Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam:

An application of selected human rights principles

World Health Organization
Western Pacific Region

WHO Library Cataloguing in Publication Data
Assessment of compulsary treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: an application of selected human rights principles.

1. Substance abuse, Intravenous - rehabilitation. 2. Substance abuse treatment centers.
3. Human rights. 4. HIV infections – transmission.

ISBN 978 92 9061 417 3 (NLM Classification: WM 270)

Contents

Acknowledgments

The information in this paper was compiled by Ms Marie Nougier, intern at WHO Western Pacific Regional Office July–August 2008, under the supervision of Ms Anjana Bhushan, Technical Officer in Health and Development; Dr Fabio Mesquita, Technical Officer for HIV/AIDS and STI; and Ms Mitra Motlagh, Technical Officer for Equity, Gender and Human Rights.

The collaborative inputs and valuable contributions of the following persons are gratefully acknowledged:

WHO Country Office in Cambodia. Mr Graham Shaw, Technical Officer.
WHO Country Office in China. Dr Guoping Ji, Senior Programme Officer for HIV/AIDS; Dr Wiwat Rojanapithayakom, HIV/AIDS Team Leader.
WHO Country Office in Malaysia. Dr Nirmal Singh
WHO Country Office in Viet Nam. Dr David Jacka, Medical Officer for HIV and IDU; Dr Masaya Kato, Medical Officer for HIV/AIDS Care and Treatment; Ms Sarah De Hovre, Technical Officer for Human Rights and Trade.
WHO Headquarters – Health and Human Rights team. Ms Helena Nygren-Krug.
WHO Headquarters – HIV team. Ms Annette Verster.
WHO Headquarters Mental Health and Substance Abuse team. Dr Nicolas Clark.
United Nations Office on Drugs and Crime. Mr Giovanni Nicotera (UNODC China), Ms Sonia Bezziccheri (UNODC Regional Centre Bangkok), Mr Jason Eligh (UNODC Vietnam), and Ms Fabienne Hariga (UNODC Headquarters, Vienna).

Acronyms

ADRA	Adventist Development and Relief Agency
AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral therapy
ATS	Amphetamine-type stimulant
AUSAID	Australian Agency for International Development
CBT	Cognitive-behavioural therapy
DHAS	Illicit Drug-Related HIV and AIDS Secretariat
FHI	Family Health International
HIV	Human immunodeficiency virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDU	Injecting drug use/r
ISDS	Institute for Social Development Studies (Viet Nam)
MDG	Millennium Development Goal
MMT	Methadone maintenance treatment
MoLISA	Ministry of Labour, War Invalids and Social Affairs (Viet Nam)
MTCT	Mother-to-child transmission
NAA	National Aids Authority (Cambodian agency)
NACD SG	National Authority for Combating Drugs (Cambodian agency) – Secretary General
NGO	Non-governmental organization
NCHADS	National Center for HIV/AIDS, Dermatology and STDs (Cambodia)
NNCC	National Narcotic Control Commission (China)
NSP	Needle and syringe programme
OST	Opioid substitution treatment
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People living with HIV/AIDS
PWID	People who inject drugs
PWUD	People who use drugs
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations International Drug Control Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counselling and testing
WHO	World Health Organization
YIDA	Yunnan Institute for Drug Abuse (China)

Glossary

Abstinence	Refraining from drug use. A person taking prescribed methadone but no illicit opioids would still be described as abstinent.
Accountability (in the context of the right to health)	The State, the duty-bearer, must provide effective mechanisms of accountability to ensure the progressive realization of the right to health to the people of the country, the rights-holders.
3AQ	These are criteria articulated in 2000 by the Committee on Economic, Social and Cultural Rights which are included in the right to health proclaimed in article 12 of the International Covenant on Economic, Social and Cultural Rights. These criteria are: availability, accessibility, acceptability and quality.
Compulsory drug treatment centre	Enforced residential drug treatment, often based on an abstinence programme. The centres can bear different names according to the countries, but "compulsory drug treatment centre" is used here.
Dependence	As applied to drugs, it implies the need for repeated doses of a drug to feel good or to avoid feeling bad. Dependence often refers to both the physical and psychological elements of drug dependence. The term also refers to the development of withdrawal symptoms on cessation of drug use.
Detoxification	The process of an individual being withdrawn from the effects of a psychoactive substance. When referring to a clinical procedure, detoxification refers to a withdrawal process that is carried out in a safe and effective manner, minimizing the withdrawal symptoms.
Drug control	The regulation by a system of laws and agencies of the production, distribution, sale and use of specific psychoactive drugs locally, nationally or internationally.
Drug testing	The analysis of body fluids (such as blood, urine or saliva), hair or other tissues for the presence of one or more psychoactive substances.
Harm reduction	Policies and programmes that focus directly on reducing the harm resulting from the use of drugs, without necessarily affecting the underlying drug use. Harm reduction strategies cover a wider range of activities than simple reduction of supply and demand.
HIV/AIDS	HIV is a retrovirus which causes chronic infection in humans; one of its targets is the human immune system, allowing opportunistic infections and cancers to occur. The most advanced stage of HIV is called AIDS.
Methadone	A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It can be given orally once a day with supervision.
Needle and syringe programme	Programme aiming at increasing the use of sterile injecting equipment so as to break the chain of transmission of blood-borne viruses by providing PWUD with sterile injecting equipment, collecting and disposing of used needles and syringes.
Needle-sharing	Use of syringes or other injecting instruments by more than one person, particularly as a method of administration of drugs. The risk of transmission of viruses and bacteria is high and many harm reduction interventions are designed partly or wholly to eliminate needle-sharing.

Non-discrimination and the right to health	Health facilities, goods and services must be available to everyone on an equal basis and without discrimination on any of the grounds prohibited by national and international law. Any discrimination in access to health care and underlying determinants of health on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, is prohibited.
Overdose	The use of any drug in such an amount that acute adverse physical or mental effects are produced.
Participation (in the context of the right to health)	The State must promote participation by everyone in decisions related to the health facilities, goods and services that affect them.
Peer outreach	Education programmes using trained members of the targeted population to promote peer education.
People who inject drugs	People who inject an illicit (or even licit) drug by the use of a syringe. Injections may be intramuscular, subcutaneous, intravenous, etc.
People who use drugs	People who use illicit drugs. Some official documents and laws used in this report still use the terms "drug user" or "injecting drug user".
Pilot project	Activity designed to promote a new initiative.
Progressive realization (in the context of the right to health)	This principle acknowledges that States may face constraints in fulfilling the right to health completely and immediately, but it is enjoined upon governments to move as expeditiously and effectively as possible towards the right to health and demonstrate progress in doing so.
Rehabilitation	The process by which an individual with a substance use disorder achieves an optimal state of health, psychological functioning, and social well-being. Rehabilitation follows the initial phase of treatment (which may involve detoxification and medical and psychiatric treatment). It encompasses a variety of approaches, including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training and work experience. There is an expectation of social reintegration into the wider community.
Relapse	A return to drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms.
Resident	Within this context, a person who, voluntarily or not, is under treatment in a compulsory rehabilitation centre.
Withdrawal syndrome	A group of symptoms of variable clustering and degree of severity which occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly in high doses. The syndrome may be accompanied by signs of physiological disturbance.

1. Background

Objective

This report has been prepared by the Western Pacific Regional Office of the WHO to describe the "compulsory treatment centres" in Cambodia, China, Malaysia and Viet Nam, and assess the treatment they provide. The main objective of this report is to use some key human rights principles as a lens through which to assess and document the situation in the compulsory drug treatment centres in a constructive way, as a basis for engaging in dialogue with policy-makers in these countries.

The assessment suggests that these centres lack effective drug treatment services. There is also a lack of prevention or care services for HIV in closed settings, where the spread of the disease is much faster than in the community. People who use drugs in the region are at risk in these settings because they do not receive drug treatment and HIV prevention services.

Methodology

This report is a desk-based review of the compulsory drug treatment centres in Cambodia, China, Malaysia and Viet Nam. The information was collected with the help of WHO staff located in the WHO country offices in Cambodia, China, Malaysia and Viet Nam. Official documents, legislations, surveys, reports, etc. from various sources, including the governments of the studied countries, were also used to conduct the research.

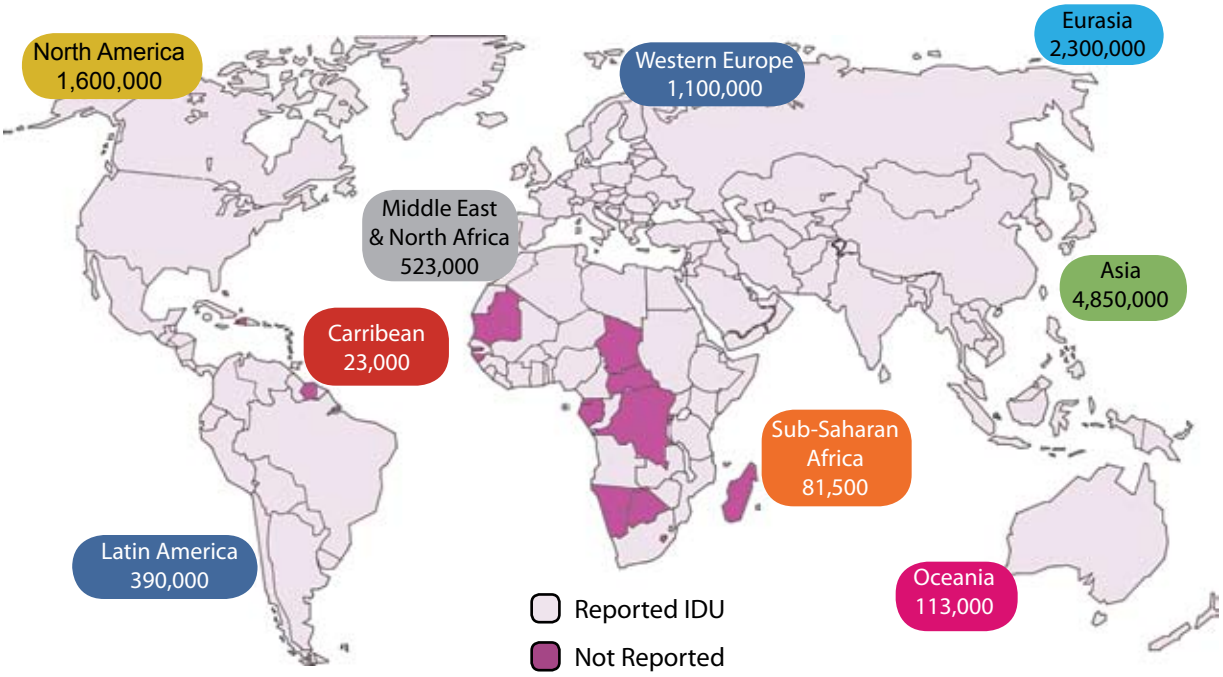
Limitations of the analysis

The review was entirely desk-based, and the findings and recommendations were necessarily limited by the absence of on-site discussions and evaluation. The information collected was also limited because of the sensitivity of the topic in Cambodia, China, Malaysia and Viet Nam. Moreover, in some countries, the legal environment is changing and access to laws and regulations is sometimes not possible.

Approximately 13 million people inject drugs worldwide.[1] Prior to the 1970s, injecting drug use was confined mainly to North America and Europe. Now, however, the phenomenon has expanded to 158 countries and territories over the world.[2] The highest proportion of people who use drugs (PWUD) can be found in Asia, where 4.85 million people were reported to inject drugs in 2008[2] (see Figure 1).

In reality, a large proportion of people use drugs only occasionally, and the number of people who are drug dependent and need drug treatment is rather low.[3] We must keep in mind, however, some health problems that are often related to drug use. Injecting drugs puts PWUD at a greater risk of overdose, infections and health problems than if drugs were taken by alternative routes such as inhalation or swallowing. These dangers include the risk of transmission of blood-borne viruses, such as hepatitis B or C and HIV, through the use, re-use or sharing of unsterilized injecting equipment. It has been estimated that, globally, up to 10% of all HIV infections occur through injecting drug use,[4] which means that there may be up to 3.3 million injecting PWUD living with HIV/AIDS.[2] Finally, some PWUD have a long history of mental illness that may not have been properly diagnosed or treated. These mental conditions may result from, or be exacerbated by, the use of drugs.

Figure 1. The global distribution of people who use drugs



Source: International Harm Reduction Association 2008.

Since the beginning of the 21st century, the HIV epidemic has been rapidly growing among PWUD in many countries of South, Central and South-East Asia. A combination of factors increases the vulnerability of many Asian countries to the rapidly expanding HIV epidemic. One of these is the region's geographical location: the region is situated between the Golden Triangle[5] and the Golden Crescent,[6] with Afghanistan being the leading producer of heroin in the world. Heroin trafficking routes out of the Golden Triangle, mostly to North America, were originally largely southwards, going through Bangkok. In the 1980s, major shifts in drug trafficking led to the opening of new trafficking routes across China, India and Viet Nam. In addition, Colombian production shifted from cocaine to heroin and Colombia became North America's most important provider of drugs. The Golden Triangle producers, therefore, appear to have turned to new markets to sell their heroin. These shifts coincided with economic changes in many parts of Asia, including an increasingly mobile population, widening social and economic disparities and the emergence of a middle class with demand and capacity to pay for a wide range of commodities, including illicit drugs. As a consequence, the number of people involved in illicit drug use and trafficking grew massively in the region.[7] To these geographical and economic factors can be added the relatively high degree of criminalization and stigma attached to drug use in Asia, the high prevalence of sexually transmitted infections, poverty, gender inequality, and the general lack of HIV prevention, care and treatment services.[8] A local lack of knowledge on HIV transmission and prevention contributed to the rapid spread of the epidemic. Nonetheless, unlike in Africa, the Asian HIV epidemic is concentrated in identifiable high-risk groups, among them PWID, sex workers and men who have sex with men.[9] Therefore, HIV prevention and control strategies in the Asian region need to focus on these high-risk groups as a matter of priority.

At the international level, the notion of harm reduction has been endorsed and promoted by many multilateral agencies and, within the United Nations, particularly by the World Health Organization, UNODC and UNAIDS in joint policy and technical statements and guidelines. Harm reduction aims to reduce the negative health consequences associated with risky behaviours related to injecting drug use, without necessarily affecting the underlying drug use. Interventions related to harm reduction may include the dissemination of information on how to reduce risks associated with drug use, the provision of services which increase the safety of PWUD, such as needle and syringe programmes, condom distribution, and the treatment of AIDS. They may also include a range of drug dependence treatment options, such as opioid substitution maintenance therapy. Harm reduction also seeks to identify and advocate modifications in laws, policies and regulations in different countries.[2]

In many parts of the world, national governments have focused their response to drugs solely or largely on the criminalization of drug-related activities. Some Asian countries have adopted particularly harsh policies in their fight against drug trafficking and use. In China, Malaysia and Viet Nam, for example, the death penalty is still commonly used against drug traffickers.[10,7,11,12] Dependent drug users are considered as criminals and not as people suffering from a disease. In countries such as Cambodia, China, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, Thailand and Viet Nam, PWUD are arrested and sent to compulsory drug treatment centres, which are supervised by custodial staff, often with little involvement of trained staff or outside health agencies. One problem related to this type of response is that it does not differentiate between people who use drugs occasionally and those who are drug dependent. As a result, some PWUD are sent to such centres though they may not need drug treatment therapy. In addition, we will show that many of these centres do not receive adequate funding and the treatment and rehabilitation services provided to those who need it is of poor quality and neither in accordance with human rights' principles nor with evidence-based drug treatment or HIV/AIDS services for people who use and people who inject drugs. The treatment of PWUD, therefore, tends to take the form of sanction rather than of therapy and the relapse rate after release from the centres is very high.[13-16]

To describe the role of compulsory drug treatment centres in treating PWUD, this report focuses on four countries of the WHO Western Pacific Region that are particularly illustrative of this form of treatment: China, Cambodia, Malaysia and Viet Nam. The report describes the treatment provided to PWUD in compulsory drug treatment centres, assesses HIV interventions at the centres, and attempts to evaluate the treatment from the perspective of the right to health.

This report underscores drug dependence as a health issue. As mental health was found to be treated efficiently through medical assistance. The Western Pacific Regional Office of WHO believes that drug dependence should be treated medically, and not with a punitive approach. The framework for analysis of the situation and development of recommendations is guided by basic principles comprised in the right to health.

The right to health was first articulated in the WHO Constitution (1948),[21,22] which states that:

> "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

Subsequently, the right to health has been endorsed in a range of international human rights instruments (see Box 2). Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), for example, states that:

> "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[23]

This article also stipulates that the States should take the necessary steps to prevent epidemics.

Box 1: The international drug control regime

The international drug control regime is based on three United Nations treaties:

- *The Single Convention on Narcotic Drugs (1961)*. The Convention aims at combating drug abuse by coordinating international action. First, it seeks to limit the possession, use, trade, distribution, export, manufacture and production of drugs exclusively to medical and scientific purposes. Second, it combats drug trafficking through international cooperation designed to deter and discourage drug traffickers. Finally, Article 38 specifies that "Parties shall give special attention to, and takes all practicable measures for, the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved".[17] Therefore, medical care of people who use drugs may include all the tools required to treat the adverse health consequences of substance abuse.

