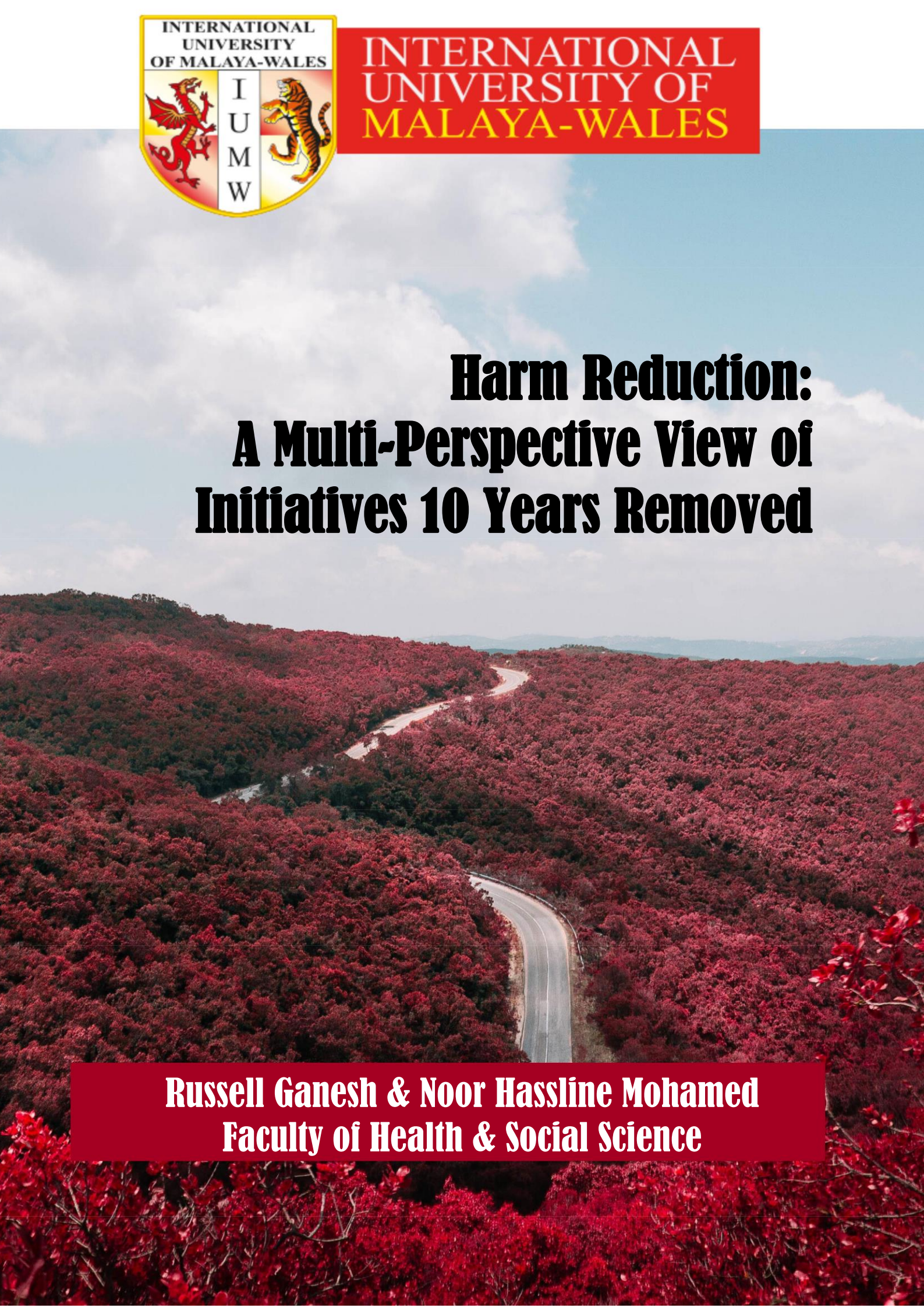
INTERNATIONAL UNIVERSITY OF MALAYA-WALES

Harm Reduction: A Multi-Perspective View of Initiatives 10 Years Removed



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Harm Reduction Initiatives: A Multi-Perspective View of Initiatives 10 Years Removed

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SYNOPSIS

Harm reduction treatments have been a relatively new initiative implemented to address drug addiction and HIV transmission in Malaysia, with great promise and results shown in the initial years of implementation. In the last five years, there has need to research how harm reduction treatment initiatives have been implemented, especially with regards to how policy and practice changes have affected stakeholders involved in harm reduction treatment initiatives in Malaysia. The study aims to explore the current state of harm reduction treatment initiatives in Malaysia through the different perspectives of stakeholders from different communities and organisations, with hopes of being able to identify successes in the overall implementation of treatment initiatives, as well as areas of future growth that can be identified through these multiple perspectives. The study interviewed six participants working across different sectors related to the implementation of initiatives using semi-structured interviews and focus groups. The results of the study can identify themes that satisfy the initial objectives of research, as well as provide recommendations for future areas of growth within stakeholders, as well as for future research.

CHAPTER 1
INTRODUCTION

INTRODUCTION

1.1 Background of the Study

Drug abuse and addiction is a universal problem all countries face to some degree. Within Malaysia, drug abuse has been a notable issue of public concern as well as research. With the influx of immigrant communities in the early 20th century bringing the first notable wave of drug abuse and addiction, a byproduct of widespread opium use, Malaysia has been battling drug abuse and addiction for the better part of a century. In this time, changing drug trends and proximity with drug producing regions, such as the Golden Triangle Region has seen addiction trends change as well. Since the 1970's (Kamarudin, 2007; Vicknasingam and Mazlan, 2008), addiction to opiates have made up a significant majority of drug addiction cases in Malaysia, leading to the nation declaring drugs as the first enemy of the state in 1983, and launching Malaysia's version of the "War on Drugs". It is a zero-tolerance approach to drugs that heavily punished offenders under the Dangerous Drugs Act, as well as an abstinence-based approach to implementing treatment, education and rehabilitation initiatives that were implemented primarily through the National Anti-Drug Agency, established in 1996 as the primary arm for drug enforcement. Subsequent efforts to address drug addiction throughout the "War on Drugs" has seen varying levels of success as the nation moved into the 21st century; arrest figures of drug abusers regularly reaching five figures, with reports of raids on drug labs, addicts and confiscating of illicit substances being trafficked being a regular occurrence on news cycles. Rehabilitation and treatment initiatives have been a challenge unto itself; incidences of relapse remain very high among Malaysian addicts, with an average of two-thirds of the patients being admitted into treatment and rehabilitation programs eventually relapsing within the first two years (Ibrahim and Kumar, 2009).

In addition to the high relapse rate, the rise of the HIV and AIDS epidemic globally at the turn of the 21st century had come to affect Malaysia as well. With a majority of addicts in the nation being addicted to opiates such as heroin and morphine, risky social practices such as sharing needles among intravenous drug

users had caused HIV infections to spread among these communities at an alarming rate; by the early 2000's, intravenous drug users were the largest population affected by HIV and AIDS infections. In 2004, the federal government responded by greenlighting the implementation of harm reduction-based treatments and initiatives, specifically methadone management (or assisted) therapy, as well as a needle syringe exchange program as the primary tools to curb the spread of HIV infections among affected communities, as well as addressing opiate addiction within the nation. While harm reduction is philosophically not a new concept and evidence-based treatment initiatives have been commonplace internationally by the end of the 20th century, Malaysia's adoption of harm reduction treatment initiatives was seen as a huge step forward, marking the first major shift into accepting more medical-based approaches to address addiction, instead of the abstinence-based punitive approach that has been historically emphasized in the nation's "War on Drugs".

Early responses to harm reduction treatment initiatives were positive, research indicated that harm reduction-based initiatives had a high efficacy and retention rates, notable improvement in social measures such as quality of life amongst patients as well as a significant reduction in the rates of HIV infections as a result of intravenous drug use (Rusdi et. al., 2007; Vicknasingam & Mazlan, 2008). In 2009, the National Anti-Drug Agency introduced the Cure and Care Rehabilitation Centres (CCRC), a rehabilitation center that uses harm reduction treatment-based initiatives, specifically medical-assisted treatments such as methadone was introduced to further upscale upon initiatives provided, and highlighted the nation's commitment to its adoption of more medical and therapeutic based measures in addressing drug addiction. Despite the efforts undertaken by the government as well as stakeholders involved in implementing various treatment initiatives to address drug addiction as well as the spread of HIV and AIDS in Malaysia, there problem is still persistent, drug related arrests have been on the rise since 2010, and relapsing addicts still make up significant proportion of cases. While incidences of HIV infections have decreased since the implementation of harm reduction treatment initiatives, statistics from the Ministry of Health (2017) indicate that

treatment prevention and coverage is still limited in in outreach, only reaching 52% of intravenous drug users (also classified as People Who Inject Drugs – PWID), and 44% of key populations across all initiatives.

Although statistics and research have discussed different measures of efficacy as well as identifying trends in drug addictions, there is little research discussing the changes within the nation's implementation of harm reduction-based treatment initiatives, and its effects in the last five years. There is also a need arising to explore the experience of the multiple stakeholders (patient, practitioner, policymaker and researcher) and their perspectives, in understanding how the implementation of harm reduction treatment initiatives and its changes over time have effected stakeholders and their role in the overall framework of how drug addiction is addressed in Malaysia. The study explored, through these multiple perspectives, the current state of harm reduction treatment initiatives in Malaysia through its developments over the last decade. The study also seeks to understand how these initiatives are implemented, in hopes of being able to identify strengths within the current framework, as well as future areas of growth that may be investigated by stakeholders in the future.

Overall, the study's exploration of the state of harm reduction treatment initiatives in Malaysia has two aims intended to achieve. Firstly, the study looks to explore how harm reduction treatment initiatives (needle & syringe exchange programmes, as well as methadone management therapy) are implemented in Malaysia. Within this aim, the study looks to understand how harm reduction has developed over the decade since it was implemented in Malaysia in 2005, through the experiences of the different stakeholders involved. The study's exploration into the phenomena also aims to identify strengths as well as challenges in any area related to the issue in hopes of not only understanding the issue but also able to present suggestions in terms of further improving the current system and policy implemented in the nation.

CHAPTER 2
LITERATURE REVIEW

LITERATURE REVIEW

2.1 Previous Studies

2.1.1 Drug Addiction and Treatments in Malaysia

Drug addiction in Malaysia has been a serious issue that has affected families, societies and the nation in general for the better part of the 20th century in the last 3 decades, since the federal government declared drugs as the primary enemy of the state in 1983. Opioid (drugs deriving from the opium poppy plant, such as heroin, morphine and opium) addiction in particular has presented the greatest drug threat towards the nation, with a majority of cases (54.87% of new cases, and 78.65% of relapse cases in 2015) admitted into rehabilitation centers across the country being for addiction to opiates, specifically heroin and morphine (Agensi Antidadah Kebangsaan, 2016). The added factor of the spreading HIV/AIDS virus, particularly among drug users who engage in intravenous drug use (IDU) and the practice of sharing needles-a common practice amongst opiate addicts in Malaysia, and the primary cause of the spread of HIV/AIDS in Malaysia – has further increased efforts of the federal government and more recently, non-governmental organizations (NGOs) in attempting to address the drug problem in Malaysia (Vicknamsingam & Mazlan, 2008).

