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Briefing paper

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Promoting Harm Reduction and Community-based Treatment to ensure a Health-based Response to Drug Use in Cambodia

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Introduction

Speaking on the UN International Day against Drug Abuse and Illicit Trafficking on June 26 in 2016, Cambodia's Prime Minister Hun Sen emphasised the role of local communities and authorities in responding to drug-related issues, and strongly encouraged the promotion and strengthening of quality community-based treatment and rehabilitation services.[1] His apparent support for a shift towards drug dependence treatment services that do not involve coercion and detention, seemed to align with the government's approval of Cambodia's first five-year National Strategic Plan for Harm Reduction 2016-2020 (NSPHR) in 2016.

However significantly increasing rates of arrest for drug-related offences, and subsequent detention or imprisonment, in recent years indicate the use of punitive measures that pose barriers to implementation of voluntary treatment and harm reduction services. Annual rates of arrests for drug-related offences (including of people who use drugs) in Cambodia have increased three-fold over three years: from 3,142 in 2014, to 7,008 (including 853 women) in 2015, to 9,933 (including 964 women) in 2016.[2] During the first six months of 2017, more than 9,600 people were arrested for drug-related offences—almost the same number of people arrested in the previous year—of whom more than 50% were reportedly people who use drugs.[3] Furthermore, in 2016, the government declared that 2,599 people who use drugs were detained in public and private rehabilitation centers despite the government's rhetoric of strong support for quality community-based treatment programmes.[4]

A 2012 estimate of the numbers of people who use drugs in Cambodia amounted to 13,000 people (with a range of 12,000 and 28,000 people), including approximately 1,300 people who inject drugs, who mainly reside in the capital city Phnom Penh.[5] Government data show a 24% rise in the number of people who use drugs, from 16,575 people in 2015 to 20,621 people in 2016, with the majority (71%) using crystal methamphetamine and increasing rates of use in some rural areas.[6] People who use drugs are at high risk of health and other harms associated with their criminalisation and punitive policy measures, as indicated by the following:

- In 2012, the HIV prevalence rate among people who use drugs was 4% and 25% among people who inject drugs,[7] far higher than the 0.6% HIV prevalence rate among the general population in 2015[8]
- 61% of people who inject drugs are aware of HIV testing, and 32.7% took the test at least once.[9] But only two out of 51 people who inject drugs are aware of the availability of needle and syringe programmes (NSPs)—a critical HIV prevention measure for people who inject drugs—and 52% of people who inject drugs have shared needle/syringes with their friends, which significantly increases the risk of HIV transmission,[10] and

- Almost half of those who are believed by Cambodia's national drug control agency, known as the National Authority for Combating Drugs, to be drug dependent (estimated at 8,822 for 2015, and 9,020 for 2016) are not accessing treatment services.[11]

It is in this context that this paper seeks to contribute to understanding of existing policies related to harm reduction in Cambodia, as well as the challenges to and opportunities for improvement in order to reduce the health and socio-economic harms associated with drug use. Following analysis of relevant policies and their implementation this paper identifies a clear need to harmonise policies on drug use and harm reduction so that health and socio-economic benefits can be maximised for both individuals and society at large.

Harm reduction as one dimension of responding to drug use in Cambodia

In 2014, Prime Minister Hun Sen recommended that health care and harm reduction services for people who use drugs should be promoted and provided at referral hospitals, health centres, community-based centres, and other places in a non-discriminatory and rights-based manner, following international medical standard.[12] He also recommended the use of temporary detention centres, however any detention of people who use drugs is not consistent with international standards for responding to drug use.[13] On the contrary, hospitals and health facilities following medical standards in the provision of drug treatment would constitute appropriate and effective components of Cambodia's response to drug dependence.

Harm reduction is a relatively new concept in Cambodia. NSPs were introduced in the mid-2000s after a long campaign by international and local civil society organisations with the aim of reducing the harms associated with injecting drug use.[14] Despite the proven success of NSPs in reducing HIV prevalence rates and increasing community safety during the early years of the programme, it was clear that the new concept was not well received by many stakeholders. There was a tendency among policy makers, law enforcement and the broader community to perceive NSPs as helping to sustain drug use and injection, as well as drug-related crime (mainly petty crime such as theft and social disturbance via disposal of used needles and syringes in public spaces). Limited awareness raising at both the policy and community levels attracted negative reactions from several sectors nationwide who leaned towards supporting the arrest and detention of people who use drugs—in an effort to take them out of the community.[15] It was only much later, in 2010, that the first methadone maintenance treatment programme (MMT), another critical harm reduction measure aimed at reducing the harms of injecting drug use, opened its doors in 2010 at the Khmer-Soviet Hospital in Phnom Penh.[16]

Since 2012, access to NSPs among people who inject drugs has remained low. The last survey in 2012 found that 31.9% of those who inject were using the same needles and syringes from their last use, and 14.4% reported that they had not receive sterile needles/syringes in the previous 12 months. As of 2013, 26.9% of the estimated 1,300 people who inject drugs throughout the country, including 32.6% of 1086 people who inject drugs in Phnom Penh, accessed NSP. 32.6% of 1086 people who inject drugs in Phnom Penh accessed MMT on a daily basis. This low demand is mainly due to low referral and high drop-out rates as no take-away doses are allowed, meaning that clients must travel to the service site each day, which is further hampered by a lack of support for transportation. The NSPHR seeks to find alternative approaches to improve the accessibility and availability of harm reduction services, one of which is community-based drug treatment.[17]