- *The Convention on Psychotropic Substances (1971).* It established an international control system for psychotropic substances. It introduced controls over a number of synthetic drugs according to their abuse potential, on the one hand, and their therapeutic value on the other.[18]

- *The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).* It imparts comprehensive measures against drug trafficking. It provides for international cooperation through the extradition of drug traffickers, controlled deliveries and transfer of proceedings. Article 14(4) indicates that "Parties to the Convention shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering [...] which includes interventions to counteract the social and health consequences of drug dependence.[19]

The first two conventions predate the HIV/AIDS epidemic, while the third one predates the explosive global growth of injection drug use. Hence, while they benefit from considerable international support, these conventions may need to be revised today because some of their provisions affect the control of the HIV epidemic.

In 1993, to help rectify this contradiction, the International Narcotics Control Board acknowledged that harm reduction had a role to play in a tertiary prevention strategy for demand reduction purposes. However, the Board pointed out that while harm reduction programmes could play a part in a comprehensive drug demand reduction strategy, it could not be carried out at the expense of—or considered a substitute for—other important activities designed to reduce the demand for illicit drugs, for example drug abuse prevention activities. Similarly, the 1998 UNGASS report noted that it would focus more on "conservative opinions of how to address the problems of drug abuse and little place, if any, [would] be given for including the results of more innovative methods such as harm-reduction".[20]

However, the drug conventions are still consistently used by many governments as a basis to deny harm reduction services.[4]

Box 2: The core international human rights conventions signed or ratified by the study countries[24]

	Cambodia	China	Malaysia	Viet Nam
International Covenant on Civil and Political rights (1966)[25]	✓			✓
International Covenant on Economic, Social and Cultural Rights (1966)[26]	✓	✓		✓
Convention on the Elimination of all Forms of Discrimination against Women (1979)[27]	✓	✓	✓	✓
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)[28]	✓	✓		
Convention on the Rights of the Child (1989)[29]	✓	✓	✓	✓
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)[30]	Signed, not ratified			
Convention on the Rights of the Persons with Disabilities (2006)[31]	Signed, not ratified	Signed, not ratified	Signed, not ratified	Signed, not ratified

To describe the role of compulsory drug treatment centres in treating PWUD, this report focuses on four countries of the WHO Western Pacific Region that are particularly illustrative of this form of treatment: China, Cambodia, Malaysia and Viet Nam. The report describes the treatment provided to PWUD in compulsory drug treatment centres, assesses HIV interventions at the centres, and attempts to evaluate the treatment from the perspective of the right to health.

This report underscores drug dependence as a health issue. As mental health was found to be treated efficiently through medical assistance, The Western Pacific Regional Office of WHO believes that drug dependence should be treated medically, and not with a punitive approach. The framework for analysis of the situation and development of recommendations is guided by basic principles comprised in the right to health.

The right to health was first articulated in the WHO Constitution (1948),[21,22] which states that:

> "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

Subsequently, the right to health has been endorsed in a range of international human rights instruments (see Box 2). Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), for example, states that:

> "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[23]

This Article also stipulates that the States should take the necessary steps to prevent epidemics.

Box 3: The 3AQ criteria[32]

Availability	Functioning public health and health-care facilities, goods and services should be available in sufficient quantity. They should include drinkable water and adequate sanitation facilities, hospitals, clinics, trained medical and professional personnel receiving competitive salaries and essential drugs as defined by the WHO Action Programme on Essential Drugs.
Accessibility	Health facilities, goods and services should be accessible to everyone without discrimination. Accessibility includes: physical accessibility (within safe physical reach for all sections of the population, especially vulnerable or marginalized groups), economic accessibility (payment for health-care services has to be based on the principles of equity, ensuring that these services, whether privately or publicly provided, are affordable for all) and information accessibility (the right to seek, receive and impart information and ideas concerning health issues, however it should not impair the right to confidentiality.)
Acceptability	All health facilities, goods and services should be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.
Quality	Health facilities, goods and services should be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and not out-of-date drugs, hospital equipment, drinkable water and adequate sanitation.

Like others, PWUD should be able to enjoy the right to health. As PWUD are particularly vulnerable to the HIV/AIDS epidemic in Asia, according to the principles mentioned above from the ICESCR, special measures may be needed to ensure their access to the services that may protect them from HIV.

In May 2000, the Committee on Economic, Social and Cultural Rights, which monitors the implementation of the ICESCR, adopted General Comment 14, in which it identified four criteria to assess the realization of the right to health—namely availability, accessibility, acceptability and quality, also called the 3AQ[32] (see Box 3). In addition to these specific criteria, three general human rights principles are seen as key to characterize the right to health, namely non-discrimination, participation and accountability. This report uses these three principles as well as the 3AQ criteria as a framework to analyse the situation of compulsory drug treatment centres for PWUD and evaluate the efforts of the Cambodian, Chinese, Malaysian and Vietnamese governments in fulfilling the right to health for PWUD.

2. Situation analysis by country

2.1 Cambodia

2.1.1 General overview

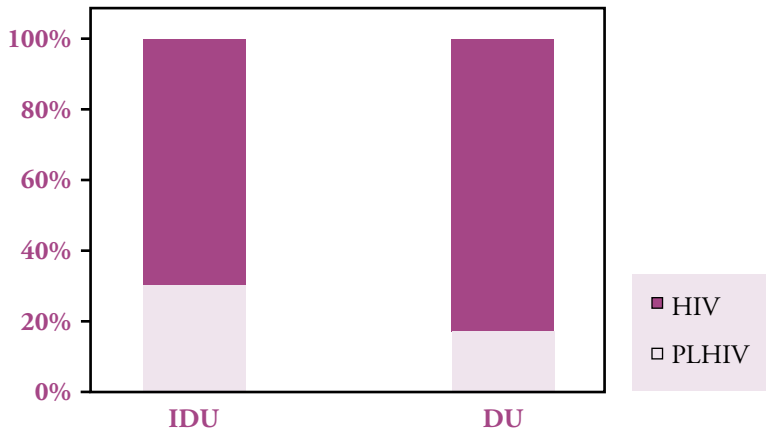
Estimates of the number of PWUD in Cambodia are limited, due to a lack of reliable official resources. In 2004, UNAIDS evaluated the number of PWUD at about 20,000 (representing 0.1% of the overall population) and, among them, 1,750 PWID.[33] A study carried out by the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) in 2007 shows that there is an HIV prevalence of 24.4% among people who inject drugs in Cambodia.[34] However, small scale surveys and routine surveillance indicate prevalence rates reaching 31% among PWID and 18% among non-injecting PWUD (see Figure 2).[35] No data are currently available concerning the proportion of HIV infections caused by drug injectors.

Cambodia is different from the three other countries in this study because it does not have a significant history of injecting drug use. The majority of drug dependent people in the country are estimated to be methamphetamine users, with smoking as the prevalent method of consumption.[36] However, the pattern of drug use in Cambodia is changing quickly. Many PWUD are shifting to injection as their mode of consumption, and injecting drug use has increased significantly from 0.6% of all PWUD in 2000 to almost 10% in 2004. This shift is mainly due to the rapidly increasing availability of cheap opiates, especially heroin. Overall, there is a growing risk of HIV transmission through drug use, either from people sharing injection equipment, or from PWUD who have unprotected sex.[35,37]

2.1.2 Legislation and policy on drug use and HIV/AIDS

At the international level, Cambodia has ratified the three United Nations Conventions on the control of drugs: the 1961 *Single Convention on Narcotic Drugs,* the 1971 *Convention on Psychotropic Substances* and the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (See Box 1 for more details on the international drug control regime).

Figure 2. Prevalence of HIV among people who use drugs



Source: DHAS 2008

Cambodia is also a State Party to a number of international human rights conventions. Box 2 shows the international human rights conventions signed, assessed or ratified by Cambodia, China, Malaysia and Viet Nam. All of these conventions, except for the International Covenant on Civil and Political Rights, recognize the right to health.

The rights of the Cambodian people are guaranteed first of all by their Constitution. Some of these rights are applicable to the residents of the compulsory drug treatment centres:

- Article 31 indicates that Cambodia respects the rights guaranteed by the United Nations Charter, the Universal Declaration of Human Rights, the covenants and conventions related to human rights, women's and children's rights.
- Article 32 stipulates that citizens have the right to life, personal freedom and security.
- Article 38 prohibits physical abuse against any individual, protects the life, honour and dignity of the citizens. Coercion, physical ill-treatment or any other mistreatment that imposes additional punishment on a detainee or prisoner shall be prohibited.
- Article 48: The state protects the rights of children according to the Convention on Children. In particular, it protects children from acts that are injurious to their education opportunities, health and welfare.[37]

The *Law on the Control of Drugs,* adopted in 1996 and amended in 2005, is the legislative framework for all illicit drug activities in Cambodia. The law strengthens the legal penalties for drug-related offences. For example, it provides for a maximum penalty of a 100,000,000 riel (US$ 25,000) fine and life imprisonment for drug traffickers. Any person arrested for offences related to drug consumption is brought to trial, unless the individual volunteers to enter into drug treatment, and the court issues an order for him/her to enter treatment at a drug treatment centre, whether the person is only an occasional drug user (and therefore does not necessarily need a drug treatment) or is drug dependent. Under the law, both methadone and buprenorphine are restricted substances.[38,39]

The Law on Prevention and Control of HIV of 2002 provides for education and information, access to HIV testing facilities, and access to health care for people living with HIV/AIDS (PLHA). The State must appropriately address all factors responsible for the spread of the HIV/AIDS epidemic in Cambodia, including through prevention education on the risks of HIV transmission associated with sex and drug use.[36] The law is important because it recognizes that, to control the HIV/AIDS epidemic, the State needs to take appropriate measures to address unsafe sex and drug use. This law may be seen as providing an opening to harm reduction initiatives.

In 1995, the government of Cambodia established the National Authority for Combating Drugs (NACD) to manage and coordinate drug control programmes in the country. The NACD comprises a range of Government agencies including health, education and social agencies. In 1997, the NACD created a Secretariat-General (NACD SG) to implement the decisions of the NACD Ministerial Committee. In 2006, the NACD signed a Memorandum of Understanding with the National AIDS Authority (NAA) to cooperate in the prevention, treatment and care of HIV/AIDS related to illicit drug use. This agreement between NAA and NACD led to the establishment of the Drug-Related HIV/AIDS Prevention, Treatment and Care (DHA) Working Group and Secretariat. The DHA developed the *National Strategic Plan on Illicit Drug-Related HIV and AIDS* (2006-2010) that includes harm reduction and related objectives concerning PWUD.[35] The plan aims to reduce the number of new HIV infections by scaling up prevention interventions, increasing coverage and the quality of care, treatment and support for drug-dependent PLHA, and alleviating the socio-economic and human impact of AIDS on drug-dependent individuals, their families, communities and society.[40]

The *Circular on the Implementation of Education, Treatment and Rehabilitation measures for drug addicts* of 2006 was issued to facilitate the implementation of a programme to address the rapidly increasing use of

illicit substances, especially methamphetamines. It stipulated that local authorities in Cambodia establish compulsory drug treatment centres for drug dependent people and encouraged the participation of communities, families and former PWUD in the process. Parents were asked to educate their children on the dangers of drugs and the community was prompted to develop prevention activities on the risks of drug use. Religious organizations were also encouraged to participate in educating PWUD and in developing treatment and rehabilitation activities through religious education.[41]

2.1.3 Treatment provided to PWUD in the compulsory drug treatment centres and HIV/AIDS interventions

Until recently, the Cambodian government tended to treat drug use as a security issue, and handled PWUD through strictly supervised drug treatment centres. However, recent efforts by a range of agencies have resulted in growing recognition by the Government, particularly the Ministry of Health, of the need to develop evidence-based health interventions in all drug treatment centres, with HIV prevention activities spearheading this approach.

There are currently 10 centres in 8 provinces of the country,[42] one run by the Phnom Penh Municipality, three by the Ministry of Social Affairs, two by the provincial police, and four by the Military Police of the Ministry of National Defence.[38] None of these centres is under the responsibility of the Ministry of Health.

Characteristics of the residents. 99% of the residents are men, 79% of whom are under 25 years of age. 51% of PWUD are unemployed, 20% are students and 8% are labourers. From interviews conducted among residents of the ten compulsory drug treatment centres during the first quarter of 2008, it appears that people with jobs mainly start to use drugs because they believe it improves their strength and productivity.[43] Students usually start to use drugs out of curiosity.

PWUD mainly use methamphetamines (87%), which cost US$1.50 per tablet, putting them within the economic grasp of many people close to, or below, the poverty line.[44] Even though injection of drugs seems to be rare in the country, according to available data on drug use, most PWID re-use or share needles and syringes because of the cost and lack of availability of sterile needles/syringes, and also because of low levels of awareness regarding HIV transmission through injecting drug use. In addition, many PWUD tend to have multiple sexual partners and 40% reported irregular or no condom use. In parallel, a 2006 study in Cambodia found high levels of both injecting and non-injecting drug use by sex workers, as well as drug use by their clients. Finally, some PWUD reported selling blood to finance their drug use. As the blood is not necessarily tested for HIV, it is another risk factor for the spread of HIV/AIDS.[45,46]

Entry procedures. A study conducted in 2008 showed that 83% of residents were entering treatment for the first time. Only one client out of 405 entered a drug treatment centre voluntarily. The majority of the residents are referred by their families, others are sent through the legal system.[43]

Most centres ask for a treatment contract to be signed between the parents of the resident or the police officer that arrested him/her and the centre, even when the resident is over 18 years old. This practice goes against the Cambodian Civil Law, (Decree 38D "Referring to Contract and other Liabilities") which gives the right to a person over 18 years old to sign his/her contracts.[47]

The centre in Siem Reap was reported to have residents who were not drug dependent. Some residents were mentally ill, but were not drug users and had been placed in the centre after being arrested by police authorities.[38]

The staff. None of the centres have trained psychologists or counsellors available onsite and few have doctors and nurses. Most staff members are administrative and law enforcement officials. Therefore, the centres are not able to cope with medical emergencies, cannot offer pharmaceutically assisted drug treatment, psychological or psychiatric assistance, and are unable to provide testing, counselling and treatment for HIV, sexually transmitted infections (STIs) or tuberculosis (TB).[38]

The cost. The *Law on the Control of Drugs* guarantees provision of free treatment in the centres. In reality, within the centres run by the Ministry of National Defence, admission costs between US$100 and US$200. Thereafter, residents or their relatives pay US$50 per month on average. Those who cannot afford to pay for the treatment tend to go to the centres run by the Ministry of Social Affairs where the services are free of charge, but the living conditions are much worse than those in the other facilities: the rooms are overcrowded, the medical equipment and personnel are even more limited than in the other centres and the nutritional value of food provided to the residents is very poor, resulting in many cases of beriberi.[13]

The treatment. The main drugs used by people who end up as residents in the treatment centres are amphetamine-type stimulants (ATS), especially methamphetamines. The best current evidence-based practice for treating ATS dependence and frequent inhalant use is psychosocial therapy, including cognitive behaviour therapy, motivational interviewing and contingency management. However, none of the centres use this kind of treatment approach, nor are such approaches available outside of treatment centres in Cambodia. Similarly, neither the centres nor the communities at large currently offer pharmacotherapy or mental health therapy for drug dependence. However, the Ministry of Health has plans to begin a methadone maintenance treatment (MMT) programme in late 2008 in the Cambodian capital, Phnom Penh. As for now, during the drug treatment phase, those who are suffering symptoms of withdrawal are simply isolated for a few days. Finally, there are no formal criteria to determine the length of the stay in the treatment centre. Usually, participants tend to stay three to six months, depending on how long the family is able to pay for the treatment.[38]

HIV prevention and treatment. Most of the centres have limited educational resources in the form of brochures for HIV and other STI prevention. None of the centres was reported to have condoms available for participants, though transmission of HIV through unprotected sex has been well documented in closed settings.[38] Antiretroviral therapy (ART) is not available in the centres, but some facilities have informal agreements with local nongovernmental organizations (NGOs) to bring such medication to the centres for residents who are former clients of the NGOs. The National Programme for HIV/AIDS in Cambodia plans to establish a basic HIV prevention strategy in the near future for such centres and to link them with nearby voluntary counselling and testing (VCT) sites and ART facilities.

Exit formalities and after-care follow-up. Most residents are released into the custody of their parents. However, the centres do not provide information to the families about how to help their relative avoid relapse. One centre, Chom Chao, does have a formal system for conducting follow-up of its participants. Some centres reported that they were doing follow-up with phone calls, while others provide the local police with the names of the former residents and ask them to check on the residents and their families.[38] These claims by the centres were not verifiable. The relapse rate in Cambodia after release from the centres is believed to be close to 100%.[13]

2.1.4 The role of NGOs and community-based organizations

There are several hundred NGOs operating in Cambodia. An increasing number of NGOs provide services to PWUD in the main urban centres of the country. These services include outreach activities which provide HIV prevention education, health promotion, home-based HIV care, referrals and condoms. Most of these NGOs have formed a network providing mutual support and referral as well as the sharing of technical training opportunities. This network is dominated by "Friends International", based in Phnom Penh. Family Health

International also provides some technical assistance to the drug treatment centre run by the Municipality of Phnom Penh, with funds from Round 7 of the Global Fund and USAID. The local NGO Inthanou provides a telephone hotline and website containing HIV/AIDS information, although not specifically targeting PWUD. Finally, the NGO Korsang, whose staff is mainly composed of ex-drug users, undertakes outreach to the drug using communities in Phnom Penh that is helping to inform policy-makers as to the nature and extent of drug dependence in the capital.[44] Korsang developed its activities during the period leading up to the national elections of July 2008.