The establishment and maintenance of a framework for drug addiction treatment and rehabilitation has by and large been a task undertaken by the federal government, an area of concern that the government is keen on addressing. In the 33 years that followed, the drug problem is still prevalent in society, and at this point national statistics on drug abuse from the National Anti-Drug Agency (AADK) and external research somewhat reflect a standstill. While great efforts and initiatives have been taken by multiple parties within, affiliated to and outside of the federal government, drug abuse and addiction rates have been consistently in the tens of thousands. According to AADK statistics, while drug use decreased in the early part of the decade (23,642 total reported cases in 2010 dropping to 19,531 in 2011 and 15,101 in 2012), it has been rapidly mentation the national drug policy increasing with 2015 recording an the highest number of cases in a 6 year period with 26,668.

These statistics also indicate that the number of new addiction cases has reached a 5-year record high with 20,289 (or 76.08%) of new cases in 2015. This significant increase in the number of drug addicts requiring treatment has put pressure on the current system and policies in Malaysia in terms of being able to adequately address and combat these issues, with current methods and practices being called into question considering the current seemingly standstill state of the war on drugs, 33 years removed.

As noted by Kamaruddin (2007), the nation has seen a history of implementing tough, zero-tolerance policy measures in addressing the threat of drug addiction in Malaysia. With the establishment of the National Anti-Drug Agency in 1996 under the Ministry of Home Affairs, the nation's drug policy has mainly employed with a punitive first-based policy where heavy penalties (including fines, incarceration and in some cases, mandatory hanging) to primarily deter drug use and the trafficking of drugs. However, while great efforts have been made to prevent drug use, the nation's efforts in treating the population of addicts have been largely deemed ineffective. With high reports of relapsed cases (Ibrahim and Kumar; 2009; Kamaruddin 2007; Vicknasingam and Mazlan, 2008) amongst addiction patients; specifically, opiate addicts being an increasingly common situation – to the extent of some patients undergo treatment multiple times. Since 1977, Malaysia has employed a system of institutionalized care based on abstinence which also known as cold-turkey approach of drugs (Kamaruddin, 2007). While historically the process of treatment has largely used the primary modality of abstinence based treatment, it is the advent of the HIV/AIDS virus, and its rapid transmission among the local intravenous drug using community at the turn of the century that prompted Malaysian officials to look at modalities of treatment that would be able to address these issues.

2.1.2 Harm Reduction Treatment Initiatives

Harm reduction at its essence can be described as a set of principles that generally dictate policies regarding how societies respond to drug-related problems (Hunt et. al., 2003). Harm reduction-based therapies primarily aim to decrease the harms

related with drug use such as intravenous drug use and needle sharing which cause the spread of HIV and AIDS, as opposed to the current abstinence-based approach which is more concerned with preventing the use and trafficking of drugs. The increasing spread of HIV/AIDS among intravenous drug users had prompted the federal government to search for solutions that would directly address this epidemic– leading to harm reduction treatment initiatives being introduced in the country in 2005 (Vicknamsingam & Mazlan, 2008; Rusdi, Zuriani, Muhamad, Mohamad, 2008), an initiative considered long overdue with the initiatives already being implemented in Europe and north America in the 1980s. The new initiatives were met initially with hesitance by officials involved and the federal government at large; over thirty years in a framework of treatment and education based on institutionalization and abstinence a practice that is now embedded into societal ideas and norms that naturally would resist this preventive or palliative-based approach to addressing the drug problem. Rather than just a social problem as abstinence-based methods can imply, harm reduction practices approach the issue from also a medical standpoint; seeking to manage and reduce the patients' addiction, in hopes of eliminating it. The approach presented an alternative to, and in some cases, a far cry from, institutionalized care that has been the primary avenue of treatment for the past three decades that was not only more financially beneficial to the federal government, but also more effective in treating addiction patients with minimal relapse rates and a marked improvement on general quality of life (Vicknasingam & Mazlan, 2008; Rusdi et. al., 2007).

Research into harm reduction treatment initiatives' efficacy as a treatment measure for addressing both HIV and AIDS transmission and drug addiction found positive results, some of which go beyond measured treatment outcomes. Kamarulzaman (2009) notes that the implementation of the initial harm reduction treatment initiatives had a observable impact even before research-based assessments had been carried out; interagency collaboration on initiatives between public health and enforcement had marked a shift in policy, acknowledging that drug use is both a health and legal issue, one that requires cooperation from stakeholders on both sides. Access to medication and treatment that previously was

either very expensive or illegal to own, such as methadone would allow more HIV-infected patients to be initiated on ART which helps manage the HIV and AIDS virus in these populations and reduce the spread of the disease. This is also seen in the implementation of the preventive harm reduction treatment initiatives such as the needle syringe exchange programme, which significantly reduced risky social injecting behaviors (particularly the sharing of needles among intravenous drug users) within a year of implementation of a pilot project, from 56% to 43% in 2006. Quality of life among patients also notable improved, with 66% of individuals within initial methadone assisted treatment programmes reporting full employment, as compared with 47% from the beginning of programme initiation.

The initial results were not just situational, as data over time had noted the positive effects the implementation of harm reduction treatment initiatives have presented over time. A retrospective study by Devi, Azriani, Zahiruddin, Ariff and Hashimah (2012) notes that significant reduction of overall drug use among patients in a local clinic within 12 months in analyzing records of 117 patients over a three-year period. Sustained success of treatment implementation was not limited just to adherence to treatment; quality of life amongst patients in methadone assisted treatments saw improvements after participating in treatment for 6 months (Baharom, Hassan, Ali & Shah, 2012), seeing significant social and psychological improvements in a retrospective study of 122 patients. These improvements were also seen over a two-year period, as found by Musa, Bakar & Khan (2011). In a quality of life assessment of 107 patients two years after they had initiated methadone assisted treatment within a local hospitals' methadone clinic reporting significant psychological, physical, social and environmental improvements among patients there. These achievements (and overall praise for the successful harm reduction treatment practices initiated by the nation in response to HIV/AIDS transmission) were noted and highlighted in a reported by the United Nations (2011), heralded as a shining example for implementing harm reduction initiatives that other nations' stakeholders can learn from.

Despite the successes in implementation and recognition from within as well as outside the nation, institutionalised care is still the predominant method of drug addiction treatment and rehabilitation used by the federal government, the main proponent of addiction-based care in Malaysia (Vicknamsingam & Mazlan, 2008; Lian and Chu, 2013). While treatment initiatives receive the support and approval of government agencies and organization, there is little knowledge regarding how these changes in implementation have affected the overall practices of different stakeholders within their implementation of harm reduction treatment initiatives within a predominantly abstinence-based, punitive first system.

2.2 Concepts and Theory

The current study's exploration of the state of harm reduction treatment initiatives in Malaysia has two aims intended to achieve. Firstly, the study explored how harm reduction treatment initiatives (needle & syringe exchange programs, as well as methadone management therapy) are implemented in Malaysia. Within this aim, the study identified how harm reduction has developed over the decade since it was implemented in Malaysia in 2005, through the experiences of the different stakeholders involved. The study's exploration into the phenomena also aims to identify strengths as well as challenges in any area related to the issue in hopes of not only understanding the issue but also able to present suggestions in terms of further improving the current system and policy implemented in the nation. In addition, the effectiveness of both harm reduction initiatives and abstinence-based care (being the active policy of rehabilitative care in Malaysia currently) in terms of the perceived the treatment by former patients or addicts who have gone through opiate addiction treatment in the nations. Then, the study expected to obtain the descriptive data that may shed light on the state and development of harm reduction and the overall state of drug rehabilitation in Malaysia in terms of policy and implementation.

Data regarding the current usage and effectiveness on the current system of treatment is largely unknown or unclear, with few, if any research discussing the implementation of treatment initiatives and its developments over the last five

years. With increasing addiction rates and continued dependence by governmental officials upon abstinence-based measures, there is a need to study the role harm implementation initiatives (and its stakeholders) plays in addressing drug addiction in Malaysia. While research mainly discusses treatment outcomes (i.e. empirical measures) and its effectives, there is a lack of significant research exploring the experiences of the multiple stakeholders within the implementation of harm reduction treatment initiatives and how these organisations work together to implement these treatment initiatives. This study aims, through this analysis of multiple perspectives, to be able to understand how these stakeholders involve themselves with the harm reduction initiatives and identify both strengths as wells as areas of future growth for stakeholders as well as regarding treatment initiatives.

The Socioecological Model (Baral, et al, 2013) is used as a framework of conceptualisation to understand the implications and impact treatment initiatives have had on an individual, network, community, as well as public policy perspective. This model allows for a clear understanding into how components (treatment initiatives, stakeholders involved) within the framework interact with each other, and how these interactions (whether direct or indirect) affect them. Triangulation within qualitative research also plays a vital role in helping to shape the framework of teamwork initiatives. Various data sources can give a multi-perspective view of a situation or initiatives, and helps to identify themes through saturation (Flik, 2010; Carter et al., 2014). Through these perspectives, the study hopes to be able to uncover themes that may help illuminate the current state of treatment initiatives, and the experiences of the stakeholders involved within the situation.

CHAPTER 3

METHOD

METHOD

3.1 Research Design

A qualitative-based approach was used to conduct the research, through the usage of semi structured interviews to collect to the data from participants. Qualitative methods were chosen as it is known regarding harm reduction initiatives in Malaysia from an implementation perspective, and the data collected is aimed at exploring themes. The usage of semi structured interview was intended to obtain the unique perspectives and experiences of different stakeholders involved in the overall framework of harm reduction treatment. Interviews were offered in addition to focus groups to provide participants a choice to be involved at their convenience.

3.2 Participants and Sampling

Participants of the study consisted of individuals who represent different stakeholders within the framework of harm reduction treatment initiatives. Stakeholders consisted of two main groups; individuals whom these treatment initiatives are designed for, such as opiate addicts undergoing methadone assisted treatments or individuals who are participating in a needle syringe exchange program conducted in Malaysia. Another group of stakeholders consists of individuals and organisations involved in the implementation of these treatment initiatives, such as practitioners, policymakers and researchers from governmental bodies as well as non-governmental organisations. Participants were selected using a combination of purposive and snowball sampling in order to obtain data from multiple perspectives to represent all stakeholders within the treatment framework. Individuals who are involved with the implementation of treatment from both governmental bodies as well as non-governmental organisations were initially identified and contacted for their participation in the study. Other participants were obtained through recommendations and further contacting to participate in the semi-structured interviews or focus groups. Participants were all at least 18 years of age, spoke English or Bahasa Malaysia, and able to give informed consent (written and verbal). There were six participants were ultimately selected

from different backgrounds and representing different to avoid information bias as well as understand the implementation of treatment initiatives through different experiences and perspectives.

3.3 Data Collection

The data was collected with the interviews or focus groups (involving two participants) being conducted in a private setting at the preference and convenience of both participant and researcher. Data was collected primarily in English. Prior to beginning the data collection process, participants were required to provide verbal as well as written consent before being as basic background information. The focus groups and interviews were audio recorded and transcribed verbatim by the researcher using transcription software for later analysis of key points, as well as field notes being taken by the research to capture non-verbal cues or follow up questions. The recruitment and data collection process continued until a point of saturation was reached, where new information discovered does not add necessary points to the overall framework of data. The data was collected using an interview topic guide designed based on the Theoretical Domains Framework (Atkins et. al., 2017), which was created for use within implementation (particularly qualitative) research. The framework provided the basis for illuminating areas of focus in terms of exploring themes that arise in the discussion of implementing harm reduction treatment initiatives in the initial stages, which proved crucial considering the exploratory nature of the current research.

