV Testing and Counselling (T&C)	Unspecified, but do exist.		Mostly gov't services.	Unknown	Unknown					Unknown
Antiretroviral Therapy (ART)	Available, but not IDU-specific.		Mostly gov't services.	Unknown	Unknown					Unknown
Prevention and treatment of STIs	Available, but not IDU-specific.			Unknown	Unknown					Unknown
Condom programs	Readily available, but not IDU-specific.	Yes	Yes	Unknown	No		Unknown	Unknown		Unknown
Targeted IEC	Yes, but relating to addiction, not harm reduction.	Yes	Yes	Unknown	Unknown		Unknown	Unknown		Unknown
Primary Health Care (including treatment of opportunistic infections)	Available, but not IDU-specific.			Unknown	Unknown		Unknown	Unknown		Unknown
Diagnosis, treatment of and vaccination for viral hepatitis	Not specified			Unknown	Unknown		Unknown	Unknown		Unknown
Prevention, diagnosis and treatment of	Not specified			Unknown	Unknown		Unknown	Unknown		Unknown

tuberculosis										
Peer Education programs		Yes		Unknown	No		Unknown	Unknown		Unknown

2b. Services in Prisons.

Estimated Prisoner Population:	2,500,000 Includes 1,565,771 (sentenced prisoners in Ministry of Justice prisons - national prison administration) + 100,000 (estimated pre-trial detainees) + 500,000 (serving administrative detention in RTL cetres, in 2005) + 350,000 (administrative detention for drug offenders and prostitutes in 2004 - U.S. State Department Human Rights Report 2006) (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Dec 05; sourced 30/7/09)
Estimated # and % of Drug Offenders:	Information not available

Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	Yes	
HIV Testing and Counselling (T&C)	Yes	Testing is compulsory for all inmates – no voluntary testing is available. It is unclear if counselling is available.
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Yes	IEC is the major HIV/AIDS prevention method targeting IDUs in the correctional system. These have been developed in unspecified locations; it is not clear if they are ongoing, nor whether they address harm reduction, or simply messages regarding prevention of drug use and relapse[2].
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Yes	Some peer education has been conducted in unspecified locations. Often this is related to reducing drug-related harms, or preventing relapse. Activities have included training of trainers, peer education, lectures, group discussions, audio and video education[2].
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		>350,000 (administrative detention for drug offenders and prostitutes in 2004 - U.S. State Department Human Rights Report 2006) (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Dec 05; sourced 30/7/09) 140,000 drug users held in 746 CCDU and receiving re-education through labour centres[10].
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Yes	Strategic Program of the Ministry of Justice for HIV/AIDS Prevention and Control (2003-2007) stipulates that testing is compulsory for all inmates[2]. NGO-provided, voluntary T&C in Kunming, Yuxi, Luoping, Chuxiong, Qujing, Yunnan provinces (for people living with HIV) – this refers to voluntary counselling only, as testing is compulsory.
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Yes	IEC is the major HIV/AIDS prevention method targeting IDUs in the correctional system. These have been developed in unspecified locations; it is not clear if they are ongoing, nor whether they address harm reduction, or simply messages regarding prevention of drug use and relapse[2].
Primary Health Care (including treatment of opportunistic infections)	Yes	NGO-provided, basic medical care in Kunming, Yuxi, Luoping, Chuxiong, Qujing, Yunnan provinces (for people living with HIV)
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Yes	Some peer education has been conducted in unspecified locations. Often this is related to reducing drug-related harms, or preventing relapse. Activities have included training of trainers, peer education, lectures, group discussions, audio and video education[2].
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Prison authorities not supportive of harm reduction for IDUs in closed settings. Commitment to harm reduction strategies in the community is not reflected in prisons and CCDU[2]. Authorities slow to implement HIV/AIDS prevention and care strategy for the correctional system. Under the Regulations on AIDS Prevention and Treatment, anti-drug abuse measures take precedence over HIV prevention approaches for IDUs.	Ministry of Justice Public Security Bureau Law enforcement authorities	Under the Strategic Program of the Ministry of Justice for HIV/AIDS Prevention and Control (2003-2007), a plan to ensure 60-95% of all prison staff, including leaders and operational personnel and both police and medical staff receive education regarding HIV prevention and, treatment for closed settings. It is unclear if comprehensive harm reduction services for IDUs would be included in this training[2]. HIV/AIDS prevention and care strategy for the correctional system exists[2].
Civil Society Engagement	Civil society engagement under the Narcotics Control Law does not extend to community harm reduction activities.	State Council AIDS Working Committee. Ministry of Health. Ministry of Public Security. Ministry of Justice. Public Security Bureau. Law enforcement authorities. NGOs and other civil society organisations.	Narcotics Control Law outlines roles of trade union groups, communist youth leagues, women's federations etc in conducting community education about narcotics control[2]. Regulations on AIDS Prevention and Treatment identifies strong societal participation towards delivery of comprehensive measures for the prevention and treatment of AIDS, through strengthened education and behavioural interventions together with care and support. Mass media campaigns involving a broad range of media are encouraged, and government institutions at all levels, associations, both profit and non-profit groups as well as individuals are identified as being required to participate[2].
Legal and Policy Environment	Imbalance of national and local government support for OST over NSPs exists[1]. Lack of clear regulatory direction at the national level creates uncertainty regarding the legality of harm reduction services at the local level[1]. Insufficient link between policy and implementation of NSPs[2] and other harm reduction services.	State Council AIDS Working Committee. Ministry of Health. Ministry of Public Security. Ministry of Justice. Public Security Bureau. Law enforcement authorities. NGOs and other civil society organisations.	Recent introduction of policy documents to guide scale-up for harm reduction[3]. Under the Regulations on AIDS Prevention and Treatment, HIV prevention programs are permitted within closed settings. However, this does not elaborate on what services are permitted[2].

	Legal and policy environment reflecting a strong approach against illicit drug use[7].		
	Adoption of central government directives at provincial or district levels regarding HIV prevention in prisons has been slow[2]		
Law Enforcement	Public Security Bureau often target NSPs and methadone maintenance clinics where they know IDUs congregate[3].	Public Security Bureau State Council AIDS Working Committee. Ministry of Health. Ministry of Public Security. Ministry of Justice. Public Security Bureau. Law enforcement authorities.	
	Narcotics Control Law promotes punishment for illegal and criminal acts involving narcotic drugs[2].		
	Narcotics Control Law provides police with wide ranging powers to; Detain IDUs in closed settings in order to be "cured" of their addiction. Conduct inspection and testing of suspected IDUs. Enforce compulsory testing of IDUs should they refuse to comply with law enforcement authorities (this undefined). RegisterHIV positive IDUs[2].		
	IDUs entering OST program required to hold valid identification and to have received permission from police. Creates fear associated with police identification of IDUs[1].		
Comprehensive Services	OST programs receive more popular, political and policy support compared with other harm reduction measures.	Ministry of Justice. Ministry of Public Security. Ministry of Health. Donors and technical agencies.	GFATM Round 6 aims to "Scale up and increase impact of (unspecified) prevention services to hard-to-reach populations, including IDUs[5]. HAARP/AusAID; AUD7.4 million (2008-2013) to bolster Chinese Government efforts to implement harm reduction for IDUs in Yunnan and Guangxi Provinces[6]. HIV/AIDS prevention and care strategy for the correctional system exists[2]. It is not clear if this addresses harm reduction activities for IDUs. UNODC supporting Ministry of Justice towards implementing harm reduction strategies.
	No policy framework exists to facilitate implementation of OST, NSPs or distribution of condoms within correctional system[2].		
	NSPs are considered too controversial and sensitive to be implemented in the correctional systems; there are no existing plans to implement these [2].		
	Given that sexual activity between inmates is not permitted in closed settings, providing condoms is		

	considered too sensitive and controversial[2].		
	National level guidance on implementation of services not as consistent at local level[1].		
Resources (Financial, human and data)	Stigma associated with health workers refusing to treat people living with HIV[3].	Ministry of Health. Donors and technical agencies.	GFATM Round 6 aims to "Scale up and increase impact of (unspecified) prevention services to hard-to-reach populations, including IDUs[5].
Involvement of IDUs in the Response	Stigma associated with IDUs in the community, amongst law enforcement authorities and within government generally may inhibit IDU involvement.	IDU groups, donors and technical agencies.	UNAIDS hopes to support the development of a national network, which hopefully will be developed during 2010[4].
Availability of Commodities			
i. Needle and Syringe programs	None identified, although NSPs generally not well accepted or supported.	State Council AIDS Working Committee. Ministry of Health.	
ii. Opioid Substitution Therapy (OST)	Limited funding for staff training results in low morale amongst OST program clinical staff[1]. Cost for methadone (some sites) prohibitive[1].		
iii. HIV Testing and Counselling (T&C)	None identified.		
iv. Antiretroviral Therapy (ART)	None identified.		
v. Prevention and treatment of STIs	None identified.		
vi. Condom programs	None identified.		
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		

Scaling Up Plans			GFATM Round 6 aims to "Scale up and increase impact of (unspecified) prevention services to hard-to-reach populations, including IDUs[5]. UNAIDS hopes to support the development of a national network, which hopefully will be developed during 2010[4]. HAARP/AusAID to bolster Chinese Government efforts to implement harm reduction for IDUs in Yunnan and Guangxi Provinces[6]. UNODC supporting Ministry of Justice towards implementing harm reduction strategies.
Capacity Building	Capacity of health care workers very limited.	State Council AIDS Working Committee. Ministry of Health. Technical agencies.	GFATM Round 6 aims to "Scale up and increase impact of (unspecified) prevention services to hard-to-reach populations, including IDUs[5].
Monitoring and Evaluation	In regard to China's UNGASS reporting, denominators and estimates of number of IDUs have never been made public. Surveys were conducted in populations covered by interventions and coverage figures are thus falsely high[4].	Ministry of Health Ministry of Justice	Web-based Integrated AIDS Information System planning to scale-up to incorporate more data fields within its 'real time' data collection.

4. Gap Analysis

- Good multi-sectoral contribution to HIV and AIDS interventions exist, but these mechanisms not reflected in a comprehensive response targeted towards IDUs.
- Civil society engagement in HIV prevention is not well reflected in harm reduction activities for IDUs.
- Legal and policy environment more committed to "dealing with drug abuse" and HIV than to delivering a rights-based approach to prevention and care. For example, anti-drug abuse measures take precedence over HIV prevention approaches for IDUs, and once identified as IDUs, HIV positive people will fall outside the Regulations on AIDS Prevention and Treatment and fall under the narcotic control.
- Poor coordination exists between central government mechanisms/directives and provincial and county level implementation, both in terms of delivery of services and law enforcement.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[11]) not currently being delivered to IDUs consistently. Emphasis on OST greatly outweighs all other services within the comprehensive package, and there is little information available regarding T&C, ART, treatment of STIs, diagnosis, treatment of and vaccination for viral hepatitis and prevention and diagnosis and treatment of tuberculosis for IDUs.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively, and to disaggregate data for IDUs. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].
- IDUs suffer widespread stigma and discrimination, from the community, law enforcement, health authorities and throughout the justice system. This discrimination is enshrined in the policy and legal framework.
- IDUs do not currently contribute to either policy development, service delivery or M&E of harm reduction services. This has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable a number of harm reduction services (especially NSPs), both in the community and correctional systems.
- There is a significant time lag between endorsement of evolving policies which support harm reduction activities, and systematic implementation at the service provision, legal and law enforcement levels.
- Harm reduction services for prisons and CCDU inadequate and pose an HIV and STI transmission threat throughout China, despite existence of HIV/AIDS prevention and care strategy for the correctional system.

5. Recommendations

- Greater commitment to the provision of a comprehensive suite of harm reduction services, (as recommended by WHO, UNODC, UNAIDS[11]), comprising a shift away from the major focus being on compulsory and voluntary OST. This may require legal and policy reform, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Greater commitment to multi-sectoral involvement in program development and delivery of harm reduction services for IDUs, including from IDU groups, is essential to reducing widespread stigma and discrimination towards IDUs, and necessary to ensure appropriateness of services.
- Greater multi-sectoral, government involvement is required to view harm reduction as being other than simply a health- or law-related issue, and is essential to facilitate scale-up to deliver comprehensive services.
- Improved communication and coordination between central government mechanisms/directives and provincial and county level implementation of services will facilitate more appropriate, effective and timely interventions for IDUs.
- Legal and policy reform towards a rights-based approach to delivering essential, comprehensive services to IDUs, rather than legally harassing IDUs through infringements of civil rights and incarceration.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Stephens, D. (2009). Law and Policy Review: July 2009, HIV/AIDS Asia Regional Program, United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.
2. Denham, G. and C. Hagarty (2008). HIV prevention, treatment, care and support in closed settings: a review of international good practice and current practices in China. Melbourne, Burnet Institute, United Nations Office on Drugs and Crime (UNODC), China.
3. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
4. Personal communication, Peter Lunding, Senior HIV Adviser, UNAIDS China, 18th December, 2009.
5. No author cited. (2009). "Global Fund to for AIDS, tuberculosis and malaria." Retrieved 15th October, 2009, from http://www.theglobalfund.org.

6. No author cited. (2009). "HIV/AIDS Asia Regional Program (HAARP)." Retrieved 23rd October, 2009, from http://www.haarp-online.org.
7. Kaufman, J., A. Kleinman, et al. (2006). AIDS and Social Policy in China. Cambridge, Harvard University Asia Centre.
8. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
9. Yin W. Scaling-up Harm Reduction program in China. Presentation at a meeting on the Development of the regional strategy for harm reduction in Asia and the pacific 2010-2015 - Confronting HIV among people who inject drugs. 7-9 December, 2009. Kuala Lumpur, Malaysia.
10. Bezziccheri, S. (2006). HIV/AIDS and custodial settings in South East Asia: an exploratory review into the issue of HIV/AIDS and custodial settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam, UNODC.
11. Yin W. Scaling-up Harm Reduction program in China. Presentation at a meeting on the Development of the regional strategy for harm reduction in Asia and the pacific 2010-2015 - Confronting HIV among people who inject drugs. 7-9 December, 2009. Kuala Lumpur, Malaysia.
12. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

India Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: India

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	NGO	Non Government Organisation
ART	Antiretroviral Therapy	NSP	Needle and syringe program
AusAID	Australian Agency for International Development	OST	Opioid Substitution Therapy
C&T	HIV Testing and Counselling	PSI	Populations Services International
CCDU	Compulsory Centres for Drug Users	SACS	State AIDS Control Society
CRS	Catholic Relief Services	SIMS	Strategic Information Management System
DFID	Department for International Development (United Kingdom)	SIMU	Strategic Information Management Unit
EC	European Commission	STI	Sexually Transmitted Infection
FHI	Family Health International	UNAIDS	Joint United Nations Programme on HIV/AIDS
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	UNDP	United Nations Development Programme
HIV	Human Immunodeficiency Virus	UNFPA	United Nations Population Fund
IDUs	People who inject drugs	UNICEF	United Nations Children's Fund
ILO	International Labour Organization	UNODC	United Nations Office on Drugs and Crime
MSJE	Ministry of Social Justice and Empowerment	USAID	United States Agency for International Development
NACO	National AIDS Control Organisation	WHO	World Health Organization
NACP-III	National AIDS Control Programme, Phase III, 2006-2011		

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Ministry of Social Justice and Empowerment (MSJE)[1]. National AIDS Control Organisation (NACO): Ministry of Health and Family Welfare (lead) National AIDS Control Programme, Phase III,	NACO and Ministry of Health and Family Welfare recognize drug injecting as a major cause of HIV spread[2]. NACP-III focuses on IDUs, and aims to ensure 50% of activities are conducted through community based organisations[3].	While targeted interventions reach a large proportions of the IDU community in some parts of India (83% in Kolkata), in most cases it is much lower (10% in Punjab)[3]. NACP-III not achieving great success for IDUs: HIV prevalence increasing, sharing of equipment is increasing, new regions emerging with significant numbers of IDUs[3].

	2006-2011 (NACP-III)	UNODC working with the MSJE on integrating HIV issues in all their drug use programs[3].	
Civil Society Engagement	Many NGOs and community based organisations, as well as private sector support for HIV prevention (not necessarily IDUs).	National AIDS Prevention and Control Policy encourages NGOs to initiate harm minimization services, including NSPs[1]. NACP-III was a decentralised process involving stakeholders from all over India[3]. Targeted Interventions for populations at high risk, such as IDUs. These include peer counselling, condom promotion, treatment of STIs and enhancing community ownership to facilitate enabling environments. These activities are being delivered through NGOs and community based organisations[3].	Under NACP-III, support to 176 NGOs (out of 1,128 working on HIV prevention) was discontinued as their interventions were not focused on Most at Risk Groups. A further 163 NGOs also had their support revoked upon being deemed to have insufficient capacity to carry-out targeted interventions[3]. While these actions ensure there are more funds available for effective, targeted interventions, they could also impact on civil society capacity to respond to HIV in future. There is no civil society federation or network that adequately represents the voice of civil society across the country[3].
Donor Commitment	Supporting NACO (not exclusively for IDUs): UNICEF, UNAIDS, UNFPA, UNODC, ILO, UNDP, WHO, World Bank, GFATM, DFID, EC, USAID, AusAid, CRS, PSI, FHI, Clinton Foundation, Gates Foundation, private industry[3].)	External aid from donor consortia is expected to contribute 35% of the NACP-III budget (for all HIV activities)[3]. A joint UN support plan has been prepared for technical assistance (with support from AusAID) in high prevalence states[2-3]. WHO, UNICEF, supporting ART, not specifically to IDUs, but this group certainly accessing mainstream ART services. UNODC working with the MSJE on integrating HIV issues into drug use programs[3]. UNODC supports OST sites in Delhi, Kolkata, Mizoram and Imphal[1]. UNESCO funding civil society working on harm reduction[4]. World Bank provides financial and technical support to NGOs and community based organisations for harm reduction[4]. GFATM Round 9 recently awarded delayed approval (USD21,000,206 in first 2 years; USD78,712,640 over five years) to meet HIV prevention, treatment and care. IDUs identified as a priority population for targeted prevention	Approval of GFATM Round 9 proposal is delayed. It is not clear when this program will commence.

		interventions[5].	
Multi-sectoral Involvement	NACO led by Ministry of Health and Family Welfare only.	Appears to be limited multi-sectoral engagement.	Multiple sectors working on HIV prevention, however limited coordination occurs across NACP-III.
Involvement of IDUs in the Response	It is anticipated that many exist… Indian Network of Harm Reduction (IHRN). North East India Harm Reduction Network (NEIHRN)		While evidence of IDU involvement is substantial, details of what that involvement constitutes are scarce.
Costed National Harm Reduction Strategy	NACO. Government of India plan of action	National AIDS Prevention and Control Policy issues guidelines for costing targeted interventions for IDUs; budgets for NSPs and OST, and recommends peer engagement and outreach to influence behaviours[1]. Current strategic plan until 2012	
Does the National Drug Strategy complement the National HIV strategy?	National AIDS Prevention and Control Policy MSJE policies	National AIDS Prevention and Control Policy prioritises "aggressive IEC campaigning, blood safety and voluntary counselling and testing". IDUs are recognized as "high risk groups", and the policy directive is unambiguously one of harm reduction[1]. National AIDS Prevention and Control Policy views criminal laws that are inconsistent with the rights of vulnerable groups as impediments to AIDS prevention … calls on the government to review these[1].	National Drug Strategies <u>do not</u> complement National HIV strategies, however there is a growing movement to address this. MSJE policies on drugs have not changed in two decades – these have not kept pace with policy development relating to HIV and AIDS[1].
Legal and Policy Environment	Indian Penal Code Narcotic Drugs and Psychotropic Substances Act, 1985	Enables harm reduction programs: Nation al AIDS Prevention and Control Policy views criminal laws that are inconsistent with the rights of vulnerable groups as impediments to AIDS prevention … calls on the government to review these[1]. Narcotic Drugs and Psychotropic Substances Act (1985 – amended 2001) distinguishes between possession for personal consumption and commercial quantities[1].	Restricts harm reduction programs: MSJE policies on drugs have not changed in two decades – these have not kept pace with policy development relating to HIV and AIDS[1]. Under the Indian Penal Code, HIV/AIDS public education campaigns relating to drug use may be punishable as obscenity. Other penal provisions may also apply, such as the sale and distribution of 'obscene' material, printing of grossly indecent material, sale of obscene objects to young persons and obscene acts and songs[1]. Possession, sale, purchase, use or consumption of opium and its derivatives, and allowing premises to be used for the commission of an offence prohibited under Narcotic Drugs and Psychotropic Substances Act, 1985[1].
Surveillance Systems	NACO, Ministry of Health and Family Welfare	National Sentinel Surveillance. Regular Behavioural Surveillance Surveys (in 2006 and	Insufficient capacity of the states and districts to effective operate SIMS. Quality of data at all levels is poor. There are expressed needs for a robust M&E system, supplemented by

		2001)[3]. Strategic Information Management System (SIMS) is being set up to improve data management and effective monitoring of NACP-III. National Family Health Survey.	appropriate human resources and capacities[3]. ART program reporting is poor; cohort tracking is being attempted through pilots. Stigma associated with HIV, and access issues prevent good data from being recorded. Also, there is no mechanism for tracking ART delivered by the private sector[3].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
Strategic Information Management System (SIMS), managed by national and state Strategic Information Management Units (SIMUs). SIMU recently introduced at national and state levels, to bring together program M&E, surveillance, and operational research. Establishment of SIMUs will intensify efforts to improve data quality from all data sources (as listed below)[3].	SIMS being set up to improve data management and effective monitoring of NACP-III.	Collected at national, state and district levels.		Insufficient capacity of the states and districts to effectively operate SIMS. Insufficient resources for state and district SIMUs. Quality of data at all levels is poor. Data from the private sector does not feed into SIMS. There are expressed needs for a robust M&E system, supplemented by appropriate human resources and capacities[3].
Behavioural Surveillance Surveys	Covers Most At Risk Groups, including IDUs.	Conducted "regularly" (in 2006 and 2001)[3].	Not specified	None identified.
National Sentinel Surveillance	Nation wide system which collects and presents sero-prevalence data from general population, antenatal care clinics and Most at Risk Groups[3].	Not specified	Not specified	IDUs not indicated/ disaggregated within National Sentinel Surveillance[3]. Sentinel surveillance of IDUs has expanded and provides useful prevalence data, but

				geographical and population coverage is still very low. No data exists from large pockets of the country[6].
Vulnerability assessment and other research studies as required during NACP-III implementation[3].		Conducted irregularly, based on particular program activities.	Not specified	Irregular data – implementation cannot be relied upon within NACP-III planning.
National Family Health Survey	Population based study: has gathered knowledge, behavioural and prevalence information from >100,000 respondents[3].	Not specified	Not specified	National Family Health Survey does not identify data relating to injecting drug use and HIV.