2.1.5 Evolution of government policies in recent years

Cambodia's response to the HIV epidemic is considered the gold standard in Asia. Between 1998 and 2006, HIV prevalence rates among the general adult population (15-49 years) dropped from 2.0% to 0.9%.[48,49]

However, the response to HIV among PWUD, including services focusing on PWUD for harm reduction and HIV prevention, care and treatment, are limited. Recently, senior government leaders have stressed the need to develop a health response to drug dependence. In 2003, the Prime Minister stated, "Drug addicted people badly need health support and support from society rather than leaving them as outlawed people of society".[50]

Currently, outreach and education on HIV/AIDS are available in 10 of the 20 provinces, but most programmes target street children and sex workers. As a result, while more than 200 voluntary counselling and confidential testing centres operate throughout the country, few PWUD are aware of the risks of contracting HIV. Few are willing to enter such government operated facilities to be tested for HIV, for fear of being sent to a compulsory drug treatment centre. Similarly, while 87% of people living with AIDS are under ART, few PWUD benefit from the treatment.[49]

There are currently two government-authorized needle and syringe programmes (NSPs) being implemented by local NGOs, both located in Phnom Penh. More NSP facilities are planned to be established in the near future. Consequently, at present, access to this service is geographically limited.

Finally, treatment options for ATS dependence are virtually non-existent, though these are the drugs most commonly used by PWUD. As for opioid dependence, although MMT is not yet available in Cambodia, political commitment to provide it is strong, and the Ministry of Health has developed a pilot MMT programme which should begin by early 2009 for up to 100 opiate-dependent PWUD in Phnom Penh, as a joint venture between the Ministry of Health and a local NGO.[35,49]

2.2 China

2.2.1 General overview

China borders both the "Golden Triangle" and the "Golden Crescent", the two main opium producing areas in the world. Since the late 1980s, the country has seen a significant surge in illicit drug use, especially heroin coming through the Southern border. According to statistics from the Office of China National Narcotic Control Commission (NNCC), the cumulative number of registered drug users in China increased from 70,000 in 1990 to 956,000 in 2007, of which 749,000 were registered as heroin users.[14]

China's HIV epidemic remains one of low prevalence overall, but with pockets of high rates of infection among specific sub-populations and in some localities. Estimates show that by the end of 2007, approximately 700,000 were HIV positive and the HIV infection rate among China's population was equivalent to 0.05%. The transmission routes of new infections in 2007 are the following: 44.7% sex (heterosexual); 12.2 % sex

Figure 3. Prevalence of HIV cases among PWID.

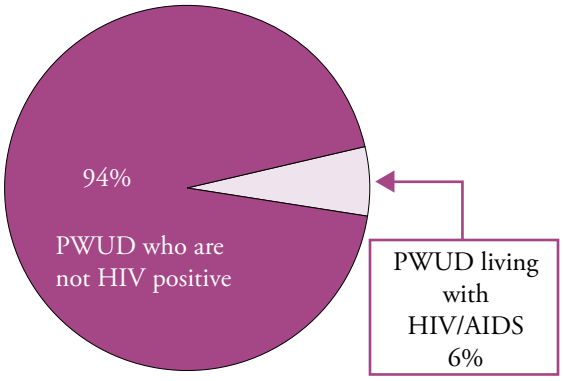
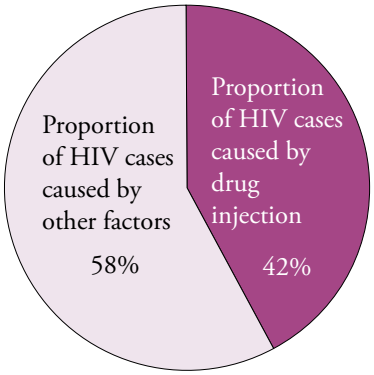


Figure 4. Proportion of HIV cases caused by drug injection.



Source: Mesquita *et al.* 2008

(homosexual); 42% IDU; MTCT 1%. Among the living HIV positives, 40.6 % were infected through heterosexual transmission.

Prevalence of HIV/AIDS among PWUD increased from 1.95% in 1996 to 6.48% in 2004. The epidemic is concentrated in Guangdong, Guangxi, Guizhou, Hunan, Sichuan, Xinjiang and Yunnan provinces, each province having over 10,000 PWUD infected by HIV/AIDS.[9]

2.2.2 Legislation and policy on drug use and HIV/AIDS

Several legal instruments (laws, regulations, action plans) provide China the legal context for the implementation of government policies intended to respond to illicit drug use, including:

1. the *Decision on Drug Prohibition,* issued in 1990;
2. the Strategic Program of the Ministry of Justice for HIV/AIDS Prevention and Control (2003-2007) issued by the Ministry of Justice in 2003;
3. the Implementation Measures on AIDS Prevention and Control at Re-education through Labour Institutions in China issued jointly by the Ministry of Justice and the Ministry of Health in 2004;
4. the Regulations on Drug Rehabilitation through Labour issued by the Ministry of Justice in 2003;
5. the State Council's 1995 *Methods of Forced Detoxification;* and
6. the Narcotics Control Law of the People's Republic of China adopted by the Standing Committee of the People's Congress on 29 December 2007, which entered into force on 1 June 2008.

This latest legal instrument is expected to change the existing rehabilitation and treatment system that, in a summarized way, is currently arranged as follows: drug users who do not seek voluntary assistance, are placed for 3 to 6 months into compulsory rehabilitation and treatment centres under the administration of the Ministry of Public Security (MOPS). Those who relapse after the mandatory rehabilitation and treatment are subject to re-education through labor under the authority of the Ministry of Justice.[14] In these centers, drug-dependence treatment, education or HIV prevention programmes are limited. More resources are available for these purposes in centers located in Eastern China and less in those based in Central and Western China.

The Law of the People's Republic of China on Narcotics Control, promulgated in December 2007 and endorsed on 1 June 2008, provides the supportive legal environment for the prevention and punishment of illegal and criminal acts involving narcotic drugs, and for the protection of citizens' physical and mental health while maintaining public order. It provides for expanded multisectoral cooperation among government agencies (particularly between the Ministries of Public Security, Health and Justice) to respond to the issue of drug use.[51] The new Narcotics Control Law introduces the concept of community drug treatment and rehabilitation as the primary means to treat people dependent on drugs with the aim to reduce drug relapse rates and help drug users to return to the society. The law also states that pregnant women and minors under 16 cannot be sent to a compulsory drug treatment centre; they can only attend community-based programmes. Finally, the compulsory drug treatment centres must provide necessary care for disabled or sick people who are drug-dependent. The centres need to be well equipped and receive the expertise of medical practitioners "in light of the needs of drug rehabilitation treatment."[52]

The exact potential and scope of the new drug law is yet to be fully grasped, as much will depend on its effective implementation.

With regard then to HIV prevention and AIDS care and treatment, three instruments are cited here: 1) The *Action Plan of China for Controlling, Preventing and Treating AIDS* (2002–2005) proposing actions to reduce high-risk behaviours and offering policy foundations for harm reduction interventions for PWUD.[53] 2) *China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS* (2006–2010) has encouraged the expansion of NSPs and MMT programmes across the country and the 3) *"Regulations on AIDS Prevention and Treatment"* issued by the State Council on 1 March 2006.[54,55]

China has ratified all three United Nations Conventions on drug control (See Box 2 for information on China's ratifications of various international human rights conventions).

2.2.3 Treatment provided to PWUD in the compulsory drug treatment centres and HIV/AIDS interventions

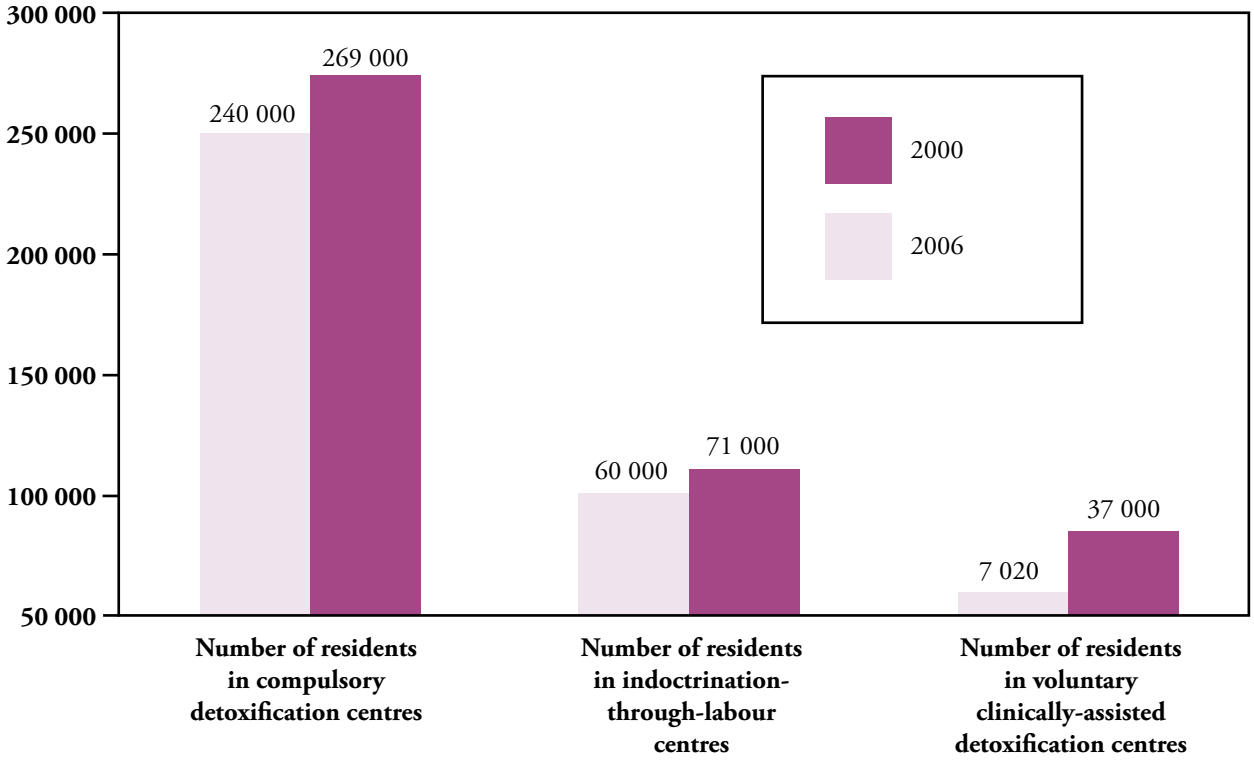
Thus, so far, the government of China has mainly relied on compulsory drug rehabilitation and treatment centres and re-education through labour centres to address the issue of PWUD. Voluntary drug treatment centres that carry out clinical drug treatment therapy also exist, but their number is limited and the cost of such treatment is high. Compulsory drug treatment centres are still the most common type of response (see Figure 5), but voluntary methadone maintenance treatment has now become one of the key elements in the government's response to drug use. By the end of 2007, 97,554 PWUD were enrolled in a MMT programme, compared to only 37,000 in 2006.[14,53,56,57]

Focus on Yunnan province to assess the situation in the drug treatment centres

The Province of Yunnan is the most exposed to drug trafficking from the Golden Triangle. In this Province, the number of PWUD is high, with no less than 91 compulsory drug treatment centres and 23 voluntary drug treatment centres.[58]

Characteristics of the residents. In the centres, most PWUD are 20 to 30 year-old men, but female adolescent users have increased rapidly since the 1990s. Between 1999 and 2000, the number of female drug users increased by 16.9% and in 2000, the Ministry of Public Security estimated the number of female drug users at 138,000. According to a survey conducted by the National Narcotics Control Commission in drug treatment centres in 14 provinces, female drug users account for 17% of residents and most are less than 25 years old.[59] Female and male drug users are sent to separate centres.[14]

Figure 5. Evolution in the treatment of drug dependence in China, 2000-2006



The educational level of PWUD is generally low, and most residents only have a primary or junior high school education. A large proportion (50%) of PWUD are unemployed and those with jobs are farmers, drivers and self-employed workers.[60,59]

Interviewed residents reported that they mainly used heroin through injection because it was cheap and easy to find. Most of them spend between 1,000 and 2,000 Yuan (US$ 146 to US $292) on drugs every month.

The use of contaminated syringes and sharing of syringes appears to be very common among PWUD. Syringe sharing is the main reason for HIV infection among PWUD, and almost all PWUD who are infected with HIV/AIDS have a history of syringe sharing. The phenomenon of multiple sexual partners is also common among PWUD, and condom use is rare.[59] In addition, a survey conducted among 126 PWUD in Kunming indicates that 39.2% of women PWUD become sex workers before using drugs, while the percentage reaches 87.8% for those who became sex workers after becoming dependent on drugs.[58] Some PWUD also rely on stealing, drug trafficking and other illegal activities to buy drugs.[59]

The staff. The compulsory drug treatment centres are staffed with few doctors and nurses who have received some professional training. Interviews conducted in Yunnan compulsory rehabilitation and treatment centres in 2003 indicate that most of the work is undertaken by public security officials. As for the voluntary drug treatment centres that offer medical treatment, although the staff is mainly composed of medical professionals, some of them lack specific training in dealing with drug dependence and occasional use.[53] Interviews with staff members indicate that PWUD are exposed to discrimination and stigma.[59,61]

Entry procedures. After admission of the PWUD to the centre, the new residents have to undergo a physical examination and diagnosis.

The cost. The cost of the therapy, which amounts from 2,000 to 3,000 Yuan (US$ 292.00 to US$ 438.00), is borne by the PWUD and their families. Those who are unable to afford such expenses can receive a reduction or exemption of the expenses, depending on their situation. Different fee schedules are adopted by the various centres, depending on the living and treatment conditions provided.[53] The voluntary treatment centres that provide clinical drug treatment are the most expensive—the cost of the treatment can reach up to 5,000 Yuan (US$ 729,00)—and many PWUD cannot afford to attend the programme.[14]

The treatment. The drug therapy is often based on drug-abstinence methods, but sometimes includes decreasing therapy with substitution medicines (opioid-type: methadone or buprenorphine), detoxification strategy (with non-opioid type medicines: clonidine or lofexidine),[62] traditional Chinese medicines[63,64] and the use of other medicines according to the situation of the patient.[53,65]

PWUD in these treatment centres follow rigid daily schedules of activities. Recovery therapy is administered in groups and there is no individual therapy. Residents attend courses on culture, the Chinese legal system, current events and health. They are also expected to write about their personal experiences, as well as attend various recreational and sports activities.[14] Interviews among PWUD in several centres of Yunnan province indicate that drug education was rather limited and superficial. Moreover, although the centres are to carry out community education, they seem to be doing it only rarely.[53]

In the voluntary drug treatment centres, residents are treated with methadone or buprenorphine for a period of 21 days. The rehabilitation stage lasts for two to three months. The therapy consists of health education, psychological recovery and recreational activities. However, there are few systematic individual therapy and rehabilitation schemes. There are also few interventions focusing exclusively on teenagers and their families.[53]

HIV prevention and treatment. Until recently, no government-run drug treatment centres in China offered a comprehensive package of HIV prevention and treatment services. Recently, through the efforts of the Yunnan Institute for Drug Abuse, HIV prevention education has been introduced in some centres. Today, HIV testing is automatic upon arrival at the centre. ART is currently available in some drug treatment centres and the government is planning to expand ART provision to other centres.[66]

Exit formalities and after-care follow-up. A contract is signed by the patient's parents, requiring that they commit themselves to recovery supervision after the patient leaves the centre. There is no after-care follow-up for the PWUD, apart from that provided by the family. Interviews in several treatment centres in Yunnan revealed a lack of community-based drug treatment, rehabilitation and after-care treatment plans for PWUD.[53] As a result, when released from the centres, PWUD have difficulties reintegrating into a society which still stigmatizes and discriminates against them, and only offers limited work opportunities. This leads to a high relapse rate that can sometimes reach up to 95%.[14]

2.2.4 The role of NGOs and community-based organizations at the national level

China has a large number of government-sponsored mass organizations, including Family Planning Associations, the All China Women's Federation, the Red Cross, Youth League, trade unions and various academic associations. These organizations support HIV/AIDS education, research and academic publications. NGOs that are independent of the government are rare in China.[67] However, the recent scaling up in MMT programs and trials of other harm reduction interventions have created some more opportunities for drug users to benefit from active advocacy strategies.