3.4 Data Analysis

Data was analysed using a thematic analysis approach (Braun & Clarke, 2006), where the data collected is analysed and patterns of relating data are identified and developed into themes and subthemes relevant to the discussion, in this case being the implementation of harm reduction treatment initiatives in Malaysia. The transcribed interviews are analysed and coded using QDA Miner, a qualitative data analysis software that facilitated in the systematic analysis of data. Themes generated from the data set emerged using a general inductive approach. The process was influenced by the initial research objectives, as well as additional

concepts generated inductively (through the perspectives and experiences of stakeholders) from the collected data. The data (and emerging themes) are analysed and coded in English, with data collected in Bahasa Malaysia translated. Quotes are screened, with those that best illuminate the essence of themes being extracted. All identifiers (both individual and organisation) are removed from transcribed interviews prior to analysis to ensure the confidentiality of the individual or the organisation participants are affiliated with.

CHAPTER 4
RESULTS

RESULTS

4.1 Findings

Six participants participated in five semi-structured interviews and one focus group. The participants were all based in the Klang Valley region of Malaysia, comprising of four male and two female participants, representing the four major stakeholder groups (practitioner, policymaker, patient and researcher) across both governmental and non-governmental organisations associated with treatment initiatives. Demographic characteristics of the participants are listed below (pseudonyms are used to maintain anonymity): -

- Sam (M) – A medical practitioner and researcher working with the enforcement community-based treatment centres
- Cat (F) – A medical practitioner and researcher working within the medical community
- Jay (M) – A policymaker working with the enforcement community
- Dza (M) – A practitioner/service provider working with non-governmental organisation
- Kim (F) – A practitioner working with non-governmental organisation
- Mat (M) - A policymaker, working with a non-governmental organisation

From the focus groups and semi structured, four major themes emerged and will be discussed, supported by illustrative quotes from the study participants. (INT = Interviewer, in bold).

4.1.1 Overview of Initiatives

As noted by previous literature, two harm reduction-based initiatives are used as the primary modalities; namely medical assisted treatments (initially known as opiate substitution treatment) is primarily through the use of methadone, or other opiate agonist or non-agonist based medication, as well as the implementation of a needle syringe exchange programme, where intravenous drug users are able to visit approved centres to exchange their used needles and syringes for clean ones. While

later findings will note the cooperation of all stakeholders that occur to some degree, it is worth noting that both initiatives are spearheaded through different communities of stakeholders.

Question 1

What are the types of harm reduction -based initiatives are primarily involved with regards to each initiative?

"Harm reduction (in Malaysia) has two main components: first, is the provision of opioid substitution therapy which is methadone, and second, is the needle syringe exchange programme..." – Sam

"Mainly in Malaysia, what we are doing especially in (this NGO) in collaboration with medical organisation, we are doing harm reduction in (the form of) NSEP (needle syringe exchange programmes), delivering condoms for sexual transmissions, also referring drug users to methadone treatments, local health clinics. That is the main goal." - Kim

Question 2

What is the role of non-governmental organisations play in implementing medical assisted treatment initiatives?

"We are not allowed to. It's a very controlled medicine, so, medical organisations are the ones who are taking care of it." – Kim

The implementation of methadone-based treatment initiatives has been a key matter concerning both the medical and enforcement communities, with collaborative efforts between the two being crucial in its development, as well as growth over time.

"We started HRT initiatives since started 2002. Of course, within this (medical organisation) itself we started prescribing methadone for opiate users - so at that point in time, governmental organisations (medical and enforcement) do not have services (related to methadone). And in 2007-2008, we started the initiative of inviting

enforcement agencies to get involved in the methadone programme. I remember at that point in time, we meet with (enforcement agency) officers and we discussed with them and telling them about the methadone itself, and how the methadone is successfully been implemented in other countries. Eventually after several meetings, even though there is some resistance from the officers there, but later on they take our ideas and we started the first pilot project (enforcement-based methadone assisted treatment) – at the point of time, we started the methadone program, help them, piloting (the project). It's actually (started) in year 2010, but in certain drug treatment centers, we start earlier, in year 2007. So, after one year, we had seen very promising result and from there, we were very convinced that we should upscale the program throughout the country. So not only involving government health, but also the enforcement community, which acts as the main stakeholder that is looking after drug addiction problems and rehabilitation but at that point in time, they still have some resistance. Until the year 2008, only then do they take the ideas and start initiating the pilot (methadone assisted treatment) project and following that establishing their own methadone assisted treatment facilities. Until now we have... 60 to 70 centres throughout Malaysia." - Sam

While the later involvement of the enforcement community in the implementation of methadone assisted treatments through their facilities is notable, it must also be pointed out that the enforcement community has always been involved with the implementation of harm reduction initiatives to some degree.

"Well, what we do is when the hospital settings were introducing methadone, MMT (medical management therapy) … when these hospital settings start introducing MMT, this organization helps them in terms of the psychosocial approach post-prescription of the MMT; what you do after that. Because the protocol shows clearly that after it's been given (the prescription of methadone) … so you must go for the aftercare programme, so they come. Individual counselling, group counselling and family counselling…" - Jay

"Support and follow up." – INT

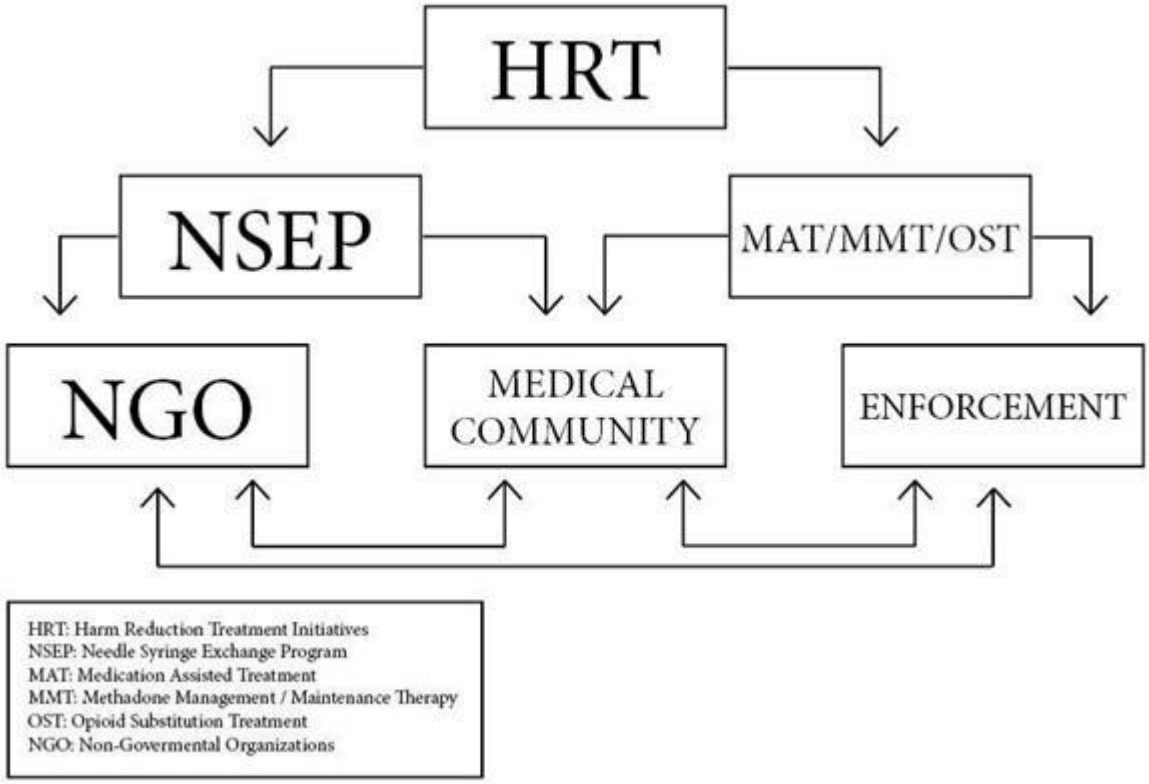
"Yeah. You must do that. So, what we did was, as far as in know – our officers were asked to help with the psychosocial services, so, they come as a walk in (client), officer work with these clients who went to the methadone program. And those are the services that we provide to help the medical organisations (in the initial stages)." Jay Providing services outside of directly participating in the implementation of harm reduction-based treatment initiatives (such as MAT and NSEP) is also a point of interest for non-governmental organisations, whom involve themselves with programs that address processes before and/or after treatment initiatives, working with various organisations both within and outside of governmental organisations.

"So, we do from outreach, to testing, and then if they test positive; linking them into treatment, and then monitoring them throughout treatment until they arrive at (a stage of) virus suppression. We also provide shelter, for people in need…Most of our work is outside... one of the programmes we run is treatment adherence. We are in six clinics and hospitals in the area, and we get referred; so, patients referred by their doctors to us, if they need support. When they either start treatment, or when they're defaulting. That's (aftercare services) some part of the work, but we also do outreach. So, we actively go out and connect with people and recruit them into (HIV) testing." – Dza

The implementation of harm reduction initiatives at its surface may just been seen as delivering methadone (or other medically assisted treatments) and clean needles to patients, but is a process of involving initiatives that address not only treatment, but situations before (such as identifying and screening) and after (such as aftercare support and services). These initiatives involve organisations across three major stakeholders; the medical and research community, the enforcement community, and non-governmental organisations. While the pre- and post-treatment initiatives have been a collaborative effort across all major stakeholders (and their affiliated organizations), the implementation of the specific harm reduction-based treatment initiatives seem to split across major organisations, illustrated in Figure 1. The needle syringe exchange programme initiative seems to be spearheaded by non-governmental organisations, while the methadone assisted treatment seems to be a

key initiative within the enforcement community. The medical community can be considered somewhat of a fulcrum, working with both enforcement communities as well as non-governmental organisations across both initiatives in supporting either initiative and acting as the catalyst for change (in the beginning, and over time), as well as the catalyst for cooperation between organisations and major stakeholders.

Figure 1: Overview of HRT initiatives and the stakeholders involved in its implementation



4.1.2 Changes & Developments

The developments throughout implementing harm reduction treatment initiatives over time has brought about changes in practices and objectives across all major stakeholders. As mentioned earlier, the enforcement community has gradually accepted and adopted the implementation of harm reduction-based treatment initiatives, developing their own methadone management treatment programme after initially being largely a supportive arm rather than being directly involved in

implementing treatment initiatives. Changes in practices were not limited to enforcement agencies; non-governmental organisations have found the services they provide also change and develop in the wake of implementing harm reduction-based treatment initiatives in Malaysia.

Question 3

What are the developments throughout implementing harm reduction treatment initiatives over time have brought about changes in your practices and objectives?

"Initially, we were meant to provide a platform in order to get medication to people, because medication wasn't easily available in Malaysia at the time (prior to the implementation of harm reduction treatment initiatives), and certainly wasn't available in government hospitals. So, we connected (private) drug companies with people living with HIV. They couldn't sell directly to patient, but they can go through us, so we connected them. The implementation of the harm reduction programme changed the HIV epidemic in Malaysia; since 2015, the new infections are now no longer among people who inject drugs. They're mainly among sexual transmissions. And among sexual transmissions, a lot of it's occurring among the LGBT community, and amongst sex workers. And our work now (within this organisation) deals a lot with this community. So, before we were linking people into care, and providing care in hospitals; but now because of this change, we have gone out to look for people for testing, which we didn't do before. So, harm reduction has changed the epidemic, changed how we operate." - Dza

This decrease in the rates of HIV incidence among intravenous drug users is seen as a major development in the implementation of treatment initiatives. The positive response in treatment outcomes had prompted a shift in policy that led to the adoption and upscaling of harm reduction-based treatment initiatives within the enforcement community. A policymaker from the enforcement community noted this shift in policy.

