idpc
International Drug Policy Consortium

Drug policy advocacy in Asia:

Challenges, opportunities and prospects

Cambodia • China • India • Indonesia • LAO PDR • Malaysia • Myanmar
Philippines • Thailand • Vietnam

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Acronyms

12D Network	Thai Civil Society Coalition for Harm Reduction
AHRN Myanmar	Asian Harm Reduction Network Myanmar
AIDS	Acquired immunodeficiency syndrome
AIIMS	India Institute of Medical Sciences
ANCD	Australian National Council on Drugs
ANPUD	Asian Network of People Who Use Drugs
ART	Anti-Retroviral Therapy
ASEAN	Association of Southeast Asian Nations
ATS	Amphetamine-Type Stimulants
AusAID	Australian Aid
BAKIN (Indonesia)	Badan Koordinasi Intelligen Nasional
BKNN (Indonesia)	Badan Koordinasi Narkotika Nasional
BMA	Bangkok Metropolitan Administration
BNN (Indonesia)	Badan Narkotika Nasional
CCDAC (Myanmar)	Central Committee for Drug Abuse Control
CCJAP	Cambodia Criminal Justice Assistance Project
CDC	Centre for Disease Control and Prevention
CHAS (Lao PDR)	Centre for HIV/AIDS and STI Control
CHC (Indonesia)	community health centres
CPDAP	Colombo Plan Drug Advisory Program
DEA	Drug Enforcement Agency
DFID (United Kingdom)	Department of Foreign and International Development
FAR	Foundation for AIDS Rights
FINGODAP	Federation of Indian NGOs for Drug Abuse Prevention
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
HAARP	HIV/AIDS Asia Regional Programme
HCPI	HIV Cooperation Programme for Indonesia
HIV	Human Immunodeficiency Virus
IAAC	Indonesian Association of Addiction Counsellors
ICDPR	Indonesia Coalition for Drug Policy Reform
ICID	Independent Committee for the Investigation, Study and Analysis of the Formulation and Implementation of the Narcotic Suppression Policy
IDPC	International Drug Policy Consortium
IFNGO	International Federation of Non-Government Organizations for the Prevention of Drug and Substance Abuse
INL	Bureau of International Narcotics and Law Enforcement Affairs
INP	Indonesian National Police
KPA (Indonesia)	*Komisi Penanggulangan AIDS (National AIDS Commission)*
Lao PDR	Lao People's Democratic Republic
LCDC	Lao Commission for Drug Control and Supervision
LEAHN	Law Enforcement and HIV Network
MAC	Malaysian AIDS Council
MANA	Myanmar Anti-Narcotics Association
MCPI	Most at Risk Population Community Partnership Initiative
MMT	Methadone Maintenance Therapy
MoF (India)	Ministry of Finance
MoH&FW (India)	Ministry of Health and Social Welfare
MoHA	Ministry of Home Affairs
MoI	Ministry of interior
MoJ	Ministry of Justice
MoJSE (India)	Ministry of Social Justice and Empowerment
MoLISA (Vietnam)	Ministry of Labour, Invalids and Social Affairs
MoPH (Thailand)	Ministry of Public Health
MoPS	Ministry of Public Security
MoSA (Indonesia)	Ministry of Social Affairs
MoU	Memorandum of Understanding
MPhA	Malaysian Pharmaceutical Association
MPS	Ministry of Public Security
NAA (Cambodia)	*National AIDS Authority*
NACD (Cambodia)	National Authority for Combating Drugs
NACO (India)	*National AIDS Control Organisation*
NADA (Malaysia)	National Anti-Drug Agency
NASP (Lao PDR)	National Strategy and Action Plan on HIV/AIDS/STI
NCHADS	The *National Centre for HIV/AIDS Dermatology and STDs*
NGO	Non-Governmental Organisation
NPMH (Cambodia)	National Programme for Mental Health
NSAP	Network to Stop AIDS in the Philippines
NSP	Needle and Syringe Programme
NSP III (Cambodia)	*National Strategic Plan*
ONCB (Thailand)	Office of the Narcotics Control Board
OST	Opioid Substitution Treatment
PCPI (Cambodia)	Police-Community Partnership Initiative
PDEA	Philippine Drug Enforcement Agency
PKNI (Indonesia)	National Drug User Network
PLCPD	Philippine Legislators' Committee on Population and Development
PNAC	Philippine National AIDS Council
RLPD (Thailand)	Thai Ministry of Justice Rights and Liberties Protection Department
SARS	Severe Acute Respiratory Syndrome
SoP	Standard operating Procedure
STI	Sexually Transmitted Infections
TDN	Thai Drug Users Network
TNI	Transnational Institute
UN	United Unions
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
WARDU (Malaysia)	Network of People Who Use Drugs
WHO	World Health Organisation

SECTION 1: EXECUTIVE SUMMARY

Objective of the Report

This report was commissioned by the International Drug Policy Consortium (IDPC), with the support of Australian Aid, for the purpose of developing a better understanding of drug policy advocacy activity in 10 Asian countries: Cambodia, China, India, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Thailand, and Vietnam. It aims to achieve three goals:

- **Identify organisations engaged in harm reduction and drug policy advocacy**
- **Identify gaps and challenges in harm reduction and drug policy advocacy that remain to be addressed**
- **Develop recommendations for prioritising new activities in harm reduction and drug policy advocacy.**

The report does not provide an exhaustive review of drug policy content, rather it focuses on the process of drug policy making (Gilson et al., 2011; Gilson & Raphaely, 2008; Walt & Gilson, 1994) and attempts to understand the relationships between key stakeholders (Gonzalez-Block, 2004; Ritter, 2009), including both policy makers and policy advocates, engaged in policy processes at local and regional level. The report combines data collected from published reports with key informant interviews to draw its conclusions.

Understanding the context of drug policies in the region

Despite the significant cultural and geographical differences that exist between the countries covered in this review, drug policy making follows a remarkably similar pattern across the region. Drug policies are generally made within a social context that disapproves of illicit drug use, constructing both intoxication and dependence as socially undesirable and a sign of moral weakness. These puritanical views are either framed from the perspective that drugs diminish a person's social responsibility (especially in the case of countries with socialist histories), detract from religiosity, or more recently as a law and order issue; with drug use equating to involvement in criminal activity.

Such a social context fits neatly with the popular view that drugs are bad and need to be eradicated from society. National governments, driven by the ethnocentric goal of preventing drugs from entering their own countries, and often with support from international donors, have supported law enforcement-led drug policies since the late 1970s. Many countries introduced drug laws that focus on harsh punishment for illicit drug manufacture, supply, possession and use. This period also marks the introduction of abstinence-based drug treatment in Asia and with the exception of India,[1] drug policy making remained the exclusive domain of law enforcement agencies, with limited input from social and health ministries who were becoming engaged in delivering abstinence-based treatment and in some cases responsible for monitoring drug use within communities.

The trend toward implementing tough law enforcement-led drug policies continued throughout the region until the 1990s when governments confronted with rapidly expanding HIV epidemics among people who used drugs were forced to reconsider their existing approaches to drug use. The advent of HIV saw significant investments from international donors, which dramatically changed how drug use was framed. Almost overnight, drug use began to be conceptualised (at least by some) as a health issue rather than exclusively a criminal one, and significant international resources began to flow into the region to prevent HIV.

The early stages of the HIV epidemic saw a flurry of activity that focused primarily on providing people who use drugs with the knowledge, skills and equipment required to prevent HIV transmission. This approach, often described as harm reduction, flew in the face of traditional approaches to drug policy and remained largely unsupported by governments throughout the region. Despite this lack of government support for harm reduction, internationally funded pilot projects started being set up, and were almost exclusively implemented through health ministries or civil society partners. The *modus operandi* was to make HIV prevention services available as a matter of urgency, and the thought prevailed that policy change could come later.

Major findings of the Report

A major finding of the current report was that, despite significant achievements in improving access to HIV-related services for people who use drugs in several countries, very little change is apparent in their drug policies. Governments across the region disproportionally invest their resources on interdiction, incarceration, coercive abstinence-based treatment and forced crop eradication programmes.

While some health-focused programmes, particularly methadone maintenance treatment (MMT) and needle and syringe programmes (NSPs) have been introduced, such interventions receive only marginal support and are seen as emergency responses to entrenched HIV epidemics. However, as highlighted in reports by the Global Commission on HIV and the Law (established by the United Nations Development Programme (UNDP)) and the Global Commission on Drug Policy (a group of eminent figures promoting informed, science-based discussion about humane and effective ways to reduce the harm caused by the drug market) in 2012, the availability and accessibility of HIV-related measures for people who use drugs are severely hampered by drug policies which criminalise and punish them. There is consequently a strong need for drug policy advocacy efforts aimed at removing these punitive measures.

Several explanations emerged to explain this phenomenon. The first is that drug policy making remains opaque and divided between the more powerful law enforcement and justice ministries that support punitive approaches, and the health ministries which tend more toward supporting harm reduction approaches to managing drug use. While most governments have set up inter-ministerial committees tasked with overseeing drug policy, they are chaired exclusively by law enforcement bodies and firmly embedded in zero-tolerance approaches. These institutional relationships significantly limit the impact that health ministries can have in mediating changes to drug policy.

1 Unlike other countries in Asia, the Ministry of Finance, Department of Revenue is the body responsible for drug policy making in India. This responsibility is largely an artifact from revenue that was generated through opium production during the British Colonial Government.

The second interesting finding to emerge from the report was that drug policy advocacy is nearly exclusively implemented through an HIV lens. This has two implications. First, advocates generally focus their efforts toward achieving goals such as increasing access to HIV-related services. Second, due to the nature of their advocacy they generally target health ministries, who – as discussed above – are largely excluded from broader drug policy debates. Across the region, this situation has resulted in a very narrow approach to drug policy advocacy compared with other regions in the world.

Several advocacy organisations explained that they focused on HIV-related advocacy because it was what they understood and what they were funded to do. This, to a certain degree, simplifies their advocacy message. Rather than dealing with the difficulties associated with affecting change in the more powerful sectors of government-related drug policy, most organisations stated that they had more impact focusing their energies at the local level where there was greater flexibility and openness to change. However, this approach adopted by the early pioneers of drug policy advocacy, focusing on delivering services now and worrying about policy change later, remains ever apparent today. In fact, it is interesting to note that some advocates interviewed for this report went to significant lengths to explain that they are not advocating for drug policy reform, but simply wanted to ensure that people who use drugs have access to HIV prevention services.

Key recommendations

In order to address the issues raised above, the report makes the following key recommendations:

1. **Increase understanding of drug policy processes** – given the opaque nature of drug policy making, it is recommended that a greater emphasis be placed on understanding *how* decisions on drug policy are made. While this report partly sought to focus on this question, largely due to the complexity of the various political systems, it was not possible to gain a clear understanding about the detailed processes that underpin drug policy making. Understanding policy processes are critical to develop targeted policy advocacy strategies, and to avoid the current situation, where the majority of advocacy efforts target stakeholders with the least amount of power to change policy.

2. **Increase the capacity of organisations to advocate for drug policy issues, beyond the delivery of harm reduction services** – in parallel with generating a more sophisticated understanding of the nature of drug policy making across the region, it is also critically important to increase the capacity of organisations to advocate on a broader range of drug policy-related issues. For example, the criminalisation of drug use, compulsory detention in the name of treatment, proportionality of sentencing for all drug offences, and the rights of farmers affected by crop eradication are all critically important drug policy issues facing the region, but these receive significantly less attention than HIV-related issues. Further, investment should be made to engage a broader range of organisations to work on drug policy advocacy, particularly those which already target their advocacy at the criminal justice and social affairs sectors of government, such as civil society organisations advocating on human rights, governance, criminal justice and development issues.

3. **Establish a regional drug policy advocacy body** – modelled on the Global Commission on Drug Policy. Such a body could undertake a detailed review of drug policy making across the region and promote alternative and evidence- based approaches that are more effective at managing the negative consequences of drug markets, as well as being consistent with health, human rights and development principles. The group could also promote alternative visions and strategies to other regional bodies such as the Association of Southeast Asian Nations (ASEAN), which continues to endorse unrealistic and harmful policy goals, such as achieving a drug-free region by 2015.

SECTION 2: INTRODUCTION

Introduction

How best to respond to the harms associated with the production, trafficking and consumption of drugs is an issue that continues to plague policy makers the world over. Despite considerable investment in reducing their supply, drugs remain a significant cause of social disharmony and a major cause of preventable disease worldwide (T. Babor, 2010).

Until recently, global drug policy has been largely shaped by an overly restrictive interpretation of the three United Nations (UN) drug conventions (Bewley-Taylor & Jelsma, 2012). In the past decade however, there has been a growing awareness that elements of the conventions are flawed, and their application have resulted in a range of unintended consequences (Barrett & Nowak, 2009; Room & Reuter, 2012). These unintended consequences include, the expansion of hugely profitable illicit drug markets run by international criminal syndicates (Werb et al., 2011), increased health harms among people who use drugs including uncontrolled epidemics of HIV and other blood-borne viruses (Bergenstrom & Abdul-Quader, 2010; Des Jarlais & Semaan, 2008; Jarlais, 2010; King & Pasquarella, 2009; Mathers et al., 2010; Small et al., 2005; Wodak & McLeod, 2008), huge expenditure on law enforcement (Willis, Anderson, & Homel, 2011) and the criminalisation of people who use drugs which has led to the incarceration of millions of otherwise law-abiding citizens (King & Pasquarella, 2009; Small et al., 2005). Increasingly, the negative effects that drug policies have on opium producers are also being recognised (Keefer & Loayza, 2010; Singer, 2008).

In light of the increasing evidence that the current global drug policy system has failed, many countries have begun a process of policy reform (Global Commission on Drug Policy, 2011). For example, 17 states in the United States of America (USA) have decriminalised cannabis in some form, with the states of Colorado and Washington set to introduce a fully regulated market akin to the sale of tobacco in 2014 (Reuter, 2013). Other countries have decriminalised the use of all drugs, such as Portugal which decriminalised the possession of up to ten days supply of all substances over a decade ago (Greenwald, 2009; Van Het Loo, Van Beusekom, & Kahan, 2002).

Despite the trend in drug policy reform in the Americas and Europe, drug policy across Asia remains relatively stagnant and firmly wedded to criminal justice responses dominated by harsh penalties for the use, sale and manufacture of controlled substances (Rahman & Croft, 2013). While other regions across the globe are actively debating alternative drug policies, the Association of South East Asian Nations (ASEAN), recently re-committed to a drug policy that aims to achieve a drug-free ASEAN region by 2015 (Borneo Bulletin, 2013).

Thus, and in the light of both significant social harm caused by drugs as well as reluctance to consider alternative drug policies in the region, this paper sets out to develop a better understanding of civil society efforts to advocate for drug policy reform and to identify opportunities for further drug policy advocacy activities in 10 Asian countries: Cambodia, China, India, Indonesia, Lao People's Democratic Republic (Lao PDR), Malaysia, Myanmar, the Philippines, Thailand, and Vietnam.

This report aims to achieve three goals:

a. **Identify organisations engaged in harm reduction and drug policy advocacy**
b. **dentify gaps and challenges in harm reduction and drug policy advocacy that remain to be addressed**
c. **Develop recommendations for prioritising new activities in harm reduction and or drug policy advocacy.**

While this report has sought to include advocacy activities on the whole spectrum of policy issues relating to drug markets, its focus is skewed towards activities relating to drug use – a likely reflection of donor funding priorities and limited space for advocating on broader drug policy issues due to entrenched views against drugs.

An exhaustive policy assessment is beyond the scope of this paper. While a number of reports have previously reviewed drug policy issues in the region (the interested reader should consult the law and policy review conducted for the Australian Government HIV/AIDS in Asia Regional Programme) and the report prepared by the Lawyers Collective HIV/AIDS Unit (2007), this paper intends to complement these resources by expanding the focus of enquiry to other aspects of drug policy making processes, including identifying the key stakeholders involved in drug policy making as well as the cultural and political context in which policy making occurs (see the conceptual framework and methodology in the Annex, which outlines the research and analytical approach used to prepare this paper).

The report is presented in four sections. The executive summary provides an overview of the report and key recommendations. The current section includes an introduction to the report and provides the reader with an outline of the conceptual framework that informed the report, as well as the methodology. The third section provides a synthesis of all the data that was collected and attempts to draw out specific trends and make recommendations that are relevant across the region. The final section provides the reader with an overview of drug policy in each of the countries covered by the report. Country-specific recommendations are also presented.

Methodology

A mixed-methods design focusing on primary and secondary qualitative data was employed for this report. The initial phase of data collection focused on published data. Peer-reviewed journal articles, as well as grey literature was searched using online databases (Medline, OVID, Ingenta Connect, JSTOR, and SSRN), Google scholar and Google web search. Table 1 lists the search terms that were used for all 10 countries in the report.

Table 1: search terms

Policy	
AND	**Drug OR illicit drug**
AND	**Harm reduction**
AND	**HIV**
AND	**Law enforcement**
AND	**Drug treatment**
AND	**Methadone**
AND	**Compulsory detention**
AND	**Making**
AND	**Process**
Advocacy	
AND	**Harm reduction**
AND	**Drug policy**
AND	**Legal reform**
AND	**Legal framework**
AND	**Compulsory detention**
Drug	
AND	**Law**
AND	**Legal reform**
Legal	
AND	**Framework**
AND	**System**

All Boolean terms will also be searched with

AND	**Vietnam**
AND	**India**
AND	**China**
AND	**Indonesia**
AND	**Malaysia**
AND	**Thailand**
AND	**Laos**
AND	**Cambodia**
AND	**Philippines**
AND	**Burma**
AND	**South East Asia**
AND	**ASEAN**
AND	**ACCORD**

Paralleling the literature search, a key informant mapping exercise was undertaken with the goal of identifying a diverse range of stakeholders engaged in policy making. The first step in mapping key informants involved generating a list of known contacts. These initial contacts were used in a snowballing recruitment drive. Attempts to recruit additional key informants were also made through social media platforms such as twitter (@drugpolicydata) and LinkedIn. This process led to 245 key informants being identified.

Accurate contact information was available for 221 of the 245 key informants on the initial list. Invitations were sent to all key informants to complete a survey using the online platform surveymonkey.com (questions are included in Appendix B).

Key informants were given three weeks to complete the survey. Following the initial email, three additional emails were sent reminding key informants to complete the survey. Of the initial 221 key informants contacted, six withdrew from the survey. 78 people responded to the survey, a response rate of 36.3 per cent.

In addition to the literature search and questionnaire, 56 key informant interviews were also conducted. These interviews used the theme guide presented in Appendix C and were conducted either face to face, or via Skype, telephone or email.

Information from the three data sources was collated and analysed using a thematic analysis as described by (Ritchie & Spencer, 2002). Analysed data was then used to produce country specific reports.

Participants reviewed the country reports during a two-day workshop help in Bangkok in August 2013. The workshop focused on reviewing the country reports and developing recommendations for future policy advocacy. Information collected during the workshop was used to update the country reports that were then sent to 189 people for a final review. Comments were received from 24 people. The report was finalised in October 2013.

SECTION 3: REGIONAL OVERVIEW

Snapshot

- There is limited advocacy activity on alternative approaches to drug policy, and more investment is required to build the capacity of a more diverse range of civil society actors to engage in drug policy advocacy.
- Some key regional drug policy issues which should be advocated on are decriminalising the use of drugs, proportionate sentencing of drug offences, closing down compulsory rehabilitation centres, and crop eradication and supply reduction measures that are consistent with development and human rights principles.
- ASEAN should be an advocacy target, particularly as it develops its new drug strategy to take effect after the current drug strategy envisioning a drug-free ASEAN ends in 2015.

Policy context

This chapter aims to achieve three goals. First to identify the major drug policy debates that cut across the 10 countries studied by this review; second, to develop recommendations for further drug policy advocacy activities at the regional level; and third, to identify key policy stakeholders that have a regional influence. It is beyond the scope of this chapter to provide a detailed contextual analysis of drug policy in Asia, however an interested reader could turn to Fischer-Tiné & Tschurenev (in press) or Rahman & Croft (2013) for this.

The three UN drug conventions, of which all countries in this review are signatories, remain very influential in shaping both national and regional drug policies in Asia. The UN conventions encourage, and in some instances require, criminal sanctions to be enacted at the national level for certain activities. Other articles prescribe actions such as extradition, crop eradication and severity of penalties. Ostensibly the drug control treaties aim to limit the use of controlled substances to scientific and medical purposes (Barrett & Nowak, 2009; Global Commission on Drug Policy, 2011; Room & Reuter, 2012).

While most countries in this review have – at least to some extent – endorsed harm reduction in their responses to drugs, drug policy in Asia tends to be punitive, framing drug use as a social or moral issue that needs to be eradicated from society. This approach is also reflected in ASEAN's drug policy, which continues to call for a drug-free ASEAN by 2015 (Borneo Bulletin, 2013; Fawthrop, 2012).

In a world where the prevailing approaches to drug policy are increasingly challenging, Asia stands out as a region that has been slow to discuss alternatives. Europe, South America, and even to some extent the USA, are trialling significant transformations to their drug policies in recognition that the dominant paradigm of prohibition has caused more harm than it has reduced the scale of the illicit drug market (Global Commission on Drug Policy, 2011). At a time when visions such as a drug-free region are clearly unachievable, it is highly important that drug policy advocacy activities persuade regional leaders to engage in discussion about drug policy reform.

Cross-cutting policy issues

Uncoordinated drug policy responses

Perhaps the major observation to emerge from the current review is that despite a significant shift among countries in the region toward recognising drug use and dependence as a social and health issue, drug policies throughout the region were universally dominated by law enforcement responses. Largely in response to HIV all countries in the review have adopted policies that support the implementation of harm reduction services such as peer education, needle and syringe distribution, and methadone maintenance therapy (MMT). Despite this, glaring inconsistencies can be observed among the drug policies in all countries.

Three key ministries played a role in developing drug policy in all of the countries in the review. Universally (with the exception of India) the ministry responsible for public security was the most dominant body in drug policy making. Public security ministries endorsed policies that supported harsh punishment for drug use, possession, manufacture and supply. The next most dominant were the ministries of social welfare who, across the board, supported policies that favoured drug demand reduction and abstinence based rehabilitation (often compulsory in nature). The third, and least powerful, were the ministries of health. These ministries generally supported policies that promoted HIV prevention among people who inject drugs, however they had little influence or engagement on broader drug policy issues.