With the Ministry of Health's Department of Mental Health and Substance Abuse as the institutional lead, the NSPHR aims to promote and strengthen services for people who use drugs in order to reduce the harms associated with their drug use. The services prioritized include NSP, MMT, services at detention centres, and HIV/AIDS prevention and treatment (including treatment for tuberculosis, hepatitis B and

hepatitis C). In the meantime, the NSPHR aims to advocate for community-based treatment and harm reduction services for people who use drugs held in detention centres, and legal services for people who use drugs facing legal measures.[18] Although it is too early to assess the results of implementation of the strategy, the decision by the NSPHR to seek to deliver treatment and harm reduction services in detention centres, instead of transitioning away from the use of detention, is contrary to the harm reduction approach.

Barriers to effective drug policy in Cambodia

A. Criminalisation of people who use drugs

The harm reduction services and approach set out in the NSPHR appears to be at odds with the drug control law[19] and Village Commune Safety Policy (VCSP). The 2012 Drug Control Law was passed at a time when the understanding of drug use and their health and other impacts on individual users and their community was limited. While the Law allows for voluntary treatment and rehabilitation (as set out in articles 101 and 104), forced treatment is allowed when it is deemed by the prosecutor or judge, supported by a medical doctor's report, to be in the interest of the person using drugs when s/he is considered as not having the capacity to make decisions for themselves and where it is in the public interest (articles 101, 107, 108, and 109).[20] The overriding objective of these clauses, however, appear to prioritise the use of forced treatment. This is further facilitated by the ambiguity of the law when it comes to the definition of 'personal use' as a legal act (in articles 45, 46, and 53), which was intended to allow for diversion of people accused of drug use away from imprisonment and toward voluntary treatment.

The Drug Control Law also provides that the prosecutor and court have the discretion to divert a person accused of using drugs from imprisonment or to postponement of sentencing if s/he agrees to enter into a 'voluntary' treatment programme and completes it (outlined in articles 53, 105, and 106). However this apparent opportunity to avoid prison and detention does not seem to have been used to protect and advance the health and well-being of people who use drugs and the community. In fact, recent years have seen increasing rates of imprisonment and detention of people who use drugs, rather than greater investment in community-based treatment.[21]

The ambiguity in the Drug Control Law, coupled with the VCSP adopted by the government in 2010 with the aim of eliminating all forms of behavior that are deemed to disturb local safety and security, aggravated the campaign against people who use drugs. The VCSP targets activities such as theft, drug use, gambling, gang activities, sex work, domestic violence and human trafficking.[22] The policy has a strong intention to maintain security and safety for the community, and groups considered to be particularly vulnerable, such as children and women. However, people who use drugs are disproportionately targeted simply because they are widely perceived as 'bad people' and 'criminals.'[23] These perceptions are not supported by evidence, for example evidence of crime committed by people who use drugs. The heavy-handed implementation of the policy in 2011 invited reactions from a coalition of NGOs working in the HIV/AIDS sector. The coalition claimed that targeting people who use drugs by law enforcement was creating a climate of fear that forced them into hiding, and avoid health and harm reduction services, therefore resulting in escalating health risks such as transmission of HIV/AIDS.[24]

B. Stigma and discrimination against people who use drugs

The social stigma and discrimination faced by people who use drugs is experienced more broadly by other vulnerable social groups including homeless people, sex workers and children living on the streets. They are all seen as social 'undesirables,' 'dirty,' 'bad,' or 'criminal', and are often arrested and detained during preparations

for public or state events.[25] Once rounded up and sent to detention centers known for abusive practices (including rape and sexual harassment), torture, overcrowding and other human rights violations.[26]

C. Detention, imprisonment and forced treatment or rehabilitation

Cambodia's use of forced detention and rehabilitation has been continuing unabated even though there is strong evidence that it neither deters nor decreases levels of drug use, but rather results in increased harms for people who use drugs and their communities.[27] Imprisonment and detention worsens the situation of people who use drugs, especially where they are already suffering problems in other health and social issues (e.g. poverty, history of trauma and abuse, mental health issues) or are otherwise vulnerable such as street children. For children, detention or imprisonment facilitates contacts with older criminals and criminal gangs, leaves them with a criminal record that severely hampers future life opportunities, exacerbates social exclusion, and deteriorates their health and social skills.[28]

In addition to being ineffective and damaging, criminalising and punishing people who use drugs with measures such as forced detention is a burden for both the criminal justice system and public health in general. Cambodia's limited resources for the criminal justice system are stretched even further with about one third of inmates in Cambodia's prisons being people who use drugs, leading to further costs arising from the negative socio-health impacts caused by overcrowding in prisons and detention facilities, and lack of essential health services.[29] Realising these adverse impacts, at least 25 countries around the world have taken measures to remove criminal and severe administrative penalties against drug use and possession of drugs for personal use. This practice is permitted under international laws and benefits from increasing levels of political support worldwide.[30]