2.2.5 Evolution in government policies in recent years

For a long time, the treatment offered to PWUD was limited to that provided in the drug treatment centres. The Yunnan Institute for Drug Abuse (YIDA) – member of the Yunnan Provincial Leading Group on HIV/

AIDS and established under the supervision of the Provincial Department of Health – is a leading Chinese institution on drug use. YIDA was the first institute in China to start a number of programmes for PWUD.[58] It focused on HIV prevention activities, drug treatment, rehabilitation and care, and the training of trainers on drug issues. YIDA initiated five pilot needle and syringe programmes and began to provide short-term methadone maintenance treatment.[7] It drew its methods from psychiatry, behavioural science, psychology, and sociology, to reintegrate PWUD in society and prevent relapse. This therapy mode has had some success, with relapse rates going down to 50%, from the 90% registered in other compulsory drug treatment centres.[58]

The 2003 SARS epidemic demonstrated to the government the impact that public health can have on social and economic stability. A considerable increase in funding and commitment from policy-makers followed and resulted in a change in China's HIV response.[68] A new form of treatment and services for PWUD began to develop, in parallel with the old system of compulsory drug treatment centres. In the past few years, China has achieved progress in its response to HIV/AIDS:

Development of HIV/AIDS surveillance. Under the direction of the Ministry of Health, the National Centre for AIDS/STD Control and Prevention (NCAIDS) has been collecting and interpreting scientific data to optimize HIV/AIDS policy formulation in China. The National HIV/AIDS Surveillance Programme has provided valuable data for monitoring trends in the epidemic and directing the government's response. By the end of 2006, there were 159 national behavioural surveillance sites in 27 Chinese provinces, covering key high-risk populations, among them PWUD. Surveillance of the epidemic has been significantly enhanced since the Ministry of Health established a web-based case reporting system in 2005.[69]

Voluntary testing and counselling. Testing services were expanded and subsidized. In 2005, the Ministry of Health, the Ministry of Justice and the Ministry of Public Security jointly implemented mass HIV screening in compulsory drug treatment centres, prisons and other settings. This practice is compulsory upon entry in the drug rehabilitation and treatment centres.[69] As for counselling and informing, an experimental study in Yunnan demonstrated that the provision of a web-based education programme had upgraded health knowledge and attitudes among both villagers and students in rural areas. Therefore, in a country that ranks first in the world for internet access, the provision of computers, proper logistic support and appropriate websites may help to reduce the gap in health knowledge between sophisticated wealthy urban centres and poorer rural areas.[70]

Needle and syringe programmes. The first needle programme was piloted by the government in the Yunnan Province and Guangxi Region in 1999. Interventions in the centres, mainly consisted in health education provided by health workers, which included handing out educational pamphlets, displaying educational posters, delivering lessons about drug abuse and HIV/AIDS by health workers, holding photo exhibitions and showing educational videos. In the community, intervention activities included handing out educational pamphlets, displaying educational posters, holding face-to-face health education sessions between health workers and PWUD, conducting peer education and dispensing and recall of needles. Local outlets such as pharmacies, hospitals and clinics were used to reach out to PWUD. Needles and syringes were distributed mainly by peer educators who visited homes of PWUD or the places where they gathered, and who usually distributed between 3 to 10 needles at a time.[54]

A study of these pilot programmes demonstrated that NSPs could reduce risk behaviours among PWUD and therefore limit HIV infections. Importantly, the rate of injecting drugs decreased. In 17 out of 31 Provinces, 775 NSPs were established by the end of 2007. By 2010, no less than 50% of PWUD in the areas implementing NSPs should be provided with clean needles and syringes. However, the programmes still face many challenges to effective implementation, the most important being the fact that there is not yet clear reference to NSP in the legal framework to tackle drug use and HIV. Therefore, the necessary cooperation with the police depends on ad hoc agreements reached at local level rather than on established national

practices which would prevent arrest of drug users who approach NSP sites. Thus effective coverage for these programmes is limited.[9,54,71]

Methadone maintenance treatment programmes. MMT is a safe and effective therapy to control dependence on opioids and its related HIV transmission among PWUD. In 2004, the Ministries of Health and Public Security and the State Food and Drug Administration joined forces to pilot China's first methadone treatment programme, establishing eight clinics nationwide. At the beginning, eligibility for participating in the programme was strictly restricted and deterred many people from accessing the treatment.

A study conducted between 2004 and 2005 in the MMT clinics indicated that, as the MMT programme progressed and the number of patients increased, local drug markets began to shrink, crime rates declined, and individuals increasingly began to understand and support the programme. Nevertheless, the dropout rate was high, and in July 2006, MMT services were adjusted and improved. The new regulations on MMT programmes lower the entry threshold and more comprehensive services were added to the standard MMT, among them, referrals for testing of hepatitis and STIs, health education, group activities, social support and skills training for future employment. MMT has now become a key component of China's drug control and HIV strategies. By the end of 2007, 503 MMT clinics were established in 22 provinces, covering close to 100,000 PWUD. By 2010, *China's Action Plan* (2006–2010) provides the expansion of MMT programmes to every county and city which registers more than 500 PWUD.[9,55] The annual retention rate among participants receiving treatment in MMT clinics in 2007 was 72%. The entry threshold appears to be still high, but actions are being taken in this regard.[72]

Anti-retroviral treatment. Prior to 2003, few people in China had access to ART, and the numbers were even lower among the PWUD community. In 2003, the Chinese government launched the China's National Free ART Programme. The Ministry of Health was entrusted with the management and supervision of treatment and care, including training and technical guidance. By the end of 2007, between 19% and 38% of people known to have AIDS were receiving ART (we need indication of the source for this figure. The note does not provide any).[73] Within this group, few are PWUD. This may be mainly due to the fact that ART is not provided in drug treatment centres and that integration of methadone clinics with ART is limited. In response to this challenge, the Ministry of Health is developing policies to generalize ART in methadone clinic services and detention centres.[66]

Funding for implementing these new policies has been sought mainly from national governmental sources, but also with some contribution from global health initiatives such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, the World Bank, United Nations agencies and bilateral donors.[68] These remarkable achievements, particularly in the scaling up of MMT, and in such a short period of time, indicate that China is strongly committed to limiting the epidemic and maintaining a low HIV prevalence in the future.

2.3. Malaysia

2.3.1 General overview

Based on data up to December 2007, it was estimated that the number of people living with HIV/AIDS in Malaysia was 69,000 out of a population of 25,347,000 (with a prevalence rate of 0.3% of the overall population) and 73.7% of HIV infections occurred among PWUD.[9] As a consequence, the epidemic in Malaysia is clearly a concentrated one, due to a high frequency of sharing injecting equipment among PWUD. In 2007, the National Anti-Drugs Agency estimated the total number of PWUD at 279,907, representing 1.1% of the overall population.[74]

Figure 6. Prevalence of HIV cases among PWID.

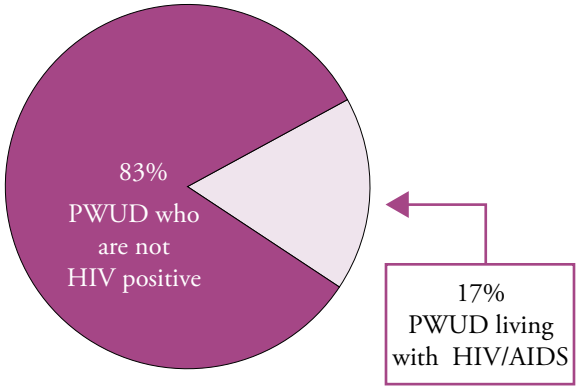
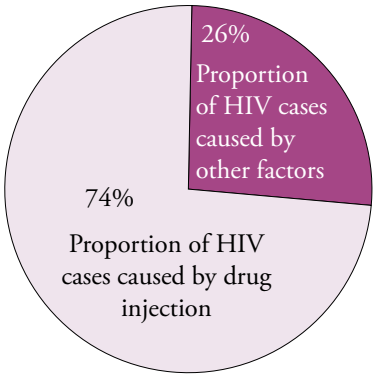


Figure 7. Proportion of HIV cases caused by drug injection.



Source: Mesquita *et al.* 2008.

2.3.2 Legislation and policy on drug use and HIV/AIDS

The Malaysian Constitution confers upon citizens several basic rights, but all of these rights may be overruled by national laws, if necessary.[75]

Malaysia, too, has ratified the three United Nations Conventions on drug control (See Box 2 for information on the international human rights conventions ratified by Malaysia).

The *Dangerous Drugs Act* (1952) describes the punishments for drug-related crimes. The possession of 5 to 15 grams of heroin can result in a life sentence, while being in possession of more than 15 grams may result in the death penalty. Drug trafficking can also be punished by the capital punishment.[12] In 2007, over 54,000 people were arrested under the Dangerous Drugs Act.[74]

The *Drug Dependants (Treatment and Rehabilitation) Act* (1983) established compulsory drug treatment centres, placed under the supervision of the Ministry of Home Affairs. Upon arrest, drug users undergo drug use testing. If the test is positive, the PWUD appears before a Magistrate, who sends the user to a drug treatment centre for a period of two years. Thus, the law does not make a distinction between occasional drug users and those who are drug dependent, in referring them to a centre. Referral by a parent or a guardian for a minor is provided for by the law. The person who uses drugs has the right of voluntary referral to a drug treatment centre, but this is rarely exercised in practice. After release from the centre, PWUD undergo after-care treatment for a period of two years.[76] The treatment for PWUD therefore lasts four years, longer than the treatment provided in China and Cambodia, which usually lasts between three months and one year.

2.3.3 Treatment provided to PWUD in the compulsory drug treatment centres and HIV/AIDS interventions

The government has established and funded 28 compulsory drug treatment centres nationwide, all run by the Ministry of Home Affairs. There are, on average, between one and three centres per state, none of which are situated in Kuala Lumpur. The average occupancy in governmental drug treatment centres is between 600 and 1500 residents.[74] The number of residents attending treatment in these centres has tended to decrease over time, due to the new harm reduction policies adopted by the government.[77] In 2007, 7,135 PWUD were sent to government-run compulsory drug treatment centres.

In 2007, another 7,195 PWUD attended the 55 private drug treatment centres registered with the National Drug Agency.[78] Private drug treatment centres accept voluntary PWUD or PWUD sent by their families. Those who attend these programmes must pay for all or part of the cost of the treatment. These private centres, often run by NGOs, are smaller (providing services to 30 people at most), and tend to have more dedicated staff and offer better support to residents attending the programme. However, as in the government-run centres, residents are not provided with medically-assisted treatment through substitution therapy.[77] Therefore, these centres are not an enduring solution for the treatment of PWUD.

The description that follows concerns the government-run compulsory drug treatment centres.

Characteristics of the residents. 97.6% of PWUD are men, aged between 20 and 39, and most of them inject heroin or morphine.[74] Very few women are reported to be PWUD, but those who are face even more social stigma and discrimination than men who inject drugs.[79]

PWUD usually have a low educational level, with 44% having attended primary school and 31% having completed a high school diploma. Most PWUD are factory workers (20%), traders (14%) or farmers (11%). They generally began using drugs under the influence of their friends, out of curiosity, or because of a need for mental occupation (they stopped going to school and/or they could not find a job).[76] Drug use is, therefore, closely related to poverty and low levels of education.

71% of PWUD were reported to share injecting equipment. Although 77.6% of PWUD within the centres were reported to be sexually active, only 18.7% used a condom during their last sexual intercourse. Finally, a large proportion of sex workers were reported to use drugs, and only few of them said they had used a condom with their most recent client. 16.8% of PWUD enrolled in drug treatment were reported to be HIV positive.[79]

The staff. The staff consists of social workers, counsellors, medical officers, religious teachers, education and military personnel and security officers.[79]

Entry procedures. Upon arrival, there is no medical examination, but HIV testing is compulsory for every new resident.

The cost. The treatment is fully subsidized by the government.[76]

The treatment. Many of the drug treatment centres are former camps of the paramilitary forces that were used against communist terrorist operations. Drug treatment is entirely abstinence-based and rehabilitation of residents is strictly supervised. In 2007, the government developed MMT pilot programmes in three prisons, but today, none of the drug treatment centres benefit from MMT.[15]

HIV prevention and treatment. The residents are automatically tested for HIV upon entry and release from the centres. HIV prevention education is limited to a short briefing upon entry. With the development of harm reduction policies by the government, ART and a few condom kits were introduced in the centres.[77]

Exit formalities and after-care follow-up: After-care day centres focus on ex-PWUD leaving the drug treatment centres. They provide a space that allows the opportunity for counselling and other related activities. There are also 18 after-care centres offering residential programmes. All recovering PWUD are required to attend a two-year after-care programme (in either a residential programme or a day centre) upon their release from drug treatment centres. In 2007, 33,317 PWUD were monitored through this follow-up system.[74] Despite this system of follow-up, the relapse rate is still high in Malaysia and can reach 70% to 90%.[15]

2.3.4 The role of NGOs and community-based organizations

At present, there are very few NGOs focusing their efforts on PWUD. The NGO Ikhlas in Kuala Lumpur has managed to achieve some success, but not much in the area of reform needed in existing laws.[78] The NGO Pengasih, whose staff is mainly composed of ex-drug users, has adopted a community-based peer outreach education programme.[80]

The Malaysian AIDS Council, created in 1992, is the umbrella organization for all NGOs working on AIDS. It receives its funds from the Ministry of Health. It also solicits donations from corporate bodies and individuals and organizes fundraising activities. The money collected goes into the Malaysian AIDS Foundation. Since its establishment, the Malaysian AIDS Council has been very active in working to reduce the stigma against AIDS victims and their families, including for PWUD.[81]

2.3.5 Evolution in government policies in recent years

From a punitive approach of sending PWUD to strictly-supervised drug treatment centres, the response to the HIV/AIDS epidemic in Malaysia has evolved rapidly in the past years. In 2005, the government realized that it was lagging with respect to the Millennium Development Goal addressing HIV/AIDS, and a new sense of urgency and commitment in responding to this challenge resulted in Malaysia's *National Strategic Plan on HIV/AIDS for 2006–2010.* Responsibility for drug treatment now rests with the Ministry of Health, the Cabinet Committee of AIDS, the National Advisory Committee on AIDS and the Technical Committee on AIDS. Recent years have also seen an increase in the willingness of religious leaders and organizations to get involved in harm reduction. The reality that the majority of those living with HIV/AIDS in the country were Muslims has encouraged the development of new programmes and sensitized Muslim leaders to the issues and the methods of preventing the spread of HIV.[79] The National Strategic Plan includes:

- *HIV surveillance system.* With the support of WHO and UNICEF, Malaysia has focused on developing and strengthening its HIV surveillance system to improve the understanding of its own epidemic and fine-tune its response appropriately.[79]
- *Voluntary testing and counselling.* The HIV Voluntary Screening Programme was piloted in 2001 and expanded nationwide in 2003. In 2006, more than 12,000 people took advantage of this facility. Premarital HIV screening has also been introduced for all Muslims wanting to get married, to promote earlier detection of HIV and thus better possibilities of treatment.[79] However, this initiative could further strain gender relations in Malaysia.
- *Needle and syringe programme.* In 2006, a pilot NSP was set up in a successful partnership with community-based organizations, law enforcement bodies and anti-drug agencies at several separate locations in Malaysia. The country now has six NSPs coordinated by the Malaysian AIDS council, which reach 3,600 PWUD. The facilities provide PWUD with free syringes and needles and education on safer injecting techniques.[79]
- *Methadone Maintenance.* Treatment programme: The MMT programme has been scaled-up continuously since it was introduced in October 2005. The country has now 74 free MMT services serving more than 4,000 PWUD. MMT has been extended to drug treatment centres and more recently to prisons, starting with a pilot project in the Pengkalan Chepa prison. Methadone availability is being enhanced and monitored by the Ministry of Health, and its cost has been reduced.[79] However, MMT provision in drug treatment centres is still a pilot project and therefore available only in three centres. In addition, laws and policies still consider methadone as illegal and police raids at methadone clinics and NSP facilities sometimes happen.
- *Antiretroviral treatment.* Since 2006, a major accomplishment has been the availability and provision of ART at no cost for PLHA, with 35% of those who fulfil the criteria for initiating ART currently under treatment.[72] The government further improved access to HIV treatment

by extending its provision to PLHA in prisons and drug treatment centres. Currently, four government-operated drug treatment centres provide ART to their residents.[72,79]

2.4. Viet Nam

2.4.1 General overview

At the end of 2008, 302,000 people in Viet Nam were estimated to be living with HIV/AIDS, a number representing 0.5% of the overall population.[82] Since 1990, the majority of reported HIV infections and AIDS cases have occurred among PWID, who represent up to 65% of PLHA.[83] The epidemic therefore remains "concentrated."[9] By the end of 2007, there were about 166,440 PWUD nationwide.[16]

2.4.2 Legislation and policy on drug use and HIV/AIDS

HIV/AIDS is one of the seven national development priorities in Viet Nam. Policies for HIV prevention, however, have been hampered by their uneasy and sometimes conflicting relationship with policies on so-called "social evils", in particular illicit drug use and sex work. The illicit drug policy in Viet Nam is based on a zero tolerance approach. Criminal activities related to drugs—production, manufacture, drug trafficking—fall under the responsibility of the Ministry of Public Security. Capital punishment is permissible for drug production and trafficking and life imprisonment for possession of drugs.

Regarding international law, Viet Nam has ratified the United Nations Conventions on drug control, as well as a number of international human rights conventions (see Box 2 for details).