The siloed manner in which countries manage their drug policies has led to significantly uncoordinated responses. For example, it is not uncommon to see policies that prescribe criminal penalties for drug use and promote police arrest quotas sit alongside policies that encourage people who use drugs to attend harm reduction services. Similarly, some countries continue to ban the possession of injecting paraphernalia in their drug control law, enforced by the public security ministry, while also endorsing needle and syringe programmes (NSPs) implemented by the health ministry. Perhaps even more problematic is the massive disconnect that was observed between policies relating to rehabilitation and drug treatment. In most countries across the region, rehabilitation services that promote abstinence through detoxification (and often "social re-education" and "labour therapy") are managed by social welfare ministries; whereas other drug treatments especially opioid substitution therapy (OST), are often managed by ministries of health. This division often means that the care a client receives depends more on which system they engage with rather than their actual needs. It also means that clients who return to drug use after a period of rehabilitation in the abstinence-based system often face punishment, with periods of imprisonment or compulsory detention.

Compulsory rehabilitation

All countries reviewed for this report endorse policies that force people who use drugs to attend some form of compulsory rehabilitation, usually starting with forced detoxification. While practices vary from country to country, compulsory rehabilitation is underpinned by the idea that drug use is undesirable and the state has the authority to enforce abstinence among the population.

Largely based on the philosophy of "social reeducation" a common practice in socialist countries, compulsory rehabilitation for people who used drugs gained momentum in Asia during the 1990s with the construction of large-scale centres in Malaysia, China and Vietnam (Jurgens & Csete, 2012; Pearshouse, 2009). Compulsory rehabilitation spread to neighbouring countries and in 2006, the United Nations Office on Drugs and Crime (UNODC) estimated that there were as many as 2 million people detained in compulsory centres in China and South East Asia (Bezziccheri, 2009).

Compulsory rehabilitation has received considerable criticism from the international community for being unethical and ineffective, as well as for the documented human right abuses suffered by detainees (Amon, Pearshouse, Cohen, & Schleifer, 2013; Human Rights Watch, 2012; International Labour Organisation et al., 2012; Jurgens & Csete, 2012; Pearshouse, 2009; Pearshouse & Amon, 2012; Wild, Roberts, & Cooper, 2002). There is now consensus among the international community at least that compulsory rehabilitation should stop immediately and that all centres should be closed down (UNODC, ESCAP, & UNAIDS, 2011).

These calls have led to a reduction in the numbers being detained in compulsory rehabilitation centres and a review of the practice by many governments across the region. While it is important to acknowledge the reduced emphasis placed on compulsory rehabilitation, a key finding of this report is that compulsory rehabilitation remains embedded in almost all countries' response to drug use.

Advocacy capacity and leadership

Another important cross-cutting policy issue to emerge from this review was the lack of organisations advocating for alternative drug policies in the region. While there are a number of organisations – both international and national – advocating for the adoption of harm reduction service delivery, very few organisations focus on advocating for alternative drug policies. The reasons for such this are that donor funding for drug policy advocacy activities are almost always linked to HIV and injecting drug use programmes, and there is little space for dialogue on alternative drug policies given the entrenched social and moral views against drugs.

Another important factor that prevents alternative drug policies from being promoted is the strong presence of regional and international bodies that are highly resistant to discussion of alternative approaches. For example, as mentioned in the introduction, ASEAN, the regional policy coordination body for South East Asia, has continued to endorse their 1998 policy to make the ASEAN region drug free by 2015 as recently as September 2013. Other regional entities, including the Colombo Plan, promote drug demand reduction and crop eradication while being critical of harm reduction. Similarly, US government funding bans on NSPs are a barrier to promoting harm reduction approaches to drug policy.

Opportunities to promote alternative drug polies are further hampered by the way in which international bodies organise consultations on drug issues which seldom provide opportunities for dialogue between government agencies from various sectors, and between government and civil society actors. For example drug policy meetings tend to be dominated by law enforcement agencies, while regional HIV meetings tend to be dominated by health ministries.

Protecting the rights of farmers

A final drug policy issue that significantly affects some countries in the region is crop eradication and supply reduction measures which negatively impact farmers whose livelihoods depend on growing crops deemed illicit. Several studies have documented the negative unintended consequences that such programmes have on often already marginalised communities, including severely limiting access to health, education and development opportunities, and other human rights abuses (Transnational Institute, 2009). Despite this, such programmes continue, often funded by countries seeking to prevent the drugs produced from crops deemed illicit from reaching their shores. Drug policy advocacy on this issue is limited in Asia, highlighting the need for engagement from a wider range of civil society organisations, particularly those already advocating on development issues in countries implementing crop eradication measures.

Recommendations on drug policy advocacy activities

In addition to the recommendation made in each of the country chapters, three key recommendations are made that cut across issues relevant to the region.

Facilitate a more critical dialogue at regional drug policy forums

As discussed above, regional drug policy forums do not facilitate the easy sharing of information between ministries of health and ministries with responsibility for drug control, and nearly all meetings exclude participation from civil society. It is critical for mechanisms to be developed that allow for more exchanges to occur between the drug control, law enforcement, social welfare, public health and civil society sectors as it relates to drug policy.

In order to achieve more critical dialogue, significant investment is required to build the capacity of civil society actors in advocating for alternative drug policies. In particular, much more investment is needed in increasing the engagement, and capacity to engage of a broad and diverse range of civil society actors, for example academic institutions and non-government organisations (NGOs) advocating on governance, human rights and development issues. Across the region, drug policy advocacy tends to focus on harm reduction service delivery and remain the domain of international agencies and other organisations providing harm reduction services. Guidelines, training materials and institutional support (financial and technical) are immediately required to address this lack of capacity in drug policy advocacy.

Target ASEAN as they deliberate on developing a new drug strategy

Significant effort should be directed at engaging with ASEAN as they deliberate on developing a new drug strategy to take effect after the current one ends in 2015. The first step in this process will require developing a better understanding

about drug policy making within ASEAN, as key informants interviewed for this report knew little about the process, key actors or the actual content of the current ASEAN drug strategy beyond its vision for a drug-free region.

ASEAN should be encouraged to endorse an evidence-based drug policy that takes a public health and human rights approach to addressing the harms stemming from drug markets. The new ASEAN drug strategy should promote the removal of criminal penalties for drug use, proportionate sentencing of drug offences (including removal of the death penalty), scaling up of evidence-based drug dependence treatment, and abolish compulsory drug detention centres (Wood et al., 2010).

Establish a regional drug policy commission

It is recommended that a group based on the Global Commission on Drug Policy be set up in Asia. The group should comprise influential leaders from the fields of academia, government and politics, undertake a detailed review of drug policies across the region and promote alternative, evidence-based approaches.

In addition to the review, the group should immediately develop a detailed strategy that outlines alternatives to crop eradication measures that are inconsistent with development and human rights principles, disproportionate sentences for drug offences, criminalising people who use drugs, and punitive, ineffective drug treatment measures such as compulsory rehabilitation centres. Such a strategy would need to address the dilemmas raised by drug courts as well as the lack of effective alternative treatment systems in much of the region. Any proposed treatment system should focus on promoting a coordinated system of services that provide evidence-based interventions to people who use drugs and their communities. The goal of such a service system is to ensure that people have access to appropriate services as their drug use evolves rather than simply promoting abstinence through a one-size-fits-all model.

Key policy stakeholders

There are a number of agencies which play key roles in drug policy across the region, however the issues and messages they advocate vary widely. These include regional associations such as ASEAN and Plan Colombo, regionally focused UN bodies such as the Joint United Nations Programme on HIV and AIDS (UNAIDS), UNODC, the World Health Organisation (WHO) and the United Nations Development Programme (UNDP), or non-government organisations such as the Australian National Council on Drugs (ANCD), Human Rights Watch, the International Drug Policy Consortium (IDPC), and the International HIV/AIDS Alliance. Foreign governments also play a significant role in shaping drug policy in the region through their embassy staff, locally embedded police force and/or drug enforcement agencies. Regional networks such as the Asian Network of People Who Use Drugs (ANPUD) and the Law Enforcement and Harm Reduction Network (LEAHN) also play an increasingly important role in drug policy dialogue. Key regional bodies and their role in drug policy issues are presented in the table opposite.

Table 1:
Key regional bodies and their role in drug policy issues

Organisation	Key advocacy issue
UNODC	Promoting a comprehensive and balanced drug policy, in line with the drug control conventions
UNDP	Judicial systems and human rights
The International Federation of Non-Government Organisations for the Prevention of Drug and Substance Abuse (IFNGO)	A membership group representing NGOs all over the world engaged in drug use and dependence activities.
Colombo Plan Drug Advisory Program (CPDAP)	Drug demand reduction
Human Rights Watch	Human right protection
IDPC	Evidence-based drug policy
Open Society Foundations (OSF)	Evidence-based drug policy, access to harm reduction services, naloxone and human rights
Global Commission on Drug Policy	Evidenced-based drug policy
Transnational Institute (TNI)	Evidence-based drug policy
AusAID	Harm reduction advocacy
International HIV/AIDS Alliance	Harm reduction advocacy

Advocacy activities	Advocacy targets
Support a range of activities that target: evidence based drug treatment, the reduction of drug supply and drug demand, closure of compulsory centres for people who use drugs and assisting countries to develop new drugs legislation. Activities include dialogue, development cooperation seminars, publications, pilot projects, study tours, advocacy guidance and statements.	National Governments
Are soon to publish a review of laws and policies related to HIV among key affected populations including people who use drugs in the 10 ASEAN countries.	National Governments
Regional meetings, policy advice, training and representing NGO members' interests at the global level.	Local NGOs working on "anti-drug" issues
Human resource development on drug control, supply reduction and training focused on abstinence-based treatment in Asia and the Pacific.	National Governments and civil society organisations
Have prepared a series of reports that have documented human rights violations associated with compulsory rehabilitation centres in East and South East Asia.	National Governments
Leading stakeholder in drug policy advocacy in Asia. IDPC coordinates a range of activities from policy analysis, research, publication, dialogue forums and advocacy capacity building among national NGOs.	National Governments and civil society organisations
Provide financial support to drug policy advocacy efforts across the region.	Civil society organisations
Research, publications, policy dialogues and workshops on regional drug market in Myanmar and neighbouring countries (India, China, Lao PDR, Thailand), focus on drug law reform, drugs & conflict, and representing rights of people who use drugs as well as opium and cannabis farmers in the region.	National Governments
Research, publications, policy dialogues and workshops on regional drug market in Myanmar and neighbouring countries (India, China, Lao PDR, Thailand), focus on drug law reform, drugs & conflict, and representing rights of people who use drugs as well as opium and cannabis farmers in the region.	Research, publications, policy dialogues and workshops on regional drug market in Myanmar and neighbouring countries (India, China, Lao PDR, Thailand), focus on drug law reform, drugs & conflict, and representing rights of people who use drugs as well as opium and cannabis farmers in the region.
Promote the development of evidenced based drug policy and the delivery of HIV prevention services to people who use drugs. Primarily delivered through the HIV/AIDS Asia Regional Programme (HAARP) and the HIV Cooperation Programme in Indonesia (HCPI).	NGOs
Improving the knowledge, increasing the evidence and building support for harm reduction among key decision makers across the countries.	National and local Governments

SECTION 4: COUNTRY PROFILES

Cambodia

Snapshot

- There is an active group of drug policy advocates in Cambodia, which has been mainly focused on harm reduction policy and technical service delivery, evidence-based drug treatment services and closing down compulsory rehabilitation centres.
- Significant gaps exist in the drug policy advocacy response, especially around advocating against the criminalisation of people who use drugs, and the inconsistencies between the Village Safety Policy and support for harm reduction outlined in the National Strategic Plan for a Comprehensive and Multi-Sectorial Response to HIV/AIDS III, 2011-2015.
- Drug policy advocacy in Cambodia remains underfunded and narrowly focused through a health and HIV lens.

Policy context

The consensus among drug policy actors in Cambodia is that drug use – except for the cultural practice of cannabis (both eaten and smoked) – remained relatively rare during the decades-long civil war and prior to the borders opening in the early 1990s (Klein, Saphonn, & Reid, 2012). By the mid-1990s Cambodia was recognised as both a transit country for drug trafficking as well as for domestic consumption, and moved to establish an inter-ministerial agency to address the drug problem. UNODC together with the WHO and UNAIDS mobilised funds and supported the newly established National Authority for Combating Drugs (NACD) to develop drug control laws (Klein et al., 2012).

Like elsewhere in South East Asia, drug use in Cambodia is constructed as a moral weakness. However, in the early 2000s and against a backdrop of rising HIV prevalence amongst people who inject drugs, the Government of Cambodia began to conceptualise drug use as a health issue rather than a criminal one (Chheng, Leang, Thomson, Moore, & Crofts, 2012). Despite this shift, drug policy remains internally inconsistent, as evidenced by the continued support for compulsory rehabilitation as well as the introduction of policies such as the Village/Commune Safety Policy. The Village/Commune Safety Policy urges authorities to fight any drug-related activities and eliminate production, dealing and use of illegal drugs in villages (Nick Thomson et al., 2012).

For example, despite positive evaluations of MMT porgrammes as well as pilot community-based treatment programmes (Klein et al., 2012), the Government of Cambodia remains committed to compulsory rehabilitation centres that are run by the police, or the military police and/or the Ministry of Social Affairs with few or no medically trained personnel (Human Rights Watch, 2009). Similarly, despite evidence of increasing HIV risk among people who use drugs, the Government of Cambodia remains committed to the Village/Commune Safety Policy. The implementation of the Village/Commune Safety Policy directly contradicts support for harm reduction outlined in the National Plan on Drug Control 2013-2015 of the NACD and the National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV/AIDS 2011-2015 of the National AIDS Authority (NAA). Nevertheless the Government has recently begun efforts to improve its harm reduction response by reviving its NSP policy under the health system, and developing standard operating procedures (SOPs) for implementing harm reduction programmes, including NSP, drug treatment and a continuum from prevention to care and treatment for most-at-risk populations.

Current advocacy activities

Closing compulsory detention centres

The release of the "Skin on the Cable" report by Human Rights Watch in 2009 was a watershed moment for drug policy in Cambodia. While the initial response was withdrawal from the Cambodia Government, the report was a significant catalyst for mobilising a range of actors to review their engagement with and in the compulsory detention centres in Cambodia. So far, three compulsory detention centres have been closed while the remainder continue to operate without support from the international community.

Integration of harm reduction services into existing government programmes

UNAIDS are advocating with the Government to begin implementing needle and syringe programs through existing health services.

Expanding evidenced-based drug treatment options

Both WHO and UNODC are working on advocating for the expansion of evidence-based drug treatment options in Cambodia. With support from AusAID, WHO has worked with the Ministry of Health (MoH) to scale up MMT programmes, now reaching over 150 people. UNODC has focused on the provision of community-based treatment for users of amphetamine-type stimulants (ATS). The UNODC project was launched in 2010 in the Banteay Meanchey Province and has now expanded to 24 communes, with over 253 trained staff available to provide health screenings and treatment services at four referral hospitals and 15 health centres.

Increasing support among operational police for harm reduction interventions

Although not strictly classified as drug policy advocacy, it is worth noting the work of UNAIDS and FHI 360 in engaging drug control authorities with the aim of improving access to harm reduction services. Cambodia's drug policy framework, especially the Village/Commune Safety Policy, has made it very difficult to reach people who use drugs in the provision of HIV prevention services (Nick Thomson et al., 2012). In order to reduce the negative consequences of the Village/Commune Safety Policy in reducing access to HIV prevention services, UNAIDS began working with the National AIDS Authority on a Most at Risk Population Community Partnership Initiative (MCPI). The MCPI has been implemented in Banteay Meanchey province and focuses on involving police and

law enforcement agencies in working more harmoniously with health agencies and supporting service delivery to target populations. The MCPI, recently re-named as the Police-Community Partnership Initiative (PCPI) is now also implemented in Phnom Penh. With support from AusAID, FHI 360 developed a national harm reduction training curriculum for the Cambodian police that has now been adopted by the national police training academy (Nick Thomson et al., 2012).

Advocacy gaps and challenges

Advocacy capacity

Capacity for drug policy advocacy is quite strong in Cambodia, though to date is has been primarily focused on health and HIV-related issues and driven by international agencies. However, a number of NGO and civil society groups have mobilised on drug policy issues in Cambodia and are well placed to contribute to continuing and expanding existing drug policy advocacy efforts. KHANA, a large and well-respected NGO has recently received funding from the European Commission-funded Asia Advocacy for Harm Reduction project, which for the first time brings specific funding for drug policy advocacy to the country.

The HAARP Cambodia team has also been actively advocating with senior government and law enforcement officials on harm reduction, either directly or indirectly through implementing partners, including FHI 360, KHANA, and Friends International.

Both Korsang and Mith Samlanh have strong connections with people who use drugs and have played an important role in representing their advocacy positions in the past. These groups provide a strong platform for increasing the involvement of people who use drugs in advocacy efforts in Cambodia.

However, despite the strong capacity noted above, one key informant mentioned that advocacy efforts remain fragmented. There is a need to develop a clear advocacy plan and coordination mechanism among the players.

Policy environment

However and despite a strong advocacy platform, a range of political constraints and friction between the various stakeholders limit drug policy advocacy. The majority of these limitations stem from different understandings of drug use, dependence and harm reduction. For example, many people still consider harm reduction as a means of encouraging drug use, rather than reducing drug use and associated harms.

Further, as mentioned above, the contradictions between the various laws and policies make project implementation difficult. This is particularly relevant for the Village/Commune Safety Policy and provisions that support harm reduction in the National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV/AIDS 2011-2015, the NACD's National Plan and the Drug Control Law. Similarly, according to a number of key informants, recently implemented human trafficking legislation has also had a significant impact on HIV prevention activities, as both sex worker and drug user clients of harm reduction services have been detained and their access to services disrupted.

Policy issues that remain unaddressed

As discussed above, key stakeholders involved in implementing programmes providing services for people who use drugs have played an active role in drug policy advocacy over the past five years. While they have mobilised around many of the major issues, efforts remain ad hoc, most often delivered through HIV-related programmes and under-funded.

A number of key informants commented that there is an urgent need to advocate for more funding of activities that directly target drug policy issues in the country, especially issues not related to HIV but important for the protection of human rights and rule of law. The idea that advocacy is limited due to the funding stream fits with the idea raised earlier about the need for drug policy advocacy to engage issues beyond health and ensuring access to harm reduction services, such as removing criminal penalties and punitive measures (e.g. detention) in response to drug use.

Recommendations for future advocacy activities

Support for the expansion of existing mechanisms of drug policy advocacy

The key policy recommendation for Cambodia focuses on expanding the sphere of issues covered by the existing harm reduction working group to include broader aspects of drug policy. One key informant suggested that the group could focus on developing a harmonised drug policy advocacy plan. Another key stakeholder commented that the MoH is in a strong position to advocate for stronger coordination across the various players engaged in drug policy.

Nationalisation of harm reduction funding

The second advocacy priority that this group should target is nationalising harm reduction funding. At the moment, nearly all funding for harm reduction services in Cambodia comes from international donors. Many stakeholders were of the view that it is important for the Government to significantly increase their ownership and commitment to support harm reduction. The stakeholders stated that increasing national funds would address issues of sustainability but more importantly it would demonstrate a national commitment to harm reduction.

Background information

Key drug policies

• Laws

Law on the Control of Drugs, 1997 – The Law on the Control of Drugs 1997 (amended in 2005, 2011 and again in 2012) is the major legislative framework governing illicit drugs and substances. The law prohibits both consumption and possession. However, the law does offer people caught using drugs (positive urine test or in possession of a small amount) a coerced choice between imprisonment for up to six months or drug treatment and parole. The law also provides for people caught using drugs to be held in treatment facilities on orders

of a Civil Court, acting on a complaint by a spouse/parents/relatives or the prosecution. The law also promotes harm reduction [Articles 45, 53, 100, and 107] including making provisions for NSP.

Law on Prevention and Control of HIV/AIDS, 2002 – The Law on Prevention and Control of HIV/AIDS, 2002 makes no explicit mention of harm reduction or programmes for people using drugs.

• Strategies / Policies

The National Strategic Plan for a Comprehensive and Multi Sectorial Response to HIV/AIDS 2011-2015 (NSP III) – NSP III supports a range of interventions that target people who use drugs including drug use prevention, education, treatment and rehabilitation as well as the provision of harm reduction services, such as NSPs as well as MMT.

Village-Commune Safety Policy, released in August 2010 – The Policy states that authorities at the commune level must ensure that there is no stealing, drug production or dealing, sex work, child trafficking, domestic violence, gangsters, illegal gaming, use of illegal weapons or crime occurring in any Cambodian commune.

The National Drug Control Master Plan 2006–2010 – The Master Plan outlines drug control, strategies objectives, key activities and summary of resource requirements. It includes the following objectives: 1) to expand access to HIV prevention information, services and commodities for people who use illicit drugs; 2) to expand access to HIV treatment, care and psychosocial services for people who use illicit drugs; 3) to provide a range of options for treatment of drug dependence and associated mental illness using evidence-based strategies; 4) to create an enabling environment which supports interventions to prevent and treat HIV/AIDS amongst people who use drugs; and 5) to develop capacity of the working group, secretariat and implementing partners.