"Well, all this while this organization's been using the psychosocial approach, and by having them treated in a residential base… before that was the drug recovery center.

Even the modality of the psychosocial (treatments) is solely based on the moral model that is an element of punishment, reward and punishment. (On the enforcement community adopting and implementing methadone assisted treatments) … Well, there was a transformation of treatment; changing from residential bases to methadone treatment facilities. I think that was because of the policy of… open policy, in treatment. We need to look at the best practices, you see…and once we are involved in the international community, we also look at what the international community is doing. And we also respect the professionals in the country, when they conduct research and so on…" - Jay

The medical community also experienced changes in the wake of the development of treatment initiatives. On changing the name of opioid substitution therapy/methadone management/maintenance therapy to Medically Assisted Treatment.

"Well we found out that methadone does more than manage and reduce harms. Rather than (seen as) a replacement of the opioid itself, it's like treatment as a medication that's to treat – like any kind of chronic disease (referring to addiction). For example, now we already know more data, people who have opioid use disorder… which means that they are addicted to heroin, to opiates; it's a chronic brain disease. Alright? It's like people who have diabetes (and other chronic diseases) …" - Cat

"I think OST or what we call now Medication Assisted Therapy, is well accepted. OST is methadone…opioid substitution therapy, but we don't use that term anymore, because sometimes it's very misleading; people misperception, (thinking) you just replace opioids with another opioid, but in actual fact, now, all over the world, it's not like that. We call it MAT because it's medication. Methadone is medical – it's doesn't just "replace" heroin. It's more than that…" - Sam

Another change in the implementation of initiatives comes in the form of objectives of treatment, as discussed by stakeholders within the medical community.

"The first (goal) of what we wanted to treat was actually opioid dependency – the disease…So, we have done that. The second thing is to reduce HIV (virus) transmission because of the needles; sharing needles – we did that. I think within 12 months we

already did it (achieve targeted goals). In 2000; we had 50000 (HIV/AIDS patients) – and they (stakeholders) started to find out that it's because of the opioid users. (Injecting drug users) Sharing their needles, and that's why it spread. So (the) number one reason how the transmission (of the virus) is by needle sharing; number two is sexual interactions – at the time that is down on the list. But now, it (harm reduction treatment initiatives) has been successful in controlling it. So now, our no. 1 HIV transmission is sex, no longer intravenous drug use. Initially, our aim is to treat their opiate dependence. But now, our aim has changed; we want them to lead a" normal" life (i.e. reintegrating into society)… so we want them to live like how you and I do; they have the ability to get a job… our former director used to say, 'you have to make our patient able to work, to play, to love'…" - Cat

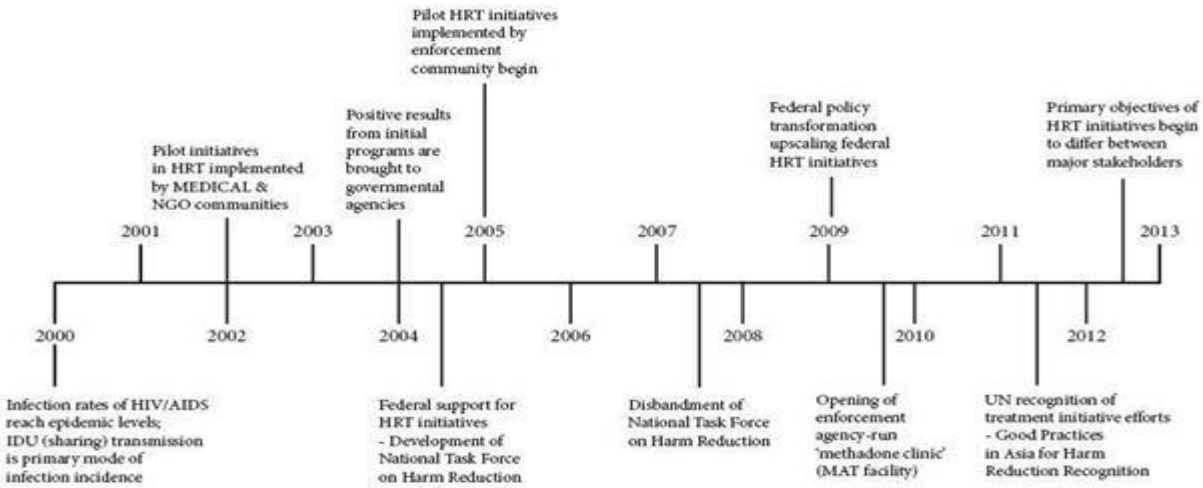
When discussing patient autonomy, Cat had this to say;

"Yes, we are promoting that. Initially, we were promoting that all addicts should be aware that there is a treatment (option) and they should come for the treatments. And now we are promoting that you (the patient) need to be independent, and we'll support you in charge. So, we told them, even convinced some of them; (saying to patients) "I can see you've been quite successful (in treatment). Once you have a stable job and all, why don't you discharge from our program? We'll still see you every 2-3 months; just like how a diabetic patient (manages their disease), you see them every 2-3 months for a check-up. So, they come in and we will check on them, whether they're okay or not these past three months; do they have problems, challenges… we'll slowly let go our hands, rather than still fully "babysit" them." - Cat

This change in objectives within stakeholders of the medical community can somewhat differ from the treatment objectives of different stakeholders, discussed in more detail in subsequent findings. In its essence, the multiple perspectives of different stakeholders shed light in understanding the current state of initiatives through two major themes. Firstly, is addressing the question of who is involved in the implementation of which treatment initiative (and their role in implementing or supporting said initiative). This framework is illustrated in Figure 2 highlighting not only how these initiatives are implemented, but also who are the stakeholders

involved in each level (pre-treatment/screening, treatment, post-treatment/aftercare). The other major theme concerns the developments over time as a result of implementing harm reduction initiatives, and how these affect changes within the practice or objectives of stakeholders, ultimately shaping the current state of initiatives seen today. These changes are illustrated in Figure 2 which highlight a timeline of key developments in initiatives since in the implementation of harm reduction initiatives in Malaysia.

Figure 2: Timeline of how harm reduction treatment initiatives have developed over time



4.1.3 Successes of Implementing Harm Reduction Treatment Initiatives.

The inception of harm reduction-based initiatives such as medical assisted treatments/therapies and the needle syringe exchange programme in Malaysia has seen great success despite its relatively short lifespan; from positive outcomes within measures of treatment, as well positive practices within the framework of initiatives that is not only effective, and has received recognition.

Question 3

To what extend the harm reduction-based initiatives such as medical assisted treatments/therapies and the needle syringe exchange programme in Malaysia has seen great success or achieve its objective?

"Well, the good thing about harm reduction is, it's worked. So, the people; the drug injection community (i.e. intravenous drug users), opiate based, knows it works. And therefore, we've been able to arrest the virus in this population…quite well actually…" - Dza

On the initial successes of the methadone assisted therapy initiatives) … *"So, at that point in time, myself, 2 professors and a medical doctor, we actually started (the pilot methadone project) with 100 patients, year 2008; and we managed to show to the enforcement community that the results of this methadone programmes are very promising. The retention rate is almost 100% at that point in time, up to one year. And most patients (start to) work. I can say it's about, 90% (of patients in the study are) working, and a majority is also working full time, you know. The use of drugs also significantly reduced, as showed by the results at that point in time…80% of them after a few months, they already had their urine sample tested for illicit substances like heroin, other substances… so with the results, we tabled it up to (policymaker at the time in) the enforcement community, and actually started the pilot project for their methadone assistance therapy program… like in rehabilitation centres, it's similar here (at the enforcement-based MAT centre), it's like an outpatient system, so they have to come on a daily basis. That's how the program (harm reduction treatment initiatives) got started in the enforcement agencies."* - Sam

While there is a noted difference in the primary objectives in applying harm reduction treatment between the enforcement community and the medical community that is explored more in depth in later findings, its efficacy is noted by the same underlying principles of reducing immediate harms and the positive effects on social factors concerning the patient as well on both sides

"Well, I still say, harm reduction is to encounter the complications of HIV/AIDS, that's all…Yeah. It's not a treatment for drug dependency – because you are introducing another psychotic substance. But the advantage of these psychoactive substances (i.e. methadone, suboxone and other medication-based harm reduction treatment initiatives) is that you can prolong the withdrawal symptoms in a person so you (the patient) can function better. We take it in the morning, you'll only come back to craving at night, for example – by the time you're sleeping already. Then tomorrow on it you go on it (administering the dosage). And then, while you are 'stable', quote unquote, then you can function as a person who can work and earn money. If you earn money, you can take care of your children; schooling. So that is, taking away all the harms; the social harms, the family harms… So, it functions in many ways, on top of (addressing) the complications of HIV, you stop drug injecting drugs by sharing the needles, and you begin to function." - Jay

A similar sentiment was echoed among stakeholders within the medical community, albeit with differing perspectives regarding the objective of treatment. (On patient retention*) "I will say that people who are on methadone, my clients – the longest I have seen (stay in treatment) is 10 years; ever since we started the research, and with us until now. And (a) majority of them, have not gone back to heroin at all; (a) majority of them get employed, within 6-9 months after they (started) on methadone. And it's still sustainable. It's not like after the whole thing (treatment process) finish, and that's"* – INT – Back to square one.

"Yeah… when people ask us "why our retention rate has reduced?" I tell them it's a good sign; that means the patient's able to go to work. That means now we have two programmes. One is the methadone (assisted treatment) program. It was initially started by the government (referring to enforcement agencies) …they would get their methadone for free, because they were unable to work, they had no money. So, last time that was the only way, then we have now, the prescription way – that means they purchase their own methadone." - Cat

When asked if this explained the decrease in retention rates;

"Yes. Because once they are working and they have stabilized (i.e. working, able to afford basic needs), they can purchase their own methadone. Then, they do not need to be inside our program. Because the program is (meant) for people who do not have income, and they need the medications… They would still come back to us every three months – two to three months (for observation). It's like a kid who can walk; why do you keep wanting to carry him? They can walk themselves; they will surprise you. I have many clients that are quite successful. Very, very successful. "– Cat

The measurable outcomes (significant reduction of IDU-based HIV/AIDS transmission, high rates of retention and improvements in terms of virus suppression, quality of life and patient autonomy) of successful treatment objectives only illuminate half the story regarding the nation's successes in implementing harm reduction initiatives. The success of treatment initiatives can be traced to one primary factor; the cooperative effort of all stakeholder, across all levels of community and organisation, both within and outside the government. This collaborative effort be the most important element of Malaysia's successful implementation of harm reduction treatment initiatives, as well as an important catalyst in instigating the developments and growth over time; such as the upscaling and adoption of harm reduction initiatives by the enforcement community (mentioned previously). As noted by some stakeholders, this can also include adopting a different perspective in terms of approach undertaken.

"They (the enforcement community) see many drug addicts no longer go into rehab centers again and again (relapsing), no longer going to prison…they're working, know. They can contribute to the society; they have a good relationship with their family once they are put-on long-term methadone treatment. So, stakeholders now start to believe it's a disease. That means they start to believe that these medications like methadone, like buprenorphine, it actually works." – Sam

"We have a lot of meetings and workshops with them and all, so I would say they are not as stem as before; they're able to accept some of our concepts…in terms of methadone a lot of them have accepted (it) quite well. "- Cat

The development of the disease model (and the establishment of addicts as 'clients/patients') may not be a recent thing in the realm of addiction research and medicine, its adoption among the enforcement community in Malaysia marks a key shift that helps the development of treatment initiatives to its current state.