Article 61 of the 1992 Vietnamese Constitution states that: "The State shall enact regulations on compulsory treatment of drug addiction."[84] Viet Nam opened its first MMT clinic on 29 April 2008. Substitution treatment is thus a relatively new method. Currently, the majority of PWUD are "treated" in abstinence-based drug treatment centres and through detoxification campaigns organized at the community level. As in Cambodia and Malaysia, the laws and regulations do not differentiate between those who use drugs occasionally and those who are drug dependent. The responsibility for dealing with PWUD and the drug treatment centres lies with the Ministry of Labour, War Invalids and Social Affairs, not the Ministry of Health.[7]

Figure 8. Prevalence of HIV cases among PWID

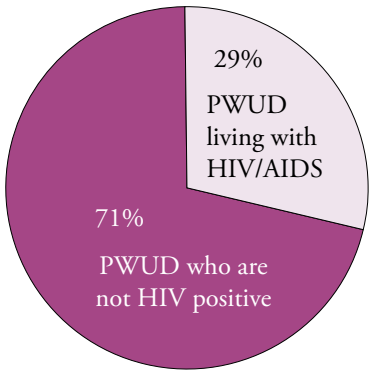
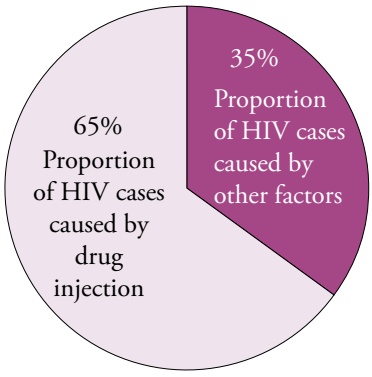


Figure 9. Prevalence of HIV cases attributed to drug injection.



Source: Mesquita *et al.* 2008.

HIV prevention measures were initiated in 1993 and predominantly involved mass education for the general population and small-scale needle/syringe distribution for PWID. In 2003, such programmes were expanded with financial support from international donors (the UK Department for International Development, the Norwegian Directorate for Development Cooperation, and the World Bank).[9]

In December 2000, the National Assembly adopted the first law on drug control and prevention: the *Law on Narcotic Drugs Prevention and Suppression.* The law recognized that the prevalence of drugs was a social problem, but it identified drug use as a "social evil".[85] The treatment period was extended to last one to two years for drug treatment, and an additional one to two years for rehabilitation. In 2003, the National Assembly enacted Resolution 16, which extended the period of compulsory drug treatment detention for an additional period of up to four years for rehabilitation. This resolution was implemented only in a selected number of provinces. Subsequently the compulsory detention period was increased to six years.

An impressive government response on HIV/AIDS over the past five years has seen an expansion of public health programmes and policies. Under the *Law on HIV/AIDS Prevention and Control* promulgated in 2006 and *Decree No. 108/2007/ND-CP* which came into effect on 1 January 2007, the Ministry of Health is specifically mandated to lead harm reduction activities for HIV prevention among most at-risk groups and to work with the Ministry of Public Security and the Ministry of Social Affairs to ensure the implementation of NSPs, condom distribution and MMT programmes.[86,87]

2.4.3 Treatment provided to PWUD in the compulsory drug treatment centres and HIV interventions

In Viet Nam, 109 government-run compulsory drug treatment centres have been established, in which 50,000 to 60,000 PWUD are required to go through drug treatment, education and occupational training for a two-year period. [16] There are also 19 privately owned centres in the country.[16] According to Vietnamese laws and regulations, there are two categories of centres: "05 centres" were established for sex workers, while "06 centres" were designed for PWUD. However, in practice, PWUD and sex workers often end up being sent to the same centres.[88] The two categories of centres are sometimes sub-divided to provide separate facilities for men, women and youths.

Characteristics of residents. 90% of PWUD are men, among whom 68% are 20 to 30 years old.[16]

Most residents said they had only received primary school education. Only 0.7% studied in high schools or colleges. 54% of PWUD are unemployed, the rest are peasants or students.[16]

PWUD most commonly use heroin by injection (78.6%), which can be found at a relatively cheap price across the country. However, the price of heroin has increased dramatically over the last 12 months. Among PWUD, unsafe cleaning methods in injecting drug use and shared injecting equipment are worrying factors. In addition, 75% of residents have more than one sexual partner, and condom use is rare (70% of PWUD reported not having used a condom during their most recent sexual intercourse).

Entry procedures. Most people who are drug dependent are admitted for compulsory treatment (86%). The remaining 13% come voluntarily.[89] Newcomers (and their families) are informed of entry procedures, benefits of the treatment and living conditions in the centre. Initial examination of the patient is then conducted. Voluntary residents reportedly tend to receive better care and access to more services than PWUD who were sent to the centres against their will.[90]

The cost. The treatment is subsidized by the government and in 2005, the government invested more than US$70 million in the centres.[91] However, the families of residents often incur substantial additional costs for food and other personal supplies, including health care. In some centres, residents sometimes work in

the factories or farms attached to the centres (referred to as "therapeutic labour") so as to reduce the financial burden for their families. However, most compulsory drug treatment centres are small and do not have any factory or external facility associated with them. [91]

The staff. Even though nurses may work in some centres, many facilities do not receive the expertise of a doctor and only employ a physician assistant. The staff is usually composed of government officials, managers or social workers who are paid relatively low salaries.[90] 49% of the staff members have only primary level education, and only 15% have received training in health care. Most have only basic knowledge of HIV or overdose prevention.[16]

Interviews in the drug treatment centres of four Vietnamese provinces indicated that staff members usually have a negative opinion concerning PWUD, suggesting that stigma is prevalent in the facilities where PWUD are treated.[90]

The treatment. Government Decree No. 108/2007/ND-CP prohibits the use of substitution therapy in the compulsory drug treatment centres,[87] thus, the treatment provided to residents is mostly abstinence-based. New residents may be provided with tranquillizers during the detoxification phase or traditional herbal preparations, sometimes combined with physiotherapy in some centres. During detoxification, about 60% of the residents are reported to suffer from various withdrawal symptoms, but lack adequate treatment for these.[90]

After the detoxification stage, residents may be sent for counselling and education in some centres. Although only a few residents reported actually telling the counsellors about their problems, 78% of them said they felt more self-confident after counselling, but drug counsellors are only employed in two centres in Ho Chi Minh City.

"Therapeutic labour" is used in most centres. It could consist of (often mandatory) labour work, knitting and tailoring, livestock breeding and farming, cleaning jobs, gardening, cooking, typing and hairdressing. These activities are seen by the staff at the centres as an important part of the treatment provided to the residents. Nevertheless, job training for residents is basic and may be inadequate for finding employment when they go back to their communities. Persistent unemployment after release from the centres is often reported to be a reason for relapse.[90]

Deteriorating infrastructure at the centres is commonly reported by staff members and residents. Facilities are sometimes short of recreational areas, communication sections, workshops for production of goods, suitable residential facilities and mostly medical and health care facilities.[90]

There appears to be some probability of escape from the centres: depending on the centres, between 1% and 30% of the residents attempt breakouts. On average, about 2% escape each year.[92]

HIV prevention and treatment. Considering the high prevalence of HIV infection among PWUD, the provision of knowledge about HIV/AIDS in the centres is crucial. Counselling was reported to be the main mode for providing PWUD with HIV prevention information. Most residents report having received information on the epidemic, mostly from mass media and health workers, but HIV prevention interventions in the centres are often limited, due to lack of capacity. For example, 67% of staff members reported that condoms were not available in the centres despite evidence that sex occurs frequently in the centres. Similarly, HIV care and treatment is largely absent because of the lack of medical equipment and trained medical workers. Implementation of small-scale ART began in a few centres in 2007, but ART is not yet available in most other centres. When ART is available, staff members lack the capacity to administer the treatment.[90] The government is currently attempting to expand access to ART in the centres, based on a proposal approved in Round 6 of the Global Fund. However, there is a lack of consensus between the Ministry of Health and

MoLISA as to how this health activity should be effectively implemented. The Ministry of Health seems to be reluctant to assume responsibility for treatment delivery in the centres, while MoLISA has no institutional capacity to deliver them itself.[91]

Another issue of note is the weak link between the centres and community-based health facilities, which undermines the continuation of ART when the PWUD are sent to, or released from, the centres, which could lead to the emergence of HIV drug resistance.

Exit formalities and after-care follow-u. The family plays an important part in helping residents avoid relapse after being in a drug treatment facility. However, collaboration between family and centre is rather weak. In most cases, family members can discuss the resident's care with a responsible member of the staff only upon request and not as a matter of course.[90]

After release, follow-up varies from province to province. In Hanoi, a system of weekly support groups known as the "B93 clubs"[93] acts as a monitoring mechanism as much as a support for PWUD. However, such follow-up processes often have poor attendance, the staff has only low-level skills and drop-out rates are high.[94] Re-incarceration for repeated drug use is common.[91] Although the officially stated relapse rate has decreased since 2000, it is still at 75%.[16] Most estimates put the relapse rate at greater than 90%.[91]

2.4.4 The role of NGOs and community-based organizations

A large number of NGOs are active in HIV/AIDS work in Viet Nam, although none of them work specifically with PWUD. Donors, as well as international NGOs such as CARE, ADRA, ISDS and FHI, support a number of local initiatives. In addition, HIV positive support groups, 70% of whom are current or ex-PWUD, provide support under the various programmes of Global Fund, PEPFAR-funded NGOs, mass organizations (e.g. Women's Union), United Nations Volunteers, and with the coordination of recently established Vietnamese People Living with HIV Network (VPN+).[7,91]

2.4.5 Evolution in government policies in recent years

In 2007, more than 11 million needles and syringes were distributed to PWUD, but the geographical coverage is limited. More than 100 million condoms were also made available to the overall population. The number of peer outreach workers who have played a critical role to deliver these services increased from 150 in 2005 to 1,000 in 2007.[72] Finally, by the end of September 2007, a total of 14,180 adults were receiving ART in the 64 Vietnamese provinces, representing 28.4% of those needing ART.[9]

In April 2008, the Vietnamese Administration for HIV/AIDS Control, under the supervision of the Ministry of Health, initiated a pilot MMT programme. This programme consists of three clinics in Ho Chi Minh City, and another three in Hai Phong. More than 600 patients are currently under MMT.[95]

At present, methadone is not allowed in the drug treatment centres (Decree 108 on HIV).[9,91] Therefore, currently, the most common form of treatment for PWUD remains that of compulsory abstinence-based rehabilitation.

3. Human rights-based analysis of the compulsory treatment of PWUD

Health is a universal human right recognised by various international binding and non-binding documents under international human rights law. This implies that PWUD should be entitled to the right to health just as others are. Article 12 of the International Covenant on Economic, Social and Cultural Rights, enjoins the governments to take the necessary steps to prevent epidemics and other diseases.[96] In the context of this Article, since PWUD are particularly vulnerable to the HIV epidemic, they would comprise a group to be specifically targeted by measures to ensure access to services that protect people from HIV.

The obligations of States (or governments) to ensure the right to health are threefold: the *obligation to respect*, protect and fulfil the right to health. The *obligation to respect* requires that governments refrain from unduly interfering, directly or indirectly, with the right to health (for example, States should refrain from denying or limiting access to health-care services, limiting access to contraceptives or infringing the right to privacy). The *obligation to protect* requires governments to prevent third parties from interfering with the right to health. (For example, States must ensure that parties such as police authorities do not limit people's access to health-related information and services.) Finally, the *obligation to fulfil* requires governments to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health over a reasonable period of time.[97]

This section analyzes how the Cambodian, Chinese, Malaysian and Vietnamese governments respect, protect and fulfil the right to health of PWUD, through the 3AQ criteria of *availability, accessibility, acceptability* and *quality* and the principles of *equality and non-discrimination, participation* and *accountability.*

3.1 The 3AQ criteria

3.1.1 Availability

Availability implies that the drug treatment centres are in adequate number and that they provide facilities, goods and services – including drinkable water, sanitation facilities, trained medical and professional personnel – in sufficient quantity to treat people dependent on drugs.

Cambodia. In the drug treatment centres, the staff is mainly composed of administrative and law enforcement officials, with few health professionals. Drugs to treat PWUD are not available at the centres,[38] and methadone is an illegal substance under Cambodian law.[39] HIV prevention, treatment and care are limited to a few educational brochures.[38]

Outside the centres, Cambodia has currently only two NSPs, both run by NGOs and located in Phnom Penh. Although MMT has not yet been established, the government intends to launch a project by the end of 2008.[35]

China. In China, few centres are attended by doctors or nurses, and most staff members are public security officials.[53] The treatment provided is not entirely abstinence-based because the residents are provided with allopathic therapy as well as Chinese traditional medicine, which was apparently efficient to treat drug dependence when it is not too serious, and to ease the withdrawal symptoms that may appear during the drug

treatment phase.[14,64] Prevention and testing of HIV has also been developed in the centres in the past three years.

Outside these centres, China has made much progress to develop harm reduction projects, among them VCT programmes, NSPs, MMT clinics and free ART programmes.[54,55,66,68] Even though these projects are still limited in their scope, China has been continuously expanding them and is, in this study, the country that has made the greatest efforts to provide adequate services to PWUD.

Malaysia. In the centres in Malaysia, too, the availability of health professionals is limited and the centres are mainly staffed by people with limited skills in health. The treatment provided to PWUD is entirely abstinence-based. HIV prevention education is limited, but ART has been introduced recently within the centres.[74]

Outside the centres, Malaysia has developed harm reduction projects in the past few years that have improved the situation of PWUD in the country: it introduced VCT, NSPs, MMT and ART. However, there seems to be some reluctance to develop a condom distribution programme, even though sexually transmitted HIV is spreading across the country.[79] In addition, methadone is still seen as an illegal substance.

Viet Nam. Drug treatment is not readily available in the centres, and many have no treatment to deal with withdrawal symptoms[90] and medical care is very limited. However, in rare occasions, some centres do use a collection of analgesics, sedatives and other pharmacological means, as well as non-traditional means to assist drug users to cope with withdrawal symptoms.

The government has set up major harm reduction policies in the past few years: under donor-funded projects, the government has made much effort to provide clean syringes and needles to PWUD, as well as to develop MMT and condom promotion programmes.[9] However, implementation of these policies is still limited, although they are being rapidly scaled up.

3.1.2 Accessibility

Drug treatment centres must be physically and economically accessible to everyone without discrimination. The residents should have the right to seek, receive and impart information, and their right to confidentiality should be respected at all times.

Physical accessibility

Cambodia. The only treatment accessible to PWUD is currently through the compulsory drug treatment centres. NSP is provided in only two centres, both located in Phnom Penh, which means that many PWUD would have to travel long distances to use these facilities. PWUD are also reluctant to go to NSP and VCT centres, because such facilities are easy targets for police raids to arrest PWUD.[35]

China. Much progress has been made to provide services to PWUD with the scaling-up of the harm reduction projects initiated in 2003. In 2006, China expanded its MMT programme, by eliminating the strict entry criteria imposed at the beginning of the process, thereby making it accessible to more PWUD.[55] Thus, PWUD have access to a new form of treatment through methadone. However, the availability of MMT still needs to be expanded to more geographical locations (it is provided in 22 provinces out of 31).

Malaysia. Malaysia is the only country in this study where ART has been expanded to drug treatment centres, which makes them more accessible for PWUD. However, the new programmes and old repressive laws on drug use contradict themselves and police raids to arrest PWUD are frequent in NSP and new MMT facilities.[79]

Viet Nam. Viet Nam has developed a MMT programme in 2008, but it is still at a pilot stage, currently providing treatment to about 600 patients in selected geographical areas (in October 2008). PWUD in other areas have limited access to recognized drug treatment or to HIV care and treatment, especially ART, and voluntary and confidential HIV testing and counselling.[9]

Economic accessibility

Viet Nam and Malaysia. The stay in the centres is subsidized by the government.[76,91] Nevertheless, in Viet Nam, families often have to pay for additional expenses to provide basic supplies to residents, including health care costs. In addition, those who are voluntarily admitted are required to pay for the service.

Cambodia and China. In Cambodia, the families of PWUD usually have to pay a high fee, though the law of the country stipulates that the treatment should be available free of charge.[13] In China, the fee can be as high as 5,000 Yuan (approximately US$735).[14] In both countries, the price of treatment corresponds, more or less, with the quality of the conditions in the centres. This may, however, lead to iniquitous outcomes for those who cannot afford to pay.

Information accessibility. In all four countries, the residents and their families receive limited information on the treatment provided to the resident. Similarly, coverage of education is still limited on HIV prevention and transmission, due to lack of suitable materials and equipment, trained staff and knowledge of HIV/AIDS.[38,66,77,90] This situation is particularly worrying in these four countries where PWUD know little about drug-related risk behaviours or their HIV status: HIV testing is frequent upon entry in the centres, but sometimes PWUD are tested without informed consent and standard pre-test and post-test counselling, and are not given the test results. The results, however, are often given to the staff, which can go against the patient's right to privacy and confidentiality.

In addition, in all four countries, the PWUD are released into the custody of their parents or other family members, but the latter receive little or no information on how to help the ex-resident after release.

3.1.3 Acceptability

The drug treatment centres should be culturally appropriate, sensitive to gender and life-cycle requirements, and respectful of medical ethics.

In three of the countries studied, with China being the exception, no distinction is made between people who use drugs occasionally and those who are drug dependent.[11,39,76,91] This is of an issue that needs attention because only some of these people need residential treatment for drug dependence.

In addition, in all four countries, the criminalization of drug use, the stigma and lack of respect towards PWUD make the services less acceptable or suitable for PWUD.