Key policy making bodies

Policy area	Key stakeholders	
	Government	Non Government
Policy coordination body	NACD	UNODC, UNAIDS, WHO
Regulation of medical industry	MoH	WHO
Drug trafficking and customs	Ministry of Interior (MoI)	UNODC
Law enforcement	MoI Cambodian Police Academy Anti-drug units within the National Police of Cambodia NACD	HAARP/AusAID, FHI 360, KHANA
Judicial system	Ministry of Justice	UNODC, Cambodia Criminal Justice Assistance Project Phase III (CCJAP)/AusAID
"Rehabilitation" and management	Ministry of Social Affairs, Veteran and Youth Rehabilitation, MoI and Ministry of National Defense	UNODC
OST	MoH, National Program for Mental Health (NPMH)	WHO, HAARP/AusAID
NSP and HIV related service delivery	NACD , MoH (NPMH & National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS)), NAA	UNAIDS, WHO, UNODC, FHI 360, KHANA, Korsang, Mith Samlanh, Friend International, HAARP/AusAID, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

Organisation	Policy issue	Advocacy activity	Target organisation
AusAID/ HAARP	Revising NSP policy Reactivating harm reduction coordination mechanism at NACD and MoH Support for improving enabling environment for harm reduction	Technical support to MoH to develop SOPs for implementing harm reduction in health system. Advocate for excluding NSP licenses for NGOs to implement NSP programme in Cambodia. Advocate for setting up harm reduction coordination mechanism at MoH for service delivery and at NACD for policy level. Technical and financial support to FHI 360 to implement the Police Community Partnership Initiative (PCPI) in Phnom Penh and to integrate harm reduction training curriculum into the Cambodia Police Academy.	MoH, WHO, FHI 360 NACD, MoH, WHO, FHI 360, KHANA, UNAIDS NACD, MoH, FHI 360, WHO NACD, MoI, FHI, Cambodia Police Academy
FHI 360	Sensitising and improving coordination between local authorities on harm reduction under the PCPI (with KHANA)	Conduct sensitisation workshops and organise regular meetings among local police, health centres, authorities, and schools, together with representatives of people who use drugs and Ministry of Interior	Local police, health centre, authorities, and schools in Phnom Penh
KHANA	Revised Drug Control Law Community- based drugs treatment	Participating in community stakeholder meetings and reviewing policy documents. KHANA uses its status as a large, well-known and experienced NGO as an advocacy platform. KHANA follows a "soft approach" through information sharing, dialogues and sharing but not confronting.	NCHADS and NACD
UNAIDS, UNODC and WHO	Revised Drugs Control Law Closing compulsory detention centres	These three UN agencies work closely in Cambodia on promoting harm reduction advocacy and the closure of compulsory detention centres. Collectively these agencies have supported study tours, policy dialogues, training workshops and provided technical guidance on policy revisions.	NACD NACD and broader advocacy with the Government
UNAIDS	NSP policy – integrating NSP into existing Government health care facilities	UNAIDS focused on normalising NSP and related interventions amongst the community, health care workers and policy makers. Other reasons for successful advocacy included having a strong working relationship with the Mental Health Programme, a unified voice (message) amongst partners, and having patience and following a step-by-step approach.	MoH, NPMH
WHO	MMT	WHO spearheaded a multi-sectorial advocacy campaign that focused on introducing MMT to Cambodia. This involved a wide range of advocacy activities including, leveraging personal relationships, study tours, assistance in writing guidelines and revising laws and policies, as well as securing funding for project implementation.	MoH
UNODC	Community-based drug treatment	Funding and technical assistance to a pilot community based treatment site in Banteay Meanchey. This site is used to advocate for the scale up of evidence-based community located drug treatment services that respect human rights norms.	NACD, MoH and the Ministry of Social Affairs, Veterans and Youth Rehabilitation
Korsang (with KHANA)	Forum for people who inject and use drugs	Organised forum between people who use and inject drugs, and stakeholders to improve quality of services and methadone adherence, and enhancing collaboration amongst relevant stakeholders. Work closely with communities, local authorities and the police to improve an enabling environment for harm reduction.	MMT staff, Health Centre and local authorities
Mith Samlanh	Protection and promotion of rights of children and youth who use drugs	Plan to sign a Memorandum of Understanding (MoU) with Phnom Penh Municipality to provide care for children and youth who are periodically rounded up by police, e.g. when an ASEAN meeting is held in Phnom Penh.	Municipal government in Phnom Penh
Human Rights Watch	Closing compulsory detention centres	Documentation of human rights abuses in compulsory detention centres and the publication of the "Skin on the cable" report. Human Rights Watch also uses letter writing and public attention rising as advocacy tools.	International community International NGOs, UN and the Government

China

Snapshot

- Despite growing interest in drug policy among some academic circles, drug policy advocacy efforts in China remain nascent at best.
- China's political context and policy process is opaque and difficult to penetrate.
- Diversifying patterns of drug use, a growing middle class and increasing engagement in public policy debates through social media all point to potential advocacy opportunities in the near future.
- Inconsistencies in the drug policies adopted by different government agencies and an overly harsh response to drug use remain the most critical advocacy issues especially in light of China's HIV epidemic.

Policy context

China's policy response to illicit drugs dates back to the 19th century opium wars fought against Britain (Windle, 2013). While these events remain historically relevant, some experts locate China's modern day response to drugs within the key national political narratives of "protecting social order", "maintaining social stability", and "building a harmonious society" (Biddulph & Xie, 2011; Trevaskes, in press). Further, China's continued reliance on a harsh response to drug use is a likely remnant of the celebrated opium eradication programme conducted by the Communist Party of China shortly after it assumed power in 1949 (Anderson, Beletsky, Burris, Davis, & Kersina, 2009; Liu, Liang, Zhao, & Zhou, 2010).

Trevaskes (in press) notes that the social stability doctrine of the post-Mao period starting in the 1980s saw the introduction of the "Strike Hard" criminal justice policy against social order crimes. Whilst this policy primarily targeted criminal offences, it frequently expanded to include behaviours that were considered socially harmful and not necessarily classified as a criminal offence. This was illustrated by the 1989 crack-down on the "Six Evils", which targeted sex work, gambling, pornography, kidnapping and selling people, deceiving people with feudal superstition, and drug use (Biddulph, 2007). It was also under the influence of the Strike Hard policy that the practice of administrative detention and compulsory treatment of people who used drugs expanded rapidly.

These punitive law enforcement responses dominated drug policy in China until the early 21st century when two key events precipitated a shift in policy. The first was the growing recognition among government officials that injecting drug use was fuelling the HIV epidemic (Sullivan & Wu, 2007). The second was the broader policy shifts outlined in President Hu Jintao's "harmonious societies" policy which introduced the idea of balancing leniency and severity, replacing the previous approach of "Strike Hard" offensives (Trevaskes, 2010).

While China's first HIV-specific policy documents – "The Medium- and Long-Term Strategic Plan for HIV/AIDS (1998–2010)" issued in 1998 and the National Action Plan on HIV/AIDS Prevention and Containment (2001–2005) issued in 2001 – both recognised the importance of addressing HIV among people who used drugs, neither clearly challenged the underlying punitive approach to managing drug use (Chu & Levy, 2005; T. Hammett et al., 2008; Gary Reid & Aitken, 2009; Yin et al., 2010). Despite a number of pilot NSPs operating in Yunnan and Guangxi in 2000, it was not until the promulgation of the HIV/AIDS Prevention and Treatment Regulations and the adjoining Five-Year Action Plan to Control HIV/AIDS (2006–10) in 2006 that drug dependency was clearly articulated as a health issue.

In 2006, following the erosion of the "Strike Hard" policy and the introduction of the multi-sectorial response to dealing with drug issues, a new policy approach emerged that began to frame drug policy as a "battle" to be fought in five key areas (Trevaskes, in press). This five-pronged policy response was further embedded in June 2008 when the Drug Control Law came into effect. In a speech given to mark the inauguration of the new law, President Hu Jintao framed drug control as a long-term mandate that should focus on drug prevention and education, law enforcement, treatment and rehabilitation, drug administration, and international cooperation.

While China's contemporary drug policy has evolved to recognise that "bringing drug addicts to justice" is no longer the ultimate goal of drug policy (Liu et al., 2010) and that drug-dependent people are "sick", "victims of their dependency", and should be treated with humanity, a chasm still remains between the public health and public security authorities with regard to the best way to handle drug-related issues (T. F. Babor, 2010). These conflicts and ambiguities are highlighted by the continued lack of support for NSPs which are seen as promoting drug use (Gary Reid & Aitken, 2009; Smith, Bartlett, & Wang, 2012), compared to the significant support given to methadone which, although seen by some as "substituting one addiction for another", still satisfies the broader goal of social control (Foucault, 1977).

Current advocacy activities

Despite considerable effort, engaging with key informants involved in drug policy in China proved difficult. Several reasons could explain this. Language barriers prevented many people from participating in interviews and from filling in the online data collection forms and the overly bureaucratic nature of government departments required key informants to forward all correspondence to their international relations section, often delaying responses beyond project timeframes. Finally and perhaps most indicative of the advocacy environment in China was the concern raised by several key informants that engaging in the mapping project may jeopardise their advocacy efforts. One organisation chose not to disclose their grantee partners due to this fear.

However, based on the information that was collected, advocacy efforts in China seem to be currently focused on the following three issues:

Closing compulsory detention centres

Human rights watch, AIDS Care China, as well as a number of UN agencies, are actively advocating for the closure of compulsory detention centres in China. The Red Ribbon Forum, supported by UNAIDS recently organised a meeting of policy makers, civil society representatives and international experts to discuss alternatives to compulsory detention in China. During this meeting the Forum agreed to develop a proposal for the phasing out of compulsory detention centres that will be submitted to the National People's Congress in 2014. The proposal will also call for a more thorough review of drug policy and drug treatment options in China.

Improving access to harm reduction services

Several organisations continue to advocate for increasing access to harm reduction services in China. Their advocacy activities include publishing research reports and evaluations, and supporting dialogue forums and study tours. The role of evidence in influencing policy change in China has been noted by many researchers (Hammett et al., 2005; Gary Reid & Aitken, 2009). However, according to T. Hammett et al. (2008), international evidence was not accepted as readily and it was data collected by indigenous agencies that had the largest impact on changing people's minds. The authors also highlighted the important role played by a group of "policy champions" that emerged to lead the campaign for harm reduction. The group included influential scholars from national public health agencies, prestigious universities and research institutes, as well as provincial and local officials.

Significant pressure from the international community was also identified as a key factor that led to the acceptance of harm reduction in China. Major donors such as the World AIDS Foundation, the World Bank, AusAID and the UK Department for International Development (DFID) insisted that large amounts of aid would be contingent upon implementation of international best practices. This was supported by International NGOs who provided technical guidance for early harm reduction projects (Yin et al., 2010). The 2003 outbreak of severe acute respiratory syndrome (SARS) in China is also seen as a significant turning point in the country's response to public health-related issues (Gill & Oakie, 2007). Not only did SARS highlight the potential economic consequences of infectious diseases, it also forced the international community and China to engage more openly.

Advancing the rights of people who use drugs

A number of local NGOs reported advocating for a reduction in administrative sanctions applied to people who use drugs. For example Yunnan Day Top is advocating for the repeal of legislation that suspends the driver licenses of people found guilty of drug use. Dongzhen provides strategic litigation and legal aid to people living with HIV, including people who inject drugs.

Advocacy gaps and challenges

Advocacy capacity

Given the reluctance of organisations in China to discuss drug policy advocacy, it is difficult to assess the advocacy capacity of civil society organisations in the country. However there is a considerable amount of scholarship that focuses on legal and health policy, especially among academics and institutions outside the traditional harm reduction industrial complex as referenced by the comparatively voluminous literature published on the topic (Biddulph, 2007; Biddulph & Xie, 2011; Congressional Executive Commission on China, 2013; Trevaskes, 2010, in press). This capacity suggests the potential for academic actors and institutions to engage in drug policy advocacy. Another interesting observation is the increasing role that civil society and social media are playing in debating, and promoting debate on, public policy issues.

Policy environment

China's centralised and opaque policy making process is a significant barrier to advocacy. Key stakeholders, when identified, are difficult to reach and even when they are reached, it is challenging to ascertain their actual role in policy making.

A clear example of the ambiguities of drug policy in China is the continued and unbridled support for compulsory detention. Although the Deputy Minister of Public Security, Zhang Xinfeng, claimed that the Drug Law embodies a philosophy of "education and treatment" through the introduction of a range of non-custodial treatment options including voluntary treatment and community rehabilitation orders (Huang 2008), the oxymoronic fallacy of compulsory registration and compulsory treatment for those that do not volunteer for treatment remains ever-present.

This fact is highlighted by a recent opinion piece written by the Director of the Chinese National Centre for AIDS/ STD Control & Prevention and former International Harm Reduction Association's Rolleston Award winner Zunyou Wu, who argued that the compulsory detention of people with problematic drug use is justified by cultural norms that place the rights of society (?o security and order) over those of the individual (Wu, 2013).[1]

Policy issues that remain unaddressed

Many policy issues remain unaddressed in China. Of key importance are removing barriers to accessing MMT, including the mandatory registration and detention of people who use drugs, and the application of the death penalty for drug crimes. While there is some work in advocating for the closure of compulsory detention centres, much more advocacy efforts are needed to push forward momentum in removing detention as a form of drug treatment.

Recommendations for future advocacy activities

Build capacity for drug policy research and advocacy by influential research and academic actors

As noted earlier, several key informants highlighted the role that scientific evidence had played in increasing the acceptance of harm reduction interventions in China, suggesting the potential for influential research and

[2] Further and despite growing international condemnation of compulsory detention of people who use drugs, (Liu et al., 2010) argues that it is not practical to discuss ending compulsory detention, and suggests that a more beneficial discussion would be on how to improve the quality of services offered inside the detention centers.

academic organisations to engage in drug policy advocacy. As demonstrated by the increasing literature on HIV and drug use in China, a significant and sophisticated workforce has developed around studying the effectiveness of various interventions such as MMT, NSP and antiretroviral therapy (ART). Despite this, however, there remains a significant gap in the scientific study of drug policy issues such as the effectiveness and impacts of measures such as compulsory registration and detention of people who use drugs, and imposing disproportionate sentences for drug offences. It is therefore recommended that a policy taskforce be supported to study a broader range of drug policy issues.

The taskforce, modelled on the Global Commission on Drug Policy, could bring together Chinese academics and leaders who could conduct research into alternatives to the current approach to drug issues. This group could build on the work already started by the (soon to be unfunded) Red Ribbon Forum.

Continue to advocate against the compulsory detention of people who use drugs

China's rapidly changing social and political landscape provides opportunities to advocate on drug policy. Given the recent moves toward reforming the system of "reeducation through labour", it is recommended that advocacy efforts focus on closing compulsory detention centres for people who use drugs. Efforts should concentrate on articulating a clear alternative to compulsory detention and ensure access to evidence-based drug treatment services in the community.

Efforts should also build on the recent social media campaign against reeducation through labour as a punishment for political dissidence, for example, by calling for the removal of all administrative detention practices.

Compulsory registration of people who use drugs

The Drug Control Law requires the compulsory registration of people who use drugs. The practice, enforced by the Ministry of Public Security (MPS), creates a major structural barrier to people accessing services for fear of being identified and subject to police checks, random drug tests, and restrictions on movement. While there has been advocacy on individual cases at the provincial level, there has not yet been advocacy for systematic change at the central government level.

Background information

Key drug policies

• Laws

Drug Control Law, 2008 – China's Drug Control Law is enacted for the purpose of preventing and punishing criminal offences related to narcotic drugs, protecting the health of citizens and to maintain social order. The law contains measures that require people who use drugs to undergo community-based detoxification programmes. The law also provides for public security departments to apply "direct forced isolation treatment" (compulsory detention) to those deemed not complying with community detoxification procedures for a period of two years.

Regulations on AIDS Prevention and Treatment, 2006 – The Regulations on AIDS Prevention and Treatment are an administrative law issued by China's State Council. The AIDS Regulations provide a legal statement of the rights of people living with HIV as a basis for implementing politically sensitive prevention measures by the Government, including condom promotion, MMT and NSPs.

• Strategies / Policies

People's War on Drugs, 2005 – The "People's War on Drugs" strategy was launched in 2005. The strategy is made up of five sections: drug prevention and education, drug treatment and rehabilitation, drug supply prevention and interdiction, "Strike Hard" drug law enforcement, and strict control and administrative measures designed to inhibit the diversion of precursor chemicals and other drugs.

National guidelines on the operation of MMT, 2006 – The National guidelines on the operation of MMT were issued by the MoH, MPS and the State Food and Drug Administration in 2006. An administrative system of national, provincial and local MMT work teams consisting of representatives from the three agencies are responsible for overseeing the implementation of regulations in compliance with the guidelines.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	National Narcotics Control Commission	
Regulation of medicines	State Food and Drug Administration	
Drug trafficking and customs	General Administration of Customs	US Drug Enforcement Agency (DEA)
Law enforcement	MPS	
Judicial system	MoJ	UNDP
"Rehabilitation" and management	MPS MoJ	
OST	National Health and Family Planning Commission (former MoH) State Food and Drug Administration Ministry of Public Security	
NSP and HIV related service delivery	MoH and National AIDS Committee, Provincial-level Centre for Disease Control	UNAIDS

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
Yunnan Daytop	Prohibition on people who use drugs maintaining a driving license	Policy dialogue and campaigning.	Yunnan Peoples committee
Yundi Harm Reduction Network	Access to Naloxone first aid for heroin overdose by peers	Policy maker dialogue, multi-organisations advocacy letter, media and academic papers.	Chinese National Centre for AIDS/ STD Control, Yunnan Health Bureau
AIDS Care China	Policy advocacy for harm reduction	Policy dialogues.	Local Government
Red Ribbon Forum	Various – compulsory drug detention was focused on this in 2013	As a platform funded by UNAIDS, it facilitates dialogue between government and non-government organisations to discuss HIV and rights-related issues.	High level political stakeholders
Asia Catalyst	Human Rights Advocacy Training	Training for NGOs including those that work with people who use drugs.	Civil society organisations advocating on human rights issues
Dongzhen	Legal representation and protection of rights for people living with HIV	Strategic litigation.	MoJ
Xintan	Access to MMT and naloxone	Letter writing.	MPS and China Political Consultative Committee
Open Society Foundations	Access of hepatitis C treatment for people who use drugs	Pilot service and advocacy activities.	Chinese National Centre for AIDS/STD Control
Human Rights Watch	Closure of compulsory detention centres	Human rights documentation International awareness raising Letter writing.	High level political stakeholders

India

Snapshot

- India's size and complex political environment makes drug policy advocacy difficult.
- Despite a number of groups currently engaging in drug policy advocacy, the overall response remains uncoordinated and narrowly focused on HIV prevention.
- Key advocacy issues include building advocacy capacity, addressing disproportionate laws for possession and increasing access to evidence-based drug treatment.
- Supporting the establishment of a national drug policy advisory group is recommended.

Policy Context

India's colonial past revenue generated from the cultivation of opium and regulation of its huge pharmaceutical industry shape contemporary drug policy in the country. In fact, prior to the 1980s, substance use was not regarded as a major political concern and Indian drug policies focused on controlling the licit drug trade and collecting revenue through licensed sales (Hasan, 1975).

Also important in understanding the policy context associated with illicit drugs in India is the strong cultural functions that the use of cannabis and opium have among some religious groups and social classes (Chopra & Chopra, 1990). Molly, Bewley-Taylor, & Neidpath (2005) reported that in attempts to defend these practices, Indian delegations at the UN protested about the international cannabis prohibition proposed under the 1961 Single Convention on Narcotic Drugs.

Both Kour (2013) and Molly et al. (2005) suggest that the shifts in Indian drug policy that occurred in the 1980s toward a greater focus on personal drug use were a result of lobbying from external parties, particularly UNODC and the US Government. Lobbying resulted in the adoption of the Drugs and Psychotropic Substances Act and set the path for India's current day approach to drug policy. However and despite a stronger focus on limiting personal consumption, formulation of drug policy in India remains within the Department of Revenue, which sits under the Ministry of Finance (Ambekar, Rao, & Agrawal, 2013).

Like elsewhere in Asia, the advent of HIV has influenced the development of India's drug policy by reintroducing ideas about reducing the harms associated with drug use rather than just trying to eliminate it (Ambekar et al., 2013). Today, drug policy in India remains subject to the same internal inconsistencies that plague other countries in the region, with the competing interests of supply, demand and harm reduction remaining largely unresolved (Lawyers Collective HIV/AIDS Unit, 2007).

Current advocacy activities

Social organisation

There is a strong focus in India on supporting sub-national networks of people who use drugs. These networks operate under the umbrella of the national India Drug Users Forum. The advocacy activities of the various networks vary depending on maturity and location. More established chapters can quickly and skilfully organise around current advocacy efforts, while newer groups tend to serve more as an information sharing forum.

Targeted advocacy efforts

Four key organisations are currently engaged in targeted advocacy efforts in India: the Lawyers Collective (strategic litigation), the Indian Harm Reduction Network (scaling up access to HIV prevention services) and the All India Institute of Medical Sciences (AIIMS) (access to evidence-based OST). The fourth key player is Alliance India, which is currently developing specific advocacy activities on harm reduction under the European Commission-funded Asia Action on Harm Reduction project (administered by the International HIV/AIDS Alliance).

State-focused advocacy efforts

Due to the size and complexity of India's political system, a number of organizations have specifically targeted their advocacy efforts at the state level. For example, organisations like the Community Network Empowerment and the Nossal Institute have long focused on advocacy efforts in North East India, a region with high levels of injecting drug use and cultivation of crops deemed illicit.

Advocacy gaps and challenges

Advocacy capacity

India has a strong tradition of civil society engagement in policy advocacy. However, and while there are a number of organisations working on drug policy, the overall response remains uncoordinated and narrowly focused on HIV prevention. Capacity among the organisations engaged in policy advocacy also varies. While there is strong engagement from people who use drugs in policy advocacy, it is sometimes difficult to distinguish between the various organisations involved as they have similar roles and often staffed by the same people.

Policy environment

The sheer size of India and its complex bureaucratic systems makes drug policy advocacy extremely difficult. While one stakeholder suggested that advocacy efforts should be targeted at the central Government, all other interviewees conceded that it would be more efficient to advocate at the state level and focus more on the interpretation and implementation of laws and policies, rather than trying to change official national policies. For example, one key informant noted that there was little – if any – guidance for state-level agencies on the implementation of national drug policies.

Similarly and as is common across the region, another major obstacle to policy advocacy in India is a lack of political will to engage in open dialogue about alternative drug policies. Public opinion about drugs also remains problematic, as it is common to blame social problems on drugs. In addition, India's drug policy – despite showing strong support for harm reduction in the National AIDS Strategy – is dominated by a tough law enforcement approach. This has resulted in a poorly coordinated policy response as evidenced by the Narcotic Drugs and Psychotropic Substances Policy, issued by the Ministry of Finance. For example the Policy fails to mention OST in the section on treatment and rehabilitation, relegating it to the section on harm reduction. The policy constructs harm reduction as helping people who use drugs to "abuse drugs safely", and requires that it lead to "de-addiction" (or abstinence). The Policy also stipulates that provision of harm reduction interventions should be limited to government recognised centres, which should maintain records of "addicts" who should be switched to de-addiction services as soon as possible – an approach contradictory to the concept of harm reduction (Ambekar et al., 2013).