2. Program Implementation.

Estimated IDU Population: 164,820 (106,518<n<223,121); (estimates from 2006)[7] *(a)*
1,112,500; (estimates from 2006)[4] *(a)*
96 463 – 189 729 male, 10 055 – 33 392 female;(estimates from 2009)[6] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	For all IDU services: 222 sites in 14 states[6]. 222 NSP sites[6].	NGOs with financial support from govt[1]; KRIPA SASO SHALOM SHARAN Sankalp Seva Dhan Sahai Trust	Not specified.	567 - 1,700	Not specified.		Yes	Unknown	0.15% (b/a)	Yes, NACP-III
Opioid Substitution	Buprenorphine in 49	Mostly	Some	4,600[6].	Unknown		Yes	Yes	0.4% (b/a)	Yes:

Therapy (OST)	sites[6]. Methadone not available[6]. Delhi, Chennai, Kolkata, Mumbai, Imphal, Manipur[1].	associated with NSPs. Mostly NGOs.	government support; eg: TTK Hospital						3.5%[8].	Methadone available in 2010[6].
HIV Testing and Counselling (T&C)		Mostly associated with NSPs.	Not specified.	Unknown	Unknown.					Unknown
Antiretroviral Therapy (ART)	Delhi, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur, Nagaland.		Administered mostly in Govt hospitals (25)	400	Unknown.				0.04% (b/a)	Unknown
Prevention and treatment of STIs		Mostly associated with NSPs			Unknown.					Unknown
Condom programs	Some services[1].	Mostly associated with NSPs			Yes and No					Yes, NACP-III
Targeted IEC	Very limited, or inadequate for IDUs[1].				No					Unknown.
Primary Health Care (including treatment of opportunistic infections)		Mostly associated with NSPs			Unknown.					Unknown.
Diagnosis, treatment of and vaccination for viral hepatitis	None identified.									Unknown.
Prevention, diagnosis and treatment of tuberculosis	None identified.									Unknown.
Peer Education programs	Common feature – ex IDUs	Mostly associated with NSPs			No		Yes			Yes, NACP-III

2b. Services in Prisons.		
Estimated Prisoner Population:	373,271 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Dec 2006; sourced 30/7/09)	
Estimated # and % of Drug Offenders:	8% prisoners in Tihar jail, New Delhi are IDUs[9].	
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs (NSPs)	Unknown	
Opioid Substitution Therapy (OST)	Yes	Commenced on small scale in Tihar jail by UNODC for 60 prisoners[8].
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		No information available
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Multi-sectoral involvement in the NACP-III is insufficient to ensure a comprehensive approach to address HIV.	NACO Ministry of Health and Family Welfare MJSE	A joint UN support plan has been prepared for technical assistance (with support from AusAID) in high prevalence states[4].
	Poor coordination between Ministry of Health and Family Welfare and MSJE.		
Civil Society Engagement	Community discrimination: in Manipur, militant outfits assaulted IDUs for having needles on their person[1].	NACO, SACS, NACP-III, law enforcement, NGOs, community-based organisations.	National AIDS Prevention and Control Policy encourages NGOs to initiate harm minimization services, including NSPs[1]. NACP-III targets interventions for populations at high risk, such as IDUs, delivered through NGOs and community based organisations. These include peer counselling, condom promotion, treatment of STIs and enhancing community ownership to facilitate enabling environments.
	Large number of NGOs have had funding cut from HIV/AIDS activities under NACP-III due to insufficient capacity to deliver and/or report on activities.		
	No civil society federation or network that adequately represents the voice of civil society across the country[3].		
	Minimum treatment standards established for NGOs and community-based organisations, however staff training/capacity inadequate[6].		
	Linkages poor between NGO-run treatment centres and government-run health care centres[6].		
Legal and Policy Environment	Methadone is illegal	MSJE	Mathadone to be available in 2010[8].
	Ambiguity within Narcotic Drugs and Psychotropic Substances Act, 1985 relating to possession of injecting equipment as a potentially abetting a crime[1].		
Law Enforcement	Ongoing incidents of law enforcement harassing outreach NSP workers[1].	NGOs implementing NSPs (with related services). Law enforcement services.	NGOs implementing NSPs (with related services) have been instrumental in working with local law enforcement to reduce harassment of IDUs. Varying success has been noted[1].
Comprehensive Services	Few services catering to female IDUs[6].	NACO, SACS, implementing agencies.	Disaggregated data by gender for IDUs informs denominators for service planning.
	Services for female IDUs not flexible to allow for child-care duties and limited		

	time availability of women[4].		SACS have power to address IDU needs in their jurisdiction.
	Majority of NACO-supported prevention interventions found in 3 north-eastern states (Nagaland, Manipur, Mizoram). Delivery of services limited in other States[6].		
	Services for drug users in prisons are limited[6].		
	Links between services providing ART, OST and TB treatment are poor[6].		
Resources (Financial, human and data)	Lack of adequate human resource and technical support resulting in slow progress to scale up NACP-III activities.	NACO SACS	NACO has put several remedial measures in place to recruit appropriate personnel and to enlist technical assistance[3]. SACS being strengthened and new offices opened in North East.
	Effective management of SACS marred by regular transfers and changes in leadership. Quality, committed human resources at implementation level difficult to maintain[3].		
Involvement of IDUs in the Response	Stigma and discrimination directed to drug users (more so than HIV+), and especially to female IDUs.	NACO, SACS, implementing agencies, law enforcement.	None identified.
Availability of Commodities			
i. Needle and Syringe programs (NSPs)	Funding restraints result in irregular supply of needles/syringes, and cause IDUs to return to unsafe injecting[1].	NACO SACS	Approval of GFATM Round 9 proposal is delayed. It is not clear when this program will commence.
ii. Opioid Substitution Therapy (OST)	OST not available to HIV-positive IDUs who are on state sponsored ART[1].	NACO SACS	Mathadone to be available in 2010[6].
	OST services disproportionately distributed in areas where need not necessarily greatest (eg: many services in the North East, and few in Punjab)[8].		
	Methadone not available[6].		
iii. HIV Testing and Counselling (T&C)	Fear of public identification and discrimination in hospitals obstruct T&C access[1].	NACO, SACS, service providers.	
	Services available in capital cities only		

iv. Antiretroviral Therapy (ART)	Efivarenz (the only treatment option for IDUs coinfected with HIV and Hepatitis C) is unavailable or inadequate at most sites[1]. Lack of testing equipment, inadequate infrastructure, and a paucity of first and second-line regimens of medications[1]. Govt cites lack of patient adherence[1]. ART program reporting is poor. Stigma associated with HIV, and access issues prevent good data from being recorded. Also, there is no mechanism for tracking ART delivered by the private sector[3].	NACO, SACS, donors, service providers.	Approval of GFATM Round 9 proposal is delayed. It is not clear when this program will commence. Patient adherence could be improved through commitment to education. SIMUs recently introduced at national and state levels, to bring together program M&E, surveillance, and operational research. Establishment of SIMU will intensify efforts to improve data quality from all data sources[3].
v. Prevention and treatment of STIs	None identified.	NACO, SACS, service providers, NGOs.	
vi. Condom programs	None identified.	NACO, SACS, service providers, NGOs.	
vii. Targeted IEC materials	None identified.	NACO, SACS, service providers, NGOs.	
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.	NACO, SACS, service providers, NGOs.	
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.	NACO, SACS, service providers, NGOs.	
x. Prevention, diagnosis and treatment of tuberculosis	None identified.	NACO, SACS, service providers, NGOs.	
xi. Peer Education programs	None identified.	NACO, SACS, service providers, NGOs.	
Scaling Up Plans	Delays to GFATM (Round 9) funding.	GFATM, NACO.	
Capacity Building	Identified within individual services.		
Monitoring and Evaluation	Insufficient capacity of the states and districts to effective operate SIMS. Insufficient resources for state and district SIMUs. Quality of data at all levels is poor. Data from the private sector does not feed into SIMS.	NACO SACS National M&E Working Group	SIMUs recently introduced at national and state levels, to bring together program M&E, surveillance, and operational research. Establishment of SIMU will intensify efforts to improve data quality from all data sources[3]. Operational Guideline for state-level SIMUs developed. Handbook on Core Indicators has been developed to standardise collection and analysis, supported by an interactive website www.nacoonline.org.

			Assessment of infrastructure and recommendations have been carried out at each SACS. Staff capacity assessment and review was conducted, resulting in capacity development activities and/or redundancy. Mentoring program implemented[3].

4. Gap Analysis

- Insufficient geographical coverage of services to IDU populations across and within different states.
- While NACP-III's revision of service-provider capacity within civil society, and discontinuation of funding for some organisations ensures that more funds are available for effective, targeted interventions, they could also impact on civil society capacity to respond to HIV in future.
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Limited multi-sectoral government contribution to addressing comprehensive harm reduction services.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[10]) not currently being delivered to IDUs consistently, particularly T&C, ART, primary health care services, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- While there is substantial evidence to confirm that IDUs have involvement in the harm reduction response in India, details of this involvement are not easily identifiable, and as such, it is unclear if IDUs contribute to policy development and decision making. Additionally, there is no civil society federation or network that adequately represents the voice of civil society across the country[2]. Limited IDU involvement has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable harm reduction services, which has not kept pace with HIV and AIDS-related developments in the past two decades. While harm reduction services do operate in practice, the legal and policy environment is such that IDUs and NSP service providers could be prosecuted for possession of injecting paraphernalia under the Narcotic Drugs and Psychotropic Substances Act, 1985[1].
- Harm reduction services for prisons and CCDU inadequate and pose an HIV and STI transmission threat throughout Bangladesh. Little is known regarding services available in CCDU, as data is rarely disaggregated for these.

5. Recommendations

- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs in all areas of India through improved coordination and planning between donors, government and technical agencies, and improved capacity of SACS to meet local needs.
- Greater, multi-sectoral government involvement which views harm reduction as not only a health issue will contribute to more effective implementation of comprehensive services.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- Urgent legal and policy reform to facilitate complementary legal requirements associated with drug- and HIV/AIDS-related activities. This could be achieved through stronger advocacy from appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit.UNODC ROSA.
2. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
3. NACO (2008). UNGASS Country Progress Report 2008, India, National AIDS Control Organisation (NACO), India.
4. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
5. Global Fund for AIDS, TB and Malaria. (2009). "Proposal Form Round 9: India" Retrieved 15th November, 2009, from http://www.theglobalfund.org/programs/country/index.aspx?lang=en&countryID=IDA
6. Reid, G. (2009). HIV/AIDS among people who inject drugs in India: the current situation and national response. Regional meeting on the development of the regional harm reduction strategy 2010-2015. Malaysia.
7. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
8. Sharma, M., E. Oppenheimerb, et al. (2009). "A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region." AIDS 23.
9. Kumar, S. (2004). Injecting Drug Use and HIV/AIDS in India: An emerging concern, UNODC.

10. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Indonesia Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Indonesia

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	IPF	International Partnership Fund for HIV and AIDS
ART	Antiretroviral Therapy	IPPNI	Indonesia Drug User Solidarity Association
AusAID	Australian Agency for International Development	MMT	Methadone Maintenance Therapy
C&T	HIV Testing and Counselling	NGO	Non Government Organisation
CCDU	Compulsory Centres for Drug Users	NSP	Needle and Syringe Program
DFID	Department For International Development (UK)	OST	Opioid Substitution Therapy
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	PKNI	Indonesian Network of Victim of Drugs
HCPI	HIV Cooperation Program for Indonesia	PLHIV	People living with HIV
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
IDUs	People who inject drugs	USAID	United States Agency for International Development

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Ministry for People's Welfare: National AIDS Commission. Narcotics Control Board.	Government committed to comprehensive harm reduction approach for IDUs[1]. Ministry for People's Welfare: National HIV and AIDS Policy for Reducing Harm Arising from Injection of Narcotic, Psychotropic and Other Addictive Substances, 2007[1]. National HIV/AIDS Strategy 2007-2010 implemented and directed by Government. National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention 2005–2009 focuses on reducing injecting drug use-related HIV	NSPs yet to be introduced in prisons, and other harm reduction services yet to be universally applied in prisons.

		transmission[2]. Harm reduction in prisons addressed through National Strategy [2].	
Civil Society Engagement	78 NGOs delivering harm reduction interventions to IDUs[3].	National HIV/AIDS Strategy 2007-2010 facilitates and encourages civil society engagement[1]. Civil society contribute to interventions and advocacy through monitoring the public 'engine': social, economic, legal, health interventions etc[4]. AusAID funding the HIV Cooperation Program for Indonesia (HCPI) works through public health system and NGOs[5].	Services provided by NGOs not available in sufficient scale.
Donor Commitment	GFATM, DFID, AusAID, USAID[7].	Scaling-up for universal access to ART: increasing coverage for drug users (IPF, GFATM, DFID, AusAID)[4]. GFATM Round 9 recently approved (USD27,723,275 in first 2 years; USD87,142,130 over five years) t to meet HIV prevention, treatment and care, and HIV-related health systems strengthening. IDUs identified as a priority population for targeted prevention interventions[6]. AusAID funding the HCPI, A$45m, 2008-2013 for IDUs in community and prisons[5]. Includes NSP, OST, peer education and outreach, T&C, condoms, STI/HIV/opportunistic infections treatment through public health system and NGOs.	Funds and personnel capacity not sufficient to enable appropriate service coverage to scale.
Multi-sectoral Involvement	Ministry for People's Welfare: National AIDS Commission, Police, Law and Human Rights, Health Services (inlc. hospitals), Narcotics Board, IDU Networks, NGOs[7].	Multi-sectoral involvement at National, Provincial, City and District levels. Civil society represented as equal members on National AIDS Commission at policy making meetings, including drug users, PLHIV, sex workers.	
Involvement of IDUs in the Response	Indonesia Drug User Solidarity Association (IPPNI) later evolved to Indonesian Network of Victim of Drugs (PKNI)[1]. Working Group on Harm Reduction (National	Civil society represented as equal members on National AIDS Commission at policy making meetings, including IDUs. National Drug Users Network hosted Drug Users Congress in 2007 and 2009.	

	AIDS Commission)[7].	Drug users represented on Working Group on Harm Reduction (National AIDS Commission)[7]. Drug user movement major advocate and driver towards scaling up of the national harm reduction response, and for greater access to and utilisation of health care services by drug users[1,4]. Drug user advocates contributed to development of: Anti discrimination bill, and Amendment to the narcotics and psychotropics bill presented to Parliament, and Input on National Strategy re drug use[7]. Drug users contribute to planning, coordination, M&E within National Aids Commission, along with Health, Police, Narcotics Control Board, prison officials[4].	
Costed National Harm Reduction Strategy	National HIV/AIDS Strategy 2007-2010.	National HIV/AIDS Strategy 2007-2010 (health sector) specifies a target of 80% of most-at-risk populations to have access to comprehensive prevention program. A multi-sectoral strategy is expected from 2010-2014. Whether costed not stated[1].	
Does the National Drug Strategy complement the National HIV strategy?	National HIV/AIDS Strategy 2007-2010. National HIV and AIDS Policy for Reducing Harm Arising from Injection of Narcotic, Psychotropic and Other Addictive Substances, 2007[1]. Narcotics Law (September, 2009).	National HIV/AIDS Strategy 2007-2010 specifies a target of 80% of most-at-risk populations to have access to comprehensive prevention program[1]. Harm Arising from Injection of Narcotic, Psychotropic and Other Addictive Substances, 2007[1] explicitly refers to the elements of comprehensive harm reduction services, including in prisons, and identifies government agencies responsible.	National Drug Strategies do complement National HIV strategies. National HIV/AIDS Strategy 2007-2010 does not explicitly articulate targets and processes for implementing comprehensive harm reduction program for IDUs. Attempts by numerous bodies (including drug user groups) to inform Parliament about the need for harm reduction to be included in the revised Narcotics Law were made[8].
Legal and Policy Environment	Prohibitive drug laws 5 and 22/1997[4]. Narcotics Law (September, 2009). Psychotropics Law (September, 2009 – unchanged from previous version).	Feb 2007: harm reduction enters public policy for HIV prevention and care - IDUs no longer criminals through Human Rights framework[4].	Despite attempts by numerous bodies (including drug user groups) to inform Parliament about the need for harm reduction to be included in the revised Narcotics Law, the following issues have been identified by the Indonesian Community Legal Aid Organization relating to the new, passed law; 1. Identifies drug addicts as criminals and they are thus subject to imprisonment. 2. Erroneously differentiates drug addicts from drug abusers,

			and only provides social rehabilitation for the former; both conditions are subject to the same social stigma, and both have the right to access to social rehabilitation. 3. Overly emphasizes the role of civil society in preventing and fighting illicit drug trafficking. Drug trafficking involves serious criminal action by powerful cartels and therefore should be dealt with by the police force, not ordinary citizens. 4. Attributes responsibility to parents if they do not report a child's addiction, and thus disproportionately criminalizes all parties. A parent's responsibility to protect their children is commonly understood as a moral and social obligation, and it is debatable if it should be regulated by the state. 5. Gives the National Narcotics Agency broader authority to conduct investigations, but no clear guidance on how it should control this internal and external mechanism. 6. Stipulates the death penalty as a punishment for some offences; this is a violation of fundamental human rights - the right to life, enshrined in the Indonesian Constitution, Universal Declaration of Human Rights, and International Covenant on Civil and Political Rights (ICCPR) which was ratified by Indonesia in 2005[8].
Surveillance Systems	National AIDS Commission	Process of a national estimation of the number of IDUs[1]. Enables development of accurate denominators against which to measure service coverage.	

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
Process of a national estimation of the number of IDUs[1].	Enables development of accurate denominators against which to measure service coverage			

2. Program Implementation.

Estimated IDU Population: 190,460 (106,518<n<247,800); (estimates from 2005)[9] *(a)*
561,925; (estimates from 2006)[10] *(a)*
219,130; (estimates from 2009)[1-2] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs	IDUs in all provinces[3]. 159 services available[1-3]; in 15 provinces[7].	78 NGOs delivering harm reductions services (not simply NSP)[1,3,7].	90 primary health centres delivering harm reductions services (not simply NSP).	49,095 for all harm reductions services (not simply NSP)[1]. 2,079 for NSPs[1].	Unknown		Unknown		1% (b/a). 22%[2].	Yes: 60% IDUs covered by NSP by 2014[4].
Opioid Substitution Therapy (OST)	Limited services exist[10].	26 – 29 sites[1-2].	12 primary health centres, 10 hospitals.	2,711[1]. 1,805[2].	Unknown		Unknown		1.4% (b/a). 1.5%[2].	Yes: Govt doubling OST in 2010.
HIV Testing and Counselling (T&C)	Exists but not specifically for IDUs				Unknown					Yes: HCPI.
Antiretroviral Therapy (ART)	No restrictions on IDU access[10].	Provided through NGO and Govt NSPs[3].		775	Unknown					Universal access for HIV+ IDUs by 2014.
Prevention and treatment of STIs	Exists but not specifically for IDUs				Unknown					Yes: HCPI.
Condom programs	Many services exist which include IDUs within target populations. IDU services most likely through other harm reduction activities (eg: NSPs)				Unknown					Yes: HCPI and others.
Targeted IEC	As above				No.					Unknown
Primary Health Care (including treatment of opportunistic infections)	12 services for IDUs[1].				Unknown					Unknown

Diagnosis, treatment of and vaccination for viral hepatitis	No services identified.									Unknown
Prevention, diagnosis and treatment of tuberculosis	No services identified.									Unknown
Peer Education programs	274 peer support groups (not only IDUs)[1].			20,000	No		Yes			

2b. Services in Prisons.

Estimated Prisoner Population:	136,017 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Oct 08; sourced 30/7/09) There are 13 prisons for people committed for drug offenses[1] 137,144 (2008, 28th Asia and Pacific Conference of Correctional Administrators, Langkawi, Malaysia)	
Estimated # and % of Drug Offenders:	40,805 (30% of total prison population) There are 13 prisons for people committed for drug offenses[1]	
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs (NSPs)	No	Bleach is available for the cleaning of injecting equipment in Kerobokan prison[2].
Opioid Substitution Therapy (OST)	Yes	Only 4/378 prisons offering OST to select inmates[1-2,10]. 35 prisoners accessing OST[1]. Kerobokan prison, Bali[1]. AusAID funding the HIV Cooperation Program for Indonesia (HCPI), which aims to support methadone maintenance therapy in prisons[5].
HIV Testing and Counselling (T&C)	Yes	Voluntary services available (although limited)[1]. Kerobokan prison, Bali.[1]. AusAID funding the HIV Cooperation Program for Indonesia (HCPI), which aims to support T&C in prisons[5].
Antiretroviral Therapy (ART)	Yes	29 prisoners. Some prisons in Bali[10]. Kerobokan prison, Bali[1]. AusAID funding the HIV Cooperation Program for Indonesia (HCPI), which aims to support ART in prisons[5].
Prevention and treatment of STIs	Unknown	
Condom programs	Yes	Intermittent availability[10]. 9 prisons[1].

		Kerobokan prison, Bali[1].
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Yes	Several prisons[1]. AusAID funding the HIV Cooperation Program for Indonesia (HCPI), which aims to support education in prisons[5].
Post-release Follow-up	No	
Explanatory note: Drug detoxification and rehabilitation figures quoted, but it is not articulated if these are compulsory, nor what type of treatment is available through these.		

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		No information available.
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	NSPs yet to be introduced in prisons, and other harm reduction services yet to be universally applied in prisons, despite policy shift towards these interventions.	Ministry for People's Welfare: National AIDS Commission Narcotics Control Board	Prison harm reduction activities are scaling-up. Collaboration and commitment from government, civil society, donors and the private sector is crucial for sustainability of interventions[3].
Civil Society Engagement	Services provided by NGOs not available in sufficient scale. Revised Narcotics Law overly emphasizes the role of civil society in preventing and fighting illicit drug trafficking. Drug trafficking involves serious criminal action by powerful cartels and therefore should be dealt with by the police force, not ordinary citizens.	National AIDS Commission, NGOs, donors and technical agencies.	Collaboration and commitment from government, civil society, donors and the private sector is crucial for sustainability of interventions[3]. HCPI works through public health system and NGOs[5].
Law Enforcement	None identified.		
Comprehensive Services	NSPs yet to be introduced in prisons, and other harm reduction services yet to be universally applied in prisons. Discrimination towards IDUs at health services	Ministry for People's Welfare: National AIDS Commission Narcotics Control Board	Harm reduction in prisons addressed through National Strategy [2].
Resources (Financial, human and data)	Funds and personnel capacity not sufficient to enable appropriate service coverage to scale.		HIV response is heavily reliant on international donor committment[3]. Collaboration and commitment from government, civil society, donors and the private sector is crucial for sustainability of interventions[3].
Involvement of IDUs in the Response	None identified.		
Availability of Commodities			
i. Needle and Syringe programs (NSPs)	None identified.	HCPI, A$45m, 2008-2013 for IDUs in community and prisons[5]. Includes NSP, OST, peer education and outreach, T&C, condoms, STI/HIV/opportunistic infections treatment through public health	HCPI to scale-up.

		system and NGOs.	
ii. Opioid Substitution Therapy (OST)	Available but at small scale.		HCPI to scale-up.
iii. HIV Testing and Counselling (T&C)	None identified.		HCPI to scale-up.
iv. Antiretroviral Therapy (ART)	None identified.		
v. Prevention and treatment of STIs	None identified.		HCPI to scale-up.
vi. Condom programs	None identified.		HCPI to scale-up.
vii. Targeted IEC materials	None identified.		HCPI to scale-up.
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		HCPI to scale-up.
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		HCPI to scale-up.
Scaling Up Plans	Some delay in delivery of services after supportive legislation is passed.	Ministry for People's Welfare: National AIDS Commission Narcotics Control Board	HCPI to scale-up through working with public health system and NGOs.
Capacity Building	Limited capacity of NGOs and other service providers to deliver services to scale. Limited capacity to conduct M&E.	National AIDS Commission, NGOs and other service providers, donors and technical agencies.	HCPI to scale-up through working with public health system and NGOs.
Monitoring and Evaluation	Insufficient information available regarding M&E systems.		

4. Gap Analysis

- Despite impressive commitment towards this, complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[11]) not currently being delivered to IDUs consistently, particularly diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- Despite supportive legislation to introduce comprehensive harm reduction services to prisons, these have not yet been enacted throughout Indonesia.
- Insufficient information is available regarding M&E systems in Indonesia, however it appears these are inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].

- The revised Narcotics Law (2009) does not adequately reflect a human rights based approach to HIV prevention, treatment and care for IDUs, nor does it attribute responsibility for harm reduction interventions appropriately in order to support comprehensive harm reduction services.
- There is a significant time lag between endorsement of evolving policies which support harm reduction activities, and systematic implementation at the service provision level.
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.