Cambodia. In Cambodia, the treatment provided to women and youth is the same as that provided to older men. This can be problematic because it may not be productive to put younger drug users together with older ones, who may have a longer history of drug use. Moreover, youth and women may require special treatment, education and care.

Another issue of concern relates to people reported to have been sent to a drug treatment centre who were not drug users. These people, found to be mentally ill, were picked up in the streets by police officers and sent to the centres for treatment.[38] As the centres are not equipped to treat mentally ill residents, this is an issue of concern for such residents and the PWUD who come into contact with them.

Finally, after release, the name of the resident is usually given to the police, who then are entitled to check up on him/her regularly for follow-up.[38] This practice can compromise the patient's anonymity and right to confidentiality and privacy.

China. Since 2008, women and youth under 16 are sent to community-based programmes, while men are sent to compulsory drug treatment centres. Upon arrival in the centres, HIV testing is compulsory, which is contrary to policies that advocate for voluntary testing only.[98]

Malaysia. No distinction is made between men, women or youth in the treatment offered to residents in the centres. In Malaysia, HIV testing is also compulsory.[77]

Viet Nam. In Viet Nam, "05 centres" are usually for female sex workers, while PWUD, who are usually men, are sent to "06 centres".[99] Upon arrival, HIV testing appears routine, though the availability and quality of counselling varies, and it is often not carried out due to lack of financial resources. Lack of confidentiality of HIV status may be an important issue depending on the centre.

3.1.4 Quality

The drug treatment centres must provide for facilities, goods and services which are scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved drugs and hospital equipment.

In every country, staff in the centres rarely include doctors, nurses, psychologists or counsellors, but often only law enforcement officials, working in sometimes run-down and crowded facilities. The staff often lack professional training on drug use and HIV prevention and care and cannot cope with medical emergencies or offer medically-managed drug treatment for PWUD.[38,53,74,90]

Cambodia. The treatment provided to PWUD is entirely abstinence-based and residents who suffer from withdrawal symptoms are simply isolated as long as the symptoms persist. Cambodian centres do not provide HIV prevention, care and treatment, except for a few educational information brochures. Finally, therapeutic work and vocational training are a core part of the treatment, but the training is not advanced enough to help them find a job after release from the centres, which is often a reason for relapse.[38]

China. The centres provide treatment of PWUD with allopathic and traditional medicine. However, staff members are often poorly trained and cannot provide a treatment of high quality.[14,53] Recently, MMT facilities have been developed in the country and currently provide treatment to about 100,000 PWUD. The treatment in MMT clinics also includes health education, group activities, social support and skill training.[55] Treatment for PWUD has therefore largely been improved, although the programme needs to be expanded to make it accessible to a larger proportion of PWUD. The cost of methadone treatment also needs to be reduced, if poorer people are to have access to it.

Malaysia. Upon arrival in the centres, every resident is tested for HIV, but no pre- or post-counselling is offered, except for a small briefing on HIV transmission.[77] However, the Malaysian government is the only one in this study that has launched free MMT and ART programmes within the drug treatment centres.[79] These programmes are currently limited because they are still at a pilot stage, but they represent a step forward for improving the treatment provided to people who are dependent on drugs.

Viet Nam. The biggest centres are not always able to cope with the high workload of new admissions. Employees at these centres have received limited training and their relatively low salaries are a disincentive to long-term employment in the facilities. The treatment for drug removal is abstinence-based. Basic health

care in the centres is not of high quality. HIV prevention and care are also limited, due to lack of medical equipment, understanding on the epidemic and availability of appropriate training and medications. In Viet Nam, as in Cambodia, vocational training provided to the residents does not train them sufficiently to find a job after release.[90]

Due, in part, to the poor quality of the care provided in the drug treatment centres in all the four study countries, the relapse rate after release quoted by various agencies reaches 60 to 100%. This reaffirms that the compulsory residential treatment approach taken in these countries is not adequate to remedy drug dependence.

3.2 Key human rights principles

3.2.1 Equality and non-discrimination

The Committee on Economic, Social and Cultural Rights summarizes the right to health as proscribing:

> "any discrimination in access of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."[100,32]

In all the countries included in this report, there is evidence of some discrimination faced by PWUD, especially those who are living with HIV/AIDS.

Outside the centres, levels of discrimination against PWUD in general, and against female drug users in particular, are still high within their own communities. Pharmacists may also be reluctant to sell clean needles and syringes to people they suspect of being PWUD. These circumstances may increase the risks of their behaviours and deter them from seeking HIV information, education and health care services.

In the centres, staff members often have a negative view of PWUD, especially those who are infected with HIV/AIDS. In Yunnan, China, a 2003 survey reported that 30% of health professionals stated that they would not treat a person living with HIV.[59]

After release from the centres, the process of reintegration into society is difficult. PWUD often suffer from discrimination and are denied access to jobs. The lack of community-based programmes to reintegrate PWUD in society is an important cause of relapse.[35,53,90]

3.2.2 Participation

A human rights-based approach to health promotes participation by the population in health-related decision-making at local, national and international levels. This requires health education, the right to express views freely, and transparent policy-making. It also requires special attention to sharing information with, and seeking the views of, vulnerable and marginalized people.[101]

In Cambodia, China, Malaysia and Viet Nam, PWUD are highly stigmatized and marginalized. When a person is found using drugs, he/she is very likely to be arrested by the police and sent to a compulsory drug treatment centre or prison. These circumstances reduce the possibility of the participation of this marginalized and vulnerable population in policy-making about their health.

3.2.3 Accountability

Rights imply duties, and duties involve accountability. Cambodia, China, Malaysia and Viet Nam have signed various international human rights conventions recognizing the right to health (see Box 2). These conventions impose obligations on the States, the duty-bearers, which are responsible for ensuring that the rights of their citizens, the right-holders, are fulfilled. Monitoring and accountability are therefore essential features of a human-rights based approach, including for the right to health. These mechanisms include judicial and non-judicial remedies[102] at the national and international level, all of which need to be accessible, transparent and effective.[101,103]

Monitoring and accountability are areas where further attention is needed, with regard to PWUD and residents of the compulsory drug treatment centres. Currently, there is no accountability mechanism in which PWUD can engage with government regarding their right to health: PWUD are not entitled to go to court and ask for the establishment of a health facility providing for a medically-assisted detoxification treatment. Similarly, no sanctions are implemented against health professionals and staff of the compulsory drug treatment centres when the rights of the residents are violated (violation of the right to confidentiality for example), although the law on HIV/AIDS in Viet Nam creates a means for this. The availability of judicial or non-judicial mechanisms enabling PWUD to hold governments accountable can help them better claim their right to health.

4. Recommendations

The International Covenant on Economic, Social and Cultural Rights recognizes that, in the interest of public health, governments may limit human rights and the 3AQ principles. However, a balance between human rights and public health should constantly be respected. The *Siracusa Principles* enjoin governments to ensure the following:

- that the restriction is provided for and carried out in accordance with the law;
- that its legitimate objective is the general interest;
- that the restriction is strictly necessary in a democratic society to achieve the objective;
- that less intrusive and restrictive means are not available to reach the same objective; and,
- that the restriction is not drafted or imposed arbitrarily.[32]

The policies surrounding the compulsory drug treatment centres do not always respect these principles. With an increased body of research on the effectiveness and cost of the compulsory drug treatment centres, alternatives to imprisonment for drug users should be strongly recommended.

We must keep in mind that the system of compulsory treatment for PWUD has been well-established in Cambodia for five years and for over 15 years in China, Malaysia and Viet Nam with a trend in the region toward increasing compulsory treatment. It may, therefore, be difficult for governments to change the system immediately. The principle of *progressive realization*, articulated in the International Covenant on Economic, Social and Cultural Rights, recognizes that countries may not be able to ensure all rights immediately, but obliges governments to demonstrate gradual progress and move as effectively as possible towards ensuring these rights, including the right to health. The principle must include non-discrimination and the participation of the beneficiaries of health development policies in the decision-making process.[104,32]

The short-term recommendations of this study thus consist of improving the current system of compulsory treatment for PWUD by moving from a punitive approach to a voluntary, medically-assisted and evidence-based one. In the immediate future, harm reduction initiatives need to be promoted, with the objective being that evidence-based drug treatment practices and a comprehensive approach to the prevention of HIV/AIDS among drug users and PWID should replace the current system of compulsory centres.

4.1 Recommendations related to the short-term objective of improving the current system of the drug treatment centres

The treatment

- First, a distinction needs to be made between PWUD occasionally and drug-dependent people. People who are dependent on drugs should have the choice to attend a drug treatment facility or not, since the right to health also includes the right to be free from non-consensual treatment.[97] The decision to attend treatment in a centre should, therefore, be voluntary, not compulsory.
- Men, women and youth should be able to access specific services, where they can benefit from a treatment mindful of gender and life-cycle requirements.
- People who are dependent on drugs need to be provided with necessary medical care. Evidence shows that opioid substitution therapy is the most efficient way to treat heroin dependence.
- Minimum staffing requirements and training are needed so that the personnel can provide adequate treatment to the residents.

Box 4. UNODC/WHO Discussion Paper on Treatment of Drug Dependent People (March 2008)

In a recent discussion paper, WHO developed for a comprehensive set of recommendations for the treatment of PWUD:

- Drug dependence can usually be treated effectively if people have access to a continuum of available and affordable treatment and rehabilitation services.
- As for other health care problems, diagnosis and comprehensive assessment processes are the basis for a personalized and effective approach to treatment planning.
- Drug-dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. It includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination.
- Several subgroups within the larger population of individuals affected by drug dependence require special consideration and, often, specialized care. These groups include adolescents, women, pregnant women, individuals with medical and psychiatric problems, sex workers, ethnic minorities and socially marginalized individuals.

Drug use should be seen as a health care condition and PWUD should be treated in the health care system rather than in the criminal justice system, where possible. Interventions for drug-dependent people in the criminal justice system should address treatment as an alternative to incarceration, and also provide drug-dependence treatment while in prison and after release. Treatment and care as an alternative to imprisonment or commenced in prison, followed by support and social reintegration after release, decrease the risk of relapse in drug use, of HIV transmission and of re-incidence in crime, with significant benefits for the individual's health, as well as the public's security and social savings. Offering treatment as an alternative to incarceration is a highly cost-effective measure for society. treatment is offered as an alternative to incarceration or other penal sanctions, but not imposed without consent

- Community participation: A community-based response can encourage behavioural changes directly in the community. The active involvement of local stakeholders, community members and the target populations is needed to establish an integrated network of community-based health care services.
- Neither detention nor forced labour has been recognized by science as treatment for drug dependence. The treatment services should reflect current research evidence.[105]

- The treatment should be free of charge, if so stipulated by the national laws. If the treatment cannot be entirely subsidized, the cost should not be an obstacle to have access to the treatment centres.
- HIV prevention education, condoms, and NSP should be provided to residents in the centres. If health care staff can be trained in it, ART should be introduced into the centres to enable PWUD living with AIDS to have access to the treatment and continue their treatment for those who have started it before beginning drug treatment. If staff capacity is insufficient in the centres, collaboration can be established between drug treatment facilities and HIV treatment centres to provide HIV care and treatment to PWUD living with HIV.
- Mandatory re-education labour is to be discouraged. Instead, the development of voluntary vocational education can help create skills that enable residents to find work after their release.

Follow-up

- Cooperation between the family and the drug treatment centres needs to be promoted. The family and the resident should receive information about the different stages of the treatment provided in

the centre. Upon release, the families should receive information on how to help them support their relatives to prevent relapse.
- Particular efforts are needed to encourage community-based activities to monitor and follow up on the health of the residents in a non-discriminatory manner. Attention should also be given to helping him/her find employment, providing support to PWUD and PLHA and establishing a network for relapse prevention.
- The use of community-based voluntary treatment centres/services as an alternative to incarceration should be encouraged.

4.2 Development of harm reduction and HIV treatment policies to replace entirely compulsory drug treatment centres

The examples of China and Malaysia show that a policy merely aiming at criminalizing drug use is not a solution in countries where the HIV epidemic is mainly driven by drug use. The recent development of harm reduction programmes in Malaysia and China has resulted in a decrease in drug-related crimes and an increase in the process of reintegration of PWUD into society.[55] In the long run, it is hoped that these measures can reduce HIV transmission among PWUD, as has happened elsewhere. Such harm reduction policies need to be initiated and expanded, so as to replace the compulsory drug treatment centres over the longer term.

The development of needle and syringe programmes. The sharing of injecting equipment is common in all the four countries of this study, and it has resulted in the rapid expansion of the HIV epidemic among PWUD. NSPs aim at reducing the transmission of HIV through the use of non-sterile injection equipment and establishing effective disposal systems for used equipment, as well as providing information on opportunities for reducing drug use in the longer term.[106] There has been no evidence of an increase in the use of drugs where such programmes were developed.[54,79]

- There is a case for re-examining the national laws penalizing PWUD who carry their own clean injecting equipment, as well as health and outreach workers who make the equipment available. Stigma, discrimination and moralistic views on drug use can be addressed through education of the community on drugs and HIV/AIDS.
- Face-to-face programmes can provide PWUD with information on the use of drugs, modes of transmission of HIV/AIDS and possible ways to reduce drug use. The people who will provide such information need to be trained in doing so.
- Promoting voluntary and confidential HIV testing and counselling as well as the distribution of condoms in NSP facilities can prevent the spread of the epidemic through sexual activity.

The development of methadone maintenance treatment. Substitution treatment consists of the administration, under medical supervision, of a prescription drug with similar action to that of the drug of dependence. Most substitution medicines are taken orally and therefore significantly reduce the rate of HIV transmission by decreasing risky injection behaviour among PWUD.[107] In July 2005, WHO added methadone and buprenorphine - the two most common medicines used for substitution maintenance therapy, with methadone being the most widely employed - to its Model List of Essential Medicines.[108] Given the evidence on the effectiveness of MMT programmes, including in prisons, it is strongly recommended that MMT services be established:

- Drug policies will need to be revised to allow for the legal distribution of methadone and buprenorphine. National laws must also endorse the new harm reduction initiatives and protect MMT facilities to prevent the police from arresting those who attend the services.
- MMT programmes eventually need nation-wide scaling-up, including extending their availability to drug-dependent people in prison settings.

- The cost of the treatment needs to be kept as low as possible to enable many PWUD to have access to the facilities.
- The medical services offered in MMT clinics should include psychological support, health education, HIV prevention, and possibly HIV treatment and care.
- In Cambodia, PWUD usually consume ATS, for which substitution therapy through methadone cannot be used as a treatment. The evidence-based best practice for treating ATS dependence, though not as effective as OST in treating heroin dependence, includes psychosocial therapy, CBT, other behavioural therapies and appropriate psychiatric care including treatment of depression.[38] Such therapy needs to be developed in Cambodia, and in the other countries where the use of ATS among PWUD is increasing (i.e. China, Malaysia).

Development of quality voluntary HIV testing, counselling and antiretroviral therapy

HIV testing and counselling services should be provided, on a voluntary basis, to the residents of the centres, in line with international standards: HIV testing should be accompanied by counselling and conducted with informed consent. Confidentiality of results should be protected.[109]

Although all four countries seem to have developed free ART, it appears that few PWUD in China and Cambodia take part in the programme.[110] ART is not available for PWUD in many drug treatment centres and PWUD often do not go to ART clinics for fear of arrest, and of stigma and discrimination from family members, friends and the community.

Appropriate measures need to be taken to address stigma and discrimination against PLHA. Harm reduction projects must convince PWUD that it is not only beneficial but also safe for them to participate in the interventions.

Compulsory drug treatment centres may not have the human resources, equipment and financial capacity to provide ART to their residents. Therefore, drug treatment centres and facilities specialized in providing HIV prevention, treatment and care should collaborate to provide health services for PWUD affected by HIV. There is a need to strengthen collaboration between the drug treatment centres and community-based health facilities, so that ART will not be interrupted when PWUD move in and out of the centres.

4.3 Recommendations on the role of NGOs and community-based organizations

At the international level, several NGOs have played a key role in supporting local harm reduction advocacy activities, as well as the implementation of harm reduction services. Several local organizations and networks targeting PWUD have also developed in the region (Korsang in Cambodia or Pengasih in Malaysia for example). These organizations can help to provide information to PWUD and their families on HIV/AIDS and drug use. Peer education is particularly useful to inform PWUD on drug-related harm.[111] NGOs may also be able to refer PWUD to appropriate facilities that could help them to cure their drug dependence. Community-based programmes are also valuable to prevent relapse after the treatment period.

Community-based implementation, monitoring and evaluation of policies are often constrained by a lack of human and financial capacity. Police presence in the proximity of the NGO premises or police raids within the facilities can deter PWUD from using the services provided. Efforts are needed so that such undue harassment of NGOs does not occur.

Finally, according to the principle of progressive realization, the beneficiaries of health policies need to have the opportunity to express their voice in the policy-making process. Local NGOs which provide outreach, education and services to PWUD may be important actors in voicing the demands of PWUD at the national level. Their participation should, therefore, be promoted by the governments.

4.4 Recommendations for governments

At the governmental level, close collaboration is needed between the different ministries dealing with illicit drugs to treat the problem of PWUD as a health issue, and not as a criminal one. There is a need to review drug control legislation and practices to ensure that inconsistencies in the laws do not hinder HIV prevention efforts.

In some countries, such as Malaysia, Viet Nam or Cambodia, drug use is stigmatized, and a shift in policies from criminalization of PWUD to considering drug use mainly as a health problem will require educational campaigns addressed to the overall population to fight stigma and discrimination towards PWUD.

Annex 1. Comparative overview of policies on drug use and HIV/AIDS in Cambodia, China, Malaysia and Viet Nam

Country	Cambodia	China	Malaysia	Viet Nam
Number of PWUD	20,000	1.16 million	279,907	166,440
Proportion of PLHA among PWUD	Up to 31% of PWUDs	6.48% of PWUD	16.8% of PWUD	28.6% of PWUD
Proportion of PWUD among PLHA	24.4% of HIV cases	29% of HIV cases	73.7% of HIV cases	65% of HIV cases
Legislation / Policies	• 5-year Master Plan of the NACD. • Law on Prevention and Control of HIV, 2002. • Law on the Control of Drugs, amended in 2005.	• Regulations on Compulsory Drug Treatment Centre, 1995. • Law of People's Republic of China on Narcotics Control, 2008. • Action Plan of China for Checking, Preventing and Treating AIDS, 2002-2005. • Action Plan for Reducing the Spread of HIV/AIDS, 2006-2010.	• Dangerous Drugs Act, 1952. • Drug Dependants (Treatment and Rehabilitation) Act, 1983.	• Law on Narcotic Drugs Prevention and Suppression, 2000, revised in 2008. • Law on HIV Prevention and Control, 2006, and Decree No 108/2007/ND-CP.
Authorities responsible for the policies	• NACD for questions relating to drug use. • Ministry of Social Affairs and Ministry of National Defense for drug treatment centres.	• Ministry of Public Security for drug treatment centres. • Ministry of Health for harm reduction initiatives since 2003.	• Home Minister for drug treatment centres. • Ministry of Health for harm reduction initiatives.	• Ministry of Labour, Invalids and Social Affairs for drug treatment centres. • Ministry of Public Security for prisons and criminal activities related to drug use. • Ministry of Health for harm reduction activities.
VCT	Yes; but limited for PWUD. Most programmes reach street children and sex workers.	Yes	HIV Voluntary Screening Programme reaching 12,000 people in 2006. Premarital screening of HIV for couples who want to get married.	228 VCT sites in the country, VCT in drug treatment centres is very limited.

Annex 1. Comparative overview of policies on drug use and HIV/AIDS in Cambodia, China, Malaysia and Viet Nam (continued)				
Country	**Cambodia**	**China**	**Malaysia**	**Viet Nam**
Needle and syringe programme	Only two NGO-provided NSP programmes; no government-operated programme.	775 NSP in 17 provinces in the end of 2007, and being scaled up.	6 NSPs in 2007 reaching 3,600 PWUD, and being scaled up.	Distribution of 11 million needles and syringes in 2007.
MMT programme	No, but programme to be developed by the end of 2008.	503 MMT clinics in the end of 2007, and being scaled up.	74 MMT clinics, reaching more than 4,000 PWUD, and being scaled up.	Limited: first MMT clinic April 2008. Currently, approx. 600 people have access to the MMT pilot project. MMT is not available in the drug treatment centres.
ART programme	ART is largely developed in the country, but it is not available in the drug treatment centres.	National Free ART Programme launched in 2003, now reaching between 19% and 28% of PLHA in the country. Programme being expanded to MMT clinics, detention centres and drug treatment centres.	35% of those fulfilling the criteria are currently receiving ART in the country. Programme recently expanded to 4 drug treatment centres and prisons.	By the end of September 2007, 14,180 adults were receiving ART, representing 28.4% of those needing ART in the country. ART limited in the drug treatment centres.
Role of NGOs and local organizations	NGO intervention for prevention education, health promotion, home-based HIV care, distribution of clean needles, syringes and condoms, provision of basic health care, outreach activities.	Role of the Yunnan Institute on Drug Abuse for the development of harm reduction initiatives. Development of new organizations since the harm reduction initiatives of the government.	Few NGOs focus on PWUD. Since 1992, the Malaysian AIDS Council has been used as an umbrella organization for all NGOs working on AIDS issues.	Some NGOs focus their activities on PWUD.

Annex 2. General overview of the situation in compulsory drug treatment centres in Cambodia, China, Malaysia and Viet Nam

Country	Cambodia	China	Malaysia	Viet Nam
Number of treatment centres	10 centres	717 compulsory drug treatment centres and 69 indoctrination-through-labour centres; 119 voluntary clinically-managed drug treatment centres (2000) in the whole country.	28 centres	109 centres
Number of residents	1719 residents in 2007.	269,000 in compulsory drug treatment centres in 2006.	7,135 residents in 2007.	Approx. 100,000 residents in 2006
Agency responsible for the centres	Ministry of Social Affairs / Ministry of National Defence.	Ministry of Public Security.	Ministry of Home Affairs.	Ministry of Labour, Invalids and Social Affairs
Characteristics of the residents	No distinction between PWUD occasionally and drug-dependent people. 99% are men. Age: 79% are younger than 25.	Distinction made between PWUD occasionally and drug-dependent people. Only the latter are sent to the centres. 83% are men, age 20 to 30.	No distinction is made between PWUD occasionally and drug-dependent people. Most are men between 20 and 39 years old. Low levels of education; most are unemployed.	No distinction is made between PWUD occasionally drug-dependent people. 95% of men, most aged 20 to 30. Low professional training and educational level.
Drugs used	ATS, but heroin by injection is increasing	Heroin by injection. ATS use is increasing.	Heroin by injection, ATS use is increasing.	Heroin by injection, ATS use is increasing.
Staff	Police and administration officers, very few nurses, no doctors.	Mainly public security officials, but few doctors and nurses.	Most are ex-army personnel, very few paramedics, laboratory technologists and trained counsellors.	Officials, managers and social workers, some nurses but very few doctors.
Cost	Free under the law, but cost of entry: US$100–US$200. Then, US$50 per month on average.	Borne by the families, around 2,000 to 3,000 yuan. Exemption for the poorest. Price differs between the centres. Clinically-managed treatment centres can cost up to 5,000 yuan.	Treatment is entirely subsidized by the government.	Treatment is subsidized by the Government, but families pay for supplementary supplies, Residents can be remunerated by enrolling in “therapeutic labour”.

Annex 2. General overview of the situation in compulsory drug treatment centres in Cambodia, China, Malaysia and Viet Nam (continued)				
Country	**Cambodia**	**China**	**Malaysia**	**Viet Nam**
Entry formalities	Most are sent by their families. Contract signed between the centre and the parents or police officers, even if the resident is over 18.	Medical examination and compulsory HIV testing.	People dependent on drugs enter treatment after a positive urine test from an accredited government hospital. Voluntary referral is also possible but rare. Compulsory HIV testing.	Information on life in the centres and medical examination. Most have already participated in a drug treatment programme.
Treatment	No pharmacotherapy or mental health therapy. Isolation during drug treatment phase. There are no formal criteria to determine the length of the treatment.	Drug abstention, sometimes with allopathic medicines and traditional Chinese medical therapy. The treatment lasts 2–3 months; 1 year at most.	Drug abstention. The treatment lasts 2 years.	No substitution therapy. Provision of tranquillizers and physiotherapy, followed by counselling and education, therapeutic labour, and few recreational activities. The treatment/rehabilitation period lasts up to 6 years with the new laws.
HIV prevention and care in the centre	Few educational resources for HIV prevention. No distribution of condoms. No ART available.	HIV prevention education, compulsory HIV testing upon entry. Programme developed to introduce ART in the centres.	HIV prevention education is limited to a briefing upon entry in the centres, before HIV testing. ART has recently been introduced in the centres, as well as a limited number of condom kits.	Limited information on HIV/AIDS. No distribution of condoms, no testing kits. ART is not widely available.
Exit formalities and follow-up	Released into the custody of parents when deemed rehabilitated by the centre. No system of follow-up. Sometimes there is follow-up by phone call, or by visits from local authorities. No community-based programmes of reintegration.	A contract is signed by the relatives who are charged with supervision of those deemed rehabilitated. No community-based drug treatment, rehabilitation and after-care treatment.	Upon release, IDUs are on follow-up at after-care centres for 2 years, but drop-out rates are high.	Weekly support groups, but poor attendance and high drop-out rates. Little participation of the family in the rehabilitation process.

Annex 2. General overview of the situation in compulsory drug treatment centres in Cambodia, China, Malaysia and Viet Nam (continued)

Country	Cambodia	China	Malaysia	Viet Nam
Relapse rate after release	Close to 100%	Between 60% and 95%	Between 70% and 90%	Officially between 70% and 80%, but most regard 95% as being closer to the real situation.
Changes in policies	Plan to develop medically-assisted detoxification, and to introduce HIV prevention and treatment in the centres.	Since 2003, the Government has developed a broad range of harm reduction measures that have improved the situation of PWUD (MMT programmes, NSPs) and of PLHA (VTC, prevention, free ART).	The number of centres and of admissions is declining due to the new harm reduction policies implemented by the government since 2005.	Development of NSPs and MMT (but still limited to some geographical locations).

Annex 3. Evidence on the prevalence of injecting drug use and HIV among people ho inject drugs in East and South East Asia

	IDU prevalence (%)			2007 IDU population			Grade	Type	Year of estimate	HIV prevalence (%)			Grade	Year of estimate
	Lower	Mid	Upper	Lower	Mid	Upper				Lower	Mid	Upper		
Brunei Darusalam	—	NK	—	—	—	—	—	—	2006	—	—	—		
Cambodia	0.01	0.02	0.09	1,096	1,918	7,671	C	CIDU	2004	14.3	22.8	31.3	B	2004, 2006
China	0.19	0.25	0.31	1,850,616	2,415,922	2,981,229	A	CIDU	2005	7.96	13.6	19.2	A	2005
DPR Korea	—	—	—	—	—	—	—	—	—	—	—	—		
Indonesia	0.13	0.14	0.16	193,496	222,559	251,622	A	CIDU	2006	31.7	42.5	53.3	A	2006
Japan	—	0.47	—	—	393,337	—	D1	CIDU	2004	—	NK	—		2004
Lao PDR	—	NK	—	—	—	—	—	—	2005	—	NK	—		2003
Malaysia	1.11	1.33	1.56	190,979	230,285	269,591	C	CIDU	2002	—	10.3	—	A	2002
Mongolia	—	NK	—	—	—	—	—	—	2006	—	0	—	C	2006
Myanmar	0.18	0.23	0.27	60,000	75,000	90,000	C	CIDU	2007	42.6	42.9	43.2	B, C	2006
Republic of Korea	—	NK	—	—	—	—	—	—	2002	—	NK	—		2002
Philippines	—	NK	—	—	—	—	—	—	2006	—	1.0	—	B	2005
Singapore	—	NK	—	—	—	—	—	—	2006	—	—	—		
Taiwan	—	NK	—	—	—	—	—	—	2001	2	13.8	25.6	B, D1	2004, 2006
Thailand	—	0.38	—	—	169,346	—	D1	CIDU	2007	—	42.5	—	A	2004
Timor Leste	—	NK	—	—	—	—	—	—	2005	—	—	—		
Viet Nam	—	0.25	—	—	142,249	—	D1	CIDU	2005	—	33.5	—	A	2006

Type of IDU population estimated:

ICU: Estimate made for "current injectors" (indirect estimates were defined as "current IDUs" unless otherwise specified;

PYIDU Estimate of "past year injectors";

LTIDU Estimate of "lifetime injectors";

REG Estimate derived from cumulative registries of drug users;

NK: Injecting drug use OR HIV reported among those who inject drugs but a prevalence estimae could not be made;

— No reports of injecting drug use or HIV among people who inject drugs identified.

Source: Adapted from Mathers, B., *et al.* Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet,* 2008, 372:1733-45.

Annex 4. Policies implemented on drug use around the world

Country	Policy implemented relating to drug use
Western Europe: Spain	It is currently estimated that about 45% of prison inmates in Spain are PWUD, and that 7% to 8% of them are infected by HIV/AIDS. Since the 1990s, and mostly in response to rising HIV rates among PWUD in the community and in prisons, there has been a marked increase in the number of prison systems providing harm reduction programmes. HIV screening is provided for prison inmates. Condoms are distributed in all prisons upon entry, in the cells where prisoners meet visitors and on demand at the medical service. The programme was initiated in 1997 and by 2001, NSPs were operating in eleven prisons. Each programme was implemented in collaboration with the regional health authorities. Kits containing a syringe, alcohol, swabs and water were distributed by local nongovernment AIDS organizations. Evaluations of these NSPs showed that there was no increase in drug use, the number of abscesses diminished and the risk of blood-borne infections decreased. In January 2002, the programme was extended for general use in all Spanish prisons.
Asia: Indonesia	Finally, 82% of prisoners dependent on drugs received MMT in 2004. There is no limit in the length of the treatment, and when inmates are discharged from prison, they are referred to continue methadone maintenance in an outpatient centre.[107,2-114] In state prisons, the HIV infection rate among inmates was estimated at 15% to 40%. In June 2005, the Ministry of Justice and Human Rights, supported by the Indonesia HIV/AIDS Prevention and Care Project and AUSAID, launched the National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres (2005–2009). The document detailing this programme, the first of its kind in Asia, provided the framework for the prevention, care, support and treatment of the HIV/AIDS epidemic inside the prison system. It includes educational sessions for prisoners, training for prisoners and staff, provision of MMT, availability of bleach and condoms, referral to voluntary counselling and testing, and referrals for support and care of prisoners living with HIV/AIDS, including provision of ART. Most programmes are led by local HIV/AIDS NGOs, working together with prison staff. Currently, only a few of the 396 prisons in Indonesia provide HIV prevention, but some potentially effective demonstration projects are ongoing. The gold standard is the Balinese prison of Kerobokan, where bleach and condoms, as well as MMT and ART, are made available to prisoners. By June 2006, MMT was provided to 33 prisoners in Kerobokan. The national strategic plan is to cover 95 prisons by 2010, 20 of them with comprehensive programmes like the one in Bali. With this project, Indonesia has confirmed that it is feasible to provide MMT to prisoners in developing countries and especially in Asia.[115-118]

Annex 4. Policies implemented on drug use around the world (continued)

Country	Policy implemented relating to drug use
Asia: Bangladesh	The SHAKTI (Stopping HIV/AIDS through Knowledge and Training Initiative) Project was initiated by CARE Bangladesh in Dhaka in 1998, with funding from international donor agencies. The programme was then expanded to about 19 districts of Bangladesh, now reaching approximately 4,400 PWUD. It focuses on behavioural change among selected high-risk populations, among them PWUD and sex workers. The programme includes clean needle and syringe distribution, information on safe injecting practices, safer sex education, condom distribution and the provision of basic health care. In 2004, it was reported that in Dhaka between 84% and 91% of PWUD were reached by the NSP of CARE Bangladesh.[119,120] As a result, HIV prevalence among PWUD was measured at 7% in 2003, as opposed to the projected estimate of 60%.[4]
Latin America: Brazil	The first NSP was established in 1989 through the local government's public health programmes in the city of Santos, and was nationally scaled up in 2002. Between 1998 and 2003, harm reduction projects increased from 8, serving 1200 PWUD, to 279, serving over 145,000 PWUD. The programmes are all supported by the national government, and, at the international level, by the World Bank and UNODC. These programmes have offered comprehensive services to PWUD and their families. The government has also issued a law based on the principles of universal access to treatment for PLHA and established ART as a human right, accessible for all, free of charge. By the end of 2003, 128,000 AIDS patients were receiving ART, 25% of whom were PWUD. These measures were accompanied with massive advertisement campaigns to fight against discrimination and stigma related to HIV/AIDS.[4]

References

1. United Nations Office on Drugs and Crime. *World drug report.* Vienna, UNODC, 2004.
2. International Harm Reduction Association. *Global state of harm reduction 2008: mapping the response to drug-related HIV and hepatitis C epidemics.* London, IHRA, 2008.
3. Fabio Mesquita [WHO Western Pacific Regional Office, HIV/AIDS and Sexually Transmitted Infections Unit], personal communication.
4. Open Society Institute. *Protecting the human rights of injection drug users: the impact of HIV and AIDS.* New York, Open Society Institute, 2005.
5. Geographical location: Myanmar, the Lao People's Democratic Republic, Viet Nam and Thailand.
6. Geographical location: Afghanistan, Iran and Pakistan.
7. Australian Agency for International Development. *Asia Regional HIV/AIDS Project, Project Design Document.* Canberra, AusAID, 2001.
8. Devaney, M. *et al. Situational analysis of illicit drug issues and responses in the Asia-Pacific region.* Canberra, Australian National Council on Drugs Research Paper 12, 2006:97-112.
9. Mesquita, F. *et al*. Accelerating harm reduction interventions to confront the HIV epidemic in the Western Pacific and Asia: the role of WHO (WPRO). *Harm Reduction Journal*, 2008, 5:26.
10. The Executive Director of the United Nation Office on Drugs and Crime called for an end to capital punishment for drug offences. In: IHRA, UNODC chief calls for end to the death penalty for drug-related offences and a greater focus on human rights, March 2008. Available at: http://www.ihrablog.net/2008/03/cnd-day-1-unodc-chief-calls-for-end-to.html, accessed 29 January 2009.
11. Standing Committee of the National People's Congress, *Decision on Drug Prohibition.* December 28, 1990.
12. *Dangerous Drugs Act, 1952*, available at: http://www.pharmacy.gov.my/html/legislations/Dangerous%20Drugs%20Act%201952(2002).pdf, accessed 29 January 2009.
13. Reported by the WHO Country Office in Cambodia, July 2008.
14. Michels, I. *et al*. Drug abuse and its treatment in China. *SUCHT*, April 2007, 53(4):228-237.
15. Reid, G. Kamarulzaman, A., Kaur Sran, S. Malaysia and harm reduction: the challenges and responses. *International Journal of Drug Policy*, 2007, 18:136-140.
16. Government of Viet Nam, Ministry of Labour, War Invalids and Social Affairs. *Overall report on the rehabilitation detoxification for the drug addicts in Viet Nam.* Hanoi, Government of Viet Nam, 2008.
17. The Convention is available at: http://www.unodc.org/documents/treaties/treaty_adherence_convention_1961.pdf, accessed 29 January, 2009.
18. The Convention is available at: http://www.unodc.org/documents/treaties/treaty_adherence_convention_1971.pdf, accessed 29 January 2009.
19. The Convention is available at: http://www.unodc.org/documents/treaties/treaty_adherence_convention_1988.pdf, accessed 29 January 2009.
20. Bluestone, K. *The UN General Assembly Special Session on Drugs: New words, old actions?* October 1997. Available at: http://www.drugtext.org/library/articles/bluestone.html, accessed 29 January 2009.
21. The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, was signed on 22 July 1946 by the representatives of 61 States (Off. Rec. WHO, 2, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005 respectively.
22. "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."
23. Article 12 of the International Covenant on Economic Social and Cultural Rights, 1966 states: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"