An effective and less costly alternative: Evidence-based and voluntary community-based treatment

Alternative measures to criminalisation and forced detention such as community-based treatment, implemented as part of an overall harm reduction approach, are implemented in many countries in the region and around the world. In the case of Malaysia, prison overcrowding and a widespread epidemic of HIV among people arrested for drug use led to the introduction of voluntary treatment services and MMT at detention centers which has led a sustained decline in HIV amongst people who inject drugs. India is another example where harsh law enforcement measures and stigma against people who use drugs led to increased rates of HIV/AIDS prevalence until community-based alternatives were later adopted.[31]

In its 2016 World Drug Report, the United Nations Office on Drugs and Crime (UNODC) reported convincing evidence that:

> Alternatives to incarceration within the community (in an outpatient or residential therapeutic setting), such as psychosocially supported pharmacological treatment for opiate dependence, can be more effective than imprisonment in reducing drug-related offences.[32]

The UNODC also released the Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia in 2014,[33] which outlines detailed principles for implementing community-based treatment, including the need to ensure:

- Informed and voluntary participation in treatment
- Respect for human rights and dignity including confidentiality
- Comprehensive approach that addresses the different needs of the individual seeking treatment, including in relation to health, family, education, employment, and housing

- Acceptance that relapse is part of the treatment process and will not stop an individual from re-accessing treatment services
- Continuum of care from outreach, basic support and harm reduction to social reintegration, and
- delivery of services in the community close to where people who use drugs live.

In a study reported by the UNODC, only one in ten people who use drugs have problems with their drug use, and may need drug dependence treatment.[34] This means that not all people who use drugs need treatment and for those who need it, no single treatment applies to all people who use drugs. An appropriate assessment of a person dependent on drugs is needed before a treatment plan can be decided to address the type of drug used, the length of consumption, the state of mental health, and the person's socio-economic and physical condition.[35] It is also critical that the treatment plan be developed in partnership with the person dependent on drugs to ensure the best possible treatment outcomes.

Examples of good practice community-based treatment services in Asia

A study analysing six case studies of community-based treatment services, that could constitute alternatives to compulsory treatment in Cambodia, China, India, Indonesia, and Vietnam, showed that their success was conditioned on the minimum requirements of services provided to people who use drugs including:

a. Voluntary access to treatment
b. Client-centred approach
c. Meaningful involvement of people who use drugs and civil society in design and implementation
d. Comprehensive health and psychosocial care services
e. Compliance with medical guidelines and subject to oversight by health professionals
f. Drug policy reform and leadership, for example to ensure voluntary access to treatment
g. Coordination with law enforcement, as appropriate, to ensure that people who need treatment are able to access it, instead of being arrested and detained[36]

For instance, China's Peace No. 1 community-based treatment centre was established in late 2013 in Yunnan Province's Yuxi city, with the involvement of local police, other public security agencies, and people who use drugs. These services include on-site rapid testing and counselling for HIV, hepatitis C, hepatitis B, and syphilis, direct distribution of naloxone to prevent overdoses, individual and group counselling, MMT, outreach and home-visits, job placement, social and community activities, and referrals to treatment for other illnesses. The comprehensive services provided to clients resulted in improved medical, economic and social outcomes. For example, as of mid-2015, the number of clients who secured employment increased and the re-incarceration rate declined.[37]

Recommendations

While diversion is provided for in Cambodia's Drug Control Law, it is yet to be implemented to the extent that the well-being and health of people who use drugs are prioritized – indeed, current diversion mechanisms refer people who use drugs to compulsory detention centres instead of voluntary health and harm reduction services. In order to improve the health and well-being of people who use drugs and communities in Cambodia, well-coordinated efforts at both the policy and implementation levels need to be mobilised including:

A. All stakeholders, including government, development partners, and civil society should take steps to improve and scale-up community-based services, in order to promote access to harm reduction services such as NSPs and overdose prevention tools such as naloxone, voluntary treatment programmes designed and implemented in accordance with international standards, as

well as programmes facilitating integration of people who use drugs into community and society.

B. The government should take necessary steps to minimise any ambiguity and conflicting messages in the existing Drug Control Law in relation to drug use, and harmonise it with other relevant policy documents such as the VCSP and NSPHR to ensure the removal of criminal punishment and compulsory detention for people who use drugs. Criminalising and punishing people who use drugs will only deter them from accessing available harm reduction and treatment services, and therefore increase risks such as HIV/AIDS transmission and overdose deaths, in turn leading to an unnecessary and preventable burden on both the public health and criminal justice system.

C. All stakeholders should accelerate awareness raising and education programmes for law enforcement, local authorities, community members and policy makers about drug use and harm reduction. Such programmes should aim at reducing stigma and discrimination against people who use drugs and sensitising community, family members and local authorities on the benefits of ensuring the availability and accessibility of harm reduction and treatment services for people who use drugs.

Endnotes

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About IDPC

The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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