5. Recommendations

- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs in all areas of Indonesia through improved coordination and planning between donors, government and technical agencies.
- Further input into the completion of the matrix will enable a more accurate picture of M&E systems available in Indonesia with which to inform harm reduction service planning and implementation.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].
- National AIDS Commission should clearly articulate to the harm reduction and HIV prevention, treatment and care community that certain ambiguities in the Narcotics Law will not impinge upon harm reduction service delivery, nor upon those IDUs who access these services.
- Supportive legislation to facilitate comprehensive harm reduction services in prisons should be enacted immediately.

6. References

1. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit. UNODC ROSA.
2. Personal communication with UNAIDS Bangladesh and Ezazul Islam Chowdhury, 25th November, 2009.
3. Asian Consortium on Drug Use, HIV, AIDS and Poverty. (2008). Response beyond borders: the South East Asia regional workshop on the prevention of HIV related to drug use, Asian Consortium on Drug Use, HIV, AIDS and Poverty.
4. Reddy, A., M. M. Hoque, et al. (2008). Article in press. "HIV transmission in Bangladesh: An analysis of IDU programme coverage. "International Journal of Drug Policy"; doi:10.1016/j.drugpo.2007.11.015.

5. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
6. Global Fund for AIDS, TB and Malaria. (2009). "Proposal Form Round 9: Indonesia" Retrieved 15th November, 2009, from http://www.theglobalfund.org/programs/country/index.aspx?lang=en&countryID=IND
7. Mboi, N. (2008). HIV Interventions for Injecting Drug Users at Multiple Levels. Harm Reduction 2008: 19th International Harm Reduction Association Conference. Barcelona, 2008
8. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. (2009). Bangladesh Country Advocacy Brief Injecting Drug Use and HIV.
9. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45
10. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
11. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Lao PDR Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Lao PDR

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	IDUs	People who inject drugs
ART	Antiretroviral Therapy	NGO	Non Government Organisation
AusAID	Australian Agency for International Development	NSP	Needle and Syringe Program
C&T	HIV Testing and Counselling	OST	Opioid Substitution Therapy
CCDU	Compulsory Centres for Drug Users	Sida	Swedish Government development agency
CHAS	Center for HIV/AIDS and STI	STI	Sexually Transmitted Infection
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	UNAIDS	Joint United Nations Programm on HIV/AIDS
HAARP	HIV/AIDS Asia Regional Program	UNODC	United Nations Office on Drugs and Crime
HIV	Human Immunodeficiency Virus	WHO	World Health Organization

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	National Task Force on HIV and Drug Use: Lao National Commission on Drug Control and Supervision, Ministry of Health, Ministry of Public Security. Centre for HIV/AIDS and STI (CHAS).	National Task Force on HIV and Drug Use conducts research on drug use and HIV, enhances coordination of key stakeholders in the drug use and HIV response, provides technical assistance in the area of drug use and HIV, explores evidence informed drug treatment options, and is drafting both a national policy on drug use and HIV and national guidelines on treatment and care for people who use drugs[1-4]. CHAS supports the National Task Force on HIV and Drug Use. It is finalizing detoxification guidelines for closed-settings and in the community with WHO/UNODC and will train services providers; and it is supporting the collection of relevant, quality data on prevalence and practices on drug	Trans-border drug use a major obstacle for Lao PDR in responding to IDU issues. Sida/HAARP supporting CHAS to discuss this, and plan interventions with cross-border counterparts[5]. The work of National Task Force on HIV and Drug Use and CHAS is finalising national policies on drug use, including those for closed settings not yet completed[5].

		use[5].	
Civil Society Engagement	Lao Bar Association Burnet Institute.	Government approval in 2009 enabling establishment of NGOs may facilitate IDU groups becoming active in policy development and implementation[2]. Burnet Institute employs a harm reduction officer to support national harm reduction processes (personal communication, Burnet Institute, September 2009).	Lawyers from the Lao Bar Association will help to review the legal environment existing in the country[4].
Donor Commitment	HIV/AIDS Asia Regional Program (HAARP), AusAID Sida supporting CHAS until late 2009, then funding from HAARP. UNODC, UNAIDS, WHO.	UNODC, UNAIDS support research into knowledge, attitudes and beliefs about HIV and AIDS, and drug use amongst different target groups, including school-aged young people[4,6]. WHO/UNODC supporting CHAS to train services providers at the community level. HAARP (AusAID) supporting multisectoral approaches through direct engagement of non-health sectors in activities such as NSP, OST, condom promotion, primary health care, T&C and ART[7]. Sida/HAARP supporting CHAS to explore measures associated with trans-border drug use, and to plan interventions with cross-border counterparts[5].	
Multi-sectoral Involvement	CHAS	National HIV/AIDS Workplan (2008-2009) comprises; multi-sectoral leadership development, community social mobilisation, health systems mobilisation for HIV and AIDS, harm reduction for IDUs, condom promotion and social marketing, community care for people living with HIV, and social support for drug rehabilitation[4].	
Involvement of IDUs in the Response	Minimal: There is no formal drug user network, nor user membership on reference groups.	Most likely limited to prevention activities at the local level[2].	Despite National Strategic and Action Plan on HIV/AIDS/STI (2006-2010) calling for involvement of drug users in the planning and implementation of prevention and rehabilitation activities, there is no drug user representation or involvement in policy or decision making bodies. Government approval in 2009 enabling establishment of NGOs may facilitate IDU groups becoming active in policy development and implementation[2].

			Most likely limited to prevention activities at the local level[2].
Costed National Harm Reduction Strategy	National Strategic Plan. National HIV/AIDS Workplan (2008-2009), CHAS.	National Strategic Plan is costed: US$ 279,500 for IDUs and HIV[1,3]. CHAS' National HIV/AIDS Workplan (2008-2009) - it is unclear if this is a costed work plan[4].	
Does the National Drug Strategy complement the National HIV strategy?	National HIV/AIDS/STI Strategic Plan (2006-2010). National Drug Demand Reduction Strategy. Drug Control Master Plan.	National HIV/AIDS/STI Strategic Plan (2006-2010) makes supportive reference to harm reduction and includes programmatic targets relevant to injecting drug use and HIV. In particular, it articulates enabling and supportive environments for IDUs through advocacy, influencing legal and policy frameworks and scaling-up universal access to ART[1,3]. National Drug Demand Reduction Strategy is based on prevention, treatment and law enforcement, and is supported by the cross-cutting components of data collection, training and networking[6].	National Drug Strategies are moving towards a state of synergy with National HIV strategies.
Legal and Policy Environment	Law on Drugs (No. 10/NA), 2007 – also referred to as Resolution No. 103/NA, December 2007. Penal Code. ACCORD 'drug-free ASEAN by 2015'.	Enables harm reduction programs: No specific HIV law, however in National HIV/AIDS/STI Strategic Plan (2006-2010): explicit, supportive reference to harm reduction and includes programmatic targets relevant to injecting drug use and HIV[1].	Restricts harm reduction programs: Law on Drugs (No. 10/NA) outlines criminal penalties for possession[2]. Penal code provides penalties for drug offenders, and especially to recidivists or those in states of drunkenness or drug abuse[2]. Provision of needles and syringes is prohibited[8]. Signatory to ACCORD 'drug-free ASEAN by 2015' strategy to eliminate opium production by 2005. Response is predominantly focused on law enforcement. An increased public health-oriented response needed.
Surveillance Systems	CHAS		IDUs not included as a population in the HIV sentinel surveillance[1,4].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				Unknown
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
CHAS: HIV Sebtinal surveillance.	This exists but little information is available.	Unknown.	Unknown	IDUs not included as a population in the HIV sentinel surveillance[1,4].

2. Program Implementation.

Estimated IDU Population: 8,150; (estimates from 2006)[8] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	No services available.									Yes: HAARP.
Opioid Substitution Therapy (OST)	Vientiane Somsagna Udomxai Sayabouri	No.	3 hospitals for 64 women. 2 Drug Treatment Centres[2].		Unknown			Unknown		Yes: HAARP.
HIV Testing and Counselling (T&C)	None identified.									Yes: HAARP.
Antiretroviral Therapy (ART)	"According to the Universal Access Report WHO, UNAIDS and UNICEF in June, 2008, Lao PDR is one of the few countries … where coverage of [ART] for people in need bounds 100%"[3].				No				100%[3].	Yes: HAARP.
Prevention and	Available, but not IDU-				Unknown					Yes: HAARP.

treatment of STIs	specific.									
Condom programs	Available, but not IDU-specific.				Unknown					Yes: HAARP.
Targeted IEC	None identified.				Unknown					Unknown
Primary Health Care (including treatment of opportunistic infections)	Available, but not IDU-specific.				Unknown					Unknown
Diagnosis, treatment of and vaccination for viral hepatitis	None identified.									Unknown
Prevention, diagnosis and treatment of tuberculosis	None identified.									Unknown
Peer Education programs	Available, but not IDU-specific.	Yes	Unknown		No					Unknown

2b. Services in Prisons.

Estimated Prisoner Population:	4,020 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, mid-2004; sourced 30/7/09)
Estimated # and % of Drug Offenders:	No information available.

Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Yes	Supported by the GFATM
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		1,000[1].
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Low prevalence of IDUs results in this being a low priority. Trans-border drug use issues complicate the development and implementation of an effective response. National policies on drug use, including those for closed settings not yet completed.	National Task Force on HIV and Drug Use. CHAS. Donors and technical agencies.	Trans-border drug use a major obstacle for Lao PDR in responding to IDU issues. Sida/HAARP supporting CHAS to discuss this, and plan interventions with cross-border counterparts[5]. The work of National Task Force on HIV and Drug Use and CHAS is finalising national policies on drug use, including those for closed settings not yet completed[5].
Civil Society Engagement	Fledgling civil society due to only recent Government approval enabling establishment of NGOs[2].	National Task Force on HIV and Drug Use, CHAS, donors and technical agencies, NGOs and community-based organisations.	Government approval in 2009 enabling establishment of NGOs may facilitate IDU groups becoming active in policy development and implementation[2].

Legal and Policy Environment	Despite National Strategic and Action Plan on HIV/AIDS/STI explicitly supporting harm reduction, no clear plan for the delivery of services and a lack of technical assistance in all aspects of comprehensive service provision[2].	National Task Force on HIV and Drug Use, CHAS, legal authorities, Lao Bar Association, donors and technical agencies.	Lawyers from the Lao Bar Association will help to review the legal environment existing in the country[4]. National HIV/AIDS/STI Strategic Plan (2006-2010) aims to promote enabling and supportive environments for IDUs through advocacy and influencing legal and policy frameworks[1,3].
	Harm reduction within National HIV Strategy lacks supportive legislative framework (i.e. there is no HIV/AIDS law)[2].		
	Some laws are in direct contradiction to harm reduction, such as illegality of possession of syringes.		
Law Enforcement	Response is predominantly focused on law enforcement. An increased public health-oriented response needed.	National Task Force on HIV and Drug Use, CHAS, law enforcement authorities, donors and technical agencies.	
Comprehensive Services	Low prevalence of IDUs results in this being a low priority.		Advocacy from donors and technical agencies required to ensure injecting drug use remains a focus within the national response to HIV and AIDS.
Resources (Financial, human and data)	Geographical accessibility in remote areas.		WHO/UNODC supporting CHAS to train services providers at the community level. HAARP (AusAID) supporting multisectoral approaches[7].
	Limited capacity of implementing agencies.		
Involvement of IDUs in the Response	Low prevalence of IDUs results in a minimal voice.	NGOs, IDU groups, donors and technical agencies.	Government approval in 2009 enabling establishment of NGOs may facilitate IDU groups becoming active in policy development and implementation[2].
Availability of Commodities			
i. Needle and Syringe programs	None identified.		Scale-up plans through HAARP.
ii. Opioid Substitution Therapy (OST)	None identified.		Scale-up plans through HAARP.
iii. HIV Testing and Counselling (T&C)	None identified.		Scale-up plans through HAARP.
iv. Antiretroviral Therapy (ART)	None identified.		Scale-up plans through HAARP.
v. Prevention and treatment of STIs	None identified.		Scale-up plans through HAARP.
vi. Condom programs	None identified.		Scale-up plans through HAARP.
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		

x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		
Scaling Up Plans	National Task Force on HIV and Drug Use still drafting a national policy on drug use and HIV and developing national guidelines on treatment and care for people who use drugs[1].	National Task Force on HIV and Drug Use, CHAS, law enforcement authorities, donors and technical agencies.	HAARP working with National Task Force on HIV and Drug Use to scale-up.
Capacity Building	Capacity of service implementers is limited.	Service providers, CHAS, donors and technical agencies.	
Monitoring and Evaluation	Capacity and systems inadequate for the collection of IDU data.	CHAS	

4. Gap Analysis

Gap analysis for this country is hampered by little available data regarding the harm reduction response. However the following points are noted;

- There is limited civil society engagement, especially from IDU groups, in the development of programs and delivery of harm reduction services. Limited IDU involvement has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Very few harm reduction services have been identified as being delivered to IDUs; complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[9]) are far from being met.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This, and the inability of systems to disaggregate data for IDUs contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[9].
- Inadequate legal and policy environment to enable harm reduction services (especially NSP).
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Very little information is available regarding harm reduction services for prisons and CCDU, however it is assumed that, these would reflect service delivery in the wider community, and would therefore be minimal and insufficient.

5. Recommendations

- Further input into the completion of the matrix will enable a more accurate picture of harm reduction needs with which to plan and implement programs for IDUs in Lao PDR.
- Immediate actioning of 2009 government approval to enable NGOs (including IDU groups) to participate in policy development and implementation for harm reduction services.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[9].
- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.

- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, HIV/AIDS Asia Regional Program. (2009). Lao PDR Country Advocacy Brief Injecting Drug Use and HIV (DRAFT)
2. Stephens, D. (2009). Law and Policy Review: July 2009, HIV/AIDS Asia Regional Program, United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.
3. No author cited. (2008). Response Beyond Borders: the South East Asia regional workshop on the prevention of HIV related to drug use, Asian Consortium on Drug Use, HIV, AIDS and Poverty.
4. Chanthone (2008). Progress in implementing harm reduction interventions in Lao PDR *(powerpoint presentation)*.
5. Chanthone (2008). HIV and Drug use, Lao PDR. Manila *(powerpoint presentation).*
6. Doussantousse, S. (2008). "The first time is free…": Research on Drugs Use Patterns among Young People in Vientiane, Lao PDR (draft), United Nations Office on Drugs and Crime (UNODC)
7. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
8. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
9. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Malaysia Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Malaysia

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	NGO	Non Government Organisation
ART	Antiretroviral Therapy	NSP	Needle and syringe program
C&T	HIV Testing and Counselling	OST	Opioid Substitution Therapy
CCA	Cabinet Committee on AIDS	STI	Sexually Transmitted Infection
CCDU	Compulsory Centres for Drug Users	TCA	Technical Committee on AIDS
HIV	Human Immunodeficiency Virus	UNDP	United Nations Development Programme
IDUs	People who inject drugs	UNFPA	United Nations Population Fund
NACA	National Advisory Committee on AIDS	UNICEF	United Nations Children's Fund
NADA	National Acupuncture Detoxification Association	WHO	World Health Organization

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	National Task Force on Harm Reduction: Ministry of Health, Malaysian AIDS Council, National Anti Drug Agency, Royal Malaysian Police, Prisons Department, Malaysian Islamic Development Department, Academics[1]. National Drug Eradication Action Council: Deputy Prime Minister (chair) Cabinet Committee on AIDS (CCA) National Advisory Committee on AIDS (NACA)	National harm reduction approach adopted in 2005, and almost exclusively funded by government[2]. National Drug Eradication Action Council supports pilot Methadone Program[3]. Malaysian AIDS Council coordinates NSPs NACA: Chaired by the Minister of Health. This is a high level advisory body to the Cabinet, providing a forum for policy issues relating to the HIV epidemic and reviews progress against annual work plans and budgets. Membership comprises Secretaries/ Directors General of the Ministries and senior representatives from civil society including, some	

	Technical Committee on AIDS (TCA)	UN Agencies (UNICEF, WHO, UNDP, UNFPA) who serve as observers [4]. CCA: Inter-Ministerial Committee chaired by the Deputy Prime Minister. Provides a forum for discourse at the highest level on policies for halting and reversing the spread of HIV/AIDS and reducing its impact[4].	
Civil Society Engagement	NACA: Membership comprises representatives from civil society including, Private sector, religious bodies and NGOs, (who will represent PLWHA)[4]. Also; Cahaya Harapan, AARG, ACC, Kawan, IKHLAS, Sahabat, ILZ, MMA, INSAF[3].	NGOs running NSPs, which include both outreach and drop-in centres, and a range of other services such as T&C, ART, condom promotion, IEC dissemination (through peer education) and referral to OST and health services.	
Donor Commitment	Expanded United Nations Theme Group on HIV/AIDS	National harm reduction approach adopted in 2005, and almost exclusively funded by government[2]. Expanded United Nations Theme Group on HIV/AIDS in Malaysia serves as a platform for interaction among UN Agencies in support of a national response.	
Multi-sectoral Involvement	Cabinet Committee on AIDS (CCA) National Advisory Committee on AIDS (NACA) Technical Committee on AIDS (TCA)	CCA: Inter-Ministerial Committee chaired by the Deputy Prime Minister[4]. NACA: Membership comprises Secretaries/ Directors General of all Ministries [4]. TCA: Develops annual work plans and budgets for implementation of the National Strategic Plan on HIV/AIDS, 2006-2010[4].	People living with HIV and AIDS and IDUs are not directly represented within NACA.
Involvement of IDUs in the Response	No.		People living with HIV and AIDS and IDUs are not directly represented within NACA.
Costed National Harm Reduction Strategy	Department of Public Health of the Ministry of Health is lead agency for coordination[4].	National harm reduction approach adopted in 2005, and almost exclusively funded by government[2]. Fully costed plans of action are developed for the six major strategies outlined in National Strategic Plan on HIV/AIDS, 2006-2010, at the national, state and district levels[4].	
Does the National Drug Strategy complement the National HIV strategy?	Commitment to a "Drug-Free Society by 2015". Third National Strategic Plan on HIV/AIDS, 2006-2010.	Commitment to a "Drug-Free Society by 2015", reinforcing stringent drug policy and stricter enforcement. Public arrests and round-ups of drug users remain common. Huge resources continue to be spent on managing, developing and maintaining Drug Rehabilitation Centres[1].	With the exception of the Commitment to a "Drug-Free Society by 2015", National Drug Strategies do complement National HIV strategies.

	National Drug Strategy	Third National Strategic Plan on HIV/AIDS, 2006-2010 explicitly aims to reduce HIV vulnerability among IDUs, and calls for OST, NSP and free ART[3,5]. Condom promotion for IDUs is also included. Specifically, "…HIV information, risk reduction counselling, safer sex information, condom use promotion and primary health care…improving access to T&C. … drug dependence treatment options … OST; and HIV/AIDS related treatment and care." [4]. Measures initiated under the National Strategic Plan on HIV/AIDS, 2006-2010 will complement and in many cases reinforce strategies in the existing National Drug Strategy[4].	
Legal and Policy Environment	National Strategic Plan on HIV/AIDS, 2006-2010. National Drug Strategy.	Enables harm reduction programs: National Strategic Plan on HIV/AIDS, 2006-2010 explicitly aims to reduce HIV vulnerability among IDUs, and calls for OST, NSP and free ART[3,5]. Condom promotion for IDUs is also included. Specifically, "…HIV information, risk reduction counselling, safer sex information, condom use promotion and primary health care…improving access to T&C. … drug dependence treatment options … OST; and HIV/AIDS related treatment and care." [4].	Restricts harm reduction programs: Provision of needles and syringes is prohibited[6]. Public arrests and round-ups of drug users remain common[1].
Surveillance Systems	AIDS/STD Section, Disease Control Division, Department of Public Health, Ministry of Health	AIDS/STD Section administers national surveillance network through participating hospitals, existing epidemiological surveillance centres and academic institutions. Data is collected and entered, and then fed into the national data processing system[4]. National Surveillance Network comprises: Case based surveillance, Serum based surveillance, Behavioural Surveillance, STI Surveillance.	The country does not conduct national HIV Sentinel Surveillance, and hence no trend data is available on HIV prevalence[8]

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
AIDS/STD Section, Disease Control Division, Department of Public Health, Ministry of Health	AIDS/STD Section oversees central coordination, monitoring and evaluation system for assessing the impact of the National Strategic Plan on HIV/AIDS, 2006-2010[4].	Reports annually	Not specified.	Scarcity of data on some indicators requires baseline, mid-term and end line assessments to be conducted from 2006-2010[4].
AIDS/STD Section, Disease Control Division, Department of Public Health, Ministry of Health	National surveillance network through participating hospitals, existing epidemiological surveillance centres and academic institutions[4]. National Surveillance Network comprises: Case based surveillance, Serum based surveillance, Behavioural Surveillance, STI Surveillance.	Ongoing: Data is collected and entered, and then fed into the national data processing system.	Reported to the Ministry of Health "for dissemination to relevant agencies and partners" [4].	Lack of capacity of staff and Surveillance Network members on methodology, Procedures and database management. Insufficient equipping of AIDS/STD Section and Data Collection Centres in terms of linking databases[4].

2. Program Implementation.

Estimated IDU Population: 205,000 (170,000<n<240,000); (estimates from 2002)[7] *(a)*
195,000; (estimates from 2006)[6] *(a)*
230,500; (estimates from 2009)[2] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	23 sites[9], including; Alor Setar, Seberang Perai, Pulau Pinang, Pahang Jengka, Pahang Kuantang, Kuala Lumpur, Kota Bharu, Johor Bharu, Kluang, Kuala Terengganu, Murni Semenyih[1].	3 NGOs[9] in 11 sites.	12 health clinic sites[9].	3,307[9]. Cumulative total: 15,537[9].	Unknown	>2m[2-3].	Yes 106 sites	Yes	7-8% (b/a) 4.4%[2].	Yes: Nat Strategic Plan
Opioid Substitution Therapy (OST)	151 facilities exist; includes hospitals, health clinics, general practices, NADA and prisons[9].			6,538[9]. Cumulative total: 10,230[9]. Other estimates: 22,000[2], 4,135[5], 17,065[1].	No[5].				4-5% (b/a) 9.1 %[2].	Yes: Nat Strategic Plan
HIV Testing and Counselling (T&C)	Referral from NSPs[1].				Unknown					Unknown
Antiretroviral Therapy (ART)					No					Yes: Nat Strategic Plan
Prevention and treatment of STIs					Unknown					Unknown
Condom programs	Through NSPs[1].	As above for NSPs		4,088[3].	No	54,778[9].	Yes			Unknown
Targeted IEC	Through NSPs[1].	As above for NSPs			No		Yes			Unknown

Primary Health Care (including treatment of opportunistic infections)					Unknown					Unknown
Diagnosis, treatment of and vaccination for viral hepatitis					Unknown					Unknown
Prevention, diagnosis and treatment of tuberculosis					Unknown					Unknown
Peer Education programs	Through NSPs[1].	As above for NSPs			No		Yes			Unknown

2b. Services in Prisons.

Estimated Prisoner Population:	50,305 (includes several thousand immigration prisoners) (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, mid-2007; sourced 30/7/09) 39,440 (2008, 28th Asia and Pacific Conference of Correctional Administrators, Langkawi, Malaysia)
Estimated # and % of Drug Offenders:	(*reference, year*)

Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	Yes	In Pengkalan Chepa Prison for 50 prisoners 11 prisons for 200 prisoners (2008 pilot)[1,5,9].
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

Additional information:
National HIV/AIDS Strategy supports effective harm reduction programs to target IDUs in closed settings (such as prisons, police lockups, drug rehabilitation centres, immigration

detention centres and private rehabilitation centres)[4].