"Initially, the government said that it's (methadone-based treatment initiatives) a replacement therapy, it's only meant for two years. After two years, you can reduce the scale of the programme supposedly. But more knowledge and more data and more technologies that we found, investigations in our brain, we found out that it's a (chronic brain) disease, that you cannot stop the treatment. And it will be a disaster if you stop it. So, we now slowly change this idea…but there are still many stakeholders that are stuck at the initial concept…I would say they (the enforcement community) are much more resilient now, much more tolerant these are 'patient'…but of course you will see some officers (in enforcement) who are very stem minded, they will still believe that patients can never change (their ways). "– Cat

A policymaker from the enforcement community had this to say when on the adoption of the disease model of addiction, said; "*But we are very are very strong on psychosocial, and there (later) is pharmacotherapy (i.e. methadone assisted treatments), you see; so let's work it together. Because we said that addiction is a disease; establish addiction as a disease. So, if it's a disease, chances must be given to every Malaysian to be treated."* - Jay

While cooperation between organisations is a key factor in the development and implementation of treatment initiatives; at its core, the success of treatment initiatives is driven by cooperative efforts of stakeholders with families and key populations within both the drug using and HIV/AIDS community. When asking a practitioner regarding the importance of cooperative efforts with key communities;

It's the cornerstone of what we do. The reason why we're successful and why governmental agencies have adopted our programs as part of their strategy to end HIV/AIDS is because we're effective; we listen to what the people need, and we deliver on those needs."– Dza

"It's a collaboration between ministerial organizations, our (non-governmental) organization, and our partner organizations on the ground – The success of HRT in Malaysia is because, I could say, 90% of the ground workers who are doing the programs down at the ground centre (i.e. among these key communities) – the drug users, recovering drug users; peers… so that's why the programme in Malaysia achieve these (targeted) goals. It brought down all the infection rates (of HIV) among the IDUs. So that's why (outreach and cooperation with communities is important)."– Kim

Families play an important role in the treatment process of an individual (Noor Hassline, 2008), and act as a tool for support and growth that works closely with stakeholders for the benefit of the patient. The importance of this relationship between families of patients, key communities and stakeholders is especially prevalent within the practices of the medical community.

"After 10 years of giving services, we also know their families, their peers, so more or less it's more like; I know not only the patient, it's like – a close network that we know. It's helping us a lot. If the patient is alone, it's harder. Because humans, you must understand; living in a group, we're social creatures, we can't live alone. So, let's say, if that person tries to clean themselves of drugs, but then all his friends are drug users; all his family members are drug users, it's very hard for them to get clean. Because once they get clean – they will be extremely alone, they will be isolated. So, it's 'better off' for them to find a… (Place that) belongs, you know? Even though it's drugs. Even though they know it's going to destroy them – but rather than living by yourself, living alone… families and societies are very important. So, our goal is to help them find a healthy group of people – so in the beginning, we do group counselling; meaning, all the methadone users, they will sit down with our counsellors – it's like a support group, like that. And sometimes it's like, this 'family' has become the 'family of the others' (source of strength and connection… yeah. It's helping each other, and families will also join in. Families will say that "we support each other, they (patient) have gone through all these things…'. You must imagine their lives – it's just so terrible, out of your imagination; rehabilitation centre treatment 3,4-7,8 times; prison, 3-4, 7-8 times. And never a day that the family sees this person to be out of drugs. So, you must

understand, what the families have gone through. They need lots of support as well. So, it helps them a lot… our role is to regain that trust. To help the family, to regain their trust on the patient. Some of the families, they become very sceptical. So, the patient says, "I want to go out," they (the family) would start to suspect – "ah, he must still be using", that kind of thing. So, it gets a lot of tension (between family members). So, we'd have to tell them; that with the help of methadone, we have the treatment for them to reduce their craving; so, they will not actively go and search for the drugs. At the same time, we also work to educate the family, "you should have some degree of trust, and let him to do this…" - Cat

While families have been important in helping patients stay and flourish within treatment, peers have been integral in helping to raise awareness on the availability or treatment initiatives and acting as the grassroots movement in addressing the spread of HIV/AIDS through IDUs. This is seen in non-governmental organisations (mentioned above), as well as within the medical community.

"Most patients are walk-in…now, now. Last time it's (through) referral. Because they don't know about methadone; they're not sure about it. And now, a majority (of patients) is from the walk-ins. They see their friends on methadone, and they see the success of it…they see how their friends obtain normal lives again, get back to (having) jobs, working and getting married and having a family – which is all they dream for." - Cat

"These successes in both treatment objectives, and collaborative efforts among various stakeholders and communities have also been recognized within local organizations, as well among international stakeholders. Regarding the needle syringe exchange program initiatives implemented) So, we started from there. When the numbers were showing good (results), the data showing good (results); we got recognition from the WHO itself. There's a book from the WHO showing that Asia's Best Practices (regarding the needle syringe exchange programme) is Malaysia. Now comes methadone therapy; first comes needles, for HIV prevention, now comes (initiatives) for recovery, methadone. So, who knows, next" … - Mat

The efforts of certain stakeholders can also recognise by local organisations, in different ways.

"I think our biggest achievement is to get our programs endorsed by the national organizations. So, we started it (pilot harm reduction treatment initiatives), and we sold the idea to them, and they paid for it. And lately in the last couple of years they've completely funded it, yeah. They've completely funded our programmes. Without harm reduction, we would have an epidemic that is largely due to injection drug use. And a lot of the resources would be (pulled to there) in treatment. Now, because harm reduction is a preventive tool, it's preventing HIV infection and therefore it's saving these resources that would've gone for treatment, to deal with it…to funnel the resources for treatment. So, it has done a great deal for this country. We (Malaysia) are quite a leading light in the world for doing this." - Dza

It can ultimately be said that family and peer cooperation and collaboration has been key in transformation of recovering addicts into not only successfully undergoing treatment and managing their addict but growing also, becoming being tools of advocacy and outreach themselves among the key populations of which they originate from, supplementing the primary treatment initiatives (needle syringe exchange programs and medication assisted treatment). This cooperation helps supplement the core effort among different stakeholders across both governmental and non-governmental organisations, which make up the backbone behind the implementation, growth and success of harm reduction treatment initiatives in Malaysia.

4.1.4 Challenges in Implementing Harm Reduction Treatment Initiatives

While treatment initiatives have largely seen successful outcomes, the implementation of harm reduction initiatives in Malaysia has also faced certain challenges. While cooperative efforts between organisations has largely remained as the backbone of implementation as well as growth of treatment initiatives, there seems to be a growing sense of disconnect amongst stakeholders; a gap that in some regards, was initially overlooked or even tolerated, in the combined effort of

reaching treatment objectives. When asked regarding the start of declining cooperation between stakeholders;

Question 4

What are the challenges you are facing in the implementation of harm reduction initiatives in Malaysia?

"When we first started the methadone program, also the needle exchange program, way back in the year 2005…I'm going to say after the pilot project. I think the policy (then) is good. But somehow along the way, suddenly… (Gestures) fading, fading away; the training is no there, there was no more interagency collaborations... the medical organizations are giving their own program, drug enforcement is giving their own program, then law enforcement is doing their own program…it's not integrated. The reason is because last time, we used to have (the) National Task Force on Harm Reduction; but after that, it was actually no more…the year 2007, or 2008 if I'm not mistaken, it's (National Task Force on Harm Reduction) is no longer there. Since then, the training is also very lacking, there was no interagency collaborations – and things start, I mean, the quality of the programs, start fading away. I believe we need to have that national task force again" … - Sam

(On the state of enforcement agency-run methadone assisted treatment centres) *"Last time, when we conduct this project, it was running quite well. And of course, we're also happy, because more and more centres are being opened… at that point of time there was collaboration between medical organisations and enforcement agencies also. Enforcement agencies provide the space, provide the staff, running the maintenance programme… Also paid for the doctors to come in and run the clinical work. Medical organisation supplies the methadone and supply the pharmacist to dispense the methadone. But now I've seen, in the last three years… more and more (harm reduction-based treatment) centres are being closed. No newer centres being opened up; even though the request from the clients is actually increasing."* - Sam

In exploring possible factors for the perceived decline, some point to the difference in approaches and objectives amongst stakeholders, despite working together

successfully on treatment initiatives. While this incongruence in ideas has been there since the beginning of implementing treatment initiatives in Malaysia (as earlier discussed in the adoption of medical assisted treatment by enforcement communities), these differences have been further cemented recently by stakeholders within the medical, as well as the enforcement communities. Despite adopting and upscaling treatment initiatives, harm reduction treatment initiatives are still used and seen as a supplementary modality of treatment among the enforcement community; specifically tailored for use within specifically targeted communities (affected with HIV/AIDS, IDU users at risk of contracting HIV). More familiar based approaches commonly used by enforcement communities in Malaysia prior to the implementation of harm reduction (particularly abstinence and punitive-based measures of treatment) are still primarily used by these communities in addressing addictions (opiate and more specifically non-opiate based substances), as highlighted by a policymaker.

"Well, all these while we have been using the psychosocial approach and having them to be treated in a (drug rehabilitation) residential base. We still have 28 centres out of 38 (using abstinence-based initiatives) … yeah, we still have that. In fact, all our services in the community is using abstinence based. What is different (in the other 10 centres) is in terms of MAT; the one that we have in those 10 facilities – and also the medical settings in the hospitals and also district services centres. So, we still go strong on the abstinence". - Jay

"For us, for people like me; health providers and so on, I see it's a good approach to use harm reduction to address drug issues in Malaysia. But now, it seems like…it's a slowdown; it's become a slowdown and looking like (it's) going back to the previous approach – what I mean is the total abstinence approach."– Sam

In discussing the development of enforcement community-run methadone assisted treatment centres, a policymaker also mentioned a key point that highlights the general objectives and approach of enforcement communities, and possible insights

into the previously discussed resistance within enforcement communities to adopt harm reduction treatment initiatives.

"Well actually, it's (harm reduction treatment-based initiatives) nothing very new to us – it's just that our ability to do that was limited because when you talk about harm reduction programs, it involves some form of authority from the medical line… if you have to prescribe the medicine for drug solution therapy, you have to be a medical doctor, and we don't have these people (at the time). Now if you are (within) syringe exchange (initiatives), we don't do that… we don't deal with syringes. And it (all three initiatives) is a package of harm reduction, which was introduced in the west - and the purpose is solely to counter the complications of HIV/AIDS, that's all. That's why harm reduction was introduced (in enforcement agencies). So with that, it comes with the package…of course we cannot take this package, unless it was instructed that we take this package and we're provided all the medical doctors then we'd do it… but we are (still) very strong on psychosocial (based initiatives) and (now) there is pharmacotherapy, you see."-Mat.

In comparison, the objectives of the enforcement community in implementing harm reduction-based treatment initiatives (being primarily aimed at addressing HIV transmission) differ from the objectives within the medical community (focusing harm reduction initiatives for addressing drug addiction). These differences sometime reverberate into the how treatment initiatives are implemented, specifically differences in practices among different stakeholders and organizations. As discussed previously, medical communities have employed an approach of building autonomy within patients undergoing treatment initiatives though an open setting of obtaining prescriptions and routine observation, in comparison with a more rigid, closed approach employed within the enforcement community. This divide is further highlighted in conversations with stakeholders within both communities.

(On the implementation of open setting-based programmes) I think it's after we start the (initial) programs… after, two years, and one or two years, we already do it. The thing is now, the government doesn't agree with us. Enforcement

communities don't agree with us. I think because it's from a different angle… so, *"if you (stakeholders) don't keep an eye on them (patients), they will do the bad thing again" …this is their philosophy."* -INT

"A lot of (methadone) clinics are still practicing high monitoring; they want the patients to come every day, every three days, to monitor them. I say, "Yeah, you can monitor them initially, but after 10 years are you going to meet them (still) every three days?" you are making the person…they'd never actually recover. Because you'd see them; all they need to do is just go and get your methadone. And this is not what I want. Initially, our aim is to treat their opiate dependence, but now our aim has changed. Our aim is, we want them to lead a normal life."-Cat.

"They would still come back to us every three months. Two to three months. If you're in the programme, they want you to come every day, it's like a direct observation treatment. You see many of the hospitals' methadone service clinics are still doing this; it's like they want the patients to come in, to drink the methadone, only they can leave. It's a much-closed setting, but the thing is - the patient cannot find a decent job. Imagine; you must go to the clinic, early in the morning, and during your session it could take from to two hours - to wait. So, do you want to hire a person who would like, morning cannot come in... Right? So, they cannot get a decent job. They can only get like, part time jobs, you know. And second thing is you also don't want them to depend on your clinic so much. So, they need some autonomy of their life, as well."-INT

While the influence of the legal elements of the enforcement community on the overall effort of implementing harm reduction initiatives will be discussed in detail in further findings, it is worth noting that within the enforcement communities, the rule of law (and the shadow of the Dangerous Drugs Act) is prioritised over treatment initiatives implemented by stakeholders, effectively making the framework of treatment to some degree, a punitive-first approach.

Differences in approaches between stakeholders can also be a result of changes among key personnel that drive key treatment initiatives. When asked as what are

the factors that contribute to the closing of methadone clinics (or the unwillingness to open new centres) among stakeholders.

"I think the top management, maybe disagree with the current move? Last time during the former director general, things are running very well. But since they change the director, we seen that more and more methadone centres being closed. I believe - I've heard from some of my other from other states, not for KL. As for example; in Perak, no more (enforcement agency-run centres administering methadone) … No more, yeah. I don't know what the reason is... maybe because of the top person disagree with harm reduction - The philosophy of harm reduction... maybe he'd been advised by wrong person maybe... or maybe because of the... don't have enough resources, I'm not sure." -Sam

(Laughs) "*but, yeah. The problem is, in my personal experience here and on the ground, the problem is, when the, the head, the leader, the leader is changed, then the program will change, and the approach will be difference. For example, within the enforcement communities; a former chief executive (in an enforcement organization), their approach is, "drug users can go for MAT, go to enforcement-based harm reduction treatment initiatives, those types of treatments. But when they're out of the organization as a chief executive, comes another executive, and they have a different approach; no more methadone, no more enforcement-based harm reduction treatment initiatives… it comes back to the rehab centre."*- Mat

"And then, the new executive comes. And a new approach again... counselling, prevention. But I'm not condemning their programs, they're programs are very good. They (enforcement communities) tried everything, they do. But, without a proper framework in any program that you have, you cannot change the leader without the same framework. So, every time the leader change, the approach will be different, and we need to do it (re-establish treatment initiatives) again and again – that's what's happening now." - Kim

When asking practitioners working with enforcement communities how changes within key personnel and executives affect their work.

"Of course, when you change philosophy, change approach too many times, there is a possibility that - you know, affects good programs you should continue. If you stop, then the things that been carried out for years, is just wasted."- Sam

Sam also notes that he has worked with three different chief executives within their organisation in the last 10 years. (On working with different chief executives) *"Yeah…But two chief executives ago, it's actually…it's not a good time. (Laughs) With regards to working in the enforcement-based facilities. At that point in time, there is resistance. But when the second chief executive comes in, things open up; they actually had a very good approach in terms of addressing drug issues in Malaysia... They follow the evidence based, which is harm reduction. Then after – the current one (chief executive), what I've seen…I don't know. Because from my observation, it looks like they're not very keen.*"- Sam

These changes in key personnel not only affected cooperative efforts between organisations, but also cooperative efforts within organisations, as a policymaker note.

"In terms of documentation, we don't have it. To say that in the past seven years, we look at the trends of treatment, we don't have a proper documentation. Studies were not run, not conducted… I'm not blaming the past; it was like that (the state of initiatives). Very difficult for me to get documentation to say - "this programme is very well conducted, an empirical study conducted from January to here, in comparison to this year, shows..." No, we don't have those kinds of things, because they (personnel at the time) are not used to it - they were not exposed maybe, or they don't have the ability... or the approach was different. And then ideas come in whenever the new chief executive comes in, they tend to buy in some ideas introduced to them, start doing it...
example, at one time, TC was there - the therapeutic community, and it was asked to all our centres to apply TC and after some time, abolish TC.. So, what is this? It becomes a confusion... so that's why when I came in, I said "we are going to continue the existing one which is good, but those who are - that if you think is really not helping, then we need to think about how to replace that thing. And then, I (re)introduced the evidence-

based... we need to have evidence based (initiatives). If we don't understand, I would have to teach you how to do it, yeah. There must be a pre-test, a post-test, intervention that you do, what happens with the intervention, and what is the progress. Yeah. So, that is how we are dealing with it now."-Stakeholders

It can be said in its essence that the current gap among organizations can be sourced primarily through the incongruent in approach and objectives among stakeholders, ultimately manifesting into separate practices within the same approach of treatment. This gap is further exacerbated by the changes in key personnel among stakeholder organisations, bringing about different approaches with each personnel change. Within the sea of inconsistency and incongruence within the current state of initiatives, the legal framework (which includes the enforcement of the Dangerous Drugs Act) by and large remains the constant that affects all stakeholders. This is highlighted through the effects of a seemingly punitive-first approach, where the enforcement of legal jurisdictions seems to be prioritised above all else and can sometimes come despite cooperative efforts amongst stake holders. When asked on enforcement organisations implementing both harm reduction-based treatment initiatives, as well as abstinence-based measures, a policy maker said:

"I think when harm reduction was introduced in the country, initiatives were made with the enforcement agency to say that there are certain people who are going through these programs. So, what they do, during those days, there is an identity card saying that you are under this programme. So, that when you are being found or caught by enforcement, if you have that card, so you'd be given a chance to go to your treatment. But if you are involved in criminal - criminal is criminal. You see, that's why in our policy we have this dual policy; criminalisation and - I think there was an understanding in this - dual policy. If you perform criminal acts, then you must be charged under criminal act. But if you don't, you are just doing drugs, you have been tested, you have positive urine, then we charge under the act that will allow you to go for treatments, not to go to the jail. So, getting you under law enforcement, it doesn't mean that it's punishing you, it's we are trying to save you - because treatment is cost

effective to non- treatment. Treatment is important for a person who is under the dependence of substance abuse; you don't go for treatment, there's no way you can function, you see." - Jay

(On the medical community and enforcement community working together) "*So, it is a challenge of sorts; because health and security are not common bedfellows."* - Dza

"However, some stakeholders note that the implementation of these policies can sometimes lead to challenges within their treatment initiative efforts, with some abstinence-based initiatives requiring a mandatory period of participation in their programme (some of which up to two years in a enforcement community-run rehabilitation centre), as highlighted by some study participants. For example - one of my clients, what happened to him is, every time he went back to his hometown, he will use heroin. Why? Because his friends - peers - the friends are all using it. So, when he goes back, they will just pull him (to use with them). So, until now, he didn't want to go back anymore. Because he realises that every time go back, he will use drugs. So, when, at that moment in time, if he uses drugs, and he get caught, he will go into the prison. Or the abstinence-based treatment programme... So then (when he) comes back, we'd have to redo the whole thing (methadone assisted treatment process) again. Most of the cases are like that. So, they'd disappear for two years because they're inside the abstinence-based rehabilitation. (Or) They'd been caught, (and spend) six months inside the jail. The thing is right, no… the prisons don't contact us (laughs). So, we also don't know; where they have been, and all that. So sometimes families contact us. They would say that "he was caught again, they will send him to remand," and all that, so we would roughly know." - Cat

This process is highlighted in excerpts from stakeholders, who note that sometimes policy and practice may sometimes differ, sometimes at the expense of treatment initiatives. Kim highlights the processes undertaken if someone is testing positive for illicit substances. A drug use is a drug use. Once your urine is (tested) positive, you'll be sent to a (abstinence-based) rehabilitation centre or prison – that is stated.

(On how offenders get sorted between rehabilitation centres and prisons) "*It's up to the judge; not the drug user, they don't make any decisions. Yeah, the judge is going to say, "Okay, you're going to rehabilitation centre... okay now you're going to prison," because now, rehabilitation centres is for opiate based- they said. And prisons are for ATS (methamphetamine-based users) – it's different, like they're (ATS users, are tried) under the poisons act… so they will be sent to prison*."

(On helping enforcement agencies with abstinence-based treatment initiatives) – *"Us? No. They have the full authorities to do it…in rehabilitation centres, or treatment for rehabilitation, after you serve those certain months you come out and you have two extra years of probation. With law and drug enforcement. So, you need to go there monthly – for two years! If not, if you didn't go for one or two months; or during the probation years you're found to have a positive urine (drug) test, mean you have already broken your terms, you'll be sentenced to three years and three cane strikes in prison. That's what happens now."* - Kim

"Even though we have done this harm reduction work on the ground, but our laws still (are) against it, against harm reduction. That is why, it's very difficult for us to expand the harm reduction program in Malaysia, because the law is still against it. For example, our patients are sometimes being caught... sometimes just because they took the methadone, they bring the methadone – takeaway sometimes, enforcement officers say, 'oh, methadone cannot be given to take away'... which is wrong. Methadone can be given to take away; so, the understanding between agencies is still… officers do not know the rules; for them, taking methadone, bringing home methadone is wrong, but we have already given to them guidelines saying that stable patients can be given takeaway up to six days. But there's no… some police do not know that."- Sam

Some practitioners note that within some agencies, the legal framework (including abstinence-based care) has always come first before laws treatment initiatives and approaches. *"Because drugs were regarded as the "enemy no. 1" in 1983, so they (stakeholders within the enforcement community) never thought that it (drug addiction) is a disease..."*- Cat

(On the reasons behind the reaffirmation of punitive based treatment measures) … *"Could be politics, usually is. It's a hard sell, the war on drugs… it still (in effect). We have zero tolerance (against drug use)."* - Dza

While other practitioners note the role of key indicators that may play a factor in the arrests of harm reduction treatment patients.

"Well, it's followed though, but it's not really implemented on the ground. Because they (enforcement agencies) di have quotas (for arrests) ... and you can imagine right. So, if you operate a harm reduction program in a town and the enforcement agencies have a quote on how many people, they need to arrest in order to meet their performance indices, you're a sitting duck. So, they just hand around; they have a radius of non-enforcement zone, but they (enforcement officers) go there… they can be outside the zone in order to address (these patients) and it has happened. Ultimately, harm reduction treatment initiatives have seen itself flourish in getting enforcement agencies by getting these enforcements to cooperate with stakeholders, even if for a brief period. So, what we do is, we get some cooperation from the stakeholders in the enforcement community. When we go down to the points, to the grounds – like going into hotspot areas, for example; we acknowledge the enforcement community there, we tell them that we are coming down to this area – so by this time please don't interrupt our work. So, we can do our work, we can meet our clients there. So, we can achieve whatever goals (we had) on that trip. So that is why the harm reduction (initiatives) still can achieve; even though there's no changes to the law whatsoever...
but after that (implementing initiatives on the ground), after we have done that work whatever they want to do, carry on lay"… - Mat

This 'line' that seems to be drawn between different stakeholders has made efforts within partner organizations that mainly focus on the collaborative efforts seem caught between satisfying different parties involved.

(On acting as the *middleman between organisations) their (other organisations) expectation is very high. "Yeah! they expect us to settle all the issues on the ground and all that, but we are trying hard at this; at my personal level. I've tried… I've tried so*

many things, to, at least like give them some feeling of relief; 'okay, we try this… okay next time we'll try to discuss it (with other stakeholders)'. Because the problems on the ground is totally different than what we are facing here. On the ground, they are facing so many thing – the clients, the stakeholders, arrests, raids, the clinics and all that; so, they are facing different things… yeah. Here, we are facing them, and our stakeholders. So, when their expectation is very high, we try our best to… there's nothing much we can do but we try our best to help." - Kim

Ultimately, the law is a significant factor in how treatment initiatives are implemented and can undo great strides in treatment without careful awareness and cooperation from involved parties; as illustrated by Cat. "*If I could quote one of the professors I worked with; they said that working with the enforcement team is like building a sandcastle; you have something (going) on, and they would have something (going) on, and sometimes it would destroy some of your castle that had been built. But some will remain, and you must just rebuild again… and again". Another key challenge in the implementation of harm reduction based-treatment initiatives in the need for more adequate aftercare services, as highlighted by stakeholders from both the enforcement and medical communities. Doing the methadone programme also has challenges; like clients who go to methadone, (but) they still take other drugs…other than methadone. Why, is because of the aftercare; the quality of the aftercare is inadequate…it is a necessity that we review the whole – to enhance the functionality, like what I said, the aftercare program; the support system.*

(On continuing or expanding on harm reduction treatment initiatives). "*Well, I have two perspectives. We can continue with the program on condition, again, we have the workforce. Not the workforce for prescription of the methadone, or whatever medication you're using, but the aftercare, you know? If we don't have that, it is going to be very tough, you see. That goes, the same thing to the non-harm reduction program. If you don't have the aftercare, it's going to be very tough. It's not adequate. We (have) a lot of things to improve, in terms of aftercare. But aftercare (also) falls under the responsibility of the community – the government has done so much; institutions have cone so much."*- Jay

One thing we don't really have is follow aftercare programmes… we don't have that in Malaysia. They (stakeholders) only have like closed settings; enforcement communities have these closed settings, but they don't have the after care. They, the enforcement community have closed setting drug retention programs, right? But they don't really have a proper framework for aftercare. They (enforcement) community don't really have a proper framework for aftercare. They only have probation, but they don't really… investigate how you're taking care of clients later.
This lack of framework can also be attributed to a limited pool of resources, human resources. The biggest challenge now is to upscale - to upscale particularly the MAT or medication assisted treatment; because most of the health clinics under the government is already overloaded- it's all sorts of things, there is a limited number of staff… including enforcement-based harm reduction treatment centres. For example; I give example like the medical communities' clinic, you know have diabetic clinic; they have hypertension clinic; they have mental health clinic as well, and you want to add another methadone clinic? But the number of staffs' remains the same, you know? And there was no incentive also... so that is why even though there is a space, but the clinics' community refuse to open. A lack of resource in terms of human resources, in terms of space, in terms of training programs also; capacity building is also lacking; they are not trained, then they are not confident to do it. I don't think skill levels are adequate now because majority of staffs' is not trained, they'll just follow what their seniors do. When they're not trained, sometimes their approach is also conflicting, you know."-Jay

"Another key challenge faced my major stakeholders within the implementation of harm reduction treatment initiatives is the inability of achieving current targeted goals of coverage amongst key populations - highlighted by the two factors that seem to contribute greatly within the situation. Firstly, is the perceptions of different communities and stakeholders across all levels that affect implementation efforts of harm reduction treatment initiatives? So, until now, we are still under - under the coverage. We are under 70%; we are supposed to cover 170000, but we couldn't do it."- Cat

"So, the problem obviously, well obviously for me but may be for you, is identifying who use drugs, or people who are at high risk of HIV acquisition. Unlike people who inject drugs, people who are at high risk in other populations may be quite well hidden. And for good reason. So, you know... stigma. They want to avoid being stigmatized. Because of the they engage in, or people they associate with, or occupation that they have - creates this risk and has a very negative perception in society. So, by them hiding, makes it very difficult for us also to identify, you know, in order to provide them with care. So, we're trying to develop novel ways to do that here. (On working with other organisations) *... We must deal with people who say things like, "they're not here to deliver services to drug users" or, you know, "if they use drugs they cannot be in our program". And there are prejudices within the community like that. So, community is not homogeneous, they have different views and different values. And unfortunately, it's hierarchical, so based on those value systems, the hierarchy is what is good for the community, and unfortunately, over the past 20 years of the war against drugs, drug use is quite low in what its value in community and therefore they get the least amount of help - regardless of which community they are. And so, it's something that is very well hidden. So, a lot of people use drugs, and they will want to get away with being identified as much as they want, as they can."*-Jay

"HIV is a social problem. when it was first - UNAIDS, was first formed, one of the first directors said that HIV is 3 epidemics in one; so, it's the HIV epidemic, it's the AIDS epidemic - so people who don't get care, progress to AIDS, is an epidemic. And it's... it's a social epidemic, in terms of perception. Within - now, with more (inaudible) medication, we've been able to solve these two... the first two epidemic. So, with good treatment, you don't progress to AIDS. With good treatment, you now... they know, for sure, you prevent infection. Right? But we've not been able to address the social epidemic... the perceptions, and values of people living with HIV, or with the fear of contraction. Because of that, people are not coming forward for testing, and they're not coming forward for treatment. And therefore, it's... you know, we're negating all, not all but some of the benefits of current medical developments, in medical science."
- Dza

"I think this medication treatment is well accepted, because of the good results that we have shown... but somehow the needle exchange program is not well accepted by the public. Especially the religious community... they still think giving needles will encourage people - will encourage people to inject more and share more." - Sam

"When we first started the harm reduction program, of course there is a lot of resistance; even for the medical assisted treatment. Particularly from the politicians, from the religious leaders... because this is the first time (a program like this was first introduced); when we first introduced opioid substitution therapy treatment, so many of the public thought it just replaces drug with another drug which is less evil, you know? So, the resistance from the public is there, because in their perception, you replace people with methadone for example, it may prolong addiction, rather than treat them. They didn't understand any chronic disease; relapse is a rule. It's a rule, you know... its common like diabetes, hypertension. It's a chronic disease. So, people used to have uncontrolled diabetes or uncontrolled hypertension; that is common among the chronic disease. So, yeah. The public didn't have that understanding. Even some agencies like enforcement agencies, even some doctors in medical communities, they don't understand this concept. So that is why, for them, drug users need to be punished; drug users need to be - shouldn't be treated as patients." – Sam.

When asked regarding what may cause these differences in perceptions among organisations despite collaborative efforts, a practitioner responded.

"I think the knowledge about harm reduction did not really pass through the ground workers. Yeah, we call them for meetings; explaining to them about the programs, but it's only stuck at the top level... not being passed down to the ground level. So that's why things like, you know... patients being caught, because of bringing home methadone; it's still happening. And of course, when you put patients in a lock up for a few days, patients' rights were denied - they were not allowed to defend themselves. And sometimes, they are- these polices are doing harm to the patients; patients (suffer) withdrawal in the lockup, sometimes they were on high dose of methadone, they got withdrawal… they lost their job inside (detainment), and nobody help them. I think these laws should be changed; patients who are under methadone should be given the

right to continue the methadone in the prison lockups for example; or maybe, instead of being remand in the lockup, they should be - because the reason for remand is because, just to wait the urine results. And now, the urine result can, can get very fast. Hospitals, within one day actually! But now, what's happening, patients being put in the lockup up to one week, sometimes more than that - they lost their job." - Sam

Because we treat these drug users as a criminal, we are not looking these drug users, this problem, as a medical punya terms, as a patient... The, treatment is just different. *"So, by being classified them as a criminal, drug user as a criminal, so they are creating stigma, discrimination. We don't really understand what drug use is. What is drug addiction? They don't have that in mind yet. All the news, and all that, they were saying that drug user is a "murderer"; "Drug user is mother of the crime"; "Drug addiction is doer of the crime"; "I'm a drug user, am I a criminal" … Because, because of the government itself. Our conservative approach... So, with that media scare, fear factor, so the society believes in that."*-Sam

Another factor in the inability to achieve current targeted goals could also be shifting patterns in drug abuse; with the inception of harm reduction treatment initiatives (and successful achievement of initial targets), a unique situation had developed among Malaysian using communities; one where there is a rise of non-opiate drug use, and a growing need to expand harm reduction treatment initiatives to include populations previously unrepresented or covered by initiatives, as discovered by stakeholders within medical and non-governmental organisations.

"So, it's (trends of HIV/AIDS transmission) shifted but the problem is we can't get the new infection below - the incidence rate of HIV, below a certain level. There are also new infections, and we can't because of our inability to reach what is called "key populations", and key populations are vulnerable to HIV infection; and they're vulnerable because of, largely because of social issues. Whether its laws against drug use, the war against drugs, poverty, migration, and a lack of access to care. So, if you want to reach that, harm reduction provides you with one channel; so, for example, let me give you an example. We know that LGBT or gay - let be very clear - gay people and men who have sex with men do use drugs. The harm reduction program as it currently

stands do not address this population. It deals very specifically with opiate use, but it cannot deal with methamphetamine for example... or non-opiate based addictions. That is an issue. So, and that is one of the - that's why it's fuelling a sexual epidemic, and that's why it's currently unaddressed and it's creating this... plateau of HIV incidence (unable to reach).”-Kim

When asked about the emergence of new populations, the practitioner said this; *“Well, the good thing about hard reduction is, it's worked. So, the people... the drug injection community, opiate based knows it works. And. therefore we've been able to arrest the virus in this population. Quite well actually. But... injection drug use is also like harm reduction, much bigger than just for this population. So for example we have people injecting hormones, injecting drugs, injecting steroids who could be sharing needles... and that is... we're not reaching them with our harm reduction programmes; it's the social injection... when injection is done for more than one person, and it's used, and it has a social value, it has social connotation. That is when it becomes a problem. A lot of it deals with sex, a lot of it deals with subgroups of people... yeah.”*

In summation, the challenges of harm reduction treatment while have not reached in a sense a state of crisis, they present barriers in terms of implementing initiatives at their fullest potential, and potentially undoing the positive and unique aspects success treatment initiatives implemented within Malaysia that has become a source of pride among stakeholders, communities and organisations within the framework of harm reduction initiatives in Malaysia.

CHAPTER 5
DISCUSSION

DISCUSSION

5.1 Discussion

The findings in the study have been able to illuminate significant data and insight into the two research objectives intended to be fulfilled; understanding how (and who is involved) in the implementation of harm reduction treatment initiatives in Malaysia, as well as identifying strengths and areas of growth through the multiple perspectives of the stakeholders who are involved across various fields and levels of community. In the Malaysian context of harm reduction treatment initiatives, this in particular refers to two main treatment initiatives offered; (i) medication assisted treatments, needle syringe exchange programmes, and (ii) medication assisted treatments (MAT) – inclusive of treatments involving (primarily) methadone, subtext, suboxone, as well as other opiate agonist and non-agonist-based medications. The medical community as mentioned, acted as the catalyst in instating changes and fostering cooperation among communities; conceiving stakeholders through evidence and tangible results as to the efficacy of harm reduction treatment initiatives. This emphasis on cooperation between organisations was (and still is) a key role in imitating change and growth amongst patients in addition to successful treatment outcomes and is the corner stone of Malaysia's successes in implementing HRT initiatives.