Policy issues that remain unaddressed

• Access to evidence-based drug treatment

Adequate access to evidence-based drug treatment remains a major concern in India. Responsibility for India's drug treatment system is divided between two ministries. The Ministry of Social Justice and Empowerment is responsible for funding over 400 "treatment and rehabilitation" centres. These centres, which follow an inpatient abstinence-based model, are rarely subject to evaluative scrutiny and seldom provide referral to NSPs or OST. The Ministry of Social Justice and Empowerment also supports 124 "de-addiction centres" within Government-run hospitals across India. However, many key informants challenged this number, suggesting the actual number of operational centres is significantly fewer.

The Ministry of Health and Family Welfare (MoH&FW), through the National AIDS Council Organisation, support over 100 OST centres in the country. 51 of these centres are in community settings run by NGOs.

Another problematic issue relevant to the need for evidence-based drug treatment is the Government's apathy toward regulating the growing number of private clinics around the country, for example, in ensuring that drug treatment standards are maintained.

• Proportionate drug sentencing laws

While the Lawyers Collective is pursuing advocacy around the issue of proportionate sentencing under the drug laws through strategic litigation, it is fair to say that the issue deserves more attention. Although the Narcotic Drugs and Psychotropic Substances Act recognises a difference between drug use and drug trafficking, largely based on threshold quantities, drug use is still considered a crime punishable by imprisonment. Despite some key informants suggesting that enforcement of criminal penalties for drug use was not often applied, and that people who used drugs were only prosecuted for other criminal offences (such as violence or theft) which would effectively depenalise drug use, people who use drugs who were interviewed stated that this was not the case in practice. The issue of proportionate drug laws was also raised by UNODC, an officer of which stated that decriminalisation of personal drug use was one of their major advocacy priority in India.

Recommendations for future advocacy activities

Establish a National Indian Drug Commission

It is recommended that a national drug policy commission be established to raise the profile of alternative approaches to drug policy and to propose mechanisms for addressing inconsistencies within the legal and policy framework. India has a strong tradition of civil society involvement and academic engagement on public policy issues. There are a number of established groups, such as the Indian Drug Users Forum, AIIMS, the Indian Psychiatric Society, the Federation of Indian NGOs for Drug Abuse Prevention (FINGODAP), the Lawyers Collective as well as the Institute for Narcotics Studies and Analysis, who are all well placed to provide inputs to such a commission.

Advocate for greater access to evidenced-based treatment

The second recommendation focuses on addressing the lack of evidence-based treatment services in India. In order to address this problem, the following steps are suggested. First, data should be collected that map the types and availability of drug treatment services across the country. Second, a document should be produced which proposes an integrated system of treatment services, thus linking the services currently funded by the Ministry of Family Welfare with OST programmes funded by the MoH. Third, existing minimum quality standards need to be reviewed and applied to all treatment providers, with regular monitoring and evaluation carried out to maintain drug treatment standards.

Proportionate sentencing of drug offences

Finally, targeted advocacy is required to address the disproportionate penalties associated with drug-related activities, especially calling for the removal of criminal penalties for the consumption of drugs. Two key approaches are recommended to tackle this issue. First it is recommended that funding be provided to continue strategic litigation and legal advocacy. Second, building on the strength of civil society networks in India, it is recommended that a campaign building on the strength of the *Support. Don't Punish.* global advocacy campaign be scaled up and maintained. Such a campaign would have the dual benefit of challenging the disproportionate penalties for drug use while at the same time raising attention to the need for more evidence-based treatment.

Background information

Key drug policies

• Laws

Narcotic Drugs and Psychotropic Substances Act, 1985 – The Narcotic Drugs and Psychotropic Substances Act, 1985, amended in 1988 and 2001, is the principal drug law in India. Under the Act, people who use drugs are subject to arrest and prosecution on charges of consumption and/or possession of small quantities of drugs. Such offences are punishable with imprisonment for six months to one year. The Act also maintains provisions for the death penalty – however, although four convictions having been made, no one has ever been executed.

Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 – The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act was established to enable the full implementation and enforcement of the Narcotic Drugs and Psychotropic Substances Act of 1985.

• Strategies / Policies

National Policy on Narcotic Drugs and Psychotropic Substances, 2012 – The policy was released in February 2012 and is the first national policy released by the government in support of the 1985 Narcotic Drugs and Psychotropic Substances Act. The policy aims to guide India's response to drug related issues, and provide coordination between various ministries, international organisations and civil society.

National AIDS Control Program III, 2007-2012 – India's NACP-III outlines a four-pronged strategy to "halt and reverse the epidemic in India over the next five years" by integrating programs for prevention, care and support and treatment. The programme recognises people who inject drugs as key partners in the response, and promotes OST and access to sterile needles and injecting equipment.

National drug demand reduction policy, 2013 – In March 2013, the Ministry of Social Justice and Empowerment released a draft demand reduction policy. At the time of printing, the policy had yet to be endorsed but according to key informants the policy is likely be released by the end of 2013. The draft policy encourages meaningful collaboration between various national and international agencies including the Government, NGOs and the private sector to prevent illicit drug use. The draft National Policy also envisages that states will develop their own Action Plans in accordance with the Policy.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	Ministry of Finance, Department of revenue Narcotics Control Board	UNODC
Regulation of medical industry	MoH&FW	WHO
Drug trafficking and customs **Law enforcement**	Ministry of Home Affairs	UNODC
Judicial system	Ministry of Law and Justice	UNODC, Indian Lawyers Collective
"Rehabilitation" and management	Ministry of Social Justice and Empowerment (MoJSE) 400+ rehabilitation centres MoH&FW – 122 'de-addiction' programmes	FINGODAP, FHI 360 AIIMS
OST	MoH&FW National AIDS Control Organisation (NACO)	WHO
NSP and HIV related service delivery	MoH&FW NACO	Alliance India, FHI 360, IHRN

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
AIIMS	Access to evidence-based drug treatment	Promotion of evidence-based guidelines for OST.	MoH&FW MoSJE
Lawyers Collective	Abolition of the death penalty Advancement of human rights	Strategic litigation. Human rights documentation. Policy dialogue and preparation of advocacy publications.	Judicial system
Indian Harm Reduction Network	Advancement of human rights, including evidenced-based services	Focal point for harm reduction advocacy in India. Build capacity and advocate on behalf of network members. Dialogues, documentation and dissemination of best practice guidance.	Ministry of Finance (MoF) MoH&FW, NACO MoSJE
Alliance India	Support to local advocates	Coordination of policy advocacy efforts. Grant making.	Civil society MoF MoH&FW, NACO MoSJE
Indian Drug Users Forum	Access to human rights including evidence-based services	Network facilitation and mobilisation of people who use drugs. Activism including protests and civil disobedience.	MoF MoH&FW, NACO MoSJE
Nossal Institute	State-level advocacy	Assisted the State AIDS Control Society in Nagaland and Manipur to develop state drug policies.	
Community Network Empowerment (Manipur)	State-level advocacy	Input into policy processes on harm reduction.	Drug policy working group in MSJE

Indonesia

Snapshot

- The drug policy advocacy response in Indonesia is strong, and includes a diverse range of actors including representation from people who use drugs.
- Despite the strong response, more resources are required to fund specific advocacy efforts.
- Key advocacy issues that still require attention include building leadership amongst policy makers, continuing to advocate against compulsory registration and forced treatment, as well as to increase access to harm reduction services in the community and prisons.

Policy context

Like many parts of colonised Asia, Indonesia's relationship to drugs dates back to the opium monopolies set up by ruling powers from the 16th to the 18th centuries (Chandra, 2002). During this time, Dutch-controlled opium was estimated to make up half of all government revenue that was generated from the Dutch East Indies Colonies (Rush, 2007).

The Dutch introduced Indonesia's first drug control policies known as the Opium Regie, which in 1894 banned the production of opium in the country. By 1904 the Government stated that all opium sold in Indonesia must be purchased abroad and processed in Batavia (now Jakarta) through a Dutch-controlled monopoly (Cribb, 1988). Refined opium was distributed to people dependent on drugs through a network of government shops of which there were over 800 at their peak in the 1930s. The Opium Regie also attempted to curtail opium consumption by placing restrictions on its use in areas designated to be drug free, and requiring people to register on a central list before being able to purchase opium from the government shops (Cribb, 1988). While this policy was unsuccessful – in fact some argue that opium use increased by 30 per cent during this time (Chandra, 2002) – parts of the policy, such as compulsory registration now underpin modern responses to drug use in the country.

While Indonesia gained independence from the Dutch in 1945, it was not until 1971 that the Government issued its first major drug policy initiative. The President instructed the National Intelligence Coordination Agency (Badan Koordinasi Intelligen Nasional – BAKIN) to eradicate counterfeit money and prevent illicit drug use, smuggling, juvenile delinquency and subversion, as well as to conduct surveillance of foreigners (Badan Narkotika Nasional, 2013).

Indonesia's first Anti-Narcotics Agency (Badan Koordinasi Narkotika Nasional – BKNN) was established in 1997 and headed by the chief of National Police, however the BKNN was not given its own budget to carry out activities, and was assumed under the broader police force budget. BKNN, was replaced with the Badan Narkotika Nasional (BNN) in 2002, and was provided with its own operational budget in 2003.

The Chief of the Indonesian police headed the BNN until the new narcotic law was released in 2009. Since then, the BNN has functioned as an entity tasked with coordinating 25 relevant government institutions in formulating and implementing national policy on drugs. However BNN recently received greater funds and has started to conduct activities, including operating rehabilitation programmes and law enforcement activities, which overlap with the mandate of the Indonesian National Police (INP) and the MoH – thereby causing some tension between the agencies.

Indonesia's current drug policy is based on an overly strict interpretation of the UN drug conventions and outlines harsh penalties for illicit use, possession and supply of controlled drugs. Even though the drug law was revised in 2009 in the light of HIV among people who use drugs, the new law retains the criminalization of drug use (Lai, Asmin, & Birgin, 2013).

The Narcotics Law, along with Government Regulation #25/2011, introduced requirements for the compulsory reporting of all people dependent on drugs over the age of 18. People dependent on drugs are required to report themselves to designated institutions for treatment and rehabilitation, including community health centres (CHCs) operated by the MoH. Article 13 of this regulation has been noted by some key informants as providing an opportunity to divert people into treatment and away from the criminal justice system. However, the way this article will be implemented remains unclear, and some suggest that it be used as another way to force people who use drugs into compulsory treatment centres.

Failure of a person who uses drugs to self-register can result in penalties ranging from a fine of Rp2 million (US$ 200) to six months' imprisonment. Under regulation #25, the failure of family members to report a relative who uses drugs may result in penalties ranging from a fine of Rp1 million (US$ 100) to three months' imprisonment (Lai et al., 2013).

Current advocacy activities

Legal aid, strategic litigation and human rights documentation

Rumah Cemara and Lembaga Bantuan Hukum Masyarakat (Community Legal Aid Institute) both focus on providing legal aid and documenting human rights violations committed against marginalised groups, including people who use drugs. These groups also support litigation in cases that are considered strategic in setting legal precedent or can be used to expose poor policy.

Access to harm reduction services including evidence-based treatment

A large number of organisations focus on advocating for increased access to harm reduction services and evidenced-based treatment. These include local organisations such as PKNI (National Drug User Network), Jangkar (the national network of organisations promoting harm reduction), the Indonesian Association of Addiction Counsellors (IAAC), the AIDS Resource Centre in Atma Jaya University (ARC) as well as AusAID's bilateral HIV Cooperation Program for Indonesia (HCPI). These organisations conduct a range of advocacy activities including dialogue, study tours, running demonstration sites and research into and documentation of good practices.

Discontinuation of compulsory registration

A number of key informants commented on the problems caused by the introduction of compulsory registration of people who use drugs in Indonesia, which has led to people avoiding services because of the fear of being registered and the subsequent negative consequences, e.g. difficulty in securing employment, and being forced into treatment. The significant advocacy efforts invested in removing compulsory registration requirement to date have not lead to significant changes in either policy or practice. Yayasan Karitas Sani Madani, Stigma Foundation, PKNI, the Indonesia Coalition for Drug Policy Reform (ICDPR), and Commitment Indonesia all reported that working on removing the requirement for compulsory registration was a major advocacy focus.

Advocacy gaps and challenges

Advocacy capacity

Drug policy advocacy capacity in Indonesia is strong with a diverse range of actors engaged in the issue. People who use drugs are well represented and seem to have established a seat at the policy making table; lawyers and civil liberty groups are also engaged, as are movements associated with HIV activism. There is also academic interest in drug policy, especially through the Atma Jaya University. While not currently active, entities such as ICDPR can offer a strong potential platform to continue strengthening drug policy advocacy in the country.

Policy environment

Civil society's active engagement in drug policy advocacy in Indonesia is an anomaly in the region. However, as is common across South East Asia, the biggest obstacle to their policy advocacy is the lack of political will to engage in open dialogue about alternative drug policies. Indonesia's drug policy, despite showing strong support for harm reduction in the National AIDS Strategy, is dominated by a tough law enforcement approach. According to some key informants, the absence of open dialogue leads to a poorly coordinated response among key stakeholders, often resulting in contradictory policies and power struggles within government ministries.

Policy issues that remain unaddressed

Although most advocacy issues are being addressed in Indonesia, at least to some degree, one major challenge is the lack of funding available for drug policy advocacy work. While Indonesia receives considerable funding for the implementation of HIV prevention, much of this money is reserved for service delivery and is not available for advocacy work.

Recommendations for future advocacy activities

Strengthen leadership in Indonesia for promoting alternative drug policies

It is recommended that groups such as ICDPR be strengthened and funded to provide leadership and promote alternative drug policies in Indonesia. Made up of a range of well-respected academics and advocates, ICDPR has the potential to play a similar role to that of the Global Commission on Drug Policy at the international level. The ICDPR, or a similar group, should be supported to advocate on specific issues such as better coordination between health, social affairs and law enforcement responses as well as the scale-up of harm reduction services both in the community and in prisons.

Continue to build on successful advocacy efforts that target prisons

Despite Indonesia leading the way in the region in terms of providing access to harm reduction measures in prisons, high morbidity and mortality amongst incarcerated people who use drugs remains a significant problem. In addition to reducing the number of people who use drugs being sentenced to prison through (ethical) diversion programmes, policy advocates in Indonesia should also continue their efforts in scaling up access to services in prisons around the country, reducing the time inmates spend in parole and increasing the availability of treatment services following arrest.

Led by the BNN, the Government of Indonesia is currently discussing a plan to release 27,000 inmates held for drug-related crimes back into the community. While these efforts should be supported, it remains important to ensure that upon release prisoners are provided with access to harm reduction services in the community.

Strengthen efforts that advocate for removing the requirement for compulsory registration

The requirement of compulsory registration remains a significant barrier to access to services. More resources need to be allocated to end the practice. Initially it is recommended that a detailed study be conducted that documents the harms caused by compulsory registration. Further it is recommended that while compulsory registration remains in place, protocols should be established to ensure that the BNN guarantees confidentiality and protection from misuse of the personal details of registered people.

Background information

Key drug policies

• Laws

Law on Narcotics 1997, revised in 2009 – The legal framework for drug control is contained in the Law on Narcotics, 1997 and the Law on Psychotropic Substances, 1997. The Narcotics Law was updated in 2009, known as #35/2009, and introduced a mechanism for diverting people who use drugs away from prison and towards treatment. The law retains the criminalisation of drug use. Moreover, the law maintains the death penalty for some drug offenses and makes it a crime for parents or guardians to fail to report children who use drugs in their care to authorities.

The Law, along with Government Regulation #25/2011 (articles 54, 55 and 128), introduced requirements for the compulsory registration of all people dependent on drugs over the age of 18. Article 19 of Government Regulation #25/2011 provides for the MoH, through CHCs, to send the

registration data to the BNN, the responsible agency for maintaining the information.

The Narcotics Law designated the MoH as the focal point for health issues (Article 1), the classification of drugs (Article 5-8), the availability of drugs for medical use (Article 9-52), and setting standards (and monitoring) of rehabilitation and medical treatment programmes (Articles 53-59 and 60-63).

Indonesia has not enacted specific legislation for HIV and AIDS. The framework for AIDS Control is set out in the National Strategic Plan for 2010-2014.

• Strategies / Policies

Indonesia's National AIDS Strategy and Action Plan, 2010-2014 – Indonesia's AIDS strategy outlines four key objectives which include 1) providing prevention to all key populations and their partners; 2) providing quality care, support and treatment; increasing access to economic and social support for people affected by HIV and AIDS; and 4) creating an enabling environment that promotes an effective response to HIV and AIDS at all levels, particularly one that empowers civil society. The strategy clearly endorses harm reduction and identifies the need for policy reform.

Drug-Free Indonesia by 2015 – In June 2011, BNN launched a new national policy and strategy for a drug-free Indonesia by 2015.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	National AIDS Commission (KPA) BNN	UNODC UNAIDS
Regulation of medical industry	MoH	WHO
Drug trafficking and customs	BNN and INP	UNODC
Law enforcement	BNN and INP	
Judicial system	The Ministry of Justice and Human Rights (prisons) The Attorney General's Department	UNDP (limited)
"Rehabilitation" and management	Ministry of Social Affairs (MoSA) BNN MoH	Colombo plan UNODC Several civil society organisations
OST	MoH (MMT) CHCs	WHO Private doctors (on the use of Buphrenorphine)
NSP and HIV-related service delivery	MoH	GFATM, AusAID, USAID Several civil society organisations

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
Jangkar	Information sharing Promotion of harm reduction	A forum that shares and disseminates information about harm reduction. JANGKAR is a representative body advocating for people who use drugs and their community (currently limited advocacy activity).	Multiple: BNN, MoH, MoSA, KPA, civil society
Peer Counsellor Association for People who Use Drugs	Assessment ofprocedures for people who use drugs who are accused in court	Process of registering legitimate counsellors in court. Certification process for legitimate peer counsellor. (active at national and provincial levels).	Criminal Justice system MoSA, Ministry of Education
Rumah Singgah PEKA	Community-based treatment	Community organising on voluntary treatment. Advocate on standardisation of voluntary, community-based treatment. Provide peer counsellor training Technical assistance to other community-based treatment services. (active at national level and in Bogor city and district).	MoSA, Ministry of Social Welfare, BNN, MoH
Stigma Foundation	Compulsory registration Decriminalisation	Dialogues, community mobilisation. (active at provincial level only).	Multiple: BNN, MoH, MoSA, KAP, civil society
IAAC	Professional recognition for drug workers Minimum standards of service	IAAC is a professional body that advocates for minimum standards of service. (currently limited advocacy activity).	MoH
Yayasan Karitas Sani Madani	Compulsory registration of people who use drugs Good policing practice	Reviewing and commenting on legislation and guides to shape good practice. Networking with other civil society organisations. (active at the provincial level).	Police, BNN, Criminal Justice System
HCPI	Implementation of best practice service delivery (Harm reduction and NSP guidelines) Drug diversion	Dialogues with stakeholders, study tours, funding to attend conferences, organizing and funding meetings, presenting evidence and sustained advocacy, joint reviews of policy situation impacting on services. (active at national level as well as engaged in activities in eight provinces).	BNN, MoH, Criminal Justice System
ARC	Criminalisation of people who use drugs Developing community based drug rehabilitation	Evidence for advocacy. Researching best practices Consultation with people who inject drugs. Provide expert advice (in local and international contexts). Dialogues with policy makers (currently limited advocacy activity).	BNN and NAC Community leaders NGOs
AYOMI	Advocate for access to treatment in Aceh	Community awareness-raising through media. Dialogue with stakeholders (Active at provincial level).	Police Judiciary Government Office
UNODC	Policy is in line with UN Drug Conventions and scientific evidence Diversion of people who use drugs	Seminars, study visits for officials to Australia and Portugal (funded by HCPI), Technical assistance in reviewing and developing related regulation (primarily active at national level).	National Parliament, Attorney General Office, Supreme court
Mitra Alam Foundation	Access to evidence-based treatment Drug diversion	Running a pilot demonstration site and using data to inform advocacy efforts (Active at provincial level).	CHC and Health Office of District/ City/province Provincial harm reduction working group Drug user organisations

Existing policy advocacy activities (continued)

Organisation	Policy issue	Advocacy activity	Target organisation
Lembaga Bantuan Hukum Masyarakat (LBH Masyarakat) (Community Legal Aid Institute)	Abolition of the death penalty and compulsory treatment The fulfilment of the right to a fair trial for all drug offenders, including the provision of legal aid	Strategic litigation, community mobilisation, policy dialogues (primarily national level activity).	Criminal justice system: judges, prosecutors and police and health authorities BNN INP MoH
Rumah Cemara	Human right violations against people who use drugs	Set up a database of human rights violations against people who use drugs. To develop skills of staff to research, record and disseminate reports of human rights abuses suffered by people who use drugs, particularly in relation to their treatment by police officers, and in closed settings such as prisons. (Active in provincial and national level).	National AIDS Commission, Ministry of Social Affairs, MoH, BNN, INP, Ministry of Justice and Human Rights
PKNI	Human rights for people who use drugs Compulsory registration and access to evidence-based treatment Decriminalisation Drug law reform	Develop evidence-base to inform policy makers of the need to improve access to evidence informed drug treatment, particularly with regard to the new 2009 laws and regulations. Advocacy activity through paralegal activity, and monitoring quality of harm reduction services, and implementation of compulsory registration requirements. (primarily active at national level).	MoH, BNN, INP, Ministry of Justice and Human Rights the Attorney General, Ministry of Social Affairs, National Aids Commission, Parliamentarians
ICDPR	Diversion and compulsory reporting Human rights of people who use drugs Access to evidence-based treatment	To host a national workshop and develop a 12-month advocacy strategy.	Parliamentarians Civil society
East Java Action/ORBIT	Rights and justice of people who use drugs	Litigation Community mobilisation. Policy dialogues. Human right documentation Developing appropriate rehabilitation services in Surabaya. (active at provincial level).	Communities Multiple government agencies
AKSI NTB	Human rights for People who use drugs to access adequate health services in society, detention and prison	Series of advocacy meetings and dialogues. (active at provincial level).	Multiple: BNN, KPA, INP, Prisons, prosecutors, Ministry of Law and Human Rights, civil society organisations
JARKON'S (organisation of people who use drugs)	Comprehensive drug rehabilitation policies for people who use drugs Full involvement of people who use drugs in North Sumatra.	Mobilise people who use drugs. Seek full involvement of people who use drugs in policy making processes. (active at provincial level).	Provincial level: Health Office, AIDS Commission, social services, police, judiciary and prosecution

LAO PDR

Snapshot

- Lao PDR's drug policy and legal framework has been significantly influenced by international pressure and remains focused on supply reduction. Drug laws contain harsh punishments for drug use and possession. The laws also mandate compulsory detoxification as well as punishment for relapsing.
- The Lao PDR Government has been slow to recognise the role of injecting drug use in spreading HIV and is lagging significantly behind its neighbours in implementing harm reduction programmes.
- Drug policy advocacy efforts remain nascent and although there is a focus on providing services to people who use drugs, little work is being done on promoting broader legal or policy reform.
- Recommendations include collecting more data to better understand policy making as well as harms associated with drug policy in the country, increasing awareness about alternative drug policy options, and supporting drug policy advocacy champions within government and civil society.

Policy context

Lao PDR was long regarded as one side of the Golden Triangle, an area responsible for producing over half of the world's opium as recently as the 1990s. Traditional and cultural use, lack of access to alternative pain medication, the economic benefits associated with the production of opium as well as international pressure all shape Lao PDR's contemporary approach to drug policy (P. T. Cohen, 2009).

In the mid-1990s largely as a response to pressure from the USA and the UN, the Laotian Government began a large-scale opium eradication campaign. The campaign outlined in the Comprehensive Drug Control Programme (known as the Master Plan) was formulated by the United Nations International Drug Control Programme (UNDCP, now known as UNODC). It was an aggressive approach to eradicating opium production and was responsible for a considerable reduction in cultivation by the early 2000s (P. T. Cohen, 2009). The Master Plan also coincided with the government revising Article 135 of the Criminal Code on Drug Trafficking and Possession to formally prohibit the production and possession of opium (among other drugs). These events set Lao PDR on its current path to a 'war on drugs' approach to drug policy and resulted in the Government declaring the country opium-free by early 2006 (UNODC, 2012).

Public policy making in Lao PDR remains opaque, and little academic or programmatic attention has focused on understanding drug policy making in the country (Thomson et al., 2005). It is also important to note that despite several years of consistent advocacy by several international development partners, knowledge about HIV and alternatives to the current approach to drug policy remains low among government officials. Few people, including actors working on drug issues in the country, have a clear understanding about the various stakeholders engaged in policy making; and those that do tend to only approach drug policy from a limited perspective. For example, people involved in HIV prevention tend to see drug policy as a health specific issue and do not have a clear understanding of the role of other agencies working on drug issues, e.g. in the field of law enforcement or alternative development. Similarly, those working on areas of drug policy, such as law enforcement and alternative development, do not necessarily see drug-related health concerns as relevant to their work.

In addition, a number of international agencies have programmes that focus on working with law enforcement in areas that relate to drug policy in Lao PDR. Significant funding and capacity-building efforts still focus on supporting the police to perform crop eradication, interdiction and control of precursor chemicals (UNODC Lao PDR, 2013). It remains difficult, however, to capture the scope and breadth of partners engaged in these activities, but they include at least: UNODC, the US State Department, and the Australian Federal Police.

Despite these barriers, a recent move by the Lao Commission for Drug Control and Supervision (LCDC) to allow a pilot NSP in Laos should be celebrated and seen as an opportunity by advocates that change is perhaps more possible than previously thought.

Current advocacy activities

Promoting harm reduction policies

A number of agencies are working on promoting harm reduction in Lao PDR. UN agencies (UNODC, UNAIDS and WHO) have focused on promoting harm reduction through the publication of good practice guidelines and encouraging dialogue with the Government. PSI, the Burnet Institute and the Nossal Institute have focused on conducting research into the health and social impacts associated with drug use and have used this data to advocate for more services for people who use drugs. AusAID's HAARP is also a major player in promoting harm reduction and has conducted a number of activities aimed at advocating for service delivery and policy change. These activities include supporting rapid assessments in six sites considered hotspots for drug use (Vientiane Capital and five provinces), helping local governments develop SoPs, as well as funding pilot projects.

All partners working on harm reduction advocacy are also engaged in helping the Government develop its first National Harm Reduction Advocacy Strategy.

Closure of compulsory detention centres

Compulsory detention of people who use drugs remains a significant issue within Lao PDR. Despite this, advocacy efforts on this issue remain uncoordinated. Human Rights Watch published a report entitled "Somsanga's Secrets: Arbitrary Detention, Physical Abuse, and Suicide inside a Lao Drug Detention Center" that documented abuse, arbitrary detention and other significant violations against people detained in the centre as a response to drug use (Human

Rights Watch, 2011b). While some actors have called for the closure of the centre, other organisations such as UNODC and Bureau of International Narcotics and Law Enforcement Affairs (INL) have advocated for improving the quality of services delivered within the centre.

Improving police practices that negatively impact people who use drugs

HAARP and the Nossal Institute both support activities that target the police and attempt to develop strategies to improve law enforcement approaches to working with marginalised groups. While these projects focus on operational policing, they also involve considerable advocacy components.

Advocacy gaps and challenges

Advocacy capacity

Advocacy capacity remains low in Lao PDR. Civil society engagement in any area of policy making remains limited and almost non-existent with regard to drug policy advocacy.

Policy environment

A major challenge to drug policy advocacy in Lao PDR is a lack of understanding about alternatives to existing drug policy approaches. This is highlighted by the inability within Lao PDR to even agree on how to translate "harm reduction" into local language.

Perhaps responsibility for the conceptual difficulty in understanding harm reduction lies in the Lao Government's commitment to the ASEAN drug strategy, which aims to achieve a drug-free region by 2015 through eliminating illicit drug use, trafficking and supply. An example of such commitment can be found in the Government's promotion of drug-free villages.

Public opinion also challenges the idea of harm reduction. The common view of people who use drugs in Lao PDR is that they are engaging in anti-social activities and lack the will to control their behaviour. Even greater disapproval is given to those who relapse in drug use after treatment. It therefore follows that the community does not see people who use drugs as deserving assistance and services which would otherwise be available to the general community.

Policy issues that remain unaddressed

A number of key advocacy issues remain unaddressed in Lao PDR. These largely relate to the aforementioned lack of capacity as well as a poor understanding of harm reduction and alternatives to current drug policy approaches. Following from this, the first major policy issue that is not being addressed is the lack of coordination in drug policy development and implementation in Lao PDR: agencies working on drug issues remain extremely siloed and dominated by the goal of eradication and becoming a drug-free nation. This ideological approach is strongly entrenched in both public perception and among policy makers. The Law on Drugs and the Penal Law outline harsh penalties for illicit drug possession and use, including relapse after treatment – additional issues that are not receiving much advocacy attention.

Recommendations for future advocacy activities

Advocacy for accurate data on HIV prevalence among people who inject drugs

A major barrier to policy reforms aimed at improving the enabling environment for service delivery is the lack of information available about drug use and HIV prevalence in Lao PDR. While some studies have recently been completed, this research needs to be translated and disseminated. Further, there is still a need to conduct more research, especially to identify gaps in knowledge and barriers to policy implementation and to advocate the inclusion of people who inject drugs as a sentinel group for national HIV surveillance, such as integrated bio-behavioural surveys. The six rapid assessments planned by HAARP for 2013-2014 are meant to support the establishment of people who inject drugs as a surveillance population for HIV in Laos.

Civil society advocacy for changes in law and policy on harm reduction and drugs

Lao PDR is currently in the process of debating the need for a harm reduction strategy. Many stakeholders believe that a national harm reduction strategy could address many of the policy inconsistencies that exist between the current legal frameworks, such as provisions in the drug law stipulating harsh penalties for drug use, possession and relapse, and compulsory detention as "treatment". Policy advocates can further encourage and support the revision of the drug law, HIV policy and the Law on HIV/AIDS Control and Prevention to incorporate appropriate references to harm reduction and reflect more contemporary data collected on drug use and HIV in Lao PDR.

To ensure the engagement of civil society in drug policy advocacy, significant investment is required to build their knowledge and capacity. International agencies already active in Lao PDR are best placed to make such an investment, and to help with cultivating opportunities for civil society engagement in drug policy making forums and processes.

Develop a communication strategy to change attitudes about harm reduction

Stigma towards people who use drugs and a misunderstanding of harm reduction remains a major barrier to advocating for drug policy reform. Drug use is commonly viewed as a moral failing and people who inject drugs are not often seen as having a human right to healthcare. At the most basic level, a communication strategy should aim to reframe harm reduction as benefiting the whole community rather than being seen as "providing service to the undeserving". It could also aim to improve understanding of drug dependence and evidence-based responses in relation to different types of drugs, amongst stakeholder agencies, parliamentarians, services providers and the community.

Develop harm reduction champions within the Government

Despite considerable effort, there remains an absence of drug policy advocates within the Government of Lao PDR. It is recommended that champions and opinion leaders are

identified and developed within the LCDC, the Ministry of Public Security (MoPS) and the MoH/Centre for HIV/AIDS and STI Control (CHAS). These leaders need to be provided with well-developed and pre-tested communication materials based on evidence from the region, including case studies showing that NSPs and other harm reduction programmes do not increase the rate of injecting drug use, and modelling on the potential effects and costs of an epidemic based on unsafe injecting in Lao PDR. Existing actors in Lao PDR, such as UNODC and HAARP, appear well placed to support these activities.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	LCDC	UNODC, HAARP, foreign embassies and consulates through the "Mini Dublin" Group
Regulation of medical industry	MoH	WHO
Drug trafficking and customs	MoHA	UNODC, INL and AusAID
Law enforcement	Ministry of Public Security, counter narcotics units operate as elements of provincial police in all provinces. Other important drug control institutions are the provincial and Vientiane committees for drug control and supervision chaired by provincial vice-governors.	Nossal Institute
Judicial system	Ministry of Justice	UNODC
"Rehabilitation" and management	LCDC (Curative Department and Pharmaceutical Regulation Section), Ministry for Labour & Social Welfare, Ministry for Public Security, Vientiane Province Committee for Drug Control (Technical and management oversight of the Somsanga Drug Treatment and Rehabilitation Centre (located in Vientiane Capital) and the MoH (Curative Department), however the Centre prefers to operate independently; for instance two community-based drug counselling services were opened separately in 2013 but are independently (not collaboratively) run by Somsanga and LCDC)	Human Rights Watch The following international organisations support the Somsanga Centre: INL – US State Department Mini Dublin Group USAID / US Embassy German Development Agency Singaporean Embassy Singapore International Foundation
OST	OST is currently unavailable in Lao PDR[1]	
NSP and HIV-related service delivery	LCDC, MoH, CHAS and Health Care Division for hospital services	HAARP UNODC

[1] LCDC has refused a study offered by AusAID HAARP on the efficacy of tincture of opium capsules as a substitution maintenance medication for heroin injection; tincture of opium capsules are currently used for detoxification and short-term treatment of people dependent on opium (and failure rates are high)

Background information

Key drug policies

• Laws

Law on HIV Control and Prevention, 2010 – The HIV/AIDS Law was enacted in 2010 after an extensive consultation process, engaging government and civil society in 2009-2010, led by CHAS. The Law does not specifically identify needs of people who use drugs nor does it create opportunities for the implementation of harm reduction interventions.

Law on Drugs, 2007 and Article 14 of Penal Law, 2008 – Two key laws shape Lao PDR's legal framework on drugs. These are the Law on Drugs, 2007 and Article 146 of Penal Law, 2008. While the Law on Drugs states that "drug addicts are to be considered as victims who need to be treated" (Article 5.5) harsh penalties and judgmental language pervade both laws. For example, Article 146 of the Penal Code outlines the punishment for heroin possession as ranging from a minimum of ten years in prison and fines for less than 100 grams, life imprisonment for 300 to 500 grams, to the death penalty for more than 500 grams. Similarly, Article 76 of the drug law states that people who use drugs who have undergone treatment and later relapse are liable for three months to a year in prison and a fine.

• Strategies / Policies

National Drug Control Master Plan, 2009-2013 – The Master Plan was developed with support from UNODC and the German Government. While the plan acknowledges people who inject drugs as a critical target population, it fails to mention harm reduction in any of its suggested intervention strategies.

Lao PDR Policy for HIV/AIDS/STI, 2009 – The Lao PDR Policy for HIV/AIDS/STI (2009) identifies people who inject drugs as a key risk group. However, the policy pays greater attention to the prevention of sexual transmission among ATS users than transmission through unsterile injecting practices. The policy recommends to "consider a pilot project on HIV and IDU to allow drug substitution and a needle exchange program".

National Strategy and Action Plan on HIV/AIDS/STI Control and Prevention (NSAP), 2011-2015 – The National Strategy and Action Plan on HIV/AIDS/STI highlights the importance of developing HIV prevention strategies for people who inject drugs. The strategy states that "…with the current HIV response rate, it is likely that the number of infections within this population will increase dramatically". The NSAP endorses harm reduction and includes the goal of reaching 60 per cent of people who inject drugs with harm reduction interventions by 2015. It fails, however, to define what interventions are to be included under the umbrella of "harm reduction".

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
UNODC, UNAIDS and WHO	Expand services to people who use drugs	Dialogue with government. Promoting harm reduction through publications. Assisting in developing local policies.	LCDC MoH CHAS
HAARP	Expand coverage of harm reduction services to people who inject drugs	Dialogue with government. Promoting harm reduction through a pilot NSP and linkage to comprehensive HIV prevention (e.g. voluntary testing and counselling, overdose interventions /STI/ tuberculosis screening) and AIDS treatment and care services, (the latter is being piloted in Houaphanh, which makes it the 9th ART site and the only one not funded by the GFATM), which is being developed and implemented with the Asian Development Bank Regional Capacity Building and Technical Assistance Project for HIV/AIDS. Advocating for developing a national harm reduction strategy Assist MOH through CHAS to establish a national prevalence rate for drug use and HIV infection among people who use and inject drugs through six new rapid assessments in Vientiane Capital and five provinces.	LCDC MoH CHAS Provincial Peoples committees
PSI	Expand services to people who use drugs	Conducted a rapid assessment to gather data to help in advocating the need to expand services.	LCDC MoH CHAS
Burnet Institute	Knowledge generation	Conducted a number of research projects looking into drug use and health (e.g. methamphetamine users and STI in 2007).	LCDC MoH CHAS

Malaysia

Snapshot

- Governments in the region have long recognised Malaysia as a leader in drug policy. While in the 1980s they paved the way for compulsory detention, Malaysia has more recently been lauded as championing a new model of voluntary treatment and care.
- However, it is important that the positive steps taken by Malaysia to set up the voluntary centres are not taken out of context. Malaysia needs to be encouraged to continue closing down its remaining compulsory detention centres and modernising its outdated legal framework on drugs.
- Civil society engagement in drug policy advocacy is strong, but funding and staff are limited.

Policy context

The history of drug use in Malaysia can be divided into the colonial and the post-independence era. During the colonial period, opium was the primary drug of choice and its use remained largely confined to immigrants from China working for the British. After independence, and increasing exposure to counter cultural movements in the 1970s, drug use spread into the emerging Malay middle class (Rusdi, Noor Zurani, Muhammand, & H, 2008). Despite this, Malaysia's primary drug law dates back to 1952, prior to independence (D Wolfe & Malinowska-Sempruch, 2004).

By the early 1980s, the prevalence of heroin use had increased to the point that the Malaysian government formed an anti-drug task force with responsibility for disrupting drug trafficking and rehabilitating heroin users (Noor Zurani, Hussain, Rusdi, & Muhammand, 2008). During this time legislation introduced under the Drug Dependence (Treatment and Rehabilitation) Act 1983 required anyone testing positive for heroin use to be sentenced to compulsory rehabilitation for two years (UNAIDS & UNDCP, 2000).

Continuing into the early 2000s, the Government saw itself as the only social force powerful enough to respond to the problems associated with drug use. It continued to pursue harsh policies and viewed drug use as a social menace that threatened the fabric of society and had to be eradicated by harsh punitive actions (Narayanan, Vicknasingam, & Robson, 2011). Supporting their goal was ASEAN's "drug free by 2015" mandate, for which Malaysia was both a signatory and a champion (Gary Reid, Kamarulzaman, & Sran, 2007). In line with these ideas, Malaysia was one of the first countries in Asia to scale up compulsory rehabilitation and by the mid-2000s had 28 government drug rehabilitation centres each with the capacity to detain up to 500 inmates. In 2008, approximately RM50 million (US$16 Million) a year was spent to run these centres (National Anti-Drug Agency, 2013).

The deeply entrenched beliefs in drug prohibition and punitive policies were shared both by religious leaders and policy makers, and only began to be challenged with the occurrence of HIV among people who injected drugs at the turn of the century (Narayanan et al., 2011). Although alternatives to Malaysia's enduring drug policy were suggested in 2000, it was not until 2003 that a pilot MMT programme was launched and 2004 when needle and syringes were distributed for the first time (Gary Reid et al., 2007).

By mid-2005 however, and after realising that Malaysia was not going to achieve goal 6 of the Millennium Development Goals (on combating HIV/AIDS and other diseases) due to the high rate of HIV among people who injected drugs, the MoH led an advocacy charge arguing that a health crisis was imminent (Tanguay, 2011). Narayanan et al. (2011) argues that NGOs also played a pivotal role in advocating for harm reduction services by educating their partners in Government, by drawing academics and medical practitioners into advocacy and by engaging the religious lobby. The authors also state that NGOs' role as project implementers helped to demonstrate the success of such programmes, as well as to deflect criticism against the state from unconvinced Islamic groups.

The most recent chapter in Malaysia's drug policy evolution relates to the establishment of "cure and care centres", which offer voluntary treatment and harm reduction services. While many have lauded Malaysia's efforts to transition away from compulsory treatment to a system of voluntary services (UNODC, 2011), others remain critical that the majority of compulsory treatment centres remain functional in the country and drug laws remain disproportionately harsh (Amon et al., 2013).

Current advocacy activities

Decriminalisation and ending compulsory detention for drug use

Decriminalisation of personal drug use and putting an end to compulsory detention emerged as the most important advocacy issue in Malaysia. Some organisations working on this issue approached it from a rights-based view, and the majority said that criminalising drug use contradicted the sentiment of the cure and care centres. However, as discussed above, there is contention about how far Malaysia is willing to formalise decriminalisation practices, and despite the initial steps toward ending compulsory detention, significant advocacy efforts are required to see legal statutes changed. One key informant even went as far as to suggest that the cure and care centres were a stunt for the international community. This was also echoed by a number of interviewees commenting on the regional attention that Malaysia had received for decommissioning some of their compulsory detention centres. While most supported Malaysia's move to opening their centres as heading in the right direction, others still contend that the cure and care centres are firmly embedded in the belief that everyone can and should be "cured" from drug use.

Forging more productive working relationships between health workers and police

The second key issue that advocates are working on in Malaysia is the need to develop better working relationships

with the police. According to several key informants, harm reduction outreach workers continue to be arrested despite harm reduction being a Government policy. Another important issue raised was that in some districts, the police have quotas of people who use drugs that they need to arrest or divert to treatment.

Repealing the death penalty and corporal punishment

Several advocates raised the need to repeal the death penalty and use of corporal punishment for drug offences. One interviewee also added that the repeal of such practices would go a long way in showing others that Malaysia is serious about moving towards a more humane response to the harms associated with drug use. While this is an important issue for some, it was not raised as a key issue amongst the majority of people interviewed.

Advocacy gaps and challenges

Advocacy capacity

Narayanan et al. (2011) recently documented the significant contribution that civil society played in challenging Malaysia's drug policy over the past decade. While this report only documented three key civil society actors currently engaged in drug policy advocacy in Malaysia (discussed further in the table below), it is clear from a number of media reports that there is ongoing discussion about alternative drug policies in Malaysia which is being led by a group of well-organised actors with strong capacity and political capital.

However, one key stakeholder stated that even though gains have been made, stigma directed at people who use drugs continues to make it difficult to attract staff to work on the issue of drug policy. The lack of staff, along with limited funding add to the complexities and challenges associated with working on drug policy advocacy in Malaysia.

Policy environment

Common to the region, people who use drugs in Malaysia are perceived as "morally weak and undeserving". This view, combined with outdated colonial laws and the growing influence of Islamic ideology that frowns on intoxication, makes it difficult to advocate for this population. Despite this, as discussed in the introduction, since the mid-2000s there has been strong engagement from civil society on drug policy issues and a greater openness to pursuing alternative polices from within some sections of the Government.

Nancy Shukri, a Minister in the Prime Minister's Department has emerged as a champion for drug policy reform. At the 7th International AIDS Society Conference held in Malaysia in June 2013, she said that the Government's policy continues to shift toward viewing drug use as a medical issue rather than a criminal justice one, also noting that ASEAN's goal for a drug-free Asia was unrealistic.

In addition to this, the Government has set up a Law Reform Committee that is currently reviewing laws relating to drug use including the Treatment and Rehabilitation Act. While few key informants understood the mandate of the Committee, it has been reported that it is now in the process of proposing amendments to Section 4(1)(b) of the Act which allows the detention of a suspected drug dependent person for up to 14 days (New Straits Times, 2013).

Policy issues that remain unaddressed

This project did not identify any significant drug policy issues that were unaddressed. However like elsewhere in the region, policy change is slow and there is a real need to ensure that the positive steps adopted by Malaysia in the last few years are not only maintained, but continued.

Funding provided to the Malaysian AIDS Council (MAC) by the European Commission funded Asia Action on Harm Reduction and Dutch Government funded-Community Action on Harm Reduction projects (both administered by the International HIV/AIDS Alliance) has supported specific drug policy advocacy projects that were not funded in the past.

Recommendations for future advocacy activities

Further advocacy on removing requirements for the compulsory detention of people who use drugs, and associated reforms to drug laws and the treatment system

It is recommended that advocacy efforts continue to focus on scaling down the compulsory detention of people who use drugs in Malaysia. The end goal of these advocacy efforts should be the total cessation of any form of compulsory detention. This would mean the closure of all compulsory detention centres, changes to the Dangerous Drugs Act and the Drug Dependence Act, as well as offering voluntary evidence-based treatment options for people in the community and prison settings.

Such advocacy efforts could include initiatives to improve awareness about the nature of drug dependence, and it being a treatable medical condition, thereby helping to reduce stigma against people dependent on drugs.

Advocating for drug law reform to remove sentencing to compulsory detention, mandatory urine testing and the death penalty

Work should also focus on helping Malaysia in their review of the drug policy framework. More attention should be paid to the Law Reform Committee. Recommendation should be developed that focus on providing clear diversion and sentencing guidelines under a new legal framework, and the cessation of compulsory sentencing, mandated testing and follow up. The new law should also repeal the death penalty.

Engaging a greater range of civil society actors in drug policy advocacy

While advocacy capacity in Malaysia is strong, it remains within a few organisations which are mainly concentrated in the HIV sector. It is therefore recommended that future efforts focus on engaging a more diverse range of actors in drug policy advocacy. Efforts should also focus on supporting policy reform advocates both in leadership roles nationally as well as regionally, especially those willing to speak out about regional polices such as ASEAN's drug-free strategy.

Background information

Key drug policies

• Laws

Dangerous Drugs Act, 1952 and the Poisons Act, 1952 – Drug control measures are contained in the Dangerous Drugs Act, 1952 and the Poisons Act, 1952. The Acts define the consumption of prohibited drugs as unlawful, and permits forced testing to detect illicit consumption. Repeated conviction for consumption results in an enhanced penalty. Possession in excess of statutorily specified amounts creates a presumption of trafficking, which carries stringent penalties, including death.

Drug Dependence (Treatment and Rehabilitation) Act, 1983 – Compulsory drug rehabilitation is mandated under the Drug Dependence (Treatment and Rehabilitation) Act, 1983. Under the Act, any person suspected of being dependent on drugs can be intercepted, compulsorily examined and detained in a treatment and rehabilitation centre for two years. Following release, the Act allows for the person to be placed under supervision for an additional two years. People convicted of consumption receive "treatment" in detention in addition to a prison sentence, with the exception of juveniles who may be exempted from a jail term. It is mandatory for all physicians to report patients treated for drug dependence.

• Strategies / Policies

National strategic plan on HIV/AIDS, 2011–2015 – Despite the barriers outlined in the aforementioned Acts, Malaysia's national HIV plan clearly endorses harm reduction. Important policies include the national policy on OST and the MoH national MMT guidelines, which allow registered medical officers to dispense methadone and buprenorphine, and the NSPs' standard operating policy and guidelines that endorse syringe distribution.

The 'Drug Lab', 2010 – The 'Drug Lab' was set up as a Government policy "think-tank" in 2010 to review the existing drug policy in the country. The group consisted of representatives from key ministries and was facilitated by a private sector consultancy.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	The National Anti-drug Agency (NADA) under MoHA	Scope Group MAC
Regulation of medical industry	MoH Ministry of International Trade and Industry	Malaysian Medical Association Malaysian Pharmaceutical Association (MPhA) Malaysian Pharmaceutical Manufacturers' Association
Drug trafficking and customs	Finance Ministry, Royal department of customs Narcotics Criminal Investigation Division of the royal Malaysian Police	Unspecified international police forces including the Australian Federal Police and the US DEA
Law enforcement	Royal Malaysian Police NADA Customs and Exercise Department	MAC
Judicial system	Minister in the Prime Minister Department in charge of the Law Attorney General Office Judiciary	MAC
"Rehabilitation" and management	NADA Prisons Department	MAC, PENADAN and PENGASIH
OST	MoH NADA Prisons department	MAC
NSP and HIV-related service delivery	MoH	MAC, Malaysian WARDU (Network of People Who Use Drugs)

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
University of Malaya, Centre for Excellence of Research in AIDS	Promote evidenced-based drug policy	Direct advocacy leaders. Assisting implementation and evaluation. Study tours. Regular feedback pertaining to programmes. Implementation Science and other studies for evidence and support. Workshops, seminars and conferences. International collaboration and support for advocacy activities.	NADA Royal Malaysian Police Attorney General Office MoH Minister in the Prime Minister Department's in charge of the Law Prisons Department Politicians Community leaders and community Affected Individuals MAC and NGOs
MAC	Decriminalisation Promotion of health and rights-informed policy Effective policing strategies	Public awareness. Generation of best practice documents. Dialogue – both public and behind the scenes. Coordination of community activities and NGOs.	National Anti-Drugs Agency Royal Malaysian Police Attorney General Office MoH Minister in the Prime Minister Department's in-charge of Law Prisons Department Politicians Community Affected Individuals
Scope Group	Access to evidence based treatment and transforming closed setting approach to treatment	Was contracted by the Government to assist in transforming compulsory detention centres. Staff were embedded in the NADA for two years. Strategic advocacy strategy was developed and implemented over a long period.	NADA Prime Minister's Office Attorney General Office
WARDU	Drug use as a health issue Scale up of harm reduction services Ending compulsory treatment	Relatively new organisation with limited funding for advocacy. Mainly focused on awareness raising and growing the strength of their network.	Civil society and key Government stakeholders

Myanmar

Snapshot

- Myanmar has a long history of illicit drug production and, despite significant suppression efforts, remains a major drug producing country.
- Advocacy efforts need to focus on ensuring the scale up of evidence-based drug dependence treatment and access to sterile injecting equipment to prevent the continued spread of HIV among people who inject drugs and into the broader community.
- Advocacy efforts also need to ensure that opium eradication campaigns do not violate the Universal Declaration of Human Rights and are implemented alongside alternative development programmes for opium-growing communities.

Policy context

Opium cultivation is embedded in the cultural history of North Eastern Myanmar and, along with its sale and use, opium has played a central role in the country for the last half century (Transnational Institute, 2003). Accounts of the opium trade date back to the late 16th century around the time opium entered other markets in South East Asia. By the 17th century influences from both the Chinese and the Dutch East Indies Company saw the production of opium in Myanmar increase, in line with growing demand and its profitability as a trading commodity (Reid & Costigan, 2002).

After annexing the southern region of Myanmar in 1852, the British started importing large quantities of opium and established a Government-controlled monopoly. In an attempt to control increasing opium use among the Burmese, the British introduced the Opium Act in 1878 that precluded the sale of opium to anyone other than registered people dependent on drugs. In 1906, the trading of opium was made illegal in Myanmar and in 1921 the sale of opium from Government shops was totally banned. Neither of these laws, however, greatly affected the use or production of opium (Spencer & Navaratnam, 1981).

Since independence from the British in 1948, international politics and internal conflict have played a huge role in shaping the drug trade and subsequent policies towards drugs in Myanmar. Shortly after independence, civil war broke out in much of Myanmar, largely due to disagreements between the central government and ethnic minorities calling for self-determination and autonomy. Political instability during the 1960s lead to increased lawlessness in the North East of Myanmar as groups that opposed the central Government continued their involvement in the opium trade and increasingly used heroin production to fund their guerrilla war (Transnational Institute, 2003). The ceasefires that were negotiated with the opposition armies in the 1980s also had little effect on reducing the opposition armies' involvement in illegal activities such as drug trafficking, illegal logging, gambling and human trafficking (Chalk, 2000).

International efforts have sought to reduce opium and heroin supply in Myanmar with alternative development programmes since the mid-1980s. However, while these programmes have contributed to an 80 per cent reduction in opium production (until 2006 when production began to increase again), they have failed to address the increasing production of ATS (Tian et al., 2011).

In more recent years, the advent of HIV amongst people who inject drugs has forced both the international community and the Government of Myanmar to reconsider the health aspects of its drug policy. Despite this, legal reform in Myanmar is convoluted and a painstakingly slow process. While there is some indication towards a willingness to consider alternatives to existing drug policies, the main laws that shape drug policy in the country have not been updated for over a decade. In fact, the Myanmar Excise Act, which prohibits the possession of hypodermic needles, is nearly 100 years old.

Current advocacy activities

Supply control and alternative development

A number of disparate agencies focus on advocating on issues associated with controlling drug supply as well as alternative development. One the one hand, TNI advances the case for policies that take into consideration the livelihoods of cannabis and opium farmers. On the other, there are a number of foreign police forces operating through respective embassies that focus more on encouraging policies that promote the eradication of all drug production in Myanmar and to ensure that drugs are not trafficked to their respective home countries. UNODC is still heavily involved in supporting supply reduction programmes in Myanmar as well as supporting national agencies to monitor opium cultivation.

Advocating for HIV prevention services for people who use drugs

Injecting drug use remains the engine of the HIV epidemic in Myanmar and despite harm reduction programmes such as NSPs operating in the country since the late 1990s (and MMT since 2006) few people who use drugs enjoy access to such programmes. A number of organisations advocate for the scale up of harm reduction services, including the Asian Harm Reduction Network in Myanmar (AHRN Myanmar), the Burnet institute, Myanmar Anti-Narcotics Association (MANA), TNI, as well as UNAIDS and UNODC. These organisations engage in a range of advocacy efforts including supporting study tours, media campaigns and running demonstration sites.

Advocacy gaps and challenges

Advocacy capacity

Advocacy capacity varies in Myanmar. Despite there being only a small number of organisations working on drug policy in Myanmar, poor coordination and a lack of collaboration were cited as barriers to advocacy.

Policy environment

Perhaps the biggest challenge to drug policy advocacy in Myanmar at the moment is the rapid, unpredictable political and socio-economic change that the country is currently experiencing. Policy making remains opaque and controlled by political elites, often behind closed doors. Drug policy continues to be dominated by a strong criminal justice approach and focuses on supply control. A commonly held view was that civil society is not provided with the opportunity to engage with the Government in policy making processes. For example, one stakeholder noted that the National Drug Users Network is meant to be a mechanism for advocacy work, but the fact that legislation requires all NGOs to register as an official organisation hinders them from actually engaging in policy advocacy.

Policy issues that remain unaddressed

Several drug policy issues remain insufficiently addressed or entirely unaddressed, in Myanmar. Due to the difficulties outlined above with engaging in drug policy making, very little attention is dedicated to advocating for changes in existing drug laws. Key informants identified several aspects of Myanmar's drug policy as problematic and requiring reform, for example, disproportionately harsh penalties affecting the most marginalised people, including people who use drugs and small-scale opium growers.

Other key informants also highlighted the need to remove legislation that criminalises the possession of needles and syringes and that supports the compulsory registration and detention of people who use drugs, as they create significant barriers that prevent access to health and social services. People who use drugs regularly report fear of detention and registration as reasons for not engaging with services. This is highlighted by the reduction in access to services during times of police crackdown.

Recommendations for future advocacy activities

Understanding the policy environment to foster drug law reform

Reforming Myanmar's system of drug laws is of critical importance. A detailed review of drug policy making should be conducted in Myanmar that focuses on garnering a better understanding of policy content, as well as the context in which it is made, including the key stakeholders and power relationships that drive policy decisions. This review should also identify opportunities for policy reform including various potential lobby groups and opportunities for engaging policy makers.

Access to harm reduction services

Advocacy efforts should continue to target opportunities for increasing access to NSPs, MMT and naloxone. Current restrictions on naloxone make overdose rescue projects almost impossible to implement.

Advocacy for development-oriented drug control policies

Myanmar remains a major opium-producing country. Therefore, unlike many other countries in the region, it is important that drug policy advocacy addresses the needs of people involved in opium cultivation. Until now, local communities have been excluded from any of the decision-making processes on drug control policies which have often resulted in direct negative impacts on their lives and livelihoods.

Background information

Key drug policies

• Laws

Narcotic Drugs and Psychotropic Substances Law, 1993 – The Narcotic Drugs and Psychotropic Substances Law (1993) outlines the penalties for illicit drug use and possession, and mandates treatment for people who use drugs. It states that if people who use drugs do not register with a government-identified facility for medical treatment, they can be imprisoned for three to five years.

Other drug laws include the **Control of Money Laundering Law (Law No. 6/2002)** and the **Myanmar Excise Act (1917**), which prohibit the possession, sale or distribution of hypodermic needles without a license. In 2001, a directive from the Myanmar Police Force Headquarters was issued to avoid making arrests for possessing hypodermic needles. However, needles are confiscated and submitted to the courts as evidence when individuals are arrested for drug possession or having needles on hand at the scene of a crime.

• Policy and Strategy

15-year Drug Eradication Plan, 1999-2014 (extended until 2019) – Myanmar launched its official 15-year counter-narcotics plan in 1999, which calls for eradicating all narcotics production and trafficking by 2014. To meet this goal, the Government of Myanmar initiated its plan in stages, using eradication combined with planned alternative development programmes in individual townships, predominantly in Shan State. In 2012, the plan was extended until 2019.

The National Strategic Plan on HIV/AIDS, 2011-2015 – The National Strategic Plan on HIV/AIDS 2011-2015 places a high priority on prevention among populations at risk of HIV, including people who use drugs. The Plan strives to achieve universal access to prevention and care, and scaling up effective initiatives through capacity building. The development of national guidelines, partnership between the Government, national and international NGOs and the private sector, and enhanced coordination form the strong foundations of the plan. The most recent operational plan includes a graduated set of targets culminating in 180,000 people who use drugs reached with harm reduction services by 2009, including NSPs and MMT.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	Central Committee for Drug Abuse Control (CCDAC), attached to MoHA	UNODC
Regulation of medical industry	MoH	WHO
Drug trafficking and customs	27 anti-drug units are responsible for trafficking Ministry of Finance and Revenue, Customs Department and the Ministry of Border Affairs	UNODC US DEA
Law enforcement	People's Police Force, MoHA	
Judicial system	MoJ	UNDP
"Rehabilitation" and management	Ministry of Social Welfare	
OST	MoH	WHO
NSP and HIV-related service delivery	CCDAC	MANA

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
TNI	To promote pragmatic policies based on harm reduction principles for consumers as well as small scale producers	Research, publications, policy dialogues and workshops on regional drug market in Myanmar and neighbouring countries (India, China, Lao PDR, Thailand), focus on drug law reform, drugs and conflict, and representing rights of people who use drugs as well as opium and cannabis farmers.	Government agencies Civil society Media Legal Advisor to the President Attorney General's Office
Burnet Institute	Non-punitive, humane drug policies which encourage the health rights of people who use drugs Increasing the role of civil society in policy advocacy	Assisted in establishing the National Drug Users Network. Media and advocacy training. Supporting journalists publish public health related articles. Supporting seminars on drug issues.	Media Civil society organisations People who inject drugs Community
AHRN Myanmar	Scale up of evidence based services Increase access to overdose prevention supplies Increasing civil society's role in policy advocacy	Established and support the Better Shade Peer Support Group to implement two drop in centres to increase their role in policy advocacy. Many advocacy opportunities are opportunistic and come about due to the country managers longevity, patience and relationship with government officials.	CCDAC MoHA MoH
MANA	Demand reduction education Harm reduction	MANA is represented by several retired high-level political officials and hence has a strong role in policy advocacy. MANA's advocacy is usually mediated through existing relationships and in private	MoHA CCDAC MoH
UNAIDS	Scale up of harm reduction services Advocating against harmful policies, mandatory detention and human rights violations	Dialogue with the Government. Preparation of best practice reports and summaries of international evidence.	MoHA CCDAC MoH President's Office
UNODC	Compliance with the UN drug treaties Access to evidence based drug treatment Promotion of harm reduction policies	Dialogue with the Government. Preparation of best practice reports and summaries of international evidence.	MoHA CCDAC

Philippines

Snapshot

- The Philippines' response to addressing HIV among people who inject drugs remains considerably delayed compared to its regional neighbours.
- Few actors are engaged in drug policy advocacy and those that are solely focus on improving access to HIV prevention interventions among people who use drugs.
- Drug use in the Philippines is still considered a social evil and discussions about alternative drug policies remain marginal.
- Short-term advocacy efforts should continue to focus on HIV prevention. However, long-term goals should also focus on legal reform including repealing law prohibiting drug paraphernalia (which prohibit the delivery of harm reduction services) and improving proportionality in sentencing of drug offences.

Policy context

A study recently conducted by the University of Santo Tomas provides a comprehensive analysis of the context of Philippine drug policy (de Jesus, Calimag, Doma, Rey & de Jesus, 2012). The following brief introduction paraphrases this work.

Historically, Philippine laws tend to be based in patterns and philosophies established under American colonialism. This is particularly true for the laws pertaining to drugs. In 1908 the Philippines introduced their first major drug policy banning opium. Further, the provisions on drugs contained in the Revised Penal Code of 1930 echo the spirit, if not the letter, of the 1914 Harrison Act. Similarly, subsequent legal enactments such as Republic Act 6425 reflect the US Marijuana Act of 1937.

Like the USA, the Philippines also emphasises a three-pronged approach to drug policy, focusing on a tough law enforcement/criminal justice approach, prevention/education and treatment. This prohibitionist framework neatly fits with the conceptualisation that all people who use drugs are "victims-sick-criminals". A review of media headlines by de Jesus et al. (2012) shows a convergence between the views of the public, policy makers and popular culture.

Policy making is often viewed as a political process and policies are often negotiated outcomes among competing interests. However, neither negotiation nor compromise were major factors in the formulation of drug policy in the Philippines, with the tough-on-drugs approach receiving universal support. Especially with the advent of HIV among people who inject drugs, divergent views questioning the dominant drug policy framework, although nascent, are beginning to appear in the Philippines.

Current advocacy activities

Advocacy for harm reduction services

The dominant form of drug policy advocacy currently being pursued in the Philippines focuses on increasing access to harm reduction services for people who inject drugs. Both USAID and the World Bank/Asian Development Bank currently fund projects targeting HIV prevention among people who use drugs in Cebu. These projects are implemented by PSI and FHI 360, but remain small in scale. WHO and UNAIDS continue to provide technical support for relevant policy and programme implementation.

Legal reform advocacy

While there is a broader legal reform project that is currently being implemented by the Philippine Legislators' Committee on Population and Development (PLCPD) with support from UNAIDS, this project mainly focuses on aspects of the legal framework concerned with HIV and does not specifically focus on drug policy.

Advocacy gaps and challenges

Advocacy capacity

Advocacy capacity remains relatively un-documented in the Philippines. Besides the excellent academic work conducted by Armando de Jesus and his colleagues, the work of other agencies related to people who use drugs focuses on delivering HIV prevention services.

Policy environment

Despite a well-documented and explosive HIV epidemic among people who inject drugs in parts of the Philippines, significant social and legal barriers continue to thwart adequate prevention programmes from being implemented. The Philippines is currently one of nine countries with more than a 25 per cent annual increase in new HIV infections. In Cebu, reported HIV prevalence among people who inject drugs is 54 per cent, with hepatitis C prevalence reaching 94 per cent.

The Philippines is a predominantly Catholic country with drug laws focusing on harsh penalties as their main mechanism of influence. Most people believe that drug dependency is due to "lack of will power" or "moral weakness". This construction of drug use along with the Philippines' strict implementation of the Dangerous Drugs Act leaves many people who inject drugs fearful of seeking health services.

Policy issues that remain unaddressed

The key advocacy issues that remain unaddressed in the Philippines include ensuring a legal basis for needle and syringe distribution, introducing concepts of proportionality in sentencing of drug offences, repealing mandatory drug testing in schools and workplaces, and developing guidelines for court-based diversion programmes.

Recommendations for future advocacy activities

Focus drug policy advocacy efforts on legal reforms to help address the HIV epidemic among people who inject drugs

As discussed above, the unaddressed HIV epidemic among people who inject drugs and their partners should remain the priority focus of advocacy efforts in the Philippines. Toward this goal it is recommended that, while harm reduction programmes are being scaled up in key high prevalence areas, a local assessment of established sites be undertaken in order to generate local evidence to support the overwhelming body of existing data on the need for a sustained scale up of harm reduction services.

In addition, a legislative review of R.A. 9165 and R.A. 8504 should be supported, with the aim of addressing the policy gaps between the two laws. Such a review could also propose solutions to ensure a legal basis for needle and syringe distribution, introduce concepts of proportionality in sentencing, repeal mandatory drug testing in schools and workplaces, and develop guidelines for court-based diversion programmes.

Build capacity of drug user networks and civil society organisations to engage in drug policy advocacy

Building on the drug policy expertise of the University of Santo Tomas, international donors and drug policy advocacy organisations should invest in building the capacity of civil society organisations, identified as having potential for influencing drug policy reform, to engage in drug policy advocacy. Such activities could start with building the capacity to analyse, monitor and evaluate developments in, and impacts of, drug laws and policies.

Background information

Key drug policies

• Laws

Comprehensive Dangerous Drugs Act (R.A. 9165), 2002 – The Comprehensive Dangerous Drugs Act sees drugs as "a threat to the territorial integrity of the State and to the well-being of its human resources." The Act outlines prohibition, prevention, and treatment as the main mechanisms to achieve its goals. The Act clearly elevates punitive interventions over health and stipulates harsh punishments for illicit possession and use, mandatory drug testing in workplaces and schools as well as court-mandated drug treatment for those caught using drugs.

Article 8 institutionalises a court-based treatment programme whereby a person dependent on drugs can be sent into a drug "rehabilitation" programme as an alternative to incarceration. Article 8 is interestingly presented under the general title of Treatment and Rehabilitation and is clearly adopted as the strategy for advancing treatment. The Act does not prescribe the type of rehabilitation offered under the drug court system, and simply refers to it as a "Centre". The Act stipulates that if a "centre" is not available, then the individual dependent on drugs may be placed under the care of a Department of Health-accredited physician.

Under the Act, possessing drug paraphernalia such as needles and syringes remains prohibited and is often used by police as evidence of drug use.

Prevention and Control of AIDS (R.A. 8504), 1988 – The policy framework in general promotes "protection of non-infected persons from contracting HIV" and "minimising the impact of condition of persons living with HIV". The Act outlines five basic components: 1) information and education; 2) the promotion of safety and universal precautions in practices and procedures; 3) the eradication of conditions that aggravate the spread of HIV infection; 4) the provision of support services to people living with HIV; and 4) multi-stakeholder governance through the Philippine National AIDS Council (PNAC). The Act alludes to drug use as a factor in HIV transmission, but does not address it in any detail.

• Strategies / Policies

The 5th AIDS Medium Term Plan of the Philippines, 2011-2016 – The Plan set out its vision to halt further spread of HIV infection and reduce the impact of disease on individuals, families and communities. It aims to broaden its reach to key populations, especially among men who have sex with men and people who inject drugs. The primary strategies include improving standards and promoting comprehensive programmes to scale up coverage of prevention as well as treatment, care and support amongst key affected populations. The comprehensive package for people who inject drugs are described in Annex A (pp. 67-72) of the document covering prevention, treatment care and support, policy interventions and capacity building of key stakeholders.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Policy coordination body	Dangerous Drugs Board (under the Office of the President) PNAC	UNAIDS (multi-lateral) Network to Stop AIDS in the Philippines (NSAP)
Policy development	Congress of the Philippines (Senate and House of Representatives) Department of Health PNAC	UNAIDS, UNDP, WHO PLCPD (though limited)
Regulation of medical industry	Department of Health	WHO
Drug trafficking and customs	Philippine Drug Enforcement Agency	
Law enforcement	Philippine Drug Enforcement Agency Philippine National Police and Bureau of Jail Management and Penology (under Department of Interior and Local Government)	Limited UNAIDS (with support from non-resident agency UNODC)
Judicial system	Department of Justice (including the Bureau of Correction Facilities and Bureau of Immigration)	UNDP as part of broader support on governance and systems, not specific to drug use
"Rehabilitation" and management	Drug testing in schools: Department of Education and the Commission on Higher Education Treatment: Department of Health	
OST	Currently not available – note: methadone is usually inappropriate for treatment, as drugs injected in the Philippines are often not opiate-based	
NSP and HIV-related service delivery	Currently not available widely, some provision by Department of Health with local government unit (focused on Cebu) – but not openly discussed or officially acknowledged	Cebu Plus (NGO) WHO FHI 360 (Mainly focussed on Cebu)

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
FHI 360	Expansion of harm reduction services (facility-based)	Data collection (needs assessment). Dialogue with stakeholders.	MoH Cebu officials
WHO	Expansion of harm reduction services (include community-based services)	Data collection (rapid assessment and stakeholders analysis) Dialogue, sharing international best practice Training of the Philippine DEA and police enforcers in Cebu	MoH Cebu officials
UNAIDS working with PLCPD in a legal-focused advocacy group targeting people-centred legislation. In relation to drug issues, UNAIDS work with NSAP	Access to cheaper medicines Amendment of the Prevention and Control of AIDS (however not specifically related to harm reduction)	Strategic policy lobbying including data collection, hosting dialogues, training civil society actors and sharing international best practice.	House of Representatives and the Senate, legislative and executive branches of government Civil society organisations

Thailand

Snapshot

- Thailand's response to drug use is primarily driven by a criminal justice framework that relies on punitive measures and compulsory detention to dissuade drug use.
- Thailand continues to embrace detention for the purpose of rehabilitation and has not officially endorsed a harm reduction policy, which has resulted in significant harm to the drug using community including some of the highest rates of HIV in Asia.
- While advocacy capacity in Thailand is strong and includes significant representation of people who use drugs, additional support, both financial and technical, is required for advocacy on reform of Thailand's harsh policies.

Policy context

Ethnic minorities have a long tradition of cultivating opium in the mountains of Northern Thailand, one axis of the Golden Triangle. Local cultivation and use continued until the 1960s, when with significant assistance from the USA, Thailand's drug policy shifted to focus on eradicating the production of opium (Renard, 2001). Crop eradication and alternative development remained the dominant drug policy responses in Thailand until the 1990s. However two significant consequences emerged from crop eradication. The first was increasing production of opium in Myanmar and Lao PDR, and corresponding trafficking across the border into Thailand to fulfil the needs of thousands of Thais dependent on opiate-based drugs. The second was that with a declining supply of opium, many Thai smokers shifted to injecting heroin which fuelled a rapid spread of HIV in the past two decades (Celentano, 2003).

The advent of HIV among people who inject drugs precipitated a second phase of drug policy in Thailand. The Thai Government neglected to recognise the important relationship between HIV and injecting drug use, and when it did begin to act, it turned to detoxification-based drug treatment as its principal approach to HIV control among people who use drugs over harm reduction (Celentano, 2003).

During the early 2000s, patterns of drug use in Thailand shifted significantly from isolated pockets of opium and heroin use to the much more prevalent use of amphetamines (locally known as "yaba"). These changing patterns of drug use lead to the third phase of Thailand's drug policy response: the "war on drugs" (Nicholas Thomson, 2010).

In early 2003, the then Thai Prime Minister, Thaksin Shinawatra, launched a campaign to rid drugs from "every square inch of the country", which included extrajudicial killings. Despite the initial timeframe of the policy being set at three months, the sentiments outlined in the "war on drugs" policy continued to influence the current responses to drug use. The policy involved increasing punishment for drug possession and use including compulsory rehabilitation, setting provincial arrest and seizure targets including "blacklists", awarding government officials for achieving targets and threatening with punishment those who fail to make the quota. The policy has received considerable condemnation from the international human rights community (Pearshouse, 2009) as well as the Independent Committee for the Investigation, Study and Analysis of the Formulation and Implementation of the Narcotic Suppression Policy (ICID) which was established by the Government of Thailand (ICID, date not recorded).

While Thailand has promised to stop the violence associated with its much criticised "war on drugs", the Government continues to advocate for a tough-on-drugs approach and people who use drugs remain marginalised in Thailand – they face long periods in compulsory detention and disproportionately high rates of HIV. Thailand remains one of the only countries in South East Asia that does not have a national harm reduction strategy (Chariyalertsak, Aramrattana & Celentano, 2009).

Current advocacy activities

Scaling up access to HIV prevention services

A number of organisations focus their advocacy efforts on the scale-up of HIV prevention services for people who use drugs. While Thailand is recognized regionally as having responded very successfully to HIV among the general community and female sex workers, HIV prevalence among people who use drugs remains at 25 per cent – among the highest in this population in East and South East Asia – due to limited access to harm reduction services (Chariyalertsak et al., 2009). Advocacy efforts that target scaling up access to HIV prevention services target both local and national policy makers with interventions such as international best practice documentation, policy dialogues, study tours and running pilot demonstration sites.

Documentation of human rights violations

Since the 2003 "war on drugs" policy a number of human rights advocates have focused on documenting human rights abuses that occurred during its period of implementation. This work has focused on developing reports and collecting evidence against perpetrators. However, until now no one has faced trial for any crimes committed under the policy.

Towards more proportionate sentencing laws in Thailand and repealing compulsory rehabilitation in detention

The Narcotics Control Act (1976) sets the framework for the criminalisation of drug use and the Narcotic Addict Rehabilitation Act B.E. 2545 (2002) stipulates the system of compulsory rehabilitation in Thailand. This Rehabilitation Act is currently under review by the Government. Amending this Act to remove provisions for compulsory treatment, pre-trial detention, carrying out urine tests for suspected people who use drugs, along with removing criminal penalties for drug use and possession for personal use should remain a key focus of advocates' activities.

In Thailand, advocates seem to be tackling the issue of disproportionate sentencing and compulsory detention

from two complementary angles. The first angle is focused on demonstrating the limitations of compulsory rehabilitation and the criminalisation of people who use drugs, from an ethical, rights- and evidence-based standpoint. The second approach is through demonstrating the effectiveness of alternatives to compulsory rehabilitation. While Thailand currently supports a voluntary system (mostly available on an out-patient basis in the community) it remains limited and of poor quality. Alternative approaches to compulsory rehabilitation also need to recognise that not all people who use drugs require treatment. Alternative approaches should focus on developing a system of services that provide a range of interventions for people who use drugs depending on their needs.

In the past few years, significant advocacy efforts have also focused on developing more proportionate sentencing laws for drug-related offences. For example in 2012 and 2013, IDPC co-hosted policy dialogues with the Thai Ministry of Justice Rights and Liberties Protection Department (RLPD) (and TNI in 2012) to advocate for more proportionate sentencing laws in Thailand.

Advocacy gaps and challenges

Advocacy capacity

Capacity across the civil society organisations engaged in drug policy advocacy in Thailand varies. International organisations such as IDPC and PSI who have offices and international staff based in Bangkok provide strong leadership and actively move the policy agenda forward. Local organisations such as the Foundation for AIDS Rights (FAR), the Thai Civil Society Coalition for Harm Reduction (12D) and Raks Thai also have strong capacity. These local organisations approach advocacy quite differently, ranging from community mobilisation for protests to seeking to establish more dialogue-based discourse with government agencies. Other actors engaged in drug policy advocacy are the Law Reform Commission of Thailand, an independent government-funded entity which is planning to hold reviews of aspects of drug laws, and Chiang Mai University, which is recognised globally as having a strong academic interest in drug policy issues.

Policy environment

Stigma and discrimination of people who use drugs universally emerged as the most significant barriers to advocacy in Thailand. Stakeholders concurred that the public still approve of tough action against people who use drugs and trafficking, and are overwhelmingly in favour of the death penalty. Since the introduction of Thailand's "war on drugs" in 2003, it is estimated that over a million people have been forcibly detained in "rehabilitation centres" with one government official estimating that over 500,000 people were sent to such centres between 1st October 2011 and 30th September 2012.

However, and despite this, one key informant remarked that Thailand's rapid adoption of the 100 per cent condom campaign in the early 1990s serves as an important case study of the Thai government's willingness to overcome public opinion and support evidence-based public health policies.

Policy issues that remain unaddressed

Based on interviews with key informants, four key drug policy and advocacy issues emerged that remain unaddressed in Thailand. Overcrowding and lack of access to medical services in closed settings, namely prisons and compulsory detention centres, is a major issue. It is estimated drug offenders constitute 65 per cent of Thailand's incarcerated population (Fawthrop, 2012). Another issue is the low capacity for drug policy advocacy among some civil society actors, which limits participation in policy making processes. Social support for tough drug enforcement, and the belief that drugs are evil and drug-related activities should be eradicated without mercy, are another policy issue that remains unaddressed.

Another challenge is the lack of donors and international agencies that support advocacy in Thailand. This is a point of frustration for some advocates – a common complaint among local policy actors was that, even though the regional headquarters of several UN agencies are based in Bangkok, they cannot or will not speak out against the Thai Government's approach. The UN contested this criticism suggesting that in Thailand, a range of UN agencies have engaged on issues relating to drug policy. The key informant suggested that the UN often engages in "quiet diplomacy" with policy makers that are not seen by other actors. A more public example of the UN's advocacy is evidenced by the Development Cooperation Seminar organised by the UN Country Team and the MoJ on effective approaches to harm reduction and drug dependence treatment in 2012.

Recommendations for future advocacy activities

Continue to advocate for the repeal of compulsory detention

Many key stakeholders suggested that compulsory detention will not be repealed until an alternative system is established. The key recommendation for drug policy in Thailand is therefore to develop a roadmap that outlines a clear plan to transition away from compulsory detention to a system of integrated voluntary and community-located and/or home-based services for people who use drugs in Thailand. The roadmap should consider both legislative and policy change, as well as the development of a system of services for people who use drugs.

Continue to advocate for more proportionate sentencing laws in Thailand

In 2013, Thailand's Minister of Justice announced a proposal for decriminalising the use of Kratom, which could be used as a platform for advocating on decriminalising the use of a broader range of drugs. International and local civil society organisations, along with agencies such as the Law Reform Commission of Thailand, should continue advocating with the Ministry of Justice, the Ministry of Public Health (MoPH) and the Office of the Narcotics Control Board (ONCB) to support reforms on removing criminal penalties (and punishments such as pre-trial detention and compulsory treatment) for the use of drugs, and the possession of drugs for personal use.

Efforts should also be made to reach out to a greater range of civil society organisations, such as those advocating on human rights and development issues, and advocacy targets or potential advocacy champions, for example, senators and parliamentarians.

Improving access to harm reduction services

The push for a national harm reduction policy continues despite the setbacks that have occurred over the past few years, through considerable efforts from Thai harm reduction advocates. A rights-based draft National Harm Reduction Policy was abandoned by the former Prime Minister, Abhisit Vejjajiva, due to a technicality over language and doubts over the legality of NSPs following the ruling by the Council of State that NSPs were inconsistent with Thailand's drug control laws. The Council of State should continue to be targeted to ensure support for harm reduction policy.

Additional advocacy efforts on harm reduction services should focus on: ensuring that field workers delivering services to people who use drugs are protected from arrest; reclassifying naloxone so that it is no longer considered a dangerous drug and direct distribution to people who use drugs is allowed; revise national harm reduction service standards and deploy an accreditation system to ensure compliance. Advocacy should also target the police as their operational policies and practices are a major barrier to access to services.

Support a national policy advocacy body

Despite the many policy recommendations targeting harm reduction and drug policy in Thailand that have been made over the past 10 years, inaction amongst policy makers still endures. Several key informants recommended establishing a committee of senior people who could serve as the key advocacy body. Playing a role similar to the Global Commission on Drug Policy, but with a national focus, the group would produce an annual report documenting the state of drug policy in Thailand. This report would be an annual stock-take of previous recommendations, and generate new ideas to overcome problems associated with the ever-changing drug market.

Media training

The final recommendation targets the media and attempts to address what one stakeholder described as an aggressive media consortium that demonises drugs and people who use drugs. There are several examples from the region of successful media training programmes that focus on promoting alternative views about drug policy, which can be adapted and conducted by drug policy advocates in Thailand. These programmes involve training, support in researching stories, as well as an annual award for the best media coverage on issues relating to drugs.

Background information

Key drug policies

• Laws

Psychotropic Substances Act, 1975, Narcotics Control Act, 1976 and Narcotics Act, 1979 – Legislation governing drug use in Thailand criminalises production, consumption, possession, and sale of a number of controlled substances. Key legislation include the Psychotropic Substances Act (1975), which outlines controlled psychotropic drugs, the Narcotics Act (1979), which lists controlled narcotic substances, and the Narcotics Control Act (1976), which outlines the criminal penalties for controlled narcotics. These acts prohibit the consumption of heroin and cannabis but allow opium to be used on prescription for medical purposes. On reasonable suspicion of use, any person can be forcibly tested.

Narcotic Addict Rehabilitation Act, 2002 – The Rehabilitation Act provides a mechanism to divert people arrested for drug use from prison to compulsory drug rehabilitation facilities. To be eligible for diversion, it must be the accused's first drug consumption offence and they must only be arrested for consumption and possession, consumption and possession for disposal, or drug consumption and disposal. Non-completion or unauthorised exit ("escape") from compulsory treatment orders attracts punishment. Under the special law on rehabilitation, the decision to prosecute or commit a person dependent on drugs to "rehabilitation" is made by an authorised committee.

• Strategy

National harm reduction strategy, 2010 – Drafted by the ONCB and the MoPH in 2010, the national harm reduction policy was put on hold after the ruling on NSPs by the Council of State. In October 2013, the ONCB launched its 2013-2014 drug control strategy, which includes a few lines in support for harm reduction services. The strategy also provides for sensitisation programmes directed at field officers in provinces on the need to collaborate with harm reduction service providers.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non-Government
Policy coordination body	ONCB	12D, TNI, IDPC, UNODC
Regulation of medical industry	MoPH, FDA	AIDS Access Foundation
Drug trafficking and customs	Ministry of Interior (Border Patrol Police, Narcotics Suppression Bureau)	
Law enforcement	Ministry of Interior (Border Patrol Police)	PSI, CHAMPION-IDU, FAR
Judicial system	Ministry of Justice	FAR, Chiang Mai Community Legal Centre, IDPC, UNODC
"Rehabilitation" and management	Overseen by the Department of Probation (MoJ), the centres are run by the military (the Royal Thai Army, Navy and Air Forces), the MoPH, the MoI, the police force and the Bangkok Metropolitan Administration (BMA)	Sangha Metta, McKean Rehabilitation Centre, RainTree Foundation, 12D, UNODC, IDPC
OST	MoPH, Thanyarak Institute, BMA	Raks Thai Foundation, Thai Drug Users Network (TDN), PSI (CHAMPION-IDU project), 12D, UNADS, WHO
NSP and HIV-related service delivery	National AIDS Management Centre, the Disease Control Department	PSI (CHAMPION-IDU project), 12D
Prisons	Department of Corrections	Thai Red Cross, PSI (CHAMPION-IDU project), Médecins Sans Frontières, Amnesty International (Thailand)

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
Amnesty International	Abolition of the death penalty	Seen as a recognised "spokesperson". Dialogue and awareness raising, use of arts, films, exhibitions, social media to reach out to wider groups of public.	Government authorities, politicians, celebrities, media and lawyers
Chiang Mai University	Facilitate evidence-based policy, strengthening community-based treatment, and alternatives to criminalisation of people who use drugs	Identify and share best practices. Conduct researches on community-based treatment.	Government agencies, civil society organisations
PSI	Evidence- and rights-based drug policies Meaningful involvement, and effective partnerships between civil society and government agencies Greater harmonisation between public health and public security Deployment of national harm reduction policy Reducing operational risks for field workers meeting health needs of people who use drugs	Community level policy dialogue with community leaders, religious leaders, health, drug control and prison officials to support service delivery (under CHAMPION-IDU). National level policy advocacy through civil society mobilisation towards the deployment of a national harm reduction policy (in partnership with 12D). Addressing policy barriers to naloxone distribution in the context of overdose prevention. Project implementation and documentation of impact. Minimising negative impact of law enforcement on people who use drugs through dialogue, law enforcement advisor on staff, SoPs, national plan development. Publishing policy discussion papers and best practice results for modelling and scale-up. Raising public awareness on drug related issues through sensitisation activities at community level.	Multiple focal points within the Government of Thailand (PR-DDC, NAMc, Thanyarak, BMA, HITAP, BOE, DOC, BATS, TUC, FDA) Civil society Law enforcement (national / community) – national police, ONCB, Royal Thai Police training academy, UNODC General population / youth
Thai AIDS Treatment Action Group (TTAG)	Evidence-based, humane, non-punitive, public health-friendly drug policy	Rights documentation. Direct action and policy advocacy.	Government of Thailand, King, National Human Rights Commission, Parliament and NGOs
12D	Harm reduction, abolished compulsory drug treatment, and drug law reform	Policy dialogue. Coordination among 12 NGO partners. Capacity building and support to partners.	Multiple focal pints within the Government of Thailand Civil society
TDN	Meaningful involvement of people who use drugs Addressing the need of people who use drugs beyond health	Networking activities. Building basic skills of people who use drugs, including skills for advocacy. Direct health service delivery. Member of the GFAMT Country Coordinating Mechanism (CCM).	Government of Thailand People who use drugs Health service providers
FAR	Legal aid for most-at-risk populations	Providing legal assistance. Building capacity of law enforcement and civil society. Drug policy advocacy with high level officials. Sits on the GFAMT CCM and the National AIDS Committee.	Government of Thailand
TNI	Evidence-, rights- and development-oriented drug policies Alternative development	Organise regional policy dialogues. Research and publications.	ONCB, academics and civil society organisations
IDPC	Evidence- and rights-based drug policies Proportionality of sentencing	Organise policy dialogues. Support local civil society advocacy capacity and activities. Networking with NGOs, international agencies and government.	MoJ, ONCB, MoPH, NGOs and international agencies

Vietnam

Snapshot

- While policy making in Vietnam remains opaque, alternative approaches to drug policy are being considered by some parts of the Government and debates about how to best help people who use drugs are becoming more open.
- Despite the considerable investment from international donors which has resulted in a large-scale MMT programme and NSPs in most regions of the country, structural barriers such as mandatory reporting and compulsory detoxification limit access to these services.
- The compulsory detention of people who use drugs remains a major policy issue in Vietnam and, although there is consensus among the international community that the practice should cease, debate about the best way to achieve this goal continues.

Policy context

Vietnam's drug policy remains strongly influenced by a broad ideological campaign against "social evils", and the Government's overly restrictive interpretation of the UN drug conventions (Edington & Bayer, 2013; Nguyen et al., 2010; Vuong et al., 2012). Despite this, in order to respond to the rapid spread of HIV among people who inject drugs, Vietnam's drug policy has undergone a degree of transformation over the past decade (Vuong et al., 2012).

Three Government bodies have responsibility for drug policy making in the country. The two most powerful ministries are the MoPS, responsible for enforcing the Drug Control Law and the Ministry of Labour, Invalids and Social Affairs (MoLISA) who, until recently were solely responsible for "managing"[1] (quản lý) people who use drugs. The advent of HIV has seen the MoH play a more substantial role in drug policy, especially as MMT gains support as an alternative to the traditional compulsory rehabilitation.

However, and despite the significant international investment in harm reduction programmes such as the supply of sterile injecting equipment, peer education, HIV testing and treatment as well as MMT, government resources remain skewed toward supply and demand reduction activities with scarce national funding being made available for HIV prevention among people who use drugs (G. Reid & Higgs, 2010).

In an attempt to focus criminal sanctions on drug production and trafficking, significant changes were made to the Law on Drug Control and the Penal Code in 2008 that downgraded drug possession from a criminal offense to an administrative one. The revised Law on Drug Control acknowledges that drug use is a social problem (not a moral one) and that people who use drugs should be provided treatment. Vietnam is currently at a crossroads and significant debate has endured over how to best provide drug treatment. As is common to many countries in the region, Vietnam is grappling with transitioning away from a system of compulsory treatment to a voluntary and community-based system.

The practice of compulsory detention has received increasing international focus in the past decade, especially from a human rights perspective (Human Rights Watch, 2012; Parry, 2011). Despite international condemnation, and a call from UN to close the centres immediately (UNODC et al., 2011), the Government still supports 121 compulsory centres and detains an estimated 35,000 people. Two significant events have occurred in relation to compulsory detention in the past few years. The first is the Law on the Handling of Administrative Violations that was passed in 2012. The Law, which no longer provides for the compulsory detention of sex workers, outlines a process for sending people dependent on drugs to compulsory centres. Essentially the law targets people dependent on drugs who do not have a fixed address or who have returned to drug use following community-based detoxification. Article 96 of the Law states that "Individuals subject to placement in compulsory drug rehabilitation facilities shall be drug addicts aged full 18 or above who have been educated at communes, wards, or district towns but are still addicted, or have not been so but do not have a permanent place of residence". It is important to note that there is no operational definition of "drug dependence", and a positive urine test is often considered as sufficient evidence to warrant compulsory detention.

Paralleling the development of the Administrative Violations law, the protocol for operating the compulsory detention centres is also being reviewed by MoLISA. MoLISA is developing a model of "open" centres, known as the "Renovation" Plan, and based on Malaysia's cure and care centres. The plan also outlines a new role for MoLISA in MMT scale-up, albeit without design details or domestic funding. The draft plan maintains a strong commitment to compulsory detention and the retention of 50 centres beyond 2020.

Current advocacy activities

Closing compulsory detention centres

While there is a general agreement about the need to close compulsory detention centres in Vietnam, consensus about the best way to achieve this goal remains divided. Since Human Rights Watch documented abuses in compulsory detention centres in Vietnam, (Human Rights Watch, 2011a), advocacy efforts have focused on a range of goals, from closing the centres completely to improving the quality of HIV and infectious disease health services delivered inside the centres. There is a low-level dialogue among international donors about the complete disengagement from the centres versus the incremental change of existing centres.

Scaling up access to methadone and community-based treatment

The USA government, along with the completed DFID/ World Bank project, has invested considerable resources in advocating for, and funding, the scale up of MMT in Vietnam. However, despite the ambitious commitment to reach 80,000

[1] The Vietnamese term quản lý loosely translates into "management". However, this can range in meaning from "administrative monitoring" to "social control" (what might translate to "parole" in English).

people with MMT by 2015, as of September 2013 only 13,000 people were enrolled in the 62 existing clinics. Advocacy efforts are currently focusing on three key issues with regard to methadone: first, on encouraging the Government to invest into the national MMT scale up rather than relying on donor money; second, on building technical capacity; and third, on removing policy barriers to accessing MMT, such as registration requirements, or, as stipulated in the draft Methadone Decree, being removed from the programme after two urine tests that are positive for heroin use.

Revision of the legal system

As stated above, policy making in Vietnam has become increasingly open and a number of international partners have been significantly engaged in revising a number of legal and policy documents that relate to HIV and drug policy issues over the past five years. For example the USAID-funded Health Policy Initiative invested considerable resources into advocating for improved access to legal services for people who use drugs. Other advocacy efforts led to the 2007 HIV Law, revisions to the Drug Law, as well as the removal of compulsory detention for sex workers within the Law on Administrative Sanctions.

Despite these successes, advocacy efforts with regard to drug policy reform have been less successful. While some advocates believe that new court proceedings outlined under the Administrative Sanctions Law are a step in the right direction, others argue that they further embed the practice of criminalising drug use and compulsory detention.

Improving access to harm reduction interventions including prevention of overdose deaths

Other policy issues that are currently being advocated for include the integration of drug treatment with HIV care, the need to increase the availability of naloxone to prevent heroin overdose deaths, access to MMT in prisons, and developing a process to deregister people who use drugs whose personal records are kept on a centrally-held database managed by MoLISA.

Despite the massive increase in advocacy activities at the central level over the past few years, significant energy is still focused on advocating with local authorities to allow projects implementing basic harm reduction services. A number of key informants stated that central-level advocacy and policy change are not sufficient. Additional efforts are required at local level (preferably by national authorities) to ensure that new laws and policies are implemented.

The local police remain a barrier to harm reduction services nationwide, as do local quota systems in which district committees are provided with an annual quota of spots in local detention centres. It remains unclear from interviews whether these quotas were seen as a reward from the Peoples' Committee or a result that local officials need to achieve to be seen as doing their job.

Advocacy gaps and challenges

Advocacy capacity

Capacity to engage in drug policy advocacy is very mixed in Vietnam. Advocacy seems to be dominated by the international players with little engagement from local civil society actors. Several key informants noted that local organisations did not have the financial resources or technical skills to engage in policy advocacy.

Policy environment

Several key informants raised frustrations about the lack of policy coordination between MoLISA and the MoH. One prominent policy researcher in the country commented that both MoLISA and the MoH compete against each other in order to maintain control over certain issues related to drug use and drug policy. This competition makes it difficult encourage dialogue about systematic changes to drug policy.

Sensitivities associated with drug policy are also a significant challenge to drug policy advocacy in the country. Key informants from both national and international agencies both discussed the potential ramifications for raising drug policy issues, due to the sensitivity of drug issues and socially controversial nature of people who use drugs, such as jeopardising relationships with government agencies.

One key informant also noted frustration with international agencies, explaining that they often change their advocacy plans as international staff come and go. Another informant suggested that the dominant focus of HIV donors comes at the expense of investment in other drug policy issues.

Policy issues that remain unaddressed

As discussed above, drug policy is undergoing considerable discussion and review in Vietnam at the moment. Three critical issues, while not unaddressed could be handled better by the international community. These are the reforms currently being discussed under the Law Handling Administrative Violations of People Who Use Drugs in Trial Proceedings at District Courts and MoLISA's 06 centre renovation plan. Both of these issues have the potential to drastically redefine how drug use is managed in Vietnam.

The third unresolved policy issue relates to an embedded system of compulsory registration, quotas and rewards for police sending people who use drugs to compulsory detention centres.

Recommendations for future advocacy activities

Build the capacity of local organisations to advocate on specific drug policy issues

As stated above, capacity remains low and few local organisations are engaged in drug policy advocacy in Vietnam. It is recommended that this issue be addressed as a matter of priority. A number of local agencies are well-placed to provide targeted advocacy on a range of specific technical issues such as access to services as well as greater involvement of affected communities in policy making processes. However greater capacity is needed for advocacy on issues such as the government's drug strategy objective of making 70 per cent of communes free of drug use. Similarly, capacity also needs to be built among new stakeholders such as legal aid and reform groups, especially as the Ordinance on Order and Procedures for Consideration and Determination of the Imposition of

Administrative Handling Measures by the People's Court is implemented. Finally there remains a good opportunity to engage academics in drug policy debates through encouraging the development of local policy research.

Strengthen advocacy against compulsory detention

Despite clear statements against compulsory detention, international actors engaged in drug policy advocacy in Vietnam are not presenting a unified advocacy position on this matter. It is recommended that the international community develop a clear advocacy position that balances the desire to assist MoLISA with transitioning toward evidence-based and voluntary drug treatment delivered in community settings, while at the same time ensuring that resources are not being diverted into compulsory rehabilitation. Such insurances might include an agreed road map for making all centres voluntary (which means clients are free from punitive measures, including relapse without being subject to penalties), agreeing to independent evaluations of the centres, and an agreed process for handling client complaints of human rights violations.

The current draft of the renovation plan outlines a strategy that sees some centres being converted into open voluntary centres while maintaining 50 custodial centres for people who fail "community-based detoxification" or provide two positive urine tests within 12 months while on the MMT programme (as indicated by Article 21.2 of the Methadone decree #96). Hence, the current plan clearly maintains a strong commitment to compulsory detention, which risks undermining the operation of voluntary centres, as the threat of compulsory detention will likely deter people who use drugs from accessing services at the voluntary centres.

In order to address these inconsistencies, it is recommended that an alternative proposal to compulsory detention be presented to the government of Vietnam, which outlines the establishment of a system offering a range of drug treatment options and harm reduction services.

Develop targeted advocacy on the judicial pathway to treatment

Targeted advocacy should be maintained to ensure that the involvement of district courts in referring people who use drugs to treatment is both ethical and effective. For example a working definition and criteria for "drug dependence" should be clearly articulated. An alternative to having the criminal justice system diagnose dependence would be possible with the development of possession thresholds within the law. For example, only those in possession of between two and five days' supply would be processed through the district court. Those in possession of less than two days' supply would receive a warning, and a non-binding referral to treatment (three warnings within one year may warrant an appearance in front of the judge), while those with more than five days' supply would be charged with trafficking.

Advocacy efforts should also ensure that defendants are not offered a coerced choice between treatment and punishment, that any sentence given is proportionate to the crime that is committed, as well as ensuring adequate judicial oversight throughout the legal process including, the right to legal counsel and appeal procedures. In addition to advocacy, it will be critical that once the new judicial system is in place, efforts should focus on awareness-raising among people who use drugs as well as developing guidance and training for lawyers, district court judges and other relevant officials.

Background information

Key drug policies

• Laws

Three key laws form the backbone of the legal and policy response to drugs in Vietnam. Together these laws outline sanctions for drug use, production and trafficking as well as the responsibilities of government agencies, organisations and individuals in drug control and HIV prevention.

Penal Code, 1999 (revised in 2009) and Law on Drug Control, 2000 – The Penal Code (1999), revised in 2009, and the Law on Drug Control (2000), revised in 2008, focus on criminal sanctions for drug production and trafficking (including the death penalty) as well as mandating compulsory detention for people who use drugs.

In theory, the revised drug law is a marked divergence from the 1999 Penal Code that defined illicit drug use as a criminal activity (National Assembly of Vietnam, 1999). However, the Law on Administrative Sanction stipulates that people who relapse to drug use following compulsory community based detoxification, or people found to be drug dependent and without a fixed address will be subject to detention in 06 centres for a period of up to two years.

In 2009, the Decree on Post Detoxification was issued under the Drug Law. The decree mandates a series of provisions for "post-rehabilitation management" for an additional period of up to two years for "drug users who are at high risk of relapsing". Post-detox management decision making power is delegated to the District People's Committee (Human Rights Watch, 2011a).

Law on HIV/AIDS Prevention and Control, 2007 – The other relevant law with respect to drug use is the Law on HIV/AIDS Prevention and Control (2007). Decree 108, authorises health authorities and peer educators to conduct harm reduction activities such as the provision of sterile injecting equipment, protection of peer outreach workers and the provision of MMT to people dependent on opiates.

Promulgated in 2012, the Decree on Opioid Substitution Therapy is another important document. The decree establishes the framework for the scale up of evidence-based MMT by the MoH. While the Law on HIV clearly supports "harm reduction" (T. M. Hammett et al., 2008; Pham Nguyen et al., 2010; Vuong et al., 2012), it does little in the way of addressing the compulsory detention of people who use drugs or challenging the tough-on-drugs spirit of the Drug Law.

• Strategies / Policies

National Strategy on Drug Prevention and Control until 2020 with a Vision to 2030, National Strategy on HIV/AIDS Prevention and Control 2011-2020 with a vision until 2030 – These two key strategies, signed by the Prime Minister in 2011, broadly outline Vietnam's approach to drug use and how people who use drugs are treated.

In June 2011, the Government of Vietnam issued an updated drug strategy drafted by the MoPS. The objectives of the strategy are:

1. To enhance the accountability of individuals, families and the broader society to prevent and eliminate drug use; and
2. To reduce the number of people who use drugs by 30 to 40 per cent, with 70 per cent of communes free of drug use.

The general objective of the new National Strategy on HIV/AIDS Prevention and Control is to control the HIV prevalence rate among the general population to reach below 0.3 per cent by 2020. The National Strategy also aims at a reduction of 50 per cent of new HIV infections by 2015 and by 80 per cent by 2020 among people who inject drugs. The strategy also aims to reach 80,000 people on Methadone by 2015. It remains unlikely that these goals will be met.

Key policy making bodies

Policy area	Key Stakeholders	
	Government	Non Government
Coordination of drug policy	The National Committee on AIDS, Drugs and Prostitution Prevention and Control. The Secretariat to the National Committee is based in the Cabinet Office and directly advises to the Deputy Prime Minister and the Chairman of the National Committee on Drug Policy Advisory Board of Secretariat the National Committee of AIDS The Drugs, Prostitution Control is a group of retired experts periodically invited to research and advise the Chairman on certain issues. The advisory board is not a Government body	UNAIDS, ABT Associates, UNODC, FHI 360
Regulation of medical industry	MoH	WHO
Drug trafficking and customs	MoPS	UNODC, US State Department
Law enforcement	MoPS	UNODC USAID (HPI)
Judicial system	MoJ	UNDP, FHI 360 (limited)
"Rehabilitation" and management	MoLISA, Departments of Social Evil Prevention	FHI 360, UNODC, GFATM, Centres for Disease Control and Prevention (CDC)/USAID and HAARP
OST	MoH	WHO, FHI 360, CDC/USAID
NSP and HIV-related service delivery	MoH, Provincial AIDS Committees	FHI 360, CDC/USAID

Existing policy advocacy activities

Organisation	Policy issue	Advocacy activity	Target organisation
UNDP	Rule of law, particularly with regard to the administrative detention of people who use drugs	Dialogues, reviews and sharing international best practice.	Government and/or National Assembly MoJ
UNAIDS	Drug policy advocacy, especially as it relates to HIV	High level advocacy dialogues, study tours and forums. UNAIDS also supports a number of civil society platforms, however these remain nascent especially in comparison to their role with the government office.	Office of the Government
UNODC	Demand and supply reduction programmes. Community-based treatment.	Until recently UNODC implemented several harm reduction projects and supported a full time dedicated HIV technical officer who had a strong relationship with MoHA and was very engaged in policy advocacy. However, in the past few years, UNODC's role has focused on community-based treatment and hosting advocacy meetings.	MoHA, MoLISA
WHO	MMT and the expansion of NSPs	High-level advocacy dialogues, study tours and forums. Preparation of SoP manuals and implementation guidelines.	Vietnamese AIDS Administration Committee
US Government agencies: PEPFAR/ USAID/CDC/ Substance Abuse and Mental Health Services Administration	Scale up of MMT, building capacity in drug dependence medicine	High level advocacy dialogues, study tours and forums. Funding. Preparation of SoP manuals and implementation guidelines.	MoH, MoLISA, Office of the Government, Hanoi Medical University
GFATM	Ethical engagement with compulsory detention centres	Main engagement has been at an international level through developing conditions around funding.	Government and MoH (as the Principal Recipient of GFATM funding)
AusAID	Access to harm reduction services	Targeted advocacy at the provincial level. Dialogues, study tours, funding for pilot studies.	Three provinces in the North of Vietnam
Atlantic philanthropies	Closure of compulsory detention centres	Targeted advocacy including dialogues, discussion paper, study tours, forums, and encouraging civil society engagement.	Multiple government stakeholders
Irish Embassy	Compulsory detention centres	The Irish Embassy supports a group of ambassadors called the Dublin Group. The group focuses on human rights issues and has raised concerns about compulsory detention centres for the past few years.	Ambassadors based in Vietnam
ABT Associates	Revision of the legal system Improving access to legal services for people who use drugs	Dialogues, study tours, conference attendance, revisions to legal statutes. ABT has recently concluded its five-year HPI grant on HIV policy in Vietnam.	Government and/or National Assembly MoJ, MoH, MoHA
FHI 360	Scale up of MMT, Access to harm reduction services, Development of clinical guidelines, and closure of compulsory detention centres	Dialogues, study tours, conference attendance, revisions to legal statutes, development of alternate strategies and discussion paper.	Government and/or National Assembly MoJ, MoH, MoHA
Supporting Communities Development Initiatives	Empowering civil society and people who use drugs to engage in policy processes and service delivery. Closure of compulsory detention centres Promote community-based treatment. Access to naloxone for overdose rescue	Supporting civil society networks through funding, capacity development and technical support. Dialogues with government and the international community. Commentary on policy drafts and government documents.	MoLISA, MoH Office of the Government

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APPENDIXES

Appendix A: Conceptual framework

This report has adopted a broad definition of drug policy that includes any laws, regulatory measures, courses of action and funding priorities concerning controlled psychoactive substances that are adopted by an individual, group or government (adapted from Kirkpatrick (2000)). This report has focused solely on policy processes that target the illicit cultivation, production, trade and use of controlled substances. Drug policy advocacy is defined as any attempt that aims to influence drug policy.

As this report focuses on drug policy advocacy, it is important that a theoretical framework that focuses on policy change is adopted. Constructing drug policymaking as a dynamic process allowed the report to provide a richer understanding of the actors, processes and context in which drug policy making occurred. As stated by Ritter, et al., (2007) drug policies must be analysed in context and with local realities and situation taken into account. Thus, drawing on the work of Seddon (2011) the report called upon a theoretical framework that could be used to understand the policy process, as well as seeking a comparative ability to explain why drug policies are different across countries.

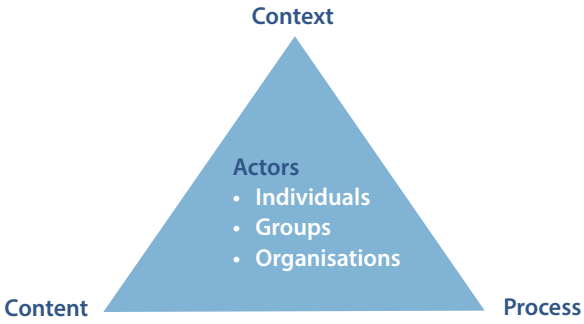
Stachowiak (2007) categorises policy change theories into six themes that are presented in Box 1 below. While all of the theories presented recognise that policy making involves an interplay between key stakeholders, as well as the political and cultural context, each theory elevates a different aspect as being central in explaining policy making. For this reason, this report primarily relies on the Walt & Gilson (1994) policy analysis triangle as the key framework.

Box 1: summary of policy change theories (adapted from Stachowiak (2007))

1. **Large Leap or Punctuated Equilibrium Theory** (Baumgartner, Jones): postulates that large change in policy can happen when the right conditions are in place.
2. **Coalition theory** (Sabatier, Jenkins-Smith): suggests that policy change can happen through coordinated activity among a range of individuals with a set of similar goals.
3. **Policy Windows Theory** (Kingdon): building on the large leaps theory, Kingdon suggests that policy can be changed during windows of opportunity. Windows of opportunity occur when policy actors successfully connect a policy solution with a policy problem in the right political context.
4. **Messaging and Frameworks Theory** (Tversky & Kahneman): states that Individuals' policy preferences or willingness to accept them will vary depending on how options are framed or presented.
5. **Power Politics theory** (Wright Mills, Domhoff): suggests that power is held within elite groups and that advocacy needs to focus on the interests of the powerful in order to achieve change.
6. **Grassroots or Community Organising Theory** (Alinsky, Biklen): offers that policy change is achieved through the collective action of the community. This theory suggests that power is dynamic and be seized by social movements.

Walt and Gilson's policy triangle breaks down the policy process into four interrelated components. As shown in Figure 1 below, the four components include context, content, process and actors. Policy context refers to both political and cultural aspects of the environment in which policy is being made. According to Walt and Gilson, the context is affected by many factors such as political stability, ideology and history. The process of policy making refers to how issues get raised and how they fare once they are on the agenda. Policy actors are the various groups that have a stake in the policy and policy making. Actors can include individuals, groups or organisations. Finally the policy content refers to what elements make up the policy. The content of the policy refers to the activities, laws, regulations and actions that the policy endorses or rejects.

Figure 1: Walt and Gilson's policy analysis triangle



Also important to the conceptual framework applied by this report is an emerging field of policy research known as morality policy. The morality policy refers to policy making for issues with a specific moral domain such as abortion, euthanasia, gun control, same-sex unions and drug use. Knill (2013) suggests that the distinctive feature of these policies is that they are shaped by conflicts over first principles, and entail a decisions over issues that are often perceived as being right or wrong.

The morality policy theory makes an important contribution to the study of drug policy because it proposes a framework for analysing political processes that cannot be resolved by argument alone (Euchner, Heichel, Nebel, & Raschzok, 2013; Heichel, Knill, & Schmitt, 2013; Keane, 2003; Wodak, 2007). Thus, this report concentrates on three issues related to the morality policy. The first issue looks at the extent to which drug policy is framed as a moral issue in Asia. Second, the hypothesis that drug policy is becoming more "evidenced-based" and that people who use drugs are considered as "patients and not criminals" (a slogan often used by civil society activists and policy makers in the region) is tested. Finally, the impact of any reframing that has occurred in the policy debate is assessed against the provision of services for people who use drugs.

Both morality policy theory and the policy triangle promote the importance of understanding policy processes over periods of time. This is especially relevant to the current work as a major focus of the project is to develop recommendations for drug policy advocacy that promote the development of alternative drug policies. As P. Cohen (1993) argues it is not possible to design alternative policies if a strong understanding of the historical perspective on present drug control ideology are not understood.

Appendix B: Survey Monkey Questionnaire

Q1. What is the name of your organisation? How is your organisation best described: a) Government Agency b) International NGO c) Local NGO d) Donor or Embassy e) United National family.

Q2. Which country are you working in? (please select one) If you work in multiple countries, please complete a new survey for each country that you work in or select the regional option.

Q3. What type of drug policy does your organisation support? Please explain the methods that your organisation uses and your main advocacy goals.

Q4. How does your organisation determine its approach to drug policy?

Q5. How are your drug policy advocacy activities funded?

Q6. Please describe a policy advocacy success that your organisation has been involved in. Specifically: a) What role did your organisation play? b) Who were the other players involved? c) What were the main factors that lead to the success?

Q7. Who are the three most important organisations that you partner with on drug policy advocacy work? Why are these organisations so important?

Q8. Who are the three most important institutions that your drug policy advocacy targets? Why are these organisations so important?

Q9. What are the three most critical drug policy advocacy issues in the country that you work? Why did you select these?

Q10. Please specify the major barriers that are preventing your organisation from achieving its drug policy advocacy agenda?

Appendix C: Key informant interview theme guide

Policy process

- How is drug policy made?
- What is the political process for making legislation?
- What levels of government are engaged in policy making?
- What are the different levels of policy?
- Does civil society have a role in policy making?
- Where does power lay within the policy making process? Are there points in which policy advocacy can influence policy outcomes?
- Who does the contemporary policy environment influence policy making?
- Is policy making open? Who are the key players in making and influencing policy making (see key policy actors)?

Policy content

- What are the key policies that relate to illicit drugs in the country?
  - When where they implemented
  - When were they last reviewed
  - Which ministries are involved in implementing them
  - How are they funded
- What were the main objectives of and strategies used in these policies?
- How do these policies frame:
  - The drug user / drug use
  - The drug dealer / trafficker
  - Methadone / drug treatment
  - Needle and syringe programmes
  - Peer education
  - Overdose prevention (naloxone)
  - The roles of law enforcement and the judiciary in handling drug related cases
- If the policy has been implemented, has it achieved its intended objectives? What are its strengths and weaknesses (or benefits and costs)?

Policy context

- How and why did illicit drug use, harm reduction and HIV emerge as policy issues?
- Why are these issues framed the way they are? How are people who use drugs framed by society?
- Are these issues linked to other issues?
- What influence do the UN drug conventions and other regional policy actives have on policy?
- What were the key factors (if any) that led to shifts in policy relating to drug use, harm reduction and HIV?
  - Identify policy successes and case studies

Key policy actors

- Who are the major state, national and international institutions and arrangements through which drug policy is influenced?
- Who are the interest groups, alliances or social forces that have taken an interest in drug related policy issues in the country / region?
- What role do these institutions play in the policy process?
- Who funds them?
  - Is funding separate, or built into existing implementation funding?
  - How much direct funding is provided to policy advocacy?
- What are their staffing profiles?
  - Are staff specifically trained in policy?
- What are their goals, objectives and approaches?
  - What are their perceived barriers to influencing the policy process?
  - What are their perceived gaps in current advocacy activities?
- Who are their key partners/towards whom do they target their advocacy efforts?
- What are the key resources that they use in policy advocacy
  - Materials
  - Networks
  - Technical assistance

Notes

The International Drug Policy Consortium (IDPC) is a global network of NGOs and professional networks that promotes objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harms.

Despite the significant cultural and geographical differences that exist between the ten South East Asian countries covered in this review, drug policy making follows a remarkably similar pattern across the region. Drug policies are generally made against a social context that disapproves of illicit drug use, constructing both intoxication and dependence as socially undesirable and a sign of moral weakness. This report aims to identify organisations engaged in harm reduction and drug policy advocacy, identify gaps and challenges in harm reduction and drug policy advocacy, and develop recommendations for prioritising new activities in harm reduction and drug policy advocacy.

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