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		28 drug rehabilitation centres[2].
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Some factions within government still not supportive of harm reduction approaches.	NACA, CCA, National Task Force on Harm Reduction, National Drug Eradication Action Council.	
Civil Society Engagement	None identified.		
Legal and Policy Environment	Methadone is illegal and provision of needles and syringes is prohibited under law.	NACA, CCA.	
Law Enforcement	Law enforcement agencies reported to not fully endorse harm reduction approaches; public arrests and periodic round-ups of IDUs remain common[1]		
Comprehensive Services	None identified.		
Resources (Financial, human and data)	Human resource insufficient; shortage of government doctors / allied health professionals.	NACA and member ministries, Donors and technical agencies, Implementing agencies.	
Involvement of IDUs in the Response	People living with HIV and AIDS and IDUs are not directly represented within NACA.		
Availability of Commodities			
i. Needle and Syringe programs	None identified.		
ii. Opioid Substitution Therapy (OST)	None identified. Despite illegality, government has approved distribution through registered services.		
iii. HIV Testing and Counselling (T&C)	None identified.		
iv. Antiretroviral Therapy (ART)	None identified.		
v. Prevention and treatment of STIs	None identified.		
vi. Condom programs	None identified.		
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		

ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		
Scaling Up Plans	None identified.		
Capacity Building	None identified.		
Monitoring and Evaluation	Lack of capacity of staff and Surveillance Network members on methodology, Procedures and database management. Insufficient equipping of AIDS/STD Section and Data Collection Centres in terms of linking databases[4].	NACA and member ministries, Donors and technical agencies.	Fully costed plans of action are developed for the six major strategies outlined in National Strategic Plan on HIV/AIDS, 2006-2010, at the national, state and district levels[4].

4. Gap Analysis

- IDUs not currently contributing to either policy development, service delivery or M&E of harm reduction services. This has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[10]) not currently being delivered to IDUs consistently, particularly ART, prevention and treatment of STIs, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems lacking reliable baseline data, and demonstrate inadequacies as a result of insufficient technical capacity and resources to conduct regular M&E effectively. This restricts Malaysia's ability to measure and manage the quality and effectiveness of its harm reduction services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- Ambiguities within the law threaten to hamper delivery of comprehensive services if law enforcement agencies are not sensitised to supporting these initiatives.
- Comprehensive harm reduction services for prisons and CCDU not currently being implemented, which therefore inadequate poses an HIV and STI transmission threat throughout Malaysia.

5. Recommendations

- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Greater involvement of IDUs in policy development, planning, implementing and monitoring harm reduction services.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[10].
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Kamarulzaman, A. Rolling Out The National Harm Reduction Programme in Malaysia. Scaling-up harm reduction services towards universal access in Asia: Models of good practice. Symposium organised by the United Nations Regional Task Force in Injecting Drug Use and HIV/AIDS for Asia and the Pacific. 11 August, 9th ICAAP. Bali, Indonesia.
2. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. (2009)..Malaysia Country Advocacy Brief Injecting Drug Use and HIV,
3. Ramly. R. Disease Control Division, Ministry Of Health Malaysia. Harm Reduction Program In Malaysia. Presentation at the The Second Sida Project Advisory Committee Meeting 10-12 November, 2008, Manila, Philippines.
4. Government of Malaysia. (2006). National Strategic Plan on HIV/AIDS, 2006-2010, Government of Malaysia.
5. No author cited. (2008). Response beyond borders: the South East Asia regional workshop on the prevention of HIV related to drug use, Asian Consortium on Drug Use, HIV, AIDS and Poverty.
6. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
7. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
8. Personal communication, UNRTF, Bangkok, 10th November, 2009.

9. Yuswan, F. (2009). Scaling-up harm reduction services: Malaysia's experience. Regional meeting on the development of the regional harm reduction strategy 2010-2015. Malaysia.
10. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Maldives Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Maldives

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	IGMH	Indira Ghandi Memorial Hospital
ART	Antiretroviral Therapy	NCC	Narcotics Control Council
AusAID	Australian Agency for International Development	NGO	Non Government Organisation
C&T	HIV Testing and Counselling	NSP	Needle and syringe program
CCDU	Compulsory Centres for Drug Users	OST	Opioid Substitution Therapy
DDPRS	Department of Drug Prevention and Rehabilitation Services	SHE	Society for Health Education
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
IDUs	People who inject drugs	SWAD	Society for Women against Drugs
IEC	Information, Education, Communication	UNODC	United Nations Office on Drugs and Crime

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Narcotics Control Council (NCC) Chair: Vice President. Members include; Ministry of Home Affairs; Ministry of Education; Ministry of Health and Family; Ministry of Human Resources, Youth and Sports; Ministry of Islamic Affairs; Maldives Customs Service; Department of Immigration and Emigration; Maldives National Defence Force; Commissioner of Police[1]. Department of Drug Prevention & Rehabilitation Services (DDPRS) under the Ministry of Health & Family[1].	NCC responsible for preventing drug trafficking and illicit use. Supports drug demand reduction by providing secretariat support to development partners for policy and programme reforms[1]. DDPRS administers and oversees drug demand reduction programmes and policies[1].	Rapidly changing political environment has led to the development of separate, vertical programs. For example, IDUs receive services from DDPRS and National STD/AIDS Programme (Ministry of Health and Family and Ministry of Home Affairs) through the prison programmes[1]. Some influential factions within government support incarceration/mandatory treatment for IDUs[1]. Emphasis of government agencies seems to relate mainly to demand and supply reduction, through law enforcement and treatment. Human rights approach to IDU harm reduction appears to be lacking from government mechanisms.

Civil Society Engagement	Little civil society engagement for harm reduction; JOURNEY. Society for Health Education (SHE). Society for Women against Drugs (SWAD)	Civil society was only recently introduced to Maldives, with a law allowing registration of NGOs being passed in 2006[2]. Civil society organisations implement elements of a comprehensive harm reduction package through a joint UN regional project supported by UNODC; OST using methadone Peer led outreach, Counselling and support services, VCT and referrals for STI, Drug treatment and rehabilitation (JOURNEY, SHE, SWAD). Provision of condoms Disseminated targeted IEC (SHE)[1,2]. These NGOs play an advisory role to DDPRS[1].	Limited understanding and capacity among civil society organizations regarding comprehensive evidence-based HIV/AIDS prevention and care programmes for IDUs[1]. Limited options for sustaining the civil society response due to over dependence on donor aid and support for institutional management[1].
Donor Commitment	UNODC AusAID European Commission	With funding from AusAID, UNODC supports the Government of Maldives in the design and implementation of its first Drug Control Master Plan which was approved in March 2008. Within this plan the government implements the comprehensive package of services for IDUs and their sex partners with the support of UNODC and local NGOs[3-4]. UNODC Regional Office for South Asia is working in partnership with the Government and provides technical cooperation and assistance, ranging from legal and policy issues to field based model interventions. UNODC is executing two regional projects which have ongoing operations in the Maldives. They are titled: 1) Prevention of transmission of HIV among drug users in SAARC countries and 2) Prevention of spread of HIV amongst vulnerable groups in South Asia. These aim to; Provide technical assistance to scale up cost effective comprehensive package of harm reduction services for IDUs; Assist Maldives to adopt OST in community and prison settings; Build capacities of service providers and civil society on drugs and HIV issues;	

		Facilitate advocacy on drugs and HIV prevention.	
Multi-sectoral Involvement	NCC Chair: Vice President. Members include; Ministry of Home Affairs; Ministry of Education; Ministry of Health and Family; Ministry of Human Resources, Youth and Sports; Ministry of Islamic Affairs; Maldives Customs Service; Department of Immigration and Emigration; Maldives National Defence Force; Commissioner of Police[1].	DDPRS administers and oversees drug demand reduction programmes and policies, whereas the National STD/AIDS Programme of the Ministry of Health and Family oversees the coordination and implementation of the HIV response guided by the Maldives National Strategic Plan on HIV (2007-2012)[1]. NCC supports the multi-sectoral coordination of drug demand reduction initiatives by providing secretariat support to development partners for policy and programme reforms[1].	Rapidly changing political environment has led to the development of separate, vertical programs. For example, IDUs receive services from DDPRS and National STD/AIDS Programme (Ministry of Health and Family and Ministry of Home Affairs) through the prison programmes[1]. Maldives demands a coordinated, harmonised and comprehensive approach to maintaining an effective response, with sufficient coverage, and ensuring sustainability to address the dual problem of drug use and HIV.
Involvement of IDUs in the Response	JOURNEY (NGO run by recovering drug users, including IDUs).	Involvement of JOURNEY (NGO run by recovering drug users, including IDUs) in planning and in advisory role[1]. IDUs also contribute to; Maldives National Advocacy Strategy (supported by UNODC). IBBS survey (GFATM supported). BCC strategy (GFATM supported). Project workplan for UNODC executed Joint UN Project on HIV prevention[1].	
Costed National Harm Reduction Strategy	Maldives National Advocacy Strategy (supported by UNODC)[1]. Drug Control Master Plan.	78,864.81 USD for the period Oct-2009 to Dec 2010 (funds not secured as yet) [1]. It is unclear if the Drug Control Master Plan is a costed national plan.	
Does the National Drug Strategy complement the National HIV strategy?	National policy on HIV/AIDS[2]. Drug Control Master Plan (March, 2008)	National Policy on HIV/AIDS espouses the principles of confidentiality, non-discrimination and informed consent. It mandates the raising of awareness about HIV transmission and calls for care and treatment of positive persons, and for a thorough information, education and communication program. It also directs that T&C should be voluntary[2]. Under the Drug Control Master Plan, the government implements the comprehensive package of services for IDUs and their sex partners with the support of UNODC and local NGOs[3].	National Drug Strategies do complement National HIV strategies. Services for IDUs are a recent development (March, 2008), and are yet to translate to comprehensive harm reduction services for IDUs. NGOs JOURNEY, SWAD and SHE implement elements of a comprehensive harm reduction package through a joint UN regional project supported by UNODC; OST using methadone Peer led outreach, Counselling and support services, VCT and referrals for STI, Drug treatment and rehabilitation (JOURNEY, SHE, SWAD). Provision of condoms

			Disseminated targeted IEC (SHE)[1-2].
Legal and Policy Environment	Law on Narcotics	Enables harm reduction programs: Law on Narcotics (specifically section 17/77) is inappropriate for HIV prevention and is currently being amended[5] to show some leniency towards drug users to facilitate rehabilitation, and this has the potential to open precedence for other harm reduction interventions[2].	Restricts harm reduction programs: Prior to completion of amendments, the following legal barriers remain in effect; "…selling, buying, giving, possession [of] illegal drug[s] is punishable with life imprisonment". Possession of 1 gram or more of any drug is tantamount to intention to sell, which can incur a sentence of life imprisonment[2]. Any act seen to be promoting drug use is illegal – this has the potential to prevent NSPs and peer education (and distribution of IECs) if seen to be promoting drug use. Likewise, the distribution of illegal drugs has potential to prohibit drug substitution activities[2].
Surveillance Systems	National AIDS Control Programme. Department of Public Health.	Surveillance and prevention is conducted by the National AIDS Control Programme, a part of the Department of Public Health[2].	

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used	Unknown

Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
National AIDS Control Programme, Department of Public Health	Surveillance conducted by National AIDS Control Programme, under the Department of Public Health[2].	Not specified.	Not specified.	

2. Program Implementation.

Estimated IDU Population: No estimates available.

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs	No services available[2].				n/a				19-31% of IDUs for all HIV prevention activites[5].	Unknown
Opioid Substitution Therapy (OST)	1 site (Methadone)[6].		DDPRS	47[1].	Unknown					Yes: UNODC supporting OST in community and prison settings.
HIV Testing and Counselling (T&C)	10 sites[1].	1 site: JOURNEY[1].	9 sites[1].		Unknown					Unknown
Antiretroviral Therapy (ART)	I centre (IGMH)		IGMH		Unknown					Unknown
Prevention and treatment of STIs	Service available from Health care facilities[1].	SHE[1].	Regional and Atoll level health care facilities[1].		Unknown					Unknown
Condom programs	No services available[2].				n/a					Unknown
Targeted IEC		SHE, DDPRS, JOURNEY[1].			Unknown					Unknown
Primary Health Care (including treatment of opportunistic infections)	None identified.				Unknown					Unknown
Diagnosis, treatment of and vaccination for viral hepatitis	None identified.				Unknown					Unknown
Prevention, diagnosis and treatment of	None identified.				Unknown					Unknown

tuberculosis										
Peer Education programs	None identified.				Unknown					Unknown

2b. Services in Prisons.

Estimated Prisoner Population:		1,125 (excludes pre-sentence detainees) (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, 2004; sourced 30/7/09).
Estimated # and % of Drug Offenders:		Approx 85% inmates in prisons are drug offenders[1]
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	Unknown
Opioid Substitution Therapy (OST)	No	N/A
HIV Testing and Counselling (T&C)	No	N/A
Antiretroviral Therapy (ART)	No	N/A
Prevention and treatment of STIs	No	N/A
Condom programs	No	N/A
Targeted IEC	Yes	Unknown
Primary Health Care (including treatment of opportunistic infections)	No	N/A
Diagnosis, treatment of and vaccination for viral hepatitis	No	N/A
Prevention, diagnosis and treatment of tuberculosis	No	N/A
Peer Education programs	Yes	Unknown
Post-release Follow-up	Yes[5].	Unknown

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		300[2].
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	No	N/A
Opioid Substitution Therapy (OST)	No	N/A
Medically Assisted Detoxification	Yes	Unknown
HIV Testing and Counselling (T&C)	No	N/A
Antiretroviral Therapy (ART)	No	N/A
Prevention and treatment of STIs	No	N/A
Condom programs	No	N/A
Targeted IEC	No	N/A
Primary Health Care (including treatment of opportunistic infections)	No	N/A
Diagnosis, treatment of and vaccination for viral hepatitis	No	N/A
Prevention, diagnosis and treatment of tuberculosis	No	N/A
Peer Education programs	Yes	Unknown
Post-release Follow-up	Yes[5].	Unknown

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	NCC and public health community not widely supportive of HIV prevention for IDUs due to low prevalence[2]. Rapidly changing political environment has led to the development of separate, vertical programs[1].	NCC and member ministries	Advocacy underway (Maldives National Advocacy Strategy) to encourage greater dialogue between government decision-makers and IDU-supportive organisations[1].
Civil Society Engagement	Young civil society in Maldives with limited capacity regarding comprehensive evidence-based HIV/AIDS prevention and care programmes for IDUs[1]. Limited options for sustaining the civil society response due to over dependence on donor aid and support for	Government. NGOs. Donor and technical agencies such as UNODC.	UNODC is executing two regional projects which have ongoing operations in the Maldives (see above). They are titled: 1) Prevention of transmission of HIV among drug users in SAARC countries and 2) Prevention of spread of HIV amongst vulnerable groups in South Asia.

	institutional management[1]. Lack of coordination among stakeholders at national level[1].		Advocacy underway (Maldives National Advocacy Strategy) to establish a Coordination Committee to assist with development of Secretariat for NCC[1].
Legal and Policy Environment	Selling, buying, giving, possession of illegal drugs is punishable with life imprisonment[2].	Government NCC	Amendments to the L aw on Narcotics are underway.
Law Enforcement	No barriers identified.		
Comprehensive Services	Some influential factions within government support incarceration/ mandatory treatment for IDUs, rather than comprehensive harm reduction interventions[1].	Government NCC	The first Drug Control Master Plan aims to implement the comprehensive package of services for IDUs and their sex partners with the support of UNODC and local NGOs[3].
Resources (Financial, human and data)	No barriers identified.		
Involvement of IDUs in the Response	No barriers identified.		
Availability of Commodities	No barriers identified.		
Scaling Up Plans	Limited options for sustaining the civil society response due to over dependence on donor aid and support for institutional management[1].	Government, NCC, donors and civil society.	UNODC is executing two regional projects which have ongoing operations in the Maldives (see above). They are titled: 1) Prevention of transmission of HIV among drug users in SAARC countries and 2) Prevention of spread of HIV amongst vulnerable groups in South Asia.
Capacity Building			
Monitoring and Evaluation	No barriers identified.		

4. Gap Analysis

Gap analysis for this country is hampered by little available data regarding the harm reduction services. However the following points are noted;

- While official rhetoric suggests a commitment to the delivery of comprehensive harm reduction services to IDUs, there is a lack of available data to support this. It would appear that complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[7]) are far from being met.
- Membership of the NCC demonstrates a breadth of multi-sectoral commitment to harm reduction, however in practice, a lack of coordination between service-implementing ministries has resulted in the creation of vertical programs which contribute both resource overlap and programming gaps, and which do not adequately contribute to a comprehensive harm reduction response.

- Emphasis of government agencies seems to relate mainly to demand and supply reduction, through law enforcement and treatment. Human rights approach to IDU harm reduction seems to be lacking in government mechanisms.
- It is not clear whether M&E systems gather data specifically relating to service delivery for IDUs. Lack of attention to this could contribute to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[7].
- Amendments to the Law on Narcotics which are necessary to facilitate delivery of comprehensive harm reduction services are yet to be concluded.
- Financial resources not sufficient to enable appropriate, sustainable service coverage to scale; currently there exists an over-dependence on donor aid and support to deliver harm reduction services.
- Personnel capacity not sufficient to enable appropriate service coverage to scale. Particularly, there is limited understanding among civil society organizations regarding comprehensive evidence-based HIV/AIDS prevention and care programmes for IDUs.
- Very little information is available regarding harm reduction services for prisons and CCDU, however it is assumed that these would be minimal and insufficient.

5. Recommendations

- Further input into the completion of service coverage information will enable a more accurate picture of harm reduction needs with which to plan and implement programs for IDUs in Maldives.
- Greater coordination of multi-sectoral, government response is required to ensure resources are more effectively utilised in the delivery of comprehensive services.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government, technical agencies and NGOs.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[7].
- Completion and implementation of amendments to the Law on Narcotics in order to facilitate uninhibited delivery of comprehensive harm reduction services.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Personal communication, Kunal Kishore, Project Co-ordinator; "Prevention of transmission of HIV among drug users in SAARC Countries", UNODC, 24th December, 2009.
2. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit. UNODC ROSA.
3. United Nations Office on Drugs and Crime. (2009). "Maldives marks first anniversary of its ever first Methadone clinic: 'Methadone was my cure'." Retrieved 10th November, 2009, from http://www.unodc.org/india/en/methadone-is-my-cure.html.
4. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
5. HIV and AIDS Data Hub for Asia-Pacific (2009). HIV and AIDS: Review in slides: Maldives, UNAIDS, UNICEF, WHO, ADB.
6. Sharma, M., E. Oppenheimerb, et al. (2009). "A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region." AIDS 23
7. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Myanmar Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Myanmar

Abbreviations			
3DF	Three Diseases Fund	HAARP	HIV/AIDS Asia Regional Program
AHRN	Asian Harm Reduction Network	HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome	IDUs	People who inject drugs
ART	Antiretroviral Therapy	MANA	Myanmar Anti Narcotics Association
AusAID	Australian Agency for International Development	NGO	Non Government Organisation
AZG/MSF-H	Médecins Sans Frontières - Holland	NSP	Needle and Syringe Program
C&T	HIV Testing and Counselling	OST	Opioid Substitution Therapy
CCDAC	Central Committee for Drug Abuse Control	STI	Sexually Transmitted Infection
CCDU	Compulsory Centres for Drug Users	UNODC	United Nations Office on Drugs and Crime

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Central Committee for Drug Abuse Control (CCDAC); Ministry of Home Affairs, comprises; Supply Reduction sectors (Crop Substitution and Income Substitution), Drug Demand sectors (Treatment and Rehabilitation, Preventive Education for students and youth, and Mass Media information for the general public), Law Enforcement sectors (the National Police Force, Customs, Immigration, the Military, Precursor Chemical Control, and Administration of confiscated assets from drug cases), and	CCDAC responsible for injecting drug use and related HIV/AIDS issues. It has been the champion of harm reduction in Myanmar over the past decade and is an essential agency both at national, regional and local levels due to its structure of working groups and the 21 Special Anti-Narcotic Squads employed throughout the country. CCDAC continues to support harm reduction including programming and advocating for policy changes which effect harm reduction and resource mobilisation. UNODC maintains an Agreement with the Ministry of Home Affairs. National Strategic Plan (NSP) on HIV/AIDS (2006-2010)	Ministry of Health lacking involvement in harm reduction other than in OST with methadone.

	International relations and cooperation[1]. National Strategic Plan (NSP) on HIV/AIDS (2006-2010) Lead agencies for health and HIV/AIDS: Ministry of Health National AIDS Program Ministry of National Planning and Economic Development	developed with contributions from all stakeholders[2].	
Civil Society Engagement	Government restrictions limit this[3]. 33 international and 12 national NGOs. AHRN, Care, MANA, UNODC, World Concern, AZG/MSF-H[4], Burnet Institute, Medicins du Monde, WHO, Marie Stopes International, National Drugs and Alcohol Research Centre, Myanmar Council of Churches, Myanmar Baptist Convention, Substance Abuse Research Association, Township Project Management Committees[2].	AHRN, MANA and UNODC provide direct service delivery to reach IDUs through outreach activities and drop-in centres. HAARP flexible funding enables UNODC, in partnership with international and local NGOs to provide drugs and HIV-related prevention, care and support, harm reduction and improving access of clients to local facilities covering 2,800 drug users (including IDUs), and sexual partners. 3DF supports behaviour change interventions for IDUs through these organisations also[2].	Female IDUs more likely than males to be stigmatized by society because their activities are considered to be doubly deviant. Existing services for IDUs are male-oriented, and do not encourage access by females[2]. Currently, there exists a lack of information on profile of female drug users. Services do not actively target female partners of male drug users[3].
Donor Commitment	HIV/AIDS Asia Regional Program (HAARP), AusAID Three Diseases Fund (3DF): USD60m over 5 years for HIV/AIDS. Donors include: Australia, European Commission (EC), Netherlands, Norway, Sweden, United Kingdom (UK)	3DF funds grants which support the National Operational Plan for HIV and AIDS, which strategically prioritises target groups (including 36,941 IDUs) for effective prevention interventions. IDU activities are being supported by 3DF in 16 townships. Activities include; behavioural change communication through peers on harm reduction and safer sex practices, promotion and provision of preventive measures like condoms, needles and syringes, creating enabling environments through advocacy to local authorities, law enforcement and communities direct provision or referral to quality treatment of STIs and T&C, creation of networks and self- help groups to promote prevention interventions and provide psychosocial support[4]. GFATM Round 9 recently approved (USD51,716,207 in first 2 years; USD157,776,471 over five years) to meet HIV prevention, treatment and care. IDUs identified as a priority population for targeted prevention interventions[5].	