24. States are required to ratify Conventions after signature, before the Convention can enter into force. If States sign, but do not ratify the Convention, they are bound by the obligation not to deprive the treaty from its object and purpose (Vienna Convention on the Law of Treaties, 1969). Many of the human rights Conventions have been ratified, but subject to reservations.
25. Available at: http://www.unhchr.ch/html/menu3/b/a_ccpr.htm, accessed 29 January 2009.
26. Available at: http://www.unhchr.ch/html/menu3/b/a_cescr.htm, accessed 29 January 2009.
27. Available at: http://www.unhchr.ch/html/menu3/b/21.htm, accessed 29 January 2009.
28. Available at: http://www.unhchr.ch/html/menu3/b/h_cat39.htm, accessed 29 January 2009.
29. Available at: http://www.unhchr.ch/html/menu3/b/k2crc.htm, accessed 29 January 2009.
30. Available at: http://www1.umn.edu/humanrts/instree/n8icprmw.htm, accessed 29 January 2009.
31. Available at: http://untreaty.un.org/English/notpubl/IV_15_english.pdf, accessed 29 January 2009.
32. World Health Organization. *25 questions and answers on health and human rights.* Health and Human Rights Publication Series. Geneva, WHO, 2002.
33. Joint United Nations Programme on HIV/AIDS (UNAIDS). *Consensus estimates of the number of problem drug users in Cambodia 2004.* Phnom Penh, UNAIDS, 2005.
34. National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS). *HIV prevalence among drug users 2007 in Cambodia.* PowerPoint presentation. Phnom Penh, NCHADS, November 2008.
35. Illicit Drug-Related HIV and AIDS Secretariat (DHAS). *National strategic plan for illicit drug use-related HIV/AIDS. Final draft with costing.* Phnom Penh, DHAS, March 31, 2008.
36. National AIDS Authority Cambodia (NAA). *Implementing guidelines of the law on the prevention and control of HIV/AIDS.* Phnom Penh, NAA, 2005.
37. *Constitution of Cambodia,* available at: http://www.constitution.org/cons/cambodia.htm, accessed 29 January 2009.
38. Illicit Drug-Related HIV and AIDS Secretariat (DHAS) *et al. Rapid assessment of treatment and rehabilitation centres in Cambodia.* Draft Version 5. Phnom Penh, DHAS, February 2008.
39. *Law on the Control of Drugs*, adopted on 9 December 1996, amended by the Royal Code No. NS/RKM/0505/014, 9 May 2005.
40. National AIDS Authority Cambodia (NAA). *National strategic plan for a comprehensive and multi-sectoral response to HIV/AIDS 2006-2010. Updated version.* Phnom Penh, NAA, December 2007.
41. Circular on the implementation of education, treatment and rehabilitation measures for drug addicts. No. 03 SR. Phnom Penh, October 23, 2006.
42. Cambodia is divided into twenty provinces.
43. Loeu, S., and Macdonald, Virginia. *Routine Analysis of Treatment Data Provided by Treatment Center run by the Government, 1st Quarterly Report of 2008.* Phnom Penh, Illicit Drug-Related HIV and AIDS Secretariat (DHAS), Drug Information Centre (DIC), National Authority for Combating Drugs (NACD) / National AIDS Authority (NAA), and World Health Organization (WHO), 2008.
44. National Authority for Combating Drugs (NACD), National AIDS .Authority (NAA), National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), National Mental Health Programme (NMHP) and the World Health Organisation (WHO), *Drug use and HIV/AIDS in Cambodia: opportunities for an integrated approach to prevention, treatment and care.* Unpublished final draft. Phnom Penh, NACD, NAA, NCHADS, NMHP and WHO, December 2005.
45. No numbers are available to determine how many PWUDs resort to selling their blood to acquire drugs.
46. World Health Organisation (WHO), United States Centers for Disease Control (US CDC). *Drug use and sexual HIV risk patterns among non-injecting and injecting drug users in Phnom Penh and Poipet, Cambodia, International Rapid Assessment Response and Evaluation (I-RARE).* Phnom Penh, WHO, US CDC, January 2005.
47. The Decree is available at: http://www.moc.gov.kh/laws_regulation/part7_eco_dev/kret38_88_contract.htm, accessed 29 January 2009.
48. This fall in HIV prevalence is a consequence of mortality combined with a substantial drop in the number of new HIV infections.

49. Seguy, N., and G. Shaw. HIV/AIDS situation update in Cambodia. September 2008.
50. Closing Keynote Address by Samdech Hun Sen, Prime Minister of the Royal Government of Cambodia, at the National Seminar on Drug Issues, Phnom Penh, 6 May 2003.
51. *The Law of the People's Republic of China on Narcotics Control,* December 29th 2007, available at: http://www.lawinfochina.com/law/display.asp?db=1&id=6604&keyword=Narcotics%20Control, accessed 29 January 2009.
52. The Law of People's Republic of China on Narcotics Control was promulgated on 29 December 2007 and entered into force on 1 June 2008.
53. Yunnan Institute for Drug Abuse (YIDA). Report of documentary analysis on the situation of drug use and youth in China. Kunming, YIDA, 2003.
54. Wu, Z. *et al*. Evaluation of a needle social marketing strategy to control HIV among injecting drug users in China. *AIDS*, December 2007, 21(8):115-122.
55. Pang, L. *et al*. Effectiveness of first eight methadone maintenance treatment clinics in China. *AIDS*, December 2007, 21(8):103-107.
56. Ministry of Public Security, People's Republic of China. The people's war against drugs got important periodic success in 2006. Beijing, People's Republic of China, 2007.
57. National Narcotics Commission (NNC), China. *Yearly report on drug abuse.* Beijing, NNC, 2000.
58. Jianhua, L., et al., *The Using Situation of Illegal Drugs in China*. Kunming, Yunnan Institute for Drug Abuse, 2003.
59. Jianhua, L., et al., *Situation Analysis of Sexual Health in Yunnan and Sichuan Provinces, Drug Users Presenting Condition Analysis*. Chiang Mai, UK-China STD/AIDS Prevention and Care Project Office, 2003.
60. The proportion of farmers, drivers and individual operators who use drugs varies according to the geographical area.
61. Based on interviews conducted by the Yunnan Institute for Drug Abuse in 2003 in several compulsory detoxification centres in the Yunnan Province.
62. Tang, Yi-Lang *et al*. Opiate addiction in China: current situation and treatments. *Addiction*, 2006, 101(5):657-665.
63. It includes Chinese medicine and acupuncture. This method was found efficient to treat opiate addiction in the long run, with a minimum of side-effects. However, it was found insufficient by itself to treat severe drug addiction. It may be used in parallel with modern medicines, such as methadone.
64. Shi, J. *et al*. Traditional Chinese medicine in treatment of opiate addiction. *Acta Pharmacologica Sinica*, October 2006, 27(10):1303-07.
65. No additional information was found on the kind of treatment used in the compulsory rehabilitation centres.
66. Zhang, F. *et al*. The Chinese free antiretroviral treatment programme: challenges and responses. *AIDS*, December 2007, 21(8):143-148.
67. Chen H-T, Quilan Liao. A pilot study of the NGO-based relational intervention model for HIV prevention among drug users in China. *AIDS Education and Prevention*, December 2005, 17(6):503-14.
68. Wang, L. Overview of the HIV/AIDS epidemic, scientific research and government responses in China. *AIDS,* December 2007, 21(8):3-7.
69. Sun, X. *et al*. The development of HIV/AIDS surveillance in China. *AIDS*, December 2007, 21(8):33-38.
70. Tian, L. *et al*. Evaluation of a web-based intervention for improving HIV/AIDS knowledge in rural Yunnan, China. *AIDS*, December 2007, 21(8):137-142.
71. Des Jarlais, D.C. *et al*. Reducing HIV Infection Among New Injecting Drug Users in the China-Viet Nam Cross Border Project. *AIDS*, December 2007, 21(8):109-114.
72. World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008.* Geneva, WHO, 2008.

73. ART coverage depends on the denominator used. Based on UNAIDS/WHO methods, 19% was the average percentage calculated. The Chinese government calculated 38% as the average.
74. National Anti-Drug Agency and Ministry of Internal Security, People's Republic of China. *Narcotics Data.* Beijing, People's Republic of China, 2007.
75. *Constitution of Malaysia,* available at: http://www.helplinelaw.com/law/constitution/malaysia/malaysia01.php, accessed 29 January 2009.
76. *Drug Dependents (Treatment and Rehabilitation) Act,* Malaysia. No. E/NL.1983/39, 1983, available at: http://css.unodc.org/doc/enl/1983-39-E.pdf, accessed 29 January 2009.
77. Reported by the WHO Country Office in Malaysia. July 2008.
78. Reid, G., G. Costigan. *Revisiting 'the Hidden Epidemic': a situation assessment of drug use in Asia in the context of HIV/AIDS.* Melbourne, The Centre for Harm Reduction, The Burnet Institute, January 2002.
79. Government of Malaysia. *UNGASS Country Progress Report Malaysia.* Kuala Lumpur, Government of Malaysia, January 2008. Available at: http://data.unaids.org/pub/Report/2008/malaysia_2008_country_progress_report_en.pdf. accessed 29 January 2009.
80. Persatuan PENGASIH Malaysia, more information available at: http://pengasih.net/index.php/about-us, accessed 29 January 2009.
81. Malaysian AIDS Council. *Strategic plan 2008-2010*. Kuala Lumpur, Malaysian AIDS Council, June 2008.
82. Viet Nam Commission for Population, Family and Children, Ministry of Health, Population Reference Bureau, *HIV/AIDS in Viet Nam.* Hanoi, Viet Nam Commission for Population, Family and Children, Ministry of Health, Population Reference Bureau, 2006.
83. United Nations Office for Drugs and Crime. *Drug abuse in Lai Chau province: rapid situation assessment.* Hanoi, UNODC, December 2001.
84. *Constitution of Viet Nam, 1992,* available at: http://www.international.ucla.edu/eas/documents/VN-cons.htm, accessed 29 January 2009.
85. United Nations Office for Drugs and Crime. *Viet Nam Country Profile, 2005.* Hanoi, UNODC, 2005. Available at: http://www.unodc.org/pdf/vietnam/country_profile_vietnam.pdf, accessed 29 January 2009.
86. *The Law on Prevention and Control of HIV/AIDS of June 29, 2006,* No. 64/2006/QH11. Available at: http://www.unaids.org.vn/sitee/upload/publications/law_on_hiv_en.pdf, accessed 29 January 2009.
87. Viet Nam Government's Decree No. 108/2007/ND-CP of June 26, 2007, Detailing the Implementation of a Number of Articles of the Law on HIV/AIDS Prevention and Control.
88. The "05/06 centres" are named after the Government's Decree No. 05 and Decree No. 06 or "Trung tam Cai nghien Phuc hoi" (detoxification or treatment and rehabilitation centre).
89. Survey conducted in the rehabilitation centres of four Vietnamese provinces. See reference [90].
90. Standing Office for Drugs Control *et al*. Project G22: Reduction of HIV infection risk due to drug abuse in Viet Nam. January 2005.
91. Reported by the WHO Country Office in Viet Nam. July 2008.
92. United Nations Office for Drugs and Crime. *HIV/AIDS and custodial settings in South East Asia: an explanatory review into the issue of HIV/AIDS and custodial settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam*. Bangkok, UNODC, November 2006.
93. The "B93 Clubs" were named after the MoLISA project No. B93.
94. Michels, I. Mission Report: Supporting the development and continuous implementation of result-oriented monitoring and evaluation framework within the AHRN-Project "Harm reduction capacity building and advocacy in Cao Bang and Son La Provinces, Viet Nam." October 2007.
95. Reported by the WHO Country Office in Viet Nam. October 2008.
96. Article 12 of the Covenant states: "1- The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2- The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of

infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

97. World Health Organization. *The Right to Health Fact Sheet No. 31.* Geneva, WHO, 2008.
98. Canadian HIV/AIDS Legal Network. *Case Studies: Human rights-based approaches to HIV/AIDS. HIV prevention services for people who use drugs: the human rights case for harm reduction measures.* Toronto, Canadian HIV/AIDS Legal Network, 2005.
99. In Viet Nam, there are different centres providing treatment for women, men and youths. They are called the 04, 05 and 06 centres.
100. General Comment No. 14, issued in 2000 by the Committee on Economic, Social and Cultural Rights.
101. Hunt, Paul and Gillian McNaughton. *Impact assessments, poverty and human rights: a case study using the right to the highest attainable standard of health.* Paris, UNESCO, May 2006.
102. Non-judicial remedies include quasi-judicial mechanisms, administrative arrangements, or civil society institutions acting as human rights watchdogs.
103. Hunt, P., Osmani, S., Nowak, M. *Summary of the draft guidelines on a human rights approach to poverty reduction.* Geneva, Office of the High Commissioner on Human Rights, March 2004.
104. Article 2 (1) of the International Covenant on Economic, Social and Cultural Rights.
105. United Nations Office on Drugs and Crime and World Health Organization. *Principles of drug dependence treatment.* Discussion paper. Geneva, UNODC and WHO, March 2008.
106. World Health Organization. *Evidence for action on HIV/AIDS and injecting drug use. Policy brief: Provision of sterile injecting equipment to reduce HIV transmission.* Geneva, WHO, March 2004.
107. World Health Organization. *Evidence for action on HIV/AIDS and injecting drug use. Policy brief: Reduction of HIV transmission through drug-dependence treatment.* Geneva, WHO, March 2004.
108. The Model List of Essential Medicines is available at: http://www.who.int/medicines/publications/08_ENGLISH_indexFINAL_EML15.pdf, accessed 29 January 2009. Methadone and buprenorphine are included in section 24.5.
109. Joint United Nations Programme on HIV/AIDS and World Health Organization. *UNAIDS/WHO Policy Statement on HIV Testing.* Geneva, WHO, June 2004.
110. In Viet Nam, 60 to 70% of people who receive ART are former or current PWUD.
111. World Health Organization. *Evidence for action on HIV/AIDS and injecting drug use. Policy brief: Reduction of HIV transmission through outreach.* Geneva, WHO, March 2004.
112. Stover, H. *Drug and HIV/AIDS Services in European Prisons.* Oldenburg, BIS-Verlag, 2002.
113. Dolan, K., Rutter, S., Wodak, A.D. Prison-based syringe exchange programmes: a review of international research and development. *Addiction*, January 2003, 98(2):153-158.
114. Government of Spain, Ministerio del Interior and Ministerio de Sanidad y Consumo. Needle Exchange in Prison - Framework Program. Madrid, Government of Spain, 2002.
115. Mesquita, F. *et al*. Public health: the leading force of the Indonesian response to the HIV/AIDS crisis among people who inject drugs. *Harm Reduction Journal*, February 2007, 7(9):4-9.
116. Winarso, I. *et al*. Indonesian national strategy for HIV/AIDS control in prisons: a public health approach for prisoners. *International Journal of Prisoner Health*, September 2006, 2(3):243-249.
117. Irwanto I. Indonesia: Facing Illicit Drug Abuse Challenges. In: *Illicit Drugs and Development: Critical Issues for Asia and the Pacific.* Development Bulletin No. 69. Development Studies Network, February 2006:44-48.
118. Irawati, I. *et al*. Indonesia sets up prison methadone maintenance treatment. *Addiction*, October 2006, 101(10):1525-26.
119. Habib, S.E. Reducing HIV-related risk behaviour among injecting drug users: the harm reduction model in Bangladesh. *Indian Journal of Community Medicine*, 2004, 29(4):175-78.
120. Azim, T., Hussein, N., Kelly, R. Effectiveness of harm reduction programmes for injecting drug users in Dhaka city. *Harm Reduction Journal*, October 2005, 2(22).