Collaborative efforts are not limited to organisations; family and community units have been key in achieving successful treatment outcomes among patients and is a unique element that provides supplementary contributions that while other side unrecognized, play a major role. While inter-organisational efforts drive the implementation initiatives, there is a clear divide in roles that to a certain extent seems to stem from acknowledgement of other stakeholders, and the skills they would best provide within certain aspects of treatment initiatives, and although support in implementing initiatives is felt from all stakeholders, some are involved in the implementation of certain initiatives more than others; the while the medical community supports both NSEP and MAT initiatives, NSEP initiatives primarily fall under the jurisdiction of non-governmental organisations, as well as harm

reduction treatment initiatives failing under the jurisdiction of both the medical as well as the enforcement community. While these stakeholders support supplementary initiatives that revolve around the pre and post-treatment process of other organisations they are not directly involved in the treatment of initiatives.

In its initial state, the treatments were very effective in achieving intended treatment outcomes between organisations despite notable differences in approach and treatment objectives Supplemented by strong representation at a policy level through a National Task Force on Harm Reduction, these initial successes provided strong evidence that necessitated and allowed for the development and adoption of later strategies first implemented around 2010. This successfulness of implemented initiatives ultimately started to shift the rates of incidence of HIV and AIDS, where the major cause of HIV and AIDS was previously through needle sharing among IDUs, had shifted to currently being through sexual transmissions. While the IDU community is still one of the major modes of spreading HIV and AIDS, this shift in infection trends had prompted certain stakeholders, within the medical community to expand their objectives of implementing harm reduction (and indirectly, certain aspects of their practices). This can be seen at the first shift in inter-organisational cooperation, where the incongruence in treatment objectives (HRT being solely for addressing HIV/AIDS within enforcement communities, and HRT being used as a treatment option for drug dependencies, in addition to halting HIV transmission within medical fraternities. While this division in ideas is not a new development among stakeholders; it has always been apparent that certain stakeholders (like the medical and enforcement community) may not see eye to eye in terms of approach or objectives of implementation, the threat of HIV/AIDS transmission becoming a full blown epidemic provided a mutual for both fraternities to work together and maximise their skills best to address the situation. But as the threat of HIV/AIDS decreased, so too did the cooperation between organisations change; coupled with the disbandment of the National Task Force on Harm Reduction, stakeholders have recently become more isolated from each other and working more internally to set up objectives and outcomes – all within their organisation. It could be said that the separation between organisations truly began when enforcement agencies began

implementing their own methadone assistance treatment programs and centres – while stakeholders still support each other's' initiatives, the division between key stakeholders becomes more apparent; despite similar initiatives, its differences in procedure and objective (with enforcement addressing emphasising HIV and AIDS transmissions and closed setting treatment at odds with the medical community championing addressing drug addiction, as well as implementing a more open-setting based procedure) begin to illustrate these differences in opinions that has long been held between key stakeholders.

While the efforts undertaken all require some level of participation from all stakeholders to come degree on another – the level of cooperation between stakeholders has certainly decreased. This may explain why organisations are unable to achieve current targets of outreach. As it stands, it can be said that Malaysia's framework for harm reduction treatment initiatives is one that is based on the strength of cooperation between organizations that help to drive the movement at the policy, practice and public levels and remains the cornerstone to Malaysia's successes in implementing harm reduction treatment initiatives. This echoes the biopsychosocial model, where all levels of society and community are integrated and a part of the overall process; with one change affecting changes within other stakeholders as well. While the initial stages has emphasised the importance of cooperation between organisations (and remains the cornerstone of successful implementation here in Malaysia), recently cooperation between organisations has declined, with each major stakeholder being involved in some part of the harm reduction treatment initiative a capacity that may not always go beyond their perspectives.

Another success of seeking conducting this research is being able identify - through the perspectives of these stakeholder - strengths within the current framework of harm reduction-based treatment initiatives offered, as well as identifying areas of future improvement that could be suggested though the assessment of the challenges faced by stakeholders in implementing initiatives. In terms of success, the brightest achievement among Malaysian stakeholders may not

just be the tangible results (i.e. statistics, treatment objectives), but how stakeholders manage to achieve this. Despite different approaches and ideas regarding how and why harm reduction initiatives should be introduced to begin with, the conceptualization of these initiatives was a collaborative effort amongst all major stakeholders. This synergy allowed for the sweeping successes in the initial processes of harm reduction, highlighted by the positive responses of retention and treatment, especially in comparison to abstinence-based treatment initiatives, which had been used as a tool for drug prevention (until this day). The positive responses to treatment (treatment efficacy, retaining of patients, and improved quality of life) provided the solid base in which a gradual shift in perception as well as increased acceptance of initiatives practices among stakeholders. These successes not only get international recognition, but also local acceptance and adoption of initiatives by enforcement or legal communities which would learn from and adopt practices that have in a sense "place" for them.

One suggestion of improvement that seems to be agreed upon both sides is the expansion of aftercare services provided. It is generally agreed by a consensus of stakeholders on multiple sides of the issue that expanding the aftercare services provided would be helpful in retaining patients who would other side get 'lost' within the system of addiction and treatment within the enforcement community, or would drop out treatment due to relapsing into illicit substances again. Another suggestion of future growth is the expansion of HRT to other key populations, as discussed above. Non-opiate injecting drug users (such as methamphetamine users) and communities with high risks for sexual transmission should be included into harm reduction treatment initiatives; as trends and patterns of abuse change, so too must organizations be flexible in being able to address incidences among different populations to the same great effect at seen in its initial stages.

It can also be suggested that an attempt to rooster intra-organisational relationship among stakeholders would be a good step forward in hopes of obtaining cooperative effort from all sides like with the initial stages of treatment. This could be achieved through the reestablishment of the National Task Force on

Harm Reduction, which can as the driving tool in promoting organization among the stakeholders of key initiatives. The inclusion of an overseeing body or committee that is in and of itself, designed primarily to promote cooperation and transparency among individual stakeholders' groups. Finally, stakeholders can improve the current state of initiatives through a growth of viewpoints; i.e., reassessing treatment objectives and goals of implementing initiatives within an organization. With the changes in trends of addiction and HIV and AIDS infection, stakeholders need to grow and adapt with the developments in knowledge and practices that come over time; a need to return to evidence-based research and planning is greatly needed to continue to be able to implement effective measures of treatment, as the quality of initiatives may deteriorate over time if left without a conducting a periodical reassessment of treatment initiatives and targeted goals of an organisation.

In its essence, harm reduction treatment initiatives have had a wide-reaching process of development over time, going through both positive and negative developments. As a treatment imitative initially tasked in the national framework as a key tool in addressing the spread of the HIV and AIDS virus, the initiatives proved highly effective in its treatment objectives, successfully lowering incidence rates amongst key population. This success is underpinned most crucially with the collaborative effort between organisations and levels of community (families, targeted communities) which has been a unique feature in the effective implementation of harm reduction treatment initiatives in Malaysia. However, with changing trends in drug use (as seen with the rise of non-opiate-based addictions) and the decreased prevalence of HIV and AIDS transmission as a result of intravenous drug use, objectives of some stakeholders have developed with this changes, looking into options to address these gaps in affected communities, as well as expanding the objectives of harm reduction treatment initiatives to also include the implementation of initiatives aimed as a tool in addressing drug addiction – both within and outside of opiate based communities.

This division is where the issue of distinct jurisdictions of initiatives among communities become of note; where long-standing differences between the proponents of abstinence based (primarily within the enforcement community) and harm reduction based initiatives (mainly based within the medical community) – and their different ideas on treatment objectives eventually manifests into an interesting dynamic between stakeholders; the enforcement community, hesitant to adopt harm reduction based initiatives outside the primary objective of addressing HIV transmission and prioritise legal jurisdictions over patient rights, working with proponents of the medical community who emphasise patient autonomy and growth over liberty and security, willing to allow patients to make mistakes (with some, even if its comes that the cost of security and the law). While both still support each other in efforts and work together to implement them, disapproval for approaches taken to implement and achieve these treatments at its current state is apparent, if not getting worse. Before it reaches a point of deterioration – a point beyond the current 'plateau' within treatment initiatives and stakeholders that seems to become more of a reality – stakeholders involved with the implementation must, in a sense, 'come back to' what made their efforts so successful in the first place – the high level of cooperation, communication and consideration among stakeholders that help built the growth and developments seen at the beginning of implementing harm reduction-based treatment initiatives in Malaysia.

5.2 Conclusion

In short, stakeholders within harm reduction treatment initiatives primarily employ two main treatment programs as the core services offered – needle syringe exchange programs, as well as medication assisted treatments. These initiatives are mainly driven by (and successful due to) the collaborative efforts between stakeholders, organisations, family and communities, which has been its source of strength, as well as growth. However, with changing trends in HIV transmission and drug addiction, coupled with a long-standing disagreement between key communities on which modality of treatment – be it harm reduction or abstinence based – has deteriorated and led to a current state of initiatives where efficacies in

treatment and coverage previously maintained are slowly deteriorating due to the differing perspectives on what key issues to focus on, as well as what approaches to take. While treatment at its core remains highly successful in treating patients' drug addiction or HIV transmissions, the argument of how things should be done among stakeholders' is potentially risking undoing all the progress made since the inception of harm-reduction based initiatives. This study, through qualitative-based analysis was able to identify these unique differences within relationship dynamics as well as perspectives and highlights strengths of harm reduction-based initiatives, as well highlights areas of future growth for stakeholders to work on together.

The interpretation of the results may be limited by the lack of perspectives from other key stakeholders, such as patients and certain stakeholders in the enforcement community, in particular those primarily tasked with law enforcement; as well as the religious community, who have a significant influence on issues of public concern within Malaysia. Their insight may help to give deeper perspectives that may not have been otherwise discussed and should be explored in future research. Being a qualitative-based study, the findings of the study cannot be generalised entire populations and communities of stakeholders but may help to give insight as to future areas of research that may be explored.

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Drug addiction in Malaysia has been a serious issue that has affected families, societies and the nation in general for the better part of the 20th century in the last three decades, since the federal government declared drugs as the primary enemy of the state in 1983. Harm reduction at its essence can be described as a set of principles that generally dictate policies regarding how societies respond to drug-related problems. The study's exploration of the state of harm reduction treatment initiatives in Malaysia has two aims intended to achieve. First, the study explored how harm reduction treatment initiatives (needle & syringe exchange programmes, as well as methadone management therapy) are implemented in Malaysia. Within this aim, the study identified how harm reduction has developed over the decade since it was implemented in Malaysia in 2005, through the experiences of the different stakeholders involved. Second, the study's exploration into the phenomena also aims to identify strengths as well as challenges in any area related to the issue in hopes of not only understanding the issue but also able to present suggestions in terms of further improving the current system and policy implemented in the nation.

Harm reduction is a set of ideas and interventions that seek to reduce the harms associated with both drug use and ineffective, racialised drug policies. Harm reduction stands in stark contrast to a punitive approach to problematic drug use—it is based on acknowledging the dignity and humanity of people who use drugs and bringing them into a community of care in order to minimise negative consequences and promote optimal health and social inclusion

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Harm reduction initiatives are targeted at people who continue their drug use despite the negative consequences, which can include overdose, relationship breakdowns, isolation, ongoing health issues, unemployment and involvement in the criminal justice system. Harm reduction strategies are evidence-based public health approaches and specifically focus on providing benefit to the individual and those around them as well as the broader community.

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