		HAARP (AusAID) supporting multisectoral approaches through direct engagement of non-health sectors in activities such as NSP, OST, condom promotion, primary health care, VCT and ART[6].	
Multi-sectoral Involvement	CCDAC. NGOs and UN agencies as listed above.	CCDAC is a multi-sectoral committee responsible for injecting drug use and related HIV/AIDS issues.	
Involvement of IDUs in the Response	Limited.	Some NGOs and UN Agencies employ peer outreach workers for their harm reduction activities. Recent efforts have begun to form a national umbrella network for drug users to improve representation in national fora.	While people living with HIV are identified for collaboration in planning, monitoring and evaluation of the National Strategic Plan on HIV/AIDS (2006-2010), no specific reference is made to inclusion of IDUs. IDUs not currently contributing to policy and strategy development.
Costed National Harm Reduction Strategy	Lead agencies for health and HIV/AIDS: Ministry of Health National AIDS Program	National Operational Plan for HIV and AIDS operationalises the National Strategic Plan on HIV/AIDS (2006-2010), articulating targets and budgets, and mechanisms for monitoring and evaluating progress[4].	
Does the National Drug Strategy complement the National HIV strategy?	National Strategic Plan on HIV/AIDS (2006-2010). National Operational Plan for HIV and AIDS[4]. Narcotic Drugs and Psychotropic Substances Law (1993).	National Strategic Plan on HIV/AIDS (2006-2010) aims to reduce HIV related risk, vulnerability and impact among IDUs[5]. This comprises NSPs and OST[1]. It explicitly prioritises "Reducing HIV-related risk, vulnerability and impact among drug users", and "Reducing HIV-related risk, vulnerability and impact among institutionalized populations"[2].	National Drug Strategies do not complement National HIV strategies, …however in practice, harm reduction activities are able to operate.
Legal and Policy Environment	Myanmar is signatory to 7 internationally binding conventions related to drugs: Agreement Concerning the Suppression of the Manufacture of Internal Trade in and Use of Prepared Opium, 1925; International Opium Convention and Protocol, 1925; Protocol Bringing under International Control Drugs Outside the Scope of the Convention, 1931; Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs and Protocol of Signature, 1931; Single Convention on Narcotic Drugs, 1961; Convention on Psychotropic Substances, 1971; United Nations Convention against Illicit	Enables harm reduction programs: National Strategic Plan on HIV/AIDS (2006-2010) aims to reduce HIV related risk, vulnerability and impact among IDUs[7]. This comprises NSPs and OST[1]. It explicitly prioritises "Reducing HIV-related risk, vulnerability and impact among drug users", and "Reducing HIV-related risk, vulnerability and impact among institutionalized populations"[2].	Restricts harm reduction programs: Provision of needles and syringes is prohibited[8], however this does not appear to hinder NGOs and UN agencies from operating. There have been some reports of needles being confiscated by police and submitted to the courts as evidence when individuals are arrested for drug possession[1]. Under the Narcotic Drugs and Psychotropic Substances Law (1993), possession of narcotic drugs is illegal. Drug users must register with a government identified facility for treatment and non-compliance with medical treatment results in 3-5 years imprisonment[7].

	Traffic in Narcotic Drugs and Psychotropic Substances, 1988; United Nations Convention against Transnational Organized Crime, 2000. Laws and regulations related to drugs and AIDS: Narcotic Drugs and Psychotropic Substances Law, 1993; Order Relating to Illicit Crop, 1993; Order of Chemical Used in Production of Narcotic Drug, 1993; Order Relating to Narcotic Drugs and Psychotropic Substances, 1996; Order of Chemical Used in Production of Narcotic Drug, 1996[2].		
Surveillance Systems	National AIDS Program	HIV surveillance system (established 1992 - expanded as a sentinel surveillance system comprising behavioural surveillance in 2003) produces valuable data for monitoring, targeting and planning of programme activities. HIV Sentinel sero-surveillance disaggregates for IDUs[4].	Inadequate gender disaggregation of data to identify numbers of female IDUs[2]. Surveillance system doesn't target female injectors because the low percentage of female injectors would not provide statistically relevant data. However, the service delivery points report on female IDUs[3].

1b. Monitoring and Evaluation (M&E) Systems.				
WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
National AIDS Program	HIV Sentinel sero-surveillance disaggregates for IDUs[4].	Not specified.	Not clearly stated, however system produces valuable data which contributes to monitoring, targeting and planning of program activities.	Inadequate gender disaggregation of data to identify numbers of female IDUs[2]. Surveillance system doesn't target female injectors because the low percentage of female injectors would not provide statistically relevant data. However, the service delivery points report on female IDUs[3].
National Strategic Plan on HIV/AIDS (2006-2010) articulates targets and budgets, and mechanisms for monitoring and evaluating progress[4].	No further details about processes are available.			

2. Program Implementation.

Estimated IDU Population: 75,000 (60,000<n<90,000); (estimates from 2007)[9] *(a)*
200,000 (150,000<n<250,000)[1] (estimates from 2008)[1] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	36 sites[7]. Divisions/States: Kachin, Shan, Mandalay, Yangon. Cities: Myitkyina, Muse, Lashio, Mandalay, Yangon, Taunggyi[7]. Available in pharmacies[8].	36 sites operated by NGOs, (12 drop-in centres in Shan and Kachin)[2-3]. AHRN, AZG, Burnet Institute, Care, CCDAC, MANA, MDM, UNODC, WHO[3].	Remaining sites operated by Govt?	10,831 (2007)[7]. 29,477 (2007) accessing HIV prevention services[10]. 8,427 IDUs accessing drop-in centres (National Progress Report 2008)[3].	Unknown	3.5m (National Progress Report 2008)[3,7,10].	Yes: 5,774 people reached (not only NSP)[7].		5-14% (b/a) 28%[10]. 12%[3].	Yes: GFATM
Opioid Substitution Therapy (OST)	8 services[7,10].	Yes	Yes	580 (2008)[3,8].	Yes (partial)		Unknown		0.3–0.8% (b/a) 0.6%[10].	Yes – to increase to 10 sites
HIV Testing and Counselling (T&C)	Available, not specific to IDUs	Yes	Yes		No					Yes: GFATM
Antiretroviral Therapy (ART)	Not specific to IDUs	Yes	Yes		No					Yes: GFATM
Prevention and treatment of STIs	Not identified.									Yes: GFATM
Condom programs	3DF supports programs; not specific	Yes	Yes	23.8m	NGOs distribute free					Yes: GFATM

	to IDUs[4].				of charge[3].					
Targeted IEC	Delivered through NSPs and other programs.	Yes	Unknown		No					Yes: GFATM
Primary Health Care (including treatment of opportunistic infections)	Not identified.				No					Yes
Diagnosis, treatment of and vaccination for viral hepatitis	Not available[3].									Unknown
Prevention, diagnosis and treatment of tuberculosis	Yes	AHRN			No					Yes
Peer Education programs	Delivered through NSPs and other programs.	Yes	Unknown		No		Yes			Yes: GFATM

2b. Services in Prisons.		
Estimated Prisoner Population:	65,063 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, mid-2007; sourced 30/7/09) 64,930 (2008, 28th Asia and Pacific Conference of Correctional Administrators, Langkawi, Malaysia)	
Estimated # and % of Drug Offenders:	Information not available	
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs (NSP)	No	
Opioid Substitution Therapy (OST)	No	
HIV Testing and Counselling (T&C)	No	Voluntary services available
Antiretroviral Therapy (ART)	No	Small number of prisons[5].
Prevention and treatment of STIs	No	
Condom programs	No	
Targeted IEC	No	
Primary Health Care (including treatment of opportunistic infections)	Yes	Limited.
Diagnosis, treatment of and vaccination for viral hepatitis	No	
Prevention, diagnosis and treatment of tuberculosis	No	
Peer Education programs	No	
Post-release Follow-up	No	

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		No information available
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	Yes	
Medically Assisted Detoxification	Yes	
HIV Testing and Counselling (T&C)	Yes	
Antiretroviral Therapy (ART)	No	
Prevention and treatment of STIs	No	
Condom programs	No	
Targeted IEC	Yes	
Primary Health Care (including treatment of opportunistic infections)	Yes	
Diagnosis, treatment of and vaccination for viral hepatitis	No	
Prevention, diagnosis and treatment of tuberculosis	No	
Peer Education programs	No	
Post-release Follow-up	No	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Gaining local support to implement harm reduction. Often political commitment will be given at a central level but then blocked at a local/regional level depending on the local political power dynamics. Ministry of Health lacking involvement in harm reduction other than in OST with methadone.	Ministry of Health. National AIDS Program. CCDAC.	
Civil Society Engagement	Government restrictions to civil society groups have the potential to limit involvement of community-based organisations.	CCDAC. Ministry of Home Affairs.	
Legal and Policy Environment	Buprenorphine is illegal Needle and syringe possession laws have the potential to inhibit NSPs.	CCDAC. Ministry of Home Affairs.	The international community must watch these attempts closely and ensure that changes to the legislation (especially with regard to diversion) do not increase the harms to drug users. CCDAC is playing an important role in attempting to reform some major legal barriers to harm reduction. Despite legal barriers, in practice, harm reduction services are being delivered.
Law Enforcement	IDUs seen as criminals – possession of needles/syringes evidence of drug use. Compulsory registration of drug user laws could force IDU activity underground.	CCDAC. Law Enforcement sectors (the National Police Force, Customs, Immigration, the Military, Precursor Chemical Control, and Administration of confiscated assets from drug cases).	3DF supporting the creation of enabling environments through advocacy to local authorities, law enforcement and communities[4].

Comprehensive Services	Coverage of OST hampered by long periods of in-patient stabilisation[7]. Cost to IDUs and stigmatisation[1,7]. Female IDUs more likely than males to be stigmatized by society because their activities are considered to be doubly deviant. Existing services for IDUs are male-oriented, and do not encourage access by females[2].	CCDAC. Donors and technical agencies. Civil society and IDU groups.	GFATM, HAARP and 3DF supporting scale-up.
Resources (Financial, human and data)	Resource gap: only half of the planned funding for harm reduction programmes in the National Strategic Plan was mobilized in 2007[7].	CCDAC.	GFATM, HAARP and 3DF supporting scale-up.
Involvement of IDUs in the Response	Government restrictions to civil society groups have the potential to limit involvement of community-based organisations.	CCDAC. Donors and technical agencies. Civil society and IDU groups.	3DF supporting the creation of IDU networks and self- help groups to promote prevention interventions and provide psychosocial support[4].
	Stigma and discrimination from law enforcement through ambiguous laws could discourage IDU involvement.		
Availability of Commodities			
i. Needle and Syringe programs	No barriers, N&S available at services free of charge and no 'stock-outs'	AHRN, AZG, Care, MANA, MDM, UNODC,	GFATM, HAARP and 3DF supporting scale-up.
ii. Opioid Substitution Therapy (OST)	Long in-patient period	CCDAC. NGOs and service providers. Donors and technical agencies.	GFATM and HAARP supporting scale-up.
	Insufficient resources to increase OST.		
	Mandatory admission for OST to hospital for 14 days and then home for maintenance. This is a barrier for some IDUs, but not for others.		
iii. HIV Testing and Counselling (T&C)	Limited numbers of organisations with permission to perform		GFATM, HAARP and 3DF supporting scale-up.
iv. Antiretroviral Therapy (ART)	None identified.		GFATM, HAARP and 3DF supporting scale-up.
v. Prevention and treatment of STIs	None identified.		GFATM, HAARP and 3DF supporting scale-up.

vi. Condom programs	Services do not actively target female partners of male drug users[3].		GFATM, HAARP and 3DF supporting scale-up.
vii. Targeted IEC materials	None identified.		GFATM, HAARP and 3DF supporting scale-up.
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		GFATM, HAARP and 3DF supporting scale-up.
Scaling Up Plans	None identified.	CCDAC. Donors and technical agencies.	GFATM, HAARP and 3DF supporting scale-up.
Capacity Building	Insufficient technical capacity of service providers and program implementers.	CCDAC. Donors and technical agencies.	
Monitoring and Evaluation	Collecting independent data is difficult[1]. There exists a lack of information on profile of female drug users, as IDU data is not disaggregated by gender.	National AIDS Program.	National Strategic Plan on HIV/AIDS (2006-2010) articulates targets and budgets, and mechanisms for monitoring and evaluating progress[4].

4. Gap Analysis

- Good multi-sectoral contribution to HIV and AIDS programming exists, however in terms of coordination of harm reduction for IDUs, non-law enforcement authorities (especially health) not well represented.
- Limited coordination of harm reduction programs between the central and implementation levels, resulting in frequently disrupted services.
- IDUs not currently contributing to either policy development, service delivery or M&E of harm reduction services. This has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable harm reduction services (especially OST and NSPs), and to encourage wider civil society involvement (especially from IDU groups).
- Wide-ranging powers of law enforcement authorities over IDUs are incompatible with the provision of effective harm reduction services.

- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[11]) not currently being delivered to IDUs consistently, particularly diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators by total IDUs and by gender) upon which to plan and deliver targeted services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].
- Financial resources (both in absolute terms, and in terms of dispersal) and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Very little information is available regarding harm reduction services for prisons and CCDU, reflecting the likelihood that any such existing services would be minimal and insufficient.

5. Recommendations

- Greater multi-sectoral, government involvement, incorporating the inclusion of non-law enforcement sectors, is required to ensure a more comprehensive approach to harm reduction.
- Greater coordination between central and implementation levels of government is essential to ensuring effective harm reduction services, and this should be strengthened through technical and mentoring support to the latter.
- Legal and policy reform to remove ambiguity about the legality of delivering harm reduction services is essential to encouraging wider civil society involvement (especially from IDU groups).
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[11].
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit. UNODC ROSA.
2. Personal communication with UNAIDS Bangladesh and Ezazul Islam Chowdhury, 25th November, 2009.
3. Personal communication, Markus Buhler, M&E Adviser, UNAIDS, Myanmar, 9th November, 2009.
4. Reddy, A., M. M. Hoque, et al. (2008). Article in press. "HIV transmission in Bangladesh: An analysis of IDU programme coverage. "International Journal of Drug Policy"; doi:10.1016/j.drugpo.2007.11.015.
5. Global Fund for AIDS, TB and Malaria. (2009). "Proposal Form Round 9: Myanmar" Retrieved 15th November, 2009, from http://www.theglobalfund.org/programs/country/index.aspx?lang=en&countryID=MYN
6. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
7. BERGENSTROM, A., SHARMA, M. & GARG, R. (2009) Myanmar Country Advocacy Brief Injecting Drug Use and HIV (DRAFT). United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.
8. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
9. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
10. Sharma, M., E. Oppenheimerb, et al. (2009). "A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region." AIDS 23.
11. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Nepal Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Nepal

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	MARPs	Most At Risk Populations
ART	Antiretroviral Therapy	NCASC	National Centre for AIDS and STD Control
C&T	HIV Testing and Counselling	NAP	National Action Plan 2006-2011
CCDU	Compulsory Centres for Drug Users	NGO	Non Government Organisation
DFID	Department for International Development (United Kingdom)	NSP	Needle and Syringe program
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	OST	Opioid Substitution Therapy
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
HSCB	HIV/AIDS and STI Control Board	USAID	United States Agency for International Development
IDUs	People who inject drugs		

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Three Year National Plan (2008 – 2010). National Centre for AIDS and STD Control (NCASC). National AIDS Coordination Committee. Ministry of Health and Population, Prime Minister. HIV/AIDS and STI Control Board (HSCB). Ministry of Home Affairs, Drug Control Program.	Three Year National Plan (2008 – 2010) allows for line Ministries to submit proposals for funding of HIV/AIDS activities to the national government[1]. NCASC, under the Ministry of Health and Population, and Prime Minister. HSCB responsible for formulating policy, resource mobilisation, monitoring program implementation, coordinating overall response on AIDS and supporting awareness and education program on HIV/AIDS[1]. National Technical Working Groups on Harm Reduction, and on OST, with leadership from Ministry of Home Affairs.	

Civil Society Engagement	Large number of NGOs providing harm reduction services[3]. The following organisations supported by UNODC[2]; Life Saving & Life Giving Society; Youth Vision; Richmond Fellowship, female; Drishti; Saarathi Nepal (Kathmandu). Richmond Fellowship, female; Naya Goreto; Aavash (Lalitpur) Prerana; Siddhi Memorial Foundation (Bhaktapur) Naulo Ghumti (Kaski) KYC Punarjivan Kendra (Sunsari) Knight Chess Club (Jhapa) Association for Helping the Helpless (Kanchanpur) BIJAM (Bara/Parsa) Namuna (Chitwan) Nagarjun Development Committee, (Rupandehi)	HIV/AIDS and Human Rights Forum (19 civil society organisations collaborating to advocate Human Rights and work as pressure group for policy development relating to HIV/AIDS)[1]. NGO representation on National Technical Working Groups on Harm Reduction and OST respectively.	Nepal Bar Association and NGOs supporting harm reduction, including NSPs, OST and needles/syringes available in stores, however this never enacted in law [1,3].
Donor Commitment	USAID, DFID, AusAID[2], UNODC[2], Royal Norwegian Embassy[7], GFATM (Round 7)[2].	USAID, DFID and the GFATM (Round 7) support national programs targeting most at risk, including IDUs[1]. AusAID supports UNODC and WHO to implement interventions such as OST, outreach, NSP, condom promotion, VCT, STI treatment and ART[4].	
Multi-sectoral Involvement	Thematic Group on IDU	Thematic Group on IDU (under Ministry of Home Affairs), also includes Ministry of Health & Population. National Health Sector Programme Implementation Plan (NHSP-IP 2005), Poverty Reduction Strategy Paper (PRSP) and United National Development Frameworks (UNDAF) have included HIV and AIDS as key component of the plan[1].	
Involvement of IDUs in the Response	Recovering Nepal and others	Many NGOs working in harm reduction are led by former/existing IDUs.	While evidence of IDU involvement is substantial, details of what that involvement constitutes are scarce.

Costed National Harm Reduction Strategy	National Drug Control Strategy Harm Reduction Strategy (inside the National HIV and AIDS Strategic plan (2006-2011)	National Drug Control Strategy in the process of finalization; costing yet to be determined[2]. The component of Harm Reduction Strategy is costed inside the National Action Plan 2006-2011. The total estimated budget is USD 13, 255, 418 for three years[2].	
Does the National Drug Strategy complement the National HIV strategy?	National HIV and AIDS Strategic plan (2006-2011)		National Drug Strategies are moving towards a state of synergy with National HIV strategies.
Legal and Policy Environment	National HIV and AIDS Strategic plan (2006-2011) Narcotic Drugs (Control) Act, 2033 (1976). National Drug Policy 2006[2]. Drug Control Strategy 2009 (still in draft form)[2].	Enables harm reduction programs: National HIV and AIDS Strategic plan (2006-2011) supports NGO-run NSPs, peer education, VCT, PHC for IDU[-3,5]. National Workplace Policy, National Policy on Drug Control (2006) and an established Nepal Policy Advocacy Panel on HIV/AIDS, all support interventions targeted towards most at risk groups (including IDUs)[1]. Legal reforms: Supreme Court has ordered government to promulgate laws to ensure confidentiality in the judicial process for cases involving people living with HIV[1]. National Drug Policy 2006 outlines the need to mitigate risk of infections and to increase access to quality treatment[2].	Restricts harm reduction programs: Narcotic Drugs (Control) Act, 2033 (1976), which states that consumption of narcotics is illegal, has the potential to restrict harm reduction activities which could be viewed as promoting drug use[3]. Operating NSPs and OST without a permit is illegal as this "facilitates" a crime in eyes of the law[3]. Nepal Bar Association and NGOs supporting harm reduction, including NSPs, OST and needles/syringes available in stores, however this never enacted in law [1,3].
Surveillance Systems	Strategic Information Unit within the NCASC.	Methodology and definitions for core indicators have been harmonised and standardised[1].	There is a lack of routine program monitoring data and systems within the NCASC[1]. Data for MARPs (including IDUs) is being collected and analysed by HSCB with technical support from UNAIDS[2]. M&E tools have not been fully operationalized at the district level[1], however, National HIV/M&E Operational Plan expected to resolve this issue[2].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used	Yes Within National Action Plan 2006-2011[2].

Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
National Surveillance Unity	Bio-Behavioural Surveys of populations at risk, (incl. IDUs)[1].	Conducted annually[2]. Routine data collected from targeted intervention service delivery areas by civil society are in place. Routine data from 2005-2007-2008 in place[2].	Collected data used for global reporting e.g. UNGASS, Health sector report etc[2].	Availability of routine data at the central level needs to be improved[1]. Surveys usually conducted in intervention areas, resulting in overestimated coverage[1]. There is a lack of routine program monitoring data and systems within the NCASC[1], however HSCB is conducting this with technical support from UNAIDS.
National HIV/M&E Operational Plan 2008-2009; Articulates standards and recognised definitions (UNGASS, WHO, Health Sector, USAID etc) while adapting them to the context of HIV epidemic in Nepal[2].	Core indicators for UNGASS[2], 1: % IDUs adopt bahaviours to reduce HIV transmission. 2. % IDUs correctly identify HIV prevention and misconceptions. 3. % IDUs reached with HIV prevention. 4. % IDUs received HIV test and result in 12 months. 5. % IDUs who are HIV infected. 6. Number needles and syringes (by gender) distributed to IDUs. 7. Number needles and syringes (by gender) returned/exchanged.	Conducted annually[2].	Data compiled at the national level by HSCB with technical support from UNAIDS[2]. Country Progress report on global commitments (eg: UNGASS). Health Sector Response Reports submitted annually and biannuallyfrom the Government of Nepa[2]. Report submitted to government and IDU support groups[2].	

2. Program Implementation.

Estimated IDU Population: 22,050 (16,100<n<28,000); (estimates from 2003)[6] *(a).*
38,750; (estimates from 2006)[5] *(a).*
28,439; (estimates from 2007, Central Bureau of Statistics)[2] *(a).*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSP)	36 sites in total[2].	25 NGOs[2].	Unspecified	7,000 (total, not /yr)[2]. 9,097 (all HR, not only NSPs)[1].	No	1,018,250[2].	Yes		18-25% (b/a) 31%[7]. 34%[2].	Yes as per NAP 2006-2011, the target for coverage is 60% by the end of 2011.
Opioid Substitution Therapy (OST)	2 sites exist [3]. Kathmandu (and Lalitpur outpost) [2]. Pokhara.		T U Teaching Hospital. Western Regional Hospital.	153	Unknown				0.4-0.5% (b/a) 0.7%[7].	Yes; NAP[2].
HIV Testing and Counselling (T&C)	Kathmand only No T&C service site specific for IDUs[2].	Youth Power Nepal (helpline), but not specific to IDUs[2].	Unspecified	Not available	Unknown				7.6%[2].	Yes; NAP[2].
Antiretroviral Therapy (ART)	No ART sites specific for IDUs[2].								23 ART sites in Nepal[2].	No
Prevention and treatment of STIs	Services available NGOs and MoH[3].				Unknown				Referral system is in place; NAP[2].	Yes; NAP[2].
Condom programs	Not specific to IDUs, but widely available[3].	Available through District Health Offices, NGO partners[2].			Distributed free of cost through public and private					Yes; NAP[2].

					service channels and through social marketing (cost) [2].					
Targeted IEC	Yes	All harm reduction partner NGOs[2].		Not specified	No	Unknown				Yes; NAP[2].
Primary Health Care (including treatment of opportunistic infections)	Not identified.				Unknown				Referral system is in place; NAP[2].	Yes; NAP[2].
Diagnosis, treatment of and vaccination for viral hepatitis	Not identified.				Unknown				Referral system is in place; NAP[2].	Yes; NAP[2].
Prevention, diagnosis and treatment of tuberculosis	Not identified.				Unknown				Referral system is in place; NAP[2].	Yes; NAP[2].
Peer Education programs	Not specified.				No					Yes; NAP[2].

2b. Services in Prisons.		
Estimated Prisoner Population:	6,700 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Jan 08; sourced 30/7/09)	
Estimated # and % of Drug Offenders:	No data available	
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs (NSP)	No	
Opioid Substitution Therapy (OST)	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	No	However condoms are highlighted in national prison policy
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	
Additional information: NAP's prevention package for prisons is planned for prisons housing more than 150 inmates due to programmatic and financial feasibility[2].		

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		No data available.
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs (NSP)	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Lack of resources from the government[2].	Government of Nepal. Ministry of Home Affairs. NCASC. Ministry of Health and Population.	Costed Harm Reduction component of the National Action Plan 2006-2011 should assist resourcing[2].
Civil Society Engagement	NGOs providing a range of harm reduction services, however capacity is low, and geographical coverage not sufficient[3]. Lack of uniform voice among civil society[2].	NGOs, International donors, Ministry of Health and Population NCASC	USAID, DFID and the GFATM (Round 7) supporting national programs targeting most at risk, including IDUs[1].
Legal and Policy Environment	Narcotic Drugs (Control) Act, 2033 (1976), has the potential to restrict harm reduction activitie[3].	Government of Nepal. Ministry of Home Affairs. Ministry of Health and Population. NCASC. Ministry of Justice.	Nepal Bar Association and NGOs supporting harm reduction, including NSPs, OST and needles/syringes available in stores, however this never enacted in law [1,3]. Continued advocacy is required to effect legal reforms.
Law Enforcement	None identified.		
Comprehensive Services	Inadequate coverage[2].	Ministry of Home Affairs, Ministry of Health and Population[2].	NSP intends to address this through scaling-up.
Resources (Financial, human and data)	Government allocation to HIV/AIDS generally insufficient to meet need. Donors assisting but shortfalls remain[2].	Government of Nepal. Ministry of Home Affairs. Ministry of Health and Population. NCASC. Donors.	USAID, DFID and the GFATM (Round 7) support national programs targeting most at risk, including IDUs[1]. AusAID supports UNODC and WHO to implement interventions such as OST, outreach, NSP, condom promotion, VCT, STI treatment and ART[4].
Involvement of IDUs in the Response	None identified	NGOs, International donors, NCASC.	
Availability of Commodities			
i. Needle and Syringe programs	None identified		NSP planning to scale-up NSP services.
ii. Opioid Substitution Therapy (OST)	Buprenorphine available through 5 sites (out of 100) in the country[2].	Ministry of Home Affairs. Ministry of Health and Population. UNODC, WHO. Youth Vision.	NSP planning to scale-up OST services.
iii. HIV Testing and Counselling (T&C)	None identified	GFATM, FPAN, FHI	NSP planning to scale-up T&C services.

iv. Antiretroviral Therapy (ART)	None identified		None specified.
v. Prevention and treatment of STIs	None identified		NSP planning to scale-up services.
vi. Condom programs	None identified	Ministry of Health and Population, GFATM[7].	NSP planning to scale-up services.
vii. Targeted IEC materials	None identified	Ministry of Health and Population, NGOs, Ministry of Home Affairs, UNDP, UNODC[2].	NSP planning to scale
viii. Primary Health Care (including treatment of opportunistic infections)	None identified		NSP planning to scale
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified		NSP planning to scale
x. Prevention, diagnosis and treatment of tuberculosis	None identified		NSP planning to scale
xi. Peer Education programs	None identified		NSP planning to scale
Scaling Up Plans	Resourcing and capacity		NSP intended to address barriers, along with the costed Harm Reduction component of the National Action Plan 2006-2011[2].
Capacity Building	Limited capacity within NGOs and government services to deliver services or to conduct M&E.	Ministry of Health and Population, NGOs, Ministry of Home Affairs, UNDP, UNODC[2].	USAID, DFID and the GFATM (Round 7) support national programs targeting most at risk, including IDUs[1]. AusAID supports UNODC and WHO to implement interventions such as OST, outreach, NSP, condom promotion, VCT, STI treatment and ART[4].
Monitoring and Evaluation	Strategic Information Unit has suffered severe staff turnover, and equipment is insufficient[1].	NCASC	Plans are under way to staff the Strategic Information Unit with a dedicated surveillance officer, and two monitoring and evaluation officers and equipment (basic computer and communications facilities)[1]. M&E is weak, as the Ministry of Home Affairs does not have capacity for this.
	There is a lack of routine program monitoring data and systems within the NCASC[1].		
	M&E tools have not been fully operationalized at the district level[1].		
	Inaccurate denominators being used by government with which to ascertain service need.		

4. Gap Analysis

- While some harm reduction services are delivered by government and civil society, legal barriers still exist which have the potential to disrupt these, or to result in legal reprisals for implementers and those who access the services.
- While a number of harm reduction services for IDUs have been identified, these are not being delivered as per the scale required, nor are they meeting the requirements for complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[8]).
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services.
- While there is substantial evidence to confirm that IDUs have involvement in the harm reduction response in Nepal, details of this involvement are not easily identifiable, and as such, it is unclear if IDUs contribute to policy development and decision making. Limited IDU involvement has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Very little information is available regarding harm reduction services for prisons and CCDU, however it is assumed that these would be minimal and insufficient.

5. Recommendations

- Legal and policy reform to facilitate unmolested delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Increased involvement of IDUs in all stages of the harm reduction response, including policy development, legal reform and delivery of services. Advocacy by IDU groups, donors and technical agencies may be required to facilitate this.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Government of Nepal. (2008). UNGASS Country Progress Report: January 2006–December 2007.
2. Personal communication, Alankar Malviya, UNAIDS Nepal, 16th December, 2009.
3. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit.UNODC ROSA.
4. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
5. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
6. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
7. Sharma, M., E. Oppenheimerb, et al. (2009). "A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region." AIDS 23.
8. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Pakistan Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Pakistan

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	HASP	HIV/AIDS Surveillance Project
ART	Antiretroviral Therapy	HIV	Human Immunodeficiency Virus
C&T	HIV Testing and Counselling	IDUs	People who inject drugs
CCDU	Compulsory Centres for Drug Users	NGO	Non Government Organisation
CIDA	Canadian International Development Agency	NSP	Needle and Syringe Program
CNSA	Control of Narcotic Substances Act	OST	Opioid Substitution Therapy
DFID	Department For International Development (United Kingdom)	SBDDS	Sukkur Blood and Drugs Donating Society
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	STI	Sexually Transmitted Infection

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	National AIDS Control Program Ministry of Health Anti Narcotics Force	National AIDS Control Program operates nationally and provincially, with approximately 80% government funding[1]. Ministry of Health supported early NGO-run NSPs[1]. Anti Narcotics Force and Ministry of Health collaborate on national scale-up of harm reduction services[1]. National AIDS Prevention and Control Program	
Civil Society Engagement	Nai Zindagi Al Nijaat Society Pakistan Society Dost Welfare Foundation Legend Society[2]. SBDDS.	Ministry of Health supported early NGO-run NSPs[1]. UNAIDS provides financial and technical support to NGOs[1]. Nai Zindagi is the principal recipient of recent GFATM Round 9 grant for the IDU component , and will work with civil	

		society organizations to roll out activities[3].	
Donor Commitment	World Bank UNAIDS UNODC DFID CIDA Futures Group AusAID GFATM (Round 9) Enhanced AIDS Control Program 2003-8[4].	World Bank provides financial support to NGOs and community-based organisations for harm reduction through National and Provincial AIDS Control Programs[4-5]. UNAIDS provides financial and technical support to NGOs[1]. UNODC implementing Pakistan component of 'Prevention of transmission of HIV among drug users in SAARC countries project (2008-2012)', working with IDUs in community and prison settings. Also, 'Drug dependence treatment & HIV/AIDS awareness in four prisons' (2007-2010), and 'HIV/AIDS prevention, treatment and care for female injecting drug users and female prisoners' (2008-2010)[6]. DFID fund national scale-up of harm reduction services[1]. Futures Group contributed to national scale-up of harm reduction services[1]. AusAID supports UNODC and WHO to implement interventions such as OST, outreach, NSP, condom promotion, T&C, STI treatment and ART[7]. GFATM: Pakistan recently secured Round 9 HIV proposal in an appeal after 7 consecutive failures in past rounds. Will scale-up to 36,000 new clients (IDUs, their partners and children) in new cities of Pakistan and the existing Government sponsored programs, and will enable coverage of up to 70% of estimated IDU population[3].	
Multi-sectoral Involvement	Ministry of Health Anti Narcotics Force	Ministry of Health supported early NGO-run NSPs[1]. Anti Narcotics Force and Ministry of Health collaborate on national scale-up of harm reduction services[1].	
Involvement of IDUs in the Response	Information not available.		
Costed National Harm Reduction	National HIV/AIDS Strategic Framework Enhanced HIV/AIDS Control Program, which	It is not clear whether these documents are costed strategies. The next strategy is scheduled for 2011-2016.	

Strategy	issued a Program Implementation Plan (PIP), 2003-8[1].		
Does the National Drug Strategy complement the National HIV strategy?	Control of Narcotic Substances Act (CNSA), 1997. National HIV/AIDS Strategic Framework. Enhanced HIV/AIDS Control Program, which issued a Program Implementation Plan (PIP), 2003-8[1].	National HIV/AIDS Strategic Framework outlines priority areas for program implementation, including harm reduction among high-risk groups (including IDUs), general awareness, management of STIs, surveillance and research, and care and support[1]. PIP would deliver comprehensive interventions through outreach, including harm reduction information and equipment (condoms, lubricants, clean needles and disinfectants), STI and drug treatment, voluntary counselling and testing and referral services through NGOs[1].	National Drug Strategies do not complement National HIV strategies.
Legal and Policy Environment	Penal Code, Prohibition (Enforcement of Hadd) Order, Control of Narcotic Substances Act, Drug Abuse Control Master Plan.	Enables harm reduction programs: Unspecified, but explicit, supportive reference to harm reduction in national policy documents[5]. The Drug Abuse Control Master Plan aims to address demand and harm reduction associated with drug use[1].	Restricts harm reduction programs: Consumption of any drugs is punishable under law – this could impact NSPs, which would be viewed as facilitating injecting[1]. Provision of needles/syringes etc is not considered abetment of a crime by the law[1]. Ambiguity within the law between the Prohibition (Enforcement of Hadd) Order and the Control of Narcotic Substances Act regarding the criminalisation of drug users[1]. Under the Control of Narcotic Substances Act, drug users are required to register with the provincial government and to carry registration cards[8].
Surveillance Systems	Enhanced AIDS Control Program 2003-8[4]. HIV/AIDS Surveillance Project (HASP)[4].	Enhanced AIDS Control Program 2003-8 measured by; Cross-sectional surveys, Incidence Monitoring, Coverage[4]. HIV/AIDS Surveillance Project (HASP)[4]. NGOs contribute to HASP and Provincial AIDS Control Program data, and can access the former[4].	National HIV/AIDS testing, reporting and surveillance system not adequate for IDU-specific data collection[1].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
Enhanced AIDS Control Program 2003-8[4].	Cross-sectional surveys, Incidence Monitoring, Coverage[4].	Routine monitoring by World Bank, DFID and other partners is done through Joint Program Review Missions. Annual third party process evaluations. Outcome and impact level monitoring is done through IBBS annual rounds[9].	Monitoring reports shared with implementers, programs and partner agencies for feedback and refinements in programming. Evaluation and bio behavioural reports are published and circulated to all stakeholders. All are also available on the NACP website[9].	
HIV/AIDS Surveillance Project (HASP)[4].	NGOs contribute to HASP and Provincial AIDS Control Program data, and can access the former[4].	Annual bio behavioural rounds are conducted in selected cities[4].	NGOs can access HASP data.	

2. Program Implementation.

Estimated IDU Population: 130,460 (125,000<n<150,000); (estimates from 2005)[10]. *(a)*
125,000; (estimates from 2006)[5]. *(a)*
91,000; (National AIDS Control Program, estimates from HASP data in 12 cities, 2009)[9]. *(a)*

2a. Service Coverage

Elements of a comprehensive	Available Data								
	Provincial (location)	INGOs/	Govt Health	Clients	Cost to	Distributed	Outreach Provided	Service	Plans for Scale-

services package	Coverage	NGOs (#)	Services (#)	Accessing Services (#) (*b*)	recipient	(#)	NGO	Govt	coverage *(b/a)*	up
Needle and Syringe programs	Services located in; Lahore, Faisalabad, Sargodha, Sialkot, Karachi, Peshawar, Quetta, Larakna, Hyderabad[8].	Nai Zindagi, Dost Foundation, Legend, Pakistan Society, Al-Nijat Society,	None identified.	20,640 for NGOs[2].	Unknown	759,441/month 223,862 per quarter[2].	Yes	Unknown	14-17% (b/a)	Unknown
Opioid Substitution Therapy (OST)	Methadone and buprenorphine not available[5,8].									Yes: pilot is planned[6,8].
HIV Testing and Counselling (T&C)	Services located in; Lahore, Faisalabad, Sargodha, Sialkot, Karachi[2].	Nai Zindagi, Pakistan Society, Al-Nijat Society	None identified.	2,560 total[2].	Yes				Approx 2% (b/a)	Unknown
Antiretroviral Therapy (ART)	Not available to all IDUs[1-2]. IDUs registered for ART after undergoing detoxification treatment[9].									Unknown
Prevention and treatment of STIs	Associated with NGO harm reduction drop-in centres and tertiary hospitals[1].	Drop-in centres[1].	Tertiary hospitals only[1].	Not stated.	Unknown					Yes: Gov't to provide throughPHC services[1].
Condom programs	Exist for IDUs[1]. Lahore, Karachi[2].	Nai Zindagi, Pakistan Society.	Not stated.	42,000[2].	Unknown		Yes		29-34% (b/a)	Unknown
Targeted IEC	Discussion on IDU-related issues prohibited, but do exist[1].				No		Yes			Unknown
Primary Health Care (including treatment of opportunistic infections)	Lahore	Nai Zindagi			Unknown		Yes			Unknown
Diagnosis, treatment of and vaccination	None identified.									Unknown

for viral hepatitis										
Prevention, diagnosis and treatment of tuberculosis	None identified.									Unknown
Peer Education programs	Services located in; Lahore, Faisalabad, Sargodha, Sialkot, Karachi[2].	Nai Zindagi, Pakistan Society, Al-Nijat Society	None identified.		Yes	440 PEs	Yes			Unknown

2b. Services in Prisons.

Estimated Prisoner Population:		99,000 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, mid-2007; sourced 30/7/09)
Estimated # and % of Drug Offenders:		(*reference, year*)
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	No	
HIV Testing and Counselling (T&C)	Yes	Mostly counselling, through Jail Inmates NGO Program, Dost Welfare Foundation: 2,300 (Peshawar), 1,500 (Haripur)[4,11]. Sukkur Blood and Drugs Donating Society [SBDDS]: HIV prevention services in 9 major jails in three cities in Sindh province (15,110 inmates)[9].
Antiretroviral Therapy (ART)	Yes	
Prevention and treatment of STIs	Yes	Jail Inmates NGO Program, Dost Welfare Foundation: 2,300 (Peshawar), 1,500 (Haripur)[4,11] and SBDDS[9].
Condom programs	Unknown	
Targeted IEC	Yes	
Primary Health Care (including treatment of opportunistic infections)	Yes	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Yes	Jail Inmates NGO Program, Dost Welfare Foundation: 2,300 (Peshawar), 1,500 (Haripur)[4,11].
Post-release Follow-up	Yes	
Additional information: UNODC implementing HIV Prevention programme in 7 prisons (not specifically for IDU)[11].		

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		No data available.
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Support, monitoring and payment of NGOs from Govt not well managed. Some NGOs have experienced delays in receiving government payment.	NGOs. Provincial-level government (Provincial AIDS Control Program).	
Civil Society Engagement	None identified.		
Legal and Policy Environment	Ambiguity within the law between the Prohibition (Enforcement of Hadd) Order and the Control of Narcotic Substances Act regarding the criminalisation of drug users.	National AIDS Control Program. Ministry of Health. Anti Narcotics Force.	
Law Enforcement	Lack of sensitization and commitment on the issue regarding the harm reduction.	Anti Narcotics Force, police.	
Comprehensive Services	IDUs face stigma and discrimination at	National AIDS Control Program, service	

	the service provision, legal and community levels.	providers, law enforcement, NGOs.	
Resources (Financial, human and data)	NGO outreach worker training needs to be provided with sufficient regularity to meet the needs of these high-turnover staff, at sufficient scale for scale-up[4].	National AIDS Control Program, donors, technical agencies, NGOs.	
Involvement of IDUs in the Response	Currently do not appear to have a voice in policy development and service delivery.	National AIDS Control Program, donors, technical agencies, NGOs.	
Availability of Commodities			
i. Needle and Syringe programs	None identified.	National AIDS Control Program, donors, technical agencies, service providers, NGOs.	
ii. Opioid Substitution Therapy (OST)	Methadone and buprenorphine not available[5,8].		OST provision is planned[10].
iii. HIV Testing and Counselling (T&C)	Not available in sufficient scale, and mostly by NGOs. Coverage around 2% for all (not HIV+) IDUs.		
iv. Antiretroviral Therapy (ART)	Not available[1-2].		
v. Prevention and treatment of STIs	None identified.		
vi. Condom programs	None identified.		
vii. Targeted IEC materials	Religious laws do not support IEC curricula that in any way refer to sex outside marriage[1].		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	NGOs report difficulty transporting outreach workers to far-reaching outreach locations[4].		
Scaling Up Plans	Province wide contracts to reach 60% coverage by 2012. Proposed program includes OST and services for wives and children of men who inject drugs. Access to HIV and AIDS services included[7].		
Capacity Building	Limited capacity of NGOs and other service providers regarding M&E data	National AIDS Control Program, donors, technical agencies, service providers,	

	collection and reporting.	NGOs.	
Monitoring and Evaluation	Difficulty for NGOs to utilise HASP data due to lack of capacity[4].	National AIDS Control Program, donors, technical agencies, NGOs.	
	No national HIV/AIDS testing, reporting and surveillance system is in place[1].		

4. Gap Analysis

- There is little multi-sectoral involvement from government in the harm reduction response.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[12]) not currently being delivered to IDUs consistently, particularly OST, ART, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis. There is a notable lack of government-delivered services, although these may increase with the recent securing of a grant under GFATM Round 9.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively, especially at the service-provider level. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[12].
- It is unclear whether IDUs contribute to either policy development, service delivery or M&E of harm reduction services. Limited IDU involvement has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Inadequate legal and policy environment to enable harm reduction services (especially OST).
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale, especially amongst service-implementing NGOs.
- Very little information is available regarding harm reduction services for prisons and CCDU, other than those delivered through a UNODC program. As the latter is directed to all inmates (and not simply IDUs), it is assumed that harm reduction activities in prisons and CCDU would be minimal and insufficient.

5. Recommendations

- Greater multi-sectoral, government involvement is required to view harm reduction as being other than simply a health-related issue, and is essential to facilitate scale-up to deliver comprehensive services.
- Commitment from government and donors to resource essential harm reduction services.
- Improved capacity building and resourcing of implementing agencies to deliver comprehensive harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[12].
- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. UNODC Regional Office for South Asia. 2007. Legal and policy concerns related to IDU harm reduction in SAARC countries Review by: Lawyers Collective HIV/AIDS Unit.UNODC ROSA.
2. Khan, A. (2008). HIV Interventions for IDUs in Pakistan: Insights from Triangulation of Program, Field and Surveillance Data World Bank.
3. Personal communication, Tariq Zafar, Nai Zindagi, 15th February, 2010.
4. Khan, A., A. Awan, et al. (2009). "Large sharing networks and unusual injection practices explain the rapid rise in HIV among IDUs in Sargodha, Pakistan." Harm Reduction Journal 6(13)
5. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
6. United Nations Office on Drugs and Crime (UNODC). (2009). "Pakistan country profile." Retrieved 12th November, 2009, from http://www.unodc.org/pakistan/en/country_information.html.
7. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.

8. Nai Zindagi, Scaling-up harm reduction services towards universal access in Asia: Models of good practice presentation, ICAAP IX; http://www.unodc.org/eastasiaandpacific/en/topics/hiv-and-aids/unrtf.html accessed 22/9/09.
9. Personal communication, Dr. Muhammad Saleem, UNAIDS Nepal, 2nd February, 2010.
10. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
11. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.(2009). Pakistan Country Advocacy Brief Injecting Drug Use and HIV (draft).
12. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Philippines Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Philippines

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	IDUs	People who inject drugs
ART	Antiretroviral Therapy	IHBBS	Philippine Integrated HIV Behavioural & Serologic Surveillance
AusAID	Australian Agency for International Development	NGO	Non Government Organisation
C&T	HIV Testing and Counselling	NSP	Needle and Syringe Program
CCDU	Compulsory Centres for Drug Users	PNAC	Philippine National AIDS Council
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	PRP	Philippines Research Program
HAARP	HIV/AIDS Asia Regional Program	OST	Opioid Substitution Therapy
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	Dangerous Drugs Board[1]; Office of the President, Department of Health, Social Welfare and Development, Department of Labor and Employment Department of Education, Department of Interior and Local Government Philippine National AIDS Council (PNAC)	Dangerous Drugs Board; policymaking and strategy formulation body for illicit drugs[1]. PNAC is made up of 26 members from government, civil society and organizations of people living with HIV, and is the central advisory, planning and policy making body on the prevention and control of HIV and AIDS in the Philippines. It is responsible for national HIV coordination[1].	
Civil Society Engagement	No names identified.	Fourth AIDS Medium Term Plan 2005-2010 commits to capacitate NGOs to implement harm reduction activities, including making available needles and syringes for exchange and strengthening partnerships with government[1].	
Donor Commitment	GFATM HAARP (AusAID)	GFATM supporting harm reduction[2].	

		HAARP supports the Philippines Research Program (PRP) which implements targeted research on IDU-related HIV/AIDS in the Philippines, with the intent of developing a profile of the pattern of IDU related harms and HIV prevalence[3].	
Multi-sectoral Involvement	Fourth AIDS Medium Term Plan 2005-2010[4].	AIDS Medium Term Plan 2005-2010 encourages NGO involvement in harm reduction activities such as NSPs[1].	
Involvement of IDUs in the Response	No information identified.		
Costed National Harm Reduction Strategy	Fourth AIDS Medium Term Plan 2005-2010[4].	Fourth AIDS Medium Term Plan 2005-2010 contributes annual, costed Operational Plans for IDU interventions[4].	
Does the National Drug Strategy complement the National HIV strategy?	Fourth AIDS Medium Term Plan 2005-2010, PNAC. National Anti-Drug Strategy (NADS).	Fourth AIDS Medium Term Plan 2005-2010 calls for intensified prevention interventions for IDUs[1]. PNAC plan (2007) to develop Guidelines on the Prevention, Care, Support and Treatment of HIV among IDUs (focus on harm reduction). Aims to facilitate alignment of all relevant policies on the prevention of drug abuse and the prevention and control of HIV/AIDS and make the necessary recommendations to appropriate bodies, agencies and institutions based on empirical data and analysis[1].	National Drug Strategies do not complement the National HIV strategies.
Legal and Policy Environment	Republic Act 9165 Comprehensive Drug Act of 2002. Comprehensive Dangerous Drug Act of 2002. Republic Act No. 8504 (The AIDS Law). Fourth AIDS Medium Term Plan 2005-2010.	Enables harm reduction programs: PNAC plan (2007) to develop Guidelines on the Prevention, Care, Support and Treatment of HIV among IDUs (focus on harm reduction). Aims to facilitate alignment of all relevant policies on the prevention of drug abuse and the prevention and control of HIV/AIDS and make the necessary recommendations to appropriate bodies, agencies and institutions based on empirical data and analysis[1]. Fourth AIDS Medium Term Plan 2005-2010: intensified prevention interventions for IDUs: 'IDUs are provided with focused STI/HIV/AIDS preventive education and skills and services'. It further aims to 'explore policy support for harm reduction program-needle exchange', in addition to 'sustaining existing harm reduction programs in identified high risk areas; advocacy among local officials to support harm reduction programs; identify and capacitate NGOs to implement the program, training of program implementers	Restricts harm reduction programs: The AIDS Law does not contain explicit provisions relating to harm reduction, however targets modes of transmission, including drug use[1]. Provision of needles and syringes is prohibited[2]. Republic Act 9165 Comprehensive Drug Act of 2002 – illegal for anyone who is not a medical practitioner to be in possession of injection paraphernalia…" The law mandates the following penalties for procession of proscribed drugs; a person found positive for use subject to 6 months rehabilitation in a government centre (1st offence), imprisonment for 6-12 years (2nd offence) and a fine ranging from 50,000 to 200,000 pesos (1,000 USD to 4,000 USD). Life imprisonment or death also imposed for possession of large quantities of illegal drugs.

		and service providers/outreach workers, dialogues with local police and government and other concerned agencies; procurement or making available needles and syringes for exchange[1].	Drug users and those providing services to them are vulnerable to arrest by police if they are apprehended with needles and syringes[1].
Surveillance Systems	Philippine Integrated HIV Behavioural & Serologic Surveillance (IHBSS)	Conducted in 23 sites in 2009. GFATM Rounds 5 and 6 support IHBBS in some sites[5].	

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used	No

Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
Philippine Integrated HIV Behavioural & Serologic Surveillance (IHBSS)[5].	Measures behavioral risk factors through a face-to-face survey, and HIV and syphilis prevalence through blood testing[5].	Conducted every 2 years[5].	Reports available from the PNAC website.	It is not clear if data is disaggregated for IDUs.

2. Program Implementation.

Estimated IDU Population: 11,000 (7,239<n<14,478); (UNGASS Country Report, 2007)[1] *(a)*
20,000; (2009)[6] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	3 sites[6] (includes pharmacy sites).	Not stated	Not stated		No	50,000[6].	Unknown			Unknown
Opioid Substitution Therapy (OST)	Not specified						Unknown			Unknown
HIV Testing and Counselling (T&C)	52 sites (not exclusively for IDUs)[6].				Unknown					Unknown
Antiretroviral Therapy (ART)	13 sites (not exclusively for IDUs)[6].				Unknown					Unknown
Prevention and treatment of STIs	Not specified									Unknown
Condom programs	Exist within NSPs and other HIV programs (not IDU-specific)				Unknown					Unknown
Targeted IEC	Exist within NSPs				No					Unknown
Primary Health Care (including treatment of opportunistic infections)	Not specified									Unknown
Diagnosis, treatment of and vaccination for viral hepatitis	Not specified									Unknown
Prevention, diagnosis and treatment of tuberculosis	Not specified									Unknown
Peer Education programs	Not specified									Unknown

2b. Services in Prisons.

Estimated Prisoner Population:	91,530 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, 2006; sourced 30/7/09) 34,154 (2008, 28th Asia and Pacific Conference of Correctional Administrators, Langkawi, Malaysia)
Estimated # and % of Drug Offenders:	No information available

Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	No	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		No data available.
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	No	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	None identified.		
Civil Society Engagement	Despite systems in place to include civil society, no clear description of active organisations.	PNAC.	Fourth AIDS Medium Term Plan 2005-2010 commits to capacitate NGOs to implement harm reduction activities[1].
Legal and Policy Environment	Methadone is illegal Provision of needles and syringes is prohibited[2] with harsh penalties.	PNAC. Law and justice authorities.	Both PNAC plan (2007) and Fourth AIDS Medium Term Plan 2005-2010 aim to facilitate alignment of all relevant policies on the prevention of drug abuse and the prevention and control of HIV/AIDS and make the necessary recommendations to appropriate bodies, agencies and institutions based on empirical data and analysis[1].
Law Enforcement	Articulated, harsh penalties delivered to those found in possession of injecting paraphernalia.	PNAC. Law and justice authorities. Law enforcement authorities.	

	Law enforcement slow to adapt to altered policies which support harm reduction.		
Comprehensive Services	Limited services available due to incompatible laws to enable harm reduction activities.	PNAC, donors and technical agencies.	Both PNAC plan (2007) and Fourth AIDS Medium Term Plan 2005-2010 aim to facilitate alignment of all relevant policies on the prevention of drug abuse and the prevention and control of HIV/AIDS and make the necessary recommendations to appropriate bodies, agencies and institutions based on empirical data and analysis[1].
Resources (Financial, human and data)	None identified.		
Involvement of IDUs in the Response	No information available.		
Availability of Commodities			
i. Needle and Syringe programs	Provision of needles and syringes is prohibited[2] with harsh penalties.		
ii. Opioid Substitution Therapy (OST)	Methadone is illegal.		
iii. HIV Testing and Counselling (T&C)	None identified.		
iv. Antiretroviral Therapy (ART)	None identified.		
v. Prevention and treatment of STIs	None identified.		
vi. Condom programs	None identified.		
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		
Scaling Up Plans	None clearly identified.		
Capacity Building	Limited technical capacity to design and implement harm reduction programs amongst government and civil society.	PNAC, donors, technical agencies.	GFATM supporting harm reduction[2].
Monitoring and Evaluation	Disaggregated data for IDUs not currently possible within M&E systems.	Philippine Integrated HIV Behavioural & Serologic Surveillance (IHBSS), GFATM.	

4. Gap Analysis

Gap analysis for this country is hampered by little available data regarding the harm reduction response. However the following points are noted;

- While there appears to be provisions for excellent multi-sectoral government and civil society engagement under PNAC, evidence of coordination and participation is not available.
- Inadequate legal and policy environment limits delivery of complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[7]), particularly regarding NSP and OST. Limited information is available to ascertain the prevalence of all other services within the comprehensive package.
- M&E systems inadequate due to inability to disaggregate data for IDUs. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[7].
- It is unclear whether IDUs contribute to either policy development, service delivery or M&E of harm reduction services. Limited IDU involvement has the potential to further contribute to community and legal stigma and discrimination of IDUs, and may result in inappropriate (and inadequate) planning and delivery of services.
- Technical capacity amongst implementing agencies insufficient to enable appropriate service coverage to scale, especially amongst service-implementing NGOs.
- Very little information is available regarding harm reduction services for prisons and CCDU however given the limited services available in the general community, it is assumed that these would be minimal and insufficient.

5. Recommendations

- Greater multi-sectoral, government and civil society involvement is required to facilitate scale-up to deliver comprehensive services, through coordinated planning and delivery of services, and advocacy to enact changes to prohibitive laws..
- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Facilitation of an enabling legal and policy environment which invites input from IDUs in the development of policy and the delivery of harm reduction services.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[7].

- Improved capacity building and resourcing of implementing agencies to deliver comprehensive harm reduction services to IDUs through improved coordination and planning between donors, government and technical agencies.
- Legal and policy reform to facilitate delivery of comprehensive harm reduction services, through advocacy of appropriate donor, UN, government and non-government agencies, as well as IDUs.
- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Stephens, D. (2009). Law and Policy Review: July 2009, HIV/AIDS Asia Regional Program, United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.
2. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
3. HIV/AIDS Asia Regional Program (HAARP). (2010). "Philippines Research Program." Retrieved 18th January, 2010, from http://www.haarp-online.org/www/html/145-philippines-research-program.asp?intLocationID=86.
4. Philippine National AIDS Council. (2009). "Philippine National AIDS Council." Retrieved 18th January, 2010, from http://www.pnac.org.ph/.
5. Philippine National AIDS Council (2009). This is it (conference presentation). Talks on HIV, Injecting Drug Use and Sex (THIS). Heritage Hotel, Manila.
6. HIV/AIDS Asia Regional Program (HAARP). (2010). "Philippines Research Program." Retrieved 18th January, 2010, from http://www.haarp-online.org/www/html/145-philippines-research-program.asp?intLocationID=86.
7. Personal communication, Zimmbodilion (Peter) Mosende, UNAIDS, 24th December, 2009.
8. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Thailand Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Thailand

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	NAPCC	National AIDS Prevention and Control Committee
ART	Antiretroviral Therapy	NGO	Non Government Organisation
BSS	Behavioral Sentinel Surveillance	NSP	Needle and syringe program
C&T	HIV Testing and Counselling	ONCB	Office of Narcotics Control Board
CCDU	Compulsory Centres for Drug Users	OST	Opioid Substitution Therapy
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	PSI	Population Services International
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
IDUs	People who inject drugs	TTAG	Thai AIDS Treatment Action Group

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	National AIDS Prevention and Control Committee (NAPCC). Ministry of Justice. Ministry of Public Health. Office of Narcotics Control Board (ONCB). National Command Centre for Combating Narcotic Drugs (NCCB); Deputy Prime Minister. Military Services	National Command Centre for Combating Narcotic Drugs came into being during the War on Drugs in 2003[1]. Ministry of Public Health acknowledges the seriousness of the HIV epidemic among IDUs and reflects this concern in the priorities of the public health national work plan[1]. Ministry of Pubic Health provides methadone at 147 sites[2-3]. Political commitment exists to provision of ART free to all people living with HIV. Military Services manage some compulsory and correction drug treatment centres[8].	Harsh criminal sanctions leave IDUs widely exposed to exploitation, harassment, abuse and arrest by the law enforcement machinery[1]. Despite the Ministry of Public Health identifying IDUs as a priority group within the public health national work plan, ONCB failed to include an HIV prevention component in the National Drug Control Action Plan 2001-2005[1]. NSPs not supported by government[2]. Military Services employ approaches to drug rehabilitation which does not incorporate a rights-based approach.

Civil Society Engagement	TTAG PSI: Ban Ozone Raks Thai Foundation (This list not exhaustive – almost definitely incomplete)	NGOs delivering NSPs and other harm reduction services through outreach and drop-in centres	Civil society consultation and engagement in policy development and mechanisms is weak[2]. Outreach workers have little legal protection regarding the delivery of their work[2].
Donor Commitment	UNAIDS supported first national meeting on harm reduction[3]. GFATM supporting harm reduction[3].	GFATM Round 8: Thai Raks Foundation, "HIV Prevention among MARPS by Promoting Integrated Outreach and Networking (CHAMPION-2) Program", Phase 1: $8,979,644[4]. GFATM Round 8: PSI, "Comprehensive HIV prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION-3)", Phase 1: $ 6,415,062[4]. GFATM Round 8: Department of Disease Control, Ministry of Public Health, "Comprehensive HIV prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION-1)", Phase 1: $6,863,815[4].	Thailand's economic status as a middle-income nation results in donors reducing their support. Subsequent increase in Thai government support for harm reduction is not apparent (with the exception of OST) [2].
Multi-sectoral Involvement	NAPCC, Ministry of Justice. Ministry of Public Health ONCB Chiang Mai University Research Institute	Rehabilitation of Narcotics Act recognizes the importance of a multi-sectoral approach to drug use reduction. Chiang Mai University Research Institute works closely with Law Enforcement for collaboration and understanding on harm reduction issues.	A lack of coordination exists between the NAPCC, ONCB, the Ministry of Justice and the Ministry of Public Health.
Involvement of IDUs in the Response	12D (coalition of organising representing drug users) TTAG	IDU-involvement in development and review of the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011.	PSI CHAMPION-3 working to build capacity of IDU organisations in terms of service delivery and involvement in policy development.
Costed National Harm Reduction Strategy	Ministry of Public Health; public health national work plan ONCB; National Drug Control Action Plan 2001-2005 National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011	Despite the Ministry of Public Health identifying IDUs as a priority group within the public health national work plan, ONCB failed to include an HIV prevention component in the National Drug Control Action Plan 2001-2005[1]. Lack of communication, information sharing, and separate mandates contribute to the absence of an integrated action plan that accounts for HIV and drug use in Thailand[1]. National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, developed through multi-sectoral collaboration between government and civil sectors, including affected populations, and approved by the NAPPC. Comprises four strategies; i) improved management to integrate HIV/AIDS responses in all sectors; ii) integration of prevention, care, treatment and impact mitigation for each population; iii) HIV/AIDS related rights protection; iv) monitoring and evaluation coupled with research on HIV prevention and alleviation.	
Does the National Drug Strategy	Narcotics Control Act of 1976. Rehabilitation of Narcotics Act.	Rehabilitation of Narcotics Act attempts to forge a more inclusive approach to drug use[1].	National Drug Strategies are moving towards a state of synergy with National HIV strategies.

complement the National HIV strategy?	Narcotics Prevention and Suppression Act of 1979. National Drug Control Action Plan 2001-2005.		While the Rehabilitation of Narcotics Act attempts to forge a more inclusive approach to drug use, the government is still mainly reliant on a penal approach to drug use[1]. National Drug Control Action Plan 2001-2005 contains no HIV component[1].
Legal and Policy Environment	Narcotics Control Act of 1976. Rehabilitation of Narcotics Act, 1991 and 2002. Act on Suppression and Prevention. Narcotics Addict Rehabilitation Act of 2002. Thai Constitution.	Enables harm reduction programs: Rehabilitation of Narcotics Act and Act on Suppression and Prevention both attempt to forge a more inclusive approach to drug use. It recognizes that drug users are akin to patients and not criminals[1]. Narcotics Addict Rehabilitation Act embodies the principle of decriminalization of drug offences and provides for alternatives to incarceration for some drug offenses[1]. Thai Constitution recognises the right of every individual to receive health services. This has led to the scaling up of universal access to ART[1].	Restricts harm reduction programs: While the Rehabilitation of Narcotics Act attempts to forge a more inclusive approach to drug use, the government is still mainly reliant on a penal approach to drug use[1]. Narcotics Addict Rehabilitation Act has not yet been widely implemented by the judicial system[1]. Possession of methadone is illegal without a prescription, thereby limiting NGOs and other organisations from delivering OST. Additionally, while possession of hypodermic needles is not illegal, the wording of the Narcotic Control Act (section 14) suggests that needles and syringes could be viewed as illegal heroin paraphernalia, which could therefore impact on the operation of NSPs[1]. Narcotics Control Act of 1976 outlines severe penal consequences of production, possession, consumption, sale and use of manufactured and psychotropic drugs and opium and its derivatives. It criminalizes the possession of extremely minor amounts of drugs, and all offences under the Act are non-bailable. It also gives wide powers of search, seizure and arrest to the police[1]. Under the existing Narcotics law, there is a presumption of guilt against the possessor of any drugs or apparatus for the manufacture of any drugs. The penal regime also makes any attempt or abetment punishable with the same severity as if the offence was actually committed[1]. It is unclear as to the extent of IDUs living with HIV who are willing to access free ART for fear of being identified by law enforcement authorities[1].

			There is no explicit anti-discrimination law specifically covering IDUs or people piving with HIV[1].
Surveillance Systems	AIDS case reporting system; Bureau of Epidemiology, Ministry of Public Health HIV Sentinel Serosurveillance Behavioral Sentinel Surveillance system (BSS)	Voluntary AIDS case reporting system (est 1984), is a confidential, hospital-based system[5]. HIV Sentinel Serosurveillance conducted biannually in 14 cities. Disaggregates for IDUs[5]. Behavioral Sentinel Surveillance system (BSS – est 1995) conducted annually[5].	Attempts to conduct surveillance amongst IDUs are compromised by unwillingness of IDUs to identify themselves as such due to the harsh penalties and social stigma associated with being a drug user[1]. AIDS case reporting system is passive, and will not pick-up those IDUs not accessing hospital treatment[5].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used	No

Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
Bureau of Epidemiology, Ministry of Public Health	Voluntary AIDS case reporting system (est 1984), is a confidential, hospital-based system[5].		Unknown	AIDS case reporting system is passive, and will not pick-up those IDUs not accessing hospital treatment.
	HIV Sentinel Serosurveillance (est 1989) to monitor the trend of HIV prevalence[5].	Conducted biannually in 14 cities.		
	Behavioral Sentinel Surveillance system (BSS – est 1995) [5].	Conducted annually.		IDUs not a specific target group of BSS

2. Program Implementation.

Estimated IDU Population: 160,528; (estimates from 2001)[6] *(a)*
90,080; (estimates from 2006)[3] *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs	Bangkok and 15 provinces	TTAG: Mitsampan Harm Reduction Center PSI: Ban Ozone Raks Thai Foundation	Also available in pharmacies[1,3,5]		No. Yes (pharmacies)		Yes	Unknown	No client data available.	Yes: GFATM CHAMPION-3
Opioid Substitution Therapy (OST)	Govt services		147 sites [2-3]. 134 sites[7].		Unknown					Unknown
HIV Testing and Counselling (T&C)	Improved referral to non-IDU-specific services in 15 provinces	PSI CHAMPION-3			Unknown					Yes: GFATM CHAMPION-3
Antiretroviral Therapy (ART)	Improved referral to non-IDU-specific services in 15 provinces	PSI CHAMPION-3			Unknown					Yes: GFATM CHAMPION-3
Prevention and treatment of STIs	Improved referral to non-IDU-specific services in 15 provinces				Unknown					Yes: GFATM CHAMPION-3
Condom programs	15 provinces	PSI CHAMPION-3			No		Yes			Yes: GFATM CHAMPION-3
Targeted IEC	15 provinces	PSI CHAMPION-3			No		Yes			Yes: GFATM CHAMPION-3
Primary Health Care (including treatment	No information available				Unknown					Unknown

of opportunistic infections)										
Diagnosis, treatment of and vaccination for viral hepatitis	No information available				Unknown					Unknown
Prevention, diagnosis and treatment of tuberculosis	No information available				Unknown					Unknown
Peer Education programs	15 provinces	PSI CHAMPION-3			No		Yes			Yes: GFATM CHAMPION-3

2b. Services in Prisons.

Estimated Prisoner Population:	166,338 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, Feb 08; sourced 30/7/09)
Estimated # and % of Drug Offenders:	114,808 ,69% respectively (Pandey, no date cited)[1].

Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	Unknown	
HIV Testing and Counselling (T&C)	Yes	Voluntary services available
Antiretroviral Therapy (ART)	Yes	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Yes	Supported by the GFATM
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

2c. Services in Compulsory Centres for Drug Users.		
Estimated Population in Centres:		67,500 in 2009 (within 90 centres under compulsory system, and 94 under correctional system. A further 18,000 within a voluntary system)[8]
Elements of a comprehensive services package		# of Inmates Accessing Services / % of Inmates Accessing Services
Needle and Syringe programs	Unknown	
Opioid Substitution Therapy (OST)	Unknown	
Medically Assisted Detoxification	Unknown	
HIV Testing and Counselling (T&C)	Unknown	
Antiretroviral Therapy (ART)	Unknown	
Prevention and treatment of STIs	Unknown	
Condom programs	Unknown	
Targeted IEC	Unknown	
Primary Health Care (including treatment of opportunistic infections)	Unknown	
Diagnosis, treatment of and vaccination for viral hepatitis	Unknown	
Prevention, diagnosis and treatment of tuberculosis	Unknown	
Peer Education programs	Unknown	
Post-release Follow-up	Unknown	

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Lack of communication, information sharing, and separate mandates contribute to the absence of an integrated action plan that accounts for HIV and drug use in Thailand[1].	NAPCC, Ministry of Justice. Ministry of Public Health ONCB	
Civil Society Engagement	None identified.		
Legal and Policy Environment	Criminalization of IDUs – if urine test positive, can arrest individual and possibly compulsory treatment. Ambiguity in the law associated with possession and provision of injecting paraphernalia has potential to impede harm reduction activities, especially NSPs	NAPCC, Ministry of Justice. Ministry of Public Health ONCB	Unless changes to the law take place, many interventions for IDUs are not possible. There is no commitment for this at present.
Law Enforcement	Policy and legal reforms towards decriminalization of drug offences and which provide alternatives to incarceration for some drug offenses not readily translated to law enforcement practices.	Ministry of Justice. Police.	PSI CHAMPION-3 working to build capacity of law enforcement to support harm reduction for IDUs. Chiang Mai University Research Institute works closely with Law Enforcement for collaboration and understanding on harm reduction issues.
Comprehensive Services	None identified.		
Resources (Financial, human and data)	None identified.		
Involvement of IDUs in the Response	None identified.		
Availability of Commodities			
i. Needle and Syringe programs	Legal issues and a lack of government commitment to harm reduction services (other than OST) a barrier to procurement of commodities.	NAPCC	Rehabilitation of Narcotics Act and Act on Suppression and Prevention both attempt to forge a more inclusive approach to drug use, incorporating elements of harm reduction [1].
ii. Opioid Substitution Therapy (OST)	None identified.		
iii. HIV Testing and Counselling (T&C)	None identified.		
iv. Antiretroviral Therapy (ART)	None identified.		

v. Prevention and treatment of STIs	None identified.		
vi. Condom programs	None identified.		
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		
Scaling Up Plans	None identified.		
Capacity Building	Limited capacity of law enforcement agencies to support harm reduction. Limited capacity of community based organisations to deliver and monitor harm reduction services.	NAPCC, Ministry of Justice. Ministry of Public Health ONCB Community-based organisations.	PSI CHAMPION-3 working to build capacity of law enforcement to support harm reduction for IDUs, and community-based organisations to implement harm reduction services.
Monitoring and Evaluation	M&E systems not fully able to identify and report on effectiveness of harm reduction activities. Limited capacity of community based organisations to monitor and report on harm reduction services.	Government health facilities, Implementing organisations.	PSI CHAMPION-3 and Raks That Foundation CHAMPION-2 working to improve the capacity of sub-recipients (SRs), sub-sub-recipients (SSRs), community based organizations and local health facilities to monitor the Program. Raks That Foundation CHAMPION-2 working to strengthen precision and implementation of strategic information system with which to improve programs and policies for IDUs.

4. Gap Analysis

Gap analysis for this country is restricted by insufficient data being available with which to complete the matrix. However the following points are noted;

- Poor multi-sectoral collaboration and commitment exist for policy development and implementation of harm reduction services for IDUs.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[9]) not currently being delivered to IDUs consistently. More information is required regarding delivery/provision of the following services to IDUs; ART, T&C, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively, particularly amongst community-based organisations and community-level health facilities. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[9].
- Ambiguities associated with legal and policy environment raise confusion over rights of service providers to deliver harm reduction services, particularly NSPs and OST.
- There is a significant time lag between endorsement of rehabilitated laws and policies which support harm reduction activities, and systematic implementation at the service provision, legal and law enforcement levels.
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale. Currently donors are contributing the bulk of resources for harm reduction activities, where the Thai Government's resource commitment is directed mainly towards OST.
- Little reliable information is available as to availability of harm reduction services for prisons and CCDU.

5. Recommendations

- Advocacy and support to government in order to encourage a greater, multi-sectoral commitment to the national harm reduction response.
- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs through improved coordination and planning between donors, government, technical agencies and implementing organisations.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[9].
- Advocacy, capacity building and technical support to ensure greater uptake of harm reduction-supportive legal and policy reforms at the law enforcement and service delivery levels.

- Legal and policy reform is required to extend comprehensive harm reduction services to prisons and CCDU in line with the Government's national HIV and STI prevention commitments.

6. References

1. Pandey, I. 'Law on the Books' and High Risk Populations in Thailand.
2. No author cited. (2008). Response beyond borders: the South East Asia regional workshop on the prevention of HIV related to drug use, Asian Consortium on Drug Use, HIV, AIDS and Poverty.
3. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
4. (2009). "Global Fund to for AIDS, tuberculosis and malaria." Retrieved 15th October, 2009, from http://www.theglobalfund.org.
5. Akarasewi, P. (2008). (Brief) Overview of the HIV Epidemic and the National HIV/AIDS surveillance, Bureau of Epidemiology, Thailand Ministry of Public Health.
6. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
7. Sharma, M., E. Oppenheimerb, et al. (2009). "A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region." AIDS 23.
8. Piromrat, K. (2009). RTAF Youth Rehabilitation Centre. Bangkok, Powerpoint presentation.
9. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.

Viet Nam Matrix, 2009

REGIONAL IDU PROGRAMME AND SERVICES ASSESSMENT: 2009 UPDATE OF POLICIES, RESOURCES AND SERVICES

Prepared for: United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Country Name: Viet Nam

Abbreviations			
AIDS	Acquired Immunodeficiency Syndrome	MOH	Ministry of Health
ART	Antiretroviral Therapy	MOLISA	Ministry of Labor, War Invalids and Social Affairs
C&T	HIV Testing and Counselling	MOPS	Ministry of Public Security
CDC	United States Centre for Disease Control	NGO	Non Government Organisation
CCDU	Compulsory Centres for Drug Users	NCADP	National Committee on AIDS, Drugs and Prostitution
DFID	Department for International Development (UK)	OST	Opioid Substitution Therapy
FHI	Family Health International	PEPFAR	President's Emergency Plan For AIDS Relief (United States)
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria	STI	Sexually Transmitted Infection
HIV	Human Immunodeficiency Virus	VAAC	Viet Nam Administration of AIDS Control
IDUs	People who inject drugs	WHO	World Health Organization

1a. National Program Support.

	Agencies Responsible	Systems / Frameworks In Place	
		Existing	Gaps
Political Commitment	National Committee on AIDS, Drugs and Prostitution Prevention and Control (NCADP)[1] Includes; Chair: Deputy Prime Minister, Office of Government, Ministry of Labor, War-Invalids and Social Affairs (MOLISA), Ministry of Health (MOH), Ministry of Public Security (MOPS). Provincial AIDS Centres: 58/63 provinces[2].	NCADP responsible for coordinating government agencies working in HIV, drug use and sex work. Steps underway to develop an anonymous card identification system to encourage IDUs to harm reduction activities[2].	Lack of coordination among government agencies within NCADP[1]. MOH revising guidelines on OST, including clinical management and regulations for management of methadone[2]. An ongoing need to develop national technical guidelines on condoms programs, NSPs[2]. Need for training manual on harm reduction interventions[2]. Finalisation and enactment of the National Master Plan on

			Methadone Substitution Treatment[2].
Civil Society Engagement	Community-based organisations, local and international NGOs, PLHIV Groups[3]. FHI, Medecins du Monde, Institute for Social Development Sciences (ISDS), Health Policy Initiative- Abt Associates, Chemonics, Catholic Relief Services, Population Services International, VICOMC[3].	Community-based organisations, local and international NGOs, PLHIV Groups represented on National Committee on NCADP[3].	
Donor Commitment	AusAID, DFID, World Bank[2,4], PEPFAR, WHO[5], Medecins du Monde[6], GFATM.	Total donor funding for HIV and AIDS in 2009: USD100m[3]. International donors funding NSPs in 59/382 districts (13%)[2]. DFID, World Bank, PEPFAR, WHO supporting OST[9]. This activity also includes HIV prevention amongst drug users and their partners through promotion of condoms, STI management and treatment and NSPs[7]. GFATM Round 9 recently approved (USD27,363,443 in first 2 years; USD101,950,596 over five years) to meet HIV prevention, treatment and care. IDUs identified as a priority population for targeted prevention interventions[8-9]. HIV/AIDS Asia Regional Program (HAARP - AusAID and Netherlands) supporting multisectoral approaches through direct engagement of non-health sectors in activities such as NSP, OST, condom promotion, primary health care, VCT and ART[10].	DFID and World Bank support of NSPs disrupted as the two donors merge their project, however outreach peer education continues[2].
Multi-sectoral Involvement	National Committee on AIDS, Drugs and Prostitution (NCADP) – see above. All ministries, provincial authorities, civil society, and international partners.	National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020 serves as a framework for all 18 Ministries, the 63 provincial authorities, civil society, and international partners[9].	
Involvement of IDUs in the Response	Not specified.	IDUs more likely to be involved in the delivery of outreach and centre-based harm reduction services.	It is unclear whether IDU groups contribute to policy development and/or program development, planning and implementation.
Costed National Harm Reduction Strategy	Ministry of Health National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020[2].	Not explicit in MOH national budgets for HIV prevention, treatment and care[2]. Next strategy from 2011-2015. Its is not clear if National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020[2] is a costed strategy.	

Does the National Drug Strategy complement the National HIV strategy?	National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020[2]. Law on HIV/AIDS Prevention and Control[1] (2006) and Decree 108/2007 ND-CP (2007). National program of action on harm reduction interventions for HIV prevention, 2007-2010[2].	Inter-Ministerial Circular 147/2007/TTLB-BTC-BYT in 2007 between MOH and Ministry of Finance includes costed norms for implementation of National Strategy on HIV and AIDS prevention and control; and National Programmes on Prevention and Control of Social Diseases, Dangerous Diseases and HIV and AIDS, period 2006 – 2010[4]. Planning and implementation guidelines prepared by Steering Committees from all relevant ministries at all levels for the National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020[2] Law on HIV/AIDS Prevention and Control facilitates a legal framework for conducting effective harm reduction interventions at scale, including clean needles and syringes, the protection of peer outreach workers from arrest and the provision of OST[1].	National Drug Strategies are moving towards a state of synergy with National HIV strategies. Guidelines currently being developed by the MOH to enact the Law on HIV/AIDS Prevention and Control[2]. Law on HIV/AIDS and the Decree 108/2007 ND-CP have set up a solid foundation for harm reduction activities[4]. Recent decrees related to the Law on Drug Prevention and Control are not complementary to the Law on HIV Prevention and Control in their respective approach to IDUs[3].
Legal and Policy Environment	Law on Drug Control. National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020[2]. The Law on HIV/AIDS (2006) and Decree 108/2007 ND-CP (2007) 1 (also known as 'The Law on Prevention and Control of HIV/AIDS')[9].	Enables harm reduction programs: Criminalisation of possession of injecting equipment has been removed from legislation[6,11]. Law on Drug Control acknowledges drug use as a social problem and that drug users should be viewed as needing assistance rather than as offenders or criminals[1]. National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2004-2010 with vision to 2020[2] and the Law on HIV/AIDS (2006) and Decree 108/2007 ND-CP (2007), provide solid legal and policy foundation for the national harm reduction response[1,12]. Law on HIV/AIDS (2006) and Decree 108/2007 ND-CP (2007) facilitates a legal framework for conducting effective harm reduction interventions at scale, including clean needles and syringes, the protection of peer outreach workers from arrest and the provision of OST[1]. Decree 108/2007 ND-CP creates a legal corridor for the implementation of HIV prevention, treatment, care and support for people living with HIV[4].	Restricts harm reduction programs: Decriminalisation of possession of injecting equipment yet to be effected at many law enforcement levels[6,11]. This approach yet to be effected at many law enforcement levels[6]. Local provincial and district approach to drug-related programs is in terms of reducing "vice" and "social evils", and punishing perpetrators[13]. No policy exists to mobilise the private sector to facilitate employment of IDUs post-detoxification[6]. However, Hai Phong People's Committee and Ho Chi Minh City Provincial AIDS Committee are seeking provincial policy to facilitate employment and vocational programmes for OST clients[3].

		Prime Minister approved The proposal of strengthening capacities of the provincial AIDS system 2010-2015 in July, 2009[2].	
Surveillance Systems	Ministry of Health	HIV surveillance, monitoring and evaluation system at central, provincial and district levels established and operating. Delivering timely and reliable data[2]. 72 testing labs in 46 cities/provinces[2].	Some provinces do not submit monthly surveillance reports[2]. Insufficient collection and management of IDU-specific data[2]. 16 provinces do not have confirmation testing labs[2]. Inadequate equipment for management of information at central and provincial level[2]. Inadequate capacity to collect and report info at provincial levels[2].

1b. Monitoring and Evaluation (M&E) Systems.

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users is used				No
Ministry/Agency Responsible Description of Systems / Frameworks in place	Existing	M&E conducted regularly? How often?	Strategies for dissemination? To whom?	Gaps
The National HIV Monitoring and Evaluation Framework	Developed in close collaboration with national and international partners (finalized in January 2007)[9].		Defines the structure of M&E systems, delineates responsibilities, establishes standard, detailed indicators, specified frequency of data collection, and provides a clear work plan[9].	
HIV surveillance, monitoring and evaluation system[2] (not necessarily for IDUs – general HIV surveillance).	Operates at central, provincial and district levels. 72 testing labs in 46 cities/provinces[2].	Conducted regularly and reported quarterly to Central Government. Delivers timely and reliable data[2-4]	Disseminated to Central Government.	16 provinces do not have confirmation testing labs[2]. Some provinces do not submit quarterly surveillance reports[2].
Central Level: National M&E Unit, MOH (HIV/AIDS/STI Surveillance Unit, Viet Nam Administration for AIDS Control, VAAC)[4].				Lack of trained staff at all levels.

Regional Level: Northern: Northern HIV and AIDS Steering Committee (National Institute for Hygiene and Epidemiology- NIHE) Central: Central HIV and AIDS Steering Committee (Pasteur Nha Trang) Southern: Southern HIV and AIDS Steering Committee (Pasteur Ho Chi Minh City) Tay Nguyen Central Highland: Tay Nguyen Central Highland HIV and AIDS Steering Committee (Pasteur Tay Nguyen)[4].				Lack of quality assurance systems for collection (especially at the community level) and analysis of data for key populations. Lack of sufficient and adequate use of M&E, which results in poor programme development, resource coordination and allocation. Lack of sufficient financial support for M&E at the provincial level[4].

2. Program Implementation.

Estimated IDU Population: 135,305; (estimates from 2005[14]) *(a)*
113,000; (estimates from 2006[6]) *(a)*
237,333; (estimated from 2009, MOLISA[9]) *(a)*

2a. Service Coverage

Elements of a comprehensive services package	Available Data									
	Provincial (location) Coverage	INGOs/ NGOs (#)	Govt Health Services (#)	Clients Accessing Services (#) (*b*)	Cost to recipient	Distributed (#)	Outreach Provided		Service coverage *(b/a)*	Plans for Scale-up
							NGO	Govt		
Needle and Syringe programs (NSPs)	42 provinces (2/3 of all provinces)[12]. 382 districts[2]. 332 services, (50 cities/provinces, 182 districts)[2].	Medecins du Monde[3]. FHI. VICOMC. ADRA[3].	Also available in pharmacies.	115,000 (total for all harm reduction)[2]. 140,254[2] for NSPs.	No.	11-22.6m[2,7,12]. Pharmacy numbers unknown[12].	Yes Total outreach (not just NSPs), 268 (37 cities, 231 districts)[2].		59% (b/a) 10-15%[4].	Yes; GFATM Rnd 9[9].
Opioid Substitution Therapy (OST)	Ho Chi Minh City. Hai Phong[2,6,12]. Ha Noi[3].		7 clinics, 3 cities sites	1,475[2] – 1,600[3].	No		Unknown		1% (b/a)	Yes; GFATM Rnd 9[9]. MOH working with Ha Noi People's Committee to commence in 6 districts, and in Tu Liem also[2]. 15 provinces by 2012; 30 provinces by 2015.
HIV Testing and Counselling (T&C)	Not specific for IDUs: 256 centres in 63 provinces[2].	FHI[2,6]. Life Gap[2].		250	No		Yes (DOTS)			Unknown

Antiretroviral Therapy (ART)	Not specific for IDUs: 285 clinics in 63/63 provinces[2].		285 clinics.	32,268.	No.					Yes: provinces planning to install more CD4 count machines[2]
Prevention and treatment of STIs	Not specific for IDUs: At least one centre in each of 63 provinces[2].				Yes					Yes; GFATM Rnd 9[9].
Condom programs	420 services, (57 cities/provinces, 363 districts)[2].	FHI, Marie Stopes International, ADRA, Abt Associates, ISDS, VICOMC, PSI, DKT[3].			No	100m[5].				Yes; GFATM Rnd 9[9].
Targeted IEC	Magazine, AIDS in the Community distributed, plus other, targeted IEC[2].	Yes	Yes		No	1,256,668 for 1st 6/12[2]				Unknown
Primary Health Care (including treatment of opportunistic infections)	Services available; not IDU-specific.	FHI			No					Yes; GFATM Rnd 9, but not specific to IDUs[9]
Diagnosis, treatment of and vaccination for viral hepatitis	No	No			Yes					Unknown
Prevention, diagnosis and treatment of tuberculosis	Not specific for IDUs: At least one centre in each of 263 districts[3].				Yes					Yes; GFATM Rnd 9, but not specific to IDUs[9].
Peer Education programs	Donor funded in 34 provinces[3].	3,260 for 1st 6/12[2] Over 1,000 peer outreach workers[5].			No		Yes			Unknown

2b. Services in Prisons.

Estimated Prisoner Population:		92,153 (http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief, mid-2007; sourced 30/7/09)
Estimated # and % of Drug Offenders:		35,000[4,12]
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs (NSPs)	Yes	Limited services available[12].
Opioid Substitution Therapy (OST)	No	
HIV Testing and Counselling (T&C)	Yes	Voluntary services available.
Antiretroviral Therapy (ART)	Yes	Very limited pilot.
Prevention and treatment of STIs	No	
Condom programs	Yes	Report in some prisons that condoms are available but for conjugal visits only[3].
Targeted IEC	No	
Primary Health Care (including treatment of opportunistic infections)	Yes	
Diagnosis, treatment of and vaccination for viral hepatitis	No	
Prevention, diagnosis and treatment of tuberculosis	Yes	Limited programming through Global Fund TB grant support[3].
Peer Education programs	No	
Post-release Follow-up	No	

Additional information:

Law on Drug Control contains measures for the rehabilitation and detention of drug users, including a mandatory period of between one and two years[1].

Government Decision 29/2007/QD-TTg on Management, Care and Support, Treatment and Counselling for People Living with HIV in closed settings (including educational, rehabilitation centres, detentions, prisons and social care centres)[4]. This not necessarily relating to IDUs.

2c. Services in Compulsory Centres for Drug Users.

Estimated Population in Centres:		60-70,000 in 84 CCDU[4,12] 80% are IDU (~48,000-56,000)[4].
Elements of a comprehensive services package		**# of Inmates Accessing Services / % of Inmates Accessing Services**
Needle and Syringe programs	No	
Opioid Substitution Therapy (OST)	No	
Medically Assisted Detoxification	Yes	Although of a rudimentary standard[5].
HIV Testing and Counselling (T&C)	Yes	In limited settings[5].
Antiretroviral Therapy (ART)	Yes	In limited settings[5].
Prevention and treatment of STIs	No	
Condom programs	No	
Targeted IEC	No	
Primary Health Care (including treatment of opportunistic infections)	Yes	Limited availability and quality[5].
Diagnosis, treatment of and vaccination for viral hepatitis	No	
Prevention, diagnosis and treatment of tuberculosis	No	In most cases persons are sent out for diagnosis and treatment, then returned[5].
Peer Education programs	Yes	Limited in scope, and focussed on drug use prevention[5].
Post-release Follow-up	Yes/No	This may be provided, but is not explicit for IDUs (just drug users, total)[13].

Additional information:

There are 90 provincial and 17 district, government-run detoxification centres, and 19 privately run centres. These are not explicitly for Injecting drug users, and it is not clear what proportion of these are compulsory or voluntary[13].

3. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
Political Commitment	Lack of coordination among government agencies within NCADP[1]. Finalisation and enactment of the National Master Plan on Methadone Substitution Treatment[2]. Need for training manual on harm reduction interventions[2].	MOLISA MOH MOPS	HAARP supporting multisectoral approaches through direct engagement of non-health sectors in harm reduction activities[10].
Civil Society Engagement	No policy exists to mobilise the private sector to facilitate employment of IDUs post-detoxification[13]. Families, the community and IDUs have not been encouraged to understand, support and participate in drug detoxification processes[13]. Lack of involvement of non-health sector.	NCAPD, NGOs, donors, technical agencies.	Hai Phong and Ho Chi Minh City Provinces are working to establish a policy to provide vocational and employment programmes for OST clients. Chemonics is supporting this effort[3]. NACPD comprises multiple sectors, potentially facilitating greater multi-sectoral involvement. HAARP supporting multisectoral approaches through direct engagement of non-health sectors in harm reduction activities[10].
Legal and Policy Environment	Recent changes to laws which are supportive of harm reduction are failing to be enacted amongst some law enforcement authorities[6,11]. Recent decrees related to the Law on Drug Prevention and Control are not complementary to the Law on HIV Prevention and Control in their respective approach to injecting drug users[3]. Police coordination with other agencies is poor.	MOPS Ministry of Justice MOLISA	National Strategy for HIV/AIDS Prevention and Control in Vietnam, 2010-2020, with orientation until 2030, aims to clarify strategies and plans, measures for long term drug use prevention and control through engagement with entire political system, and leadership of The Party and other authorities. This will articulate division of responsibilities[2,11]. Efforts to speed-up role-out of changes to drug laws, especially in regards to management of recovering IDUs[11].
Law Enforcement	The new National Strategy on Drug Prevention and Control to 2020 with a Vision to 2030 may negatively affect law enforcement approaches to IDUs as they relate to HIV prevention	Ministry of Justice. Police. NCAPD.	Criminalisation of possession of injecting equipment has been removed from legislation[6,11]. Law on Drug Control acknowledges drug use as a social problem and that drug users should be viewed as needing

	services[3]. Vision towards a drug-free ASEAN by 2015 hampers harm reduction within some government agencies who maintain zero-tolerance towards drug use[12].		assistance rather than as offenders or criminals[1]. Law on HIV/AIDS (2006) and Decree 108/2007 ND-CP (2007) facilitates a legal framework for conducting effective harm reduction interventions at scale[1].
Comprehensive Services	Insufficient resources for commodities. Confusion at law enforcement level regarding legality of NSPs and other services.		Law on HIV/AIDS (2006) and Decree 108/2007 ND-CP (2007) facilitates a legal framework for conducting effective harm reduction interventions at scale [1]. Efforts to speed-up role-out of changes to drug laws, especially in regards to management of recovering IDUs[11].
Resources (Financial, human and data)	Lack of resources (human, financial). Reaching IDUs in mountainous areas.	NCAPD.	Development, approval, review and implementation of proposals to ensure appropriate resources for drug prevention and control activities[11].
Involvement of IDUs in the Response	Stigma and discrimination of drug users within families and the community limits opportunities for IDUs (generally, and also those emerging from detoxification) from accessing employment and other services[13].		
Availability of Commodities			
i. Needle and Syringe programs	Shortage (and absence) of services in many provinces and cities[2-3]. An ongoing need to develop national technical guidelines on NSPs[2]	Central, provincial/city and district government[13], NGOs and donor agencies[2].	International donors funding NSPs in 59/382 districts (13%)[2]. DFID, World Bank, PEPFAR, WHO supporting OST[5]. GFATM Round 9 will meet HIV prevention, treatment and care for IDUs[8-9]. HAARP will support multisectoral approaches through direct engagement of non-health sectors[10].
ii. Opioid Substitution Therapy (OST)	MOH to complete guidelines on OST, including clinical management and regulations for management of methadone[2] Inadequate policies, mechanisms and legal structure to support locally managed and implemented drug detoxification processes[13].		
iii. HIV Testing and Counselling (T&C)	Capacity to provide care, treatment and support in closed settings needs to be developed rapidly and the		

	linkage between the CCDU and communities should be strengthened in order to continue treatment without interruption[4].		
iv. Antiretroviral Therapy (ART)	None identified.		
v. Prevention and treatment of STIs	None identified		
vi. Condom programs	Ongoing shortage of condoms[2]. An ongoing need to develop national technical guidelines on condoms programs[2].		
vii. Targeted IEC materials	None identified.		
viii. Primary Health Care (including treatment of opportunistic infections)	None identified.		
ix. Diagnosis, treatment of and vaccination for viral hepatitis	None identified.		
x. Prevention, diagnosis and treatment of tuberculosis	None identified.		
xi. Peer Education programs	None identified.		
Scaling Up Plans	None identified.	Central, provincial/city and district government[13], NGOs and donor agencies[2].	GFATM Round 9 recently approved to meet HIV prevention, treatment and care requirements of IDUs[8-9].
Capacity Building	Capacity of service providers generally low, particularly at the district implementation level.	Central, provincial/city and district government[13], NGOs and donor agencies[2].	Donor agencies working on building capacity of service providers regarding certain aspects of harm reduction and M&E.
Monitoring and Evaluation	Inadequate equipment for management of information at central and provincial level[2,13]. Inadequate capacity to collect and report info at provincial levels[2].		Scaling-up of surveillance in 10 more districts in 2009[2]. Donor agencies working on building capacity of service providers regarding certain aspects of harm reduction and M&E.

4. Gap Analysis

- A lack of coordination exists amongst government agency members of NCADP, both at the national level, and between national and sub-national agencies, which has the potential to slow enactment of legal and policy reforms towards comprehensive harm reduction services.
- Financial resources and personnel capacity not sufficient to enable appropriate service coverage to scale.
- Insufficient technical guidelines and other capacity building interventions contribute to sub-optimal delivery of harm reduction services to IDUs.
- While civil society engagement does occur, the private sector and IDU groups are yet to be included in policy development and program planning for comprehensive harm reduction activities.
- There is a significant time lag between endorsement of evolving policies which support harm reduction activities, and systematic implementation at the service provision, legal and law enforcement levels.
- IDUs suffer widespread stigma and discrimination, from the community, law enforcement, health authorities and throughout the justice system. Legal frameworks need to be enacted to protect IDUs from institutional discrimination.
- Complete comprehensive services (as recommended by WHO, UNODC, UNAIDS[15]) not currently being delivered to IDUs consistently, particularly primary health care services, diagnosis, treatment of and vaccination for viral hepatitis and prevention, diagnosis and treatment of tuberculosis.
- M&E systems inadequate due to a lack of technical capacity and resources to conduct regular M&E effectively. This contributes to inadequate IDU population estimates (denominators) upon which to plan and deliver services, and little ability to measure and manage the quality and effectiveness of those services. M&E processes not currently adhering to targets outlined in WHO, UNODC, UNAIDS Technical Guide[15].
- Harm reduction services for prisons and CCDU are inadequate in that they do not reflect services available in the general community. This poses an HIV and STI transmission threat throughout Viet Nam.

5. Recommendations

- Improved capacity building and resourcing of implementing agencies to deliver harm reduction services to IDUs in all areas of Viet Nam through improved coordination and planning between donors, government and technical agencies, and development of technical guidelines to assist service delivery.
- Greater, multi-sectoral government involvement which views harm reduction as not only a health issue will contribute to more effective implementation of comprehensive services.
- Technical capacity building and ongoing support to M&E system implementers, particularly regarding means for measuring effectiveness of services.
- Revision of M&E systems to align with targets outlined in WHO, UNODC, UNAIDS Technical Guide[15].

- Enactment of an enabling environment which encourages civil society (and in particular, IDU groups) to engage with policy development processes, and planning and implementation of comprehensive harm reduction services.
- Legal and policy reform is required to ensure comprehensive harm reduction services to prisons and CCDU are reflective of community-wide services.

6. References

1. Stephens, D. (2009). Law and Policy Review: July 2009, HIV/AIDS Asia Regional Program, United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.
2. MOH (2009). HIV/AIDS control and prevention for the first six months 2009 and working plan for the last six months of 2009, Ministry of Health, Socialist Republic of Vietnam.
3. Global Fund for AIDS, TB and Malaria. (2009). "Proposal Form Round 9: Vietnam" Retrieved 15th November, 2009, from http://www.theglobalfund.org/programs/country/index.aspx?lang=en&countryID=VTN
4. Government of Vietnam. (2007). Third country report on following up the implementation to the Declaration of Commitment on HIV and AIDS, Socialist Republic of Vietnam.
5. Asian Consortium on Drug Use, HIV, AIDS and Poverty. (2008). Response beyond borders: the South East Asia regional workshop on the prevention of HIV related to drug use, Asian Consortium on Drug Use, HIV, AIDS and Poverty.
6. Cook, C. and N. Kanaef (2008). The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics, International Harm Reduction Association.
7. Fujita, M., Z. Pengfei, et al. (2009). Good practice in Asia: Targeted HIV prevention for injecting drug users and sex workers: Viet Nam's first large-scale national harm reduction initiative, World Health Organization Country Office for Viet Nam.
8. Government of Vietnam. (2007). Third country report on following up the implementation to the Declaration of Commitment on HIV and AIDS, Socialist Republic of Vietnam.
9. Viet Nam Country Coordinating Mechanism (2009). GFATM Proposal Round 9. Ha Noi.
10. AusAID (2009). Australia's Harm Reduction Programs: Asia Pacific Region. Meeting on the development of the regional strategy for harm reduction in Asia and the Pacific 2010-2015. Kuala Lumpur, Malaysia.
11. MOPS (2009). Current situation of illicit drug use and control, Ministry of Public Security, Socialist Republic of Vietnam.
12. United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. (2009). Viet Nam Country Advocacy Brief Injecting Drug Use and HIV (DRAFT)

13. MOLISA (2009). Current situation of commercial sex prevention and control, and drug detoxification and rehabilitation, Ministry of Labor, War Invalids and Social Affairs (MOLISA), Socialist Repoublic of Vietnam.
14. Mathers, B., L. Degenhardt, et al. (2008). "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." The Lancet 372: 1733-45.
15. WHO (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization.