Policy analysis

The transition to harm reduction: Understanding the role of non-governmental organisations in Malaysia

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Background: The transition of drug policy from prohibition to harm reduction has never been easy. The deeply entrenched belief in prohibition shared by policy makers and religious leaders provided little room for alternatives, and change came only slowly. The non-governmental organisations (NGOs) in Malaysia played a pivotal role in effecting such a change. Understanding how they did so may be instructive for other similarly placed countries.

Methods: Data collected via reviews of published secondary sources, media reports and in-depth interviews with pioneers of harm reduction drawn from NGOs, medical practitioners and the police were analysed to construct the paper.

Results: The policy change was the outcome of competition between three groups in the drug policy subsystem – the state, the Muslim religious lobby and the NGOs. Developments such as the poor outcomes from the prohibition programmes and the outbreak of HIV/AIDS did not change policy but did lead to a rethink of core beliefs in the state alliance and spawned a state-NGO partnership. The subsequent failure to meet the Millennium Development Goal with respect to HIV/AIDS in 2005 – was seen as a failure of the Health Ministry which then led the final charge for a policy change arguing that a health crisis was imminent. The NGOs played a pivotal role in this process by educating their partners in the state coalition, by drawing academics and medical practitioners into advocacy and by engaging the religious lobby (albeit with varying success). They were also frontline players in implementing harm reduction programmes and successfully deflected criticims from unconvinced Islamic groups away from the state.

Conclusion: Given their central role in the needle-syringe exchange programme, the NGOs are well positioned to convince injecting drug users to opt for voluntary medical treatment. This can potentially reduce both the harm from drug use and the prevalence of it.

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Introduction

Drug policies that incorporate harm reduction suggest an acceptance of drug use and efforts to minimise its effects on both the user and society (Goldstein & Kalant, 1990). Yet the transition from the traditional prohibition approach to perspectives embracing harm reduction has not always been easy. Accepting harm reduction requires a willingness to give up expectations of achieving a ‘drug-free’ society. Not surprisingly, the move to harm reduction has met with resistance almost everywhere (Bollinger, 2004; Goldberg, 2004; Hakkarainen, Tigerstedt, & Tammi, 2007; Hathaway & Tousaw, 2008; Radimecky, 2004). In Muslim societies, the deeply entrenched belief in prohibition shared by policy makers and religious leaders provided little room for alternatives, and change comes but slowly (Nissaramanesh, Trace, & Roberts, 2005; Hasnain, 2005).

In the late 1980s, policy makers in Malaysia, a progressive Southeast Asian country with a large Muslim population, were under considerable pressures to restructure its drug policy. Faced with the ineffectiveness of the traditional forced incarceration and rehabilitation approach, Malaysian authorities confronted several obstacles in considering alternative harm reduction measures: their deeply embedded faith in the conventional approach, conservative Islamic groups that endorsed such a strategy and an emerging group of non-governmental organisations (NGOs) anxious to try alternative approaches.

This study examines the pivotal role played by NGOs in bringing about a policy change in favour of harm reduction and in its subsequent implementation. The role of NGOs in assuring the reservations of conservative religious elements may be instructive.
for similarly placed societies where the number of people living with HIV/AIDS has been rising rapidly.

Methods

Primary data

Primary information was collected via in-depth interviews with five key advocates of harm reduction and one representative of the Royal Malaysia Police – the key agency enforcing the traditional criminal justice approach. The interviewees included an infectious disease expert who held key positions in the Malaysian AIDS Council (MAC), a government medical practitioner participating in the treatment of drug users, the president of an NGO involved in the pilot needle and syringe exchange programme (NSEP), two outreach workers assisting in the NSEP and the head of one of the State Narcotics Division of the Royal Malaysian Police. These subjects were purposively selected based on their in-depth knowledge of local drug policy and familiarity with the implementation of harm reduction in Malaysia. More actors involved in harm reduction were interviewed because their role was largely behind-the-scenes and has remained outside the public domain. The motivation, methods and approaches of the prevailing coercive approach, on the other hand, are well known and well documented.

Secondary data

The evolution of drug policy was traced through a review of published secondary data sources including peer-reviewed journal articles, government agency reports, and unpublished materials (including that accessed via the internet) as indicated in the references. Media reports from 2005 to 2008 on the debate surrounding the introduction of harm reduction were also studied. Familiarity with all these materials helped us frame the questions for the in-depth interviews and assisted in the eventual writing of the paper.

Framework of analysis

We hypothesise that a policy subsystem consists of different groups of actors – each driven by a set of core beliefs that define their objectives and a core of policies that seek to translate the objectives into reality. In order to implement the policies, each group develops a set of instruments. Moreover, they either operate on their own or form coalitions to further their ends.

The policy that eventually comes into force therefore reflects the core beliefs of the dominant group that has succeeded in establishing its objective. A major policy change can occur due to a number of reasons – for example, political expediency, response to serious crisis, fear of a backlash from the electorate or some powerful group in society, a shift in the distribution of power within the dominant group that results in new coalitions, or a change in core beliefs. Unanticipated events external to the policy subsystem can also act as a catalyst for change.

Results

The advent of illicit drug use

Illicit drug use emerged in the late 1960s. Malaysia, located close to the Golden Triangle, became a lucrative market for drug suppliers. Drug use grew rapidly especially amongst the economically productive male, Malay Muslim population. Heroin was and remains the most widely used drug; one third (32.8%) of all ‘detected’ users (those who were apprehended and underwent the mandatory test) tested positive for heroin. Between 1988 and 2006, there were 300,241 registered drug users in Malaysia, constituting 1.1% of the general population. Another worrying trend for the health authorities was the growing number of HIV/AIDS cases amongst drug users. HIV cases between 1986 and 2006 numbered around 72,500 with nearly three quarters being injecting drug users (NADA, 2007).

The government saw itself as the only competent authority powerful enough to meet the rising drug problem. It adopted the dominant approach advanced by the US and officially sanctioned and popularised by the United Nations (UN): addiction was a social malaise that threatened the fabric of society and had to be eradicated by tough actions (Bullington, 2004). This spirit dominated Malaysian drug policy until the 1990s; the ultimate objective was the restoration of a ‘drug free’ society.

The dominance of the prohibition coalition

Three main groups of actors operated in the drug policy subsystem; the dominant state with its many enforcement agencies subscribed to the core belief that illicit drug use was primarily a deviant behaviour and should be eradicated. Its policy core consisted of eliminating drug suppliers through strict enforcement and tough laws (including a mandatory death sentence for convicted suppliers) and reducing demand by arresting drug users and committing them to forced rehabilitation at government run centres. The instruments used to implement the policy core were the law enforcement agencies and government rehabilitation centres. In the Malaysian context, where virtually all important agencies are creations of the central government and headed by handpicked appointees, the agencies had no independent views but simply followed orders (menurut perintah).

The second group was a somewhat looser one that we call the Muslim religious lobby. It consisted of Muslim religious leaders drawn from both sides of the political divide – the ruling government and the main Islamic opposition party, PAS – held together by a common core belief that drug use was an act forbidden in Islam. Being divided by politics they did not coalesce around a single organisation but shared the same perspective. The core belief differed in emphasis from that held by the state; whilst the state saw it primarily as a criminal justice problem, the religious groups saw it mainly as a moral problem. By indulging in immoral behaviour, however, illicit drug users were also considered deviants. Despite the difference, the policy core was identical – the eradication of illicit drug use. The Muslim group therefore embraced the policy instruments utilised by the state.

The third group consisted of many non-governmental organisations (NGOs) affiliated with the Malaysian AIDS Council set up in 1992. Their involvement in the drug debate began later as the weaknesses in the prohibition approach surfaced. Influenced by knowledge gained through international affiliations, their core beliefs were shaped by the philosophy of harm reduction; the decision to continue drug use was a personal one but users should be assisted in minimising harm to themselves and society. The core policy held that those continuing with drug use by choice or habit should be provided with services that minimise the harm and any decision to enter treatment or rehabilitation should be voluntary. The instruments of implementation include access to services that reduce harm and minimising repressive enforcement measures.

The arena controlling drug use and drug dependence was tightly circumscribed by the state and its allied agencies – mainly controlled or supervised by the Ministry of Home Affairs. They included, at different times, a narcotics section created within the Criminal Investigations Department (CID) of the Royal Malaysia Police (NNA, 1997), a separate Central Narcotic Bureau and a Drugs Secretariat. The anti-drug National Task Force, under the Ministry of Home Affairs, coordinated all drug related activities in the coun-
try. There was also a National Committee on Drugs. This group of government agencies held fast to their turf – from containment of drug use to detoxification of users and institutional rehabilitation. A National Narcotics Agency (NNA) was created in 1996 (renamed National Anti Drug Agency or NADA in 2004) by merging the National task force and the Treatment and Rehabilitation section of the Ministry of Home Affairs. The NNA reports to the National Drug Council chaired by the Minister of Home Affairs (NNA, 1997). A detoxification programme, begun in 1975, using 24 government hospitals designated as detoxification centres, was overseen by the Ministry of Home Affairs, not Health. Rehabilitation centres, established in 1976 were also placed under the Ministry of Home Affairs, not Health. By 2007 there were 29 such government drug rehabilitation centres. Drug users detained are mandated to undergo rehabilitation at these centres and unauthorised treatment for drug dependence, even by registered medical practitioners, was against the law.

The Muslim lobby lent tacit and sometime vociferous support to abstention from drugs through voluntary abstinence, persuasion or force as it was in harmony with the Islamic view (Hasnain, 2005).

The NGOs, at this stage working independently, without resources or an organised front, were totally sidelined from the debate on drug policy, detoxification or rehabilitation. It was also unclear if they had a common position. However, this did not stop them from ground level activities. Several NGOs with reservations about the effectiveness of criminalising drug users began actively engaging them despite limited resources. The Pink Triangle, established in 1987, was the earliest; others like Ikhas, Pengasih, Pendamai and Intan Life Zone followed. Barred legally from offering treatment or alternative rehabilitation measures, they provided advice, information and counselling about HIV/AIDS. In time, small safe drop-in centres providing food, shelter and basic medical care were established. Some like the Pink Triangle went further by distributing condoms and flyers encouraging safer sex.

In sum, the prohibition approach was being implemented by a tight alliance of government agencies loosely supported by an informal coalition of Muslim religious groups (united by philosophy rather than organisation). The NGOs were numerous but largely voiceless. Thus, there was neither room nor clamour for alternative views on drug policy.

**The State-NGO coalition**

This state of affairs continued until the mid-1980s when three developments external to the policy arena eroded the faith in the enforcement approach and forced the state, a key player in the prohibition alliance, to reassess its core beliefs. First, despite tough laws allowing for incarceration and forced rehabilitation drug use was rising rapidly; the number of users per 100,000 population increased from 6.8 in 1970 to 841.4 per 100,000 by 1984 (Navaratnam, Foong, & Kulalmoli, 1992). Second, the officially administered abstinence-based rehabilitation centres experienced high relapse rates (ranging from 70 to 90%) within the first year following discharge (Reid, Kamarulzaman, & Sran, 2007). Third, HIV/AIDS amongst drug users saw a significant increase in the late 1980s; between 1986 and 2004, 74% of the 69,461 HIV cases reported comprised of injecting drug users (MOH, 2009).

It was in this environment that ideas of harm reduction emerged – introduced by front line NGOs with international affiliations. Their advocacy helped loosen the state alliance by creating a small difference between the state and its enforcement agencies. On the one hand, key officials at the highest level appeared open to reconsidering the policy core by accepting that alternative approaches may be necessary, although they continued to hold firmly to the core belief that drug use was a deviant behaviour. On the other hand, this change at the highest levels had not yet seeped down to the enforcement agencies whose actions continued to reflect the prevailing policy core. Thus, despite the loosening of the state alliance, no shift in policy was forthcoming. Two other factors reinforced the status quo. First, concrete alternatives such as harm reduction, gaining ground in Europe (Bergeron & Kopp, 2002), were viewed as being premised on liberal western philosophy and contradictory to local values. Second, a strong backlash from Muslim religious leaders and organisations was feared.

Nonetheless, the loosening of the state alliance triggered a realignment of forces. Departing from its long standing approach, the state forged a partnership with NGOs. The Ministry of Health mooted the formation of the Malaysian AIDS Council (MAC) in 1992 to serve as an umbrella organisation for NGOs working to prevent HIV/AIDS. The government started providing small annual financial allocations to NGOs affiliated with the MAC to continue their outreach work amongst drug users and HIV/AIDS sufferers. In 1993, the cooperation was cemented further with the formation of the National Coordination Committee on AIDS, chaired by the Secretary General of the Health, and representation from various ministries, the private sector and the MAC.

The new state-NGO coalition paved the way for changes in the instruments used though not necessarily their respective core beliefs. The NGOs led by the MAC focussed on the problem of HIV/AIDS amongst drug users (rather than drug use per se) and led a high profile advocacy on the need to consider alternatives that focused not on eliminating illicit drug use per se but containing the harm to users and society. The MAC advocacy was led by the outspoken Marina Mahathir during the crucial formative years. According to our informants, her passionate leadership, connections and her position as the daughter of the (then) Prime Minister commanded a level of attention amongst key policy makers that would have been impossible for someone else. Her personality and perseverance played a significant role in softening the attitude of many of the stakeholders within the governmentrubric. Programmes such as methadone maintenance therapy (MMT), the needle and syringe exchange programme (NSEP) and the distribution of free condoms to encourage its use were all brought out into the open arena for public discussion and debate due to her efforts through the MAC (TA Report, 2005).

Not all NGOs supported alternative therapies, however. A small group offering abstinence based treatment for a charge feared that the widespread adoption of publicly funded harm reduction initiatives would undermine their services. But a larger group of NGOs that had been prevented by law from experimenting with alternatives quickly backed the MAC. Ikhas, an NGO operating in the Chow Kit area – the main and the oldest drug using community in the country – started offering drug users shelter and other forms of assistance. It also provided bleach to clean injecting equipment to minimise the spread of infections without serious interference from the authorities, probably because of its ties with the MAC.

Initially, academics played virtually no role in harm reduction advocacy. Active research on drug use and alternative treatment approaches were non-existent at that time; knowledge was based on research in developed countries. Similarly, apart from a small group of physicians, some of whom were based in universities, the medical fraternity remained largely uninvolved. But this changed when an individual who was both a medical practitioner and a professor of infectious diseases became the deputy president of the MAC. She helped strengthen the harm reduction coalition by drawing in the medical and academic fraternities.

The state-NGO partnership also split the religious lobby – one that supported alternative approaches (drawn largely, but not exclusively, from government sanctioned religious bodies) and another that did not (comprising largely, but not exclusively, groups aligned with the opposition Islamic party).
As part of its effort to engage the religious lobby, the MAC took a group of officially sanctioned Muslim religious leaders to Uganda to observe local imams (religious leaders) in the forefront of the fight against HIV/AIDS. They also attended the first International Muslim Leaders Consultation (IMLC) on HIV/AIDS in Kampala and met Muslim leaders from other countries involved in AIDS work.

In 2003, in what marked the beginnings of a formal split in the loose Islamic coalition, the MAC was joined by the government’s Islamic Development Department (Jakim) in organising the second IMLC. Marina Mahathir, as president of MAC, stressed the importance of commitment by religious leaders to harm reduction:

When we go out onto the field, religious questions pop up, and even though we have the knowledge to answer, since we are not the ulamas, we are seen as not qualified to do so (Damis, 2003).

Despite the call for cooperation, the division of opinions amongst religious groups was very evident. As one observer noted:

What began as an objection to the contents of a presenter’s paper snowballed into a week-long argument between the conservatives and the liberals about how the problem should be tackled, what the problem is, and whose solution is Islamic? Meanwhile, non-governmental organisations, social workers, health-care workers and people living with AIDS stood in the sidelines and shook their heads in disbelief (Damis, 2003).

The opposing views within the Muslim groups derived from differences in Islamic viewpoints. The supporters of harm reduction rallied around an interpretation that allowed an illegal act to be legalised in order to preserve human life, though this concession came with several preconditions and requirements. The proposed measures were temporary. The opponents, on the other hand, adhered strictly to the original rule in Islamic law which disallowed any measure that could lead to disaster or harm. They saw harm reduction initiatives in this negative light (Yasmin Hanani, 2010). After all, harm reduction offered no promise to reduce illicit drug use which was considered an immoral behaviour.

And whilst the growing threat of the HIV/AIDS epidemic helped unseat the abstention coalition in Switzerland (Kühler, 2001), the impending epidemic was used in Malaysia by opposing groups to strengthen their respective stances. It undermined the state coalition’s core belief in drug eradication and helped modify the core policy of prohibition to include alternatives. The conservative Muslim faction, however, claimed the epidemic was just punishment for acts forbidden by Islam and there was no need to alleviate it through harm reduction programmes (Damis, 2003). Furthermore, dispensing condoms amongst HIV sufferers was seen as abetting the act of sex outside of marriage if it involved hetero-sexual partners, and encouraging gay sex if it involved same sex partners. The conservative Muslim solution to HIV/AIDS was:

abstinence from shameful deeds, cleanliness of both physical and spiritual dimensions,[and]...proper attire...These measures may curb the spread of HIV/AIDS...[by]...preventing individuals from approaching risky behaviour...like free-sex, prostitution and homosexuality, and sharing contaminated needles (Asmawati, 2007).

The states response to the conservative group was built on the more liberal interpretation. The Director General of the government supervised Islamic Development Department (Jakim), for example, lamented:

How sad it would be if there are leaders and ulamas who think that HIV/AIDS is a curse from God and, therefore, the sufferers deserve it and do not need to be helped. ...the causes of this illness are multiple and the innocent suffer just as badly from this terrible disease (Damis, 2003).

Religious leaders aligned to the ruling government including the Chairman of the National Fatwa Council, the Imam of the National Mosque and the Minister in the Prime Minister’s Department in charge of Islamic affairs also espoused the liberal interpretation (Damis, 2003), although not all officially appointed Muslim consultant jurists or Muftis shared the liberal view (Asmawati, 2007).

The efforts of the MAC not only divided the Islamic lobby but also helped remould the official perspective through the formation of its advocacy wing, in January 2004. (The Prime Minister also changed that year.) Known as the National Harm Reduction Working Group (HRWG), it presented the rationale behind the harm reduction initiative and evidence about its effectiveness elsewhere to the authorities, right from the (new) Prime Minister and Deputy Prime Minister down to government agencies involved directly and indirectly with illicit drug use like the Royal Malaysian Police Force, the prisons department and, finally, religious groups. These efforts culminated in it being called to present the evidence for harm reduction to the Cabinet Committee on Drug Use in early 2005. Marina Mahathir described the progress thus: “Before, it was zero tolerance for drug use and that was it. That’s changing...we’re taking baby steps” (TA Report, 2005).

Despite these gains, the government did not publicly endorse harm reduction. The perceived strength of the religious lobby was an important deterrent to change. Given Malaysia’s large Muslim population, it was deemed imprudent to brush aside their reservations altogether. The authorities were further circumscribed by the fear that the Islamic-based major opposition party would capitalise on any move considered contrary to Islamic law. It had openly condemned the needle exchange and condom distribution proposals (PAS, 2005). Nevertheless, the MAC was relentless in its work to soften religious reserve. Marina Mahathir recalled:

It took us a long while and several failed attempts before we finally found a way of engaging them in the issue. We developed a training manual on HIV for religious leaders, and we’ve been...doing workshops and training. The response has been so good that now they want us to do more. (TA Report, 2005).

The consolidation and ascendancy of the harm reduction coalition

The advent of the new Prime Minister was to prove to be an asset because he was widely respected as an Islamic scholar as well. Within a year, an unanticipated external development provided the opportunity to finally shake the unswerving faith of the state and its agencies in the prohibition approach, and undermine the conservative religious groups within and outside the government. In 2005, it became known that Malaysia had failed to achieve just one of the targets in the Millennium Development Goal (MDG) set by the United Nations (UNGASS, 2005) – that of arresting the spread of HIV/AIDS.

The failure shifted the focus onto the Ministry of Health under whose jurisdiction HIV/AIDS (but not drug use) fell. Ministry officials were forced to relook at the data, now from purely a public health perspective. The WHO warning that Malaysia was facing an imminent HIV epidemic with 15,000 AIDS orphans heightened the urgency. The responsibility to lead the final charge therefore fell on the Health Ministry and they did so by successfully presenting harm reduction as an approach that can address an impending public health emergency. A Health Ministry official was quoted as say-
ing. “The government was persuaded by the alarming [HIV/AIDS] statistics and the success of similar [harm reduction] schemes in orthodox Islamic countries like Iran and Indonesia” (Bardan, 2005).

To prepare the ground, in mid–2005 the Deputy Prime Minister disclosed that 64,000 people had been infected with HIV/AIDS; he further warned that this number could rise to 200,000–300,000 in the course of two to three years if drastic alternative strategies were not implemented. In comments aimed at pre-empting Muslim reaction, he argued that under such urgent circumstances Islam permitted harm reduction measures. More specifically, he declared:

Under Islamic jurisprudence, anything forbidden was permissible in an emergency situation that could lead to death (The Star, 27 June 2005).

Thanks to MAC efforts it was now widely known that HIV/AIDS, prevalent amongst injecting drug users (IDUs), was largely affecting the male Malay Muslim population. The national figures indicated that by 2002 about 70% of registered drug users were Malay males (NADI, 2003). The more liberal Muslim scholars therefore sought refuge in the provision that the sanctity of life, held paramount in Islam, tolerated a minor harm if it helped prevent a greater harm (Shaikh Mohd, 2005; Kamarulzaman, 2006).

The need to implement a harm reduction programme was no longer in question but the manner of doing so without losing much support amongst the Muslim constituency was still unclear. The government therefore began cautiously with a pilot methadone maintenance therapy (MMT) programme in 2005. The programme except ‘program’ in computers involved 1200 injecting drug users in three states. It was placed under the Ministry of Health rather than with the traditional enforcement agencies because methadone was (and is) a controlled substance and its prescription and dispensing were only allowed under medical supervision and by medical practitioners (Mazlan, Schottenfeld, & Chawarski, 2006). Government hospitals were pressed into service as therapy centres for the programme. The initial success prompted a widening of the coverage in 2007–5000 drug users. However, a needle syringe exchange programme (NSEP) was firmly ruled out (Reid et al., 2007) even though the HIV epidemic in Malaysia is driven primarily through injecting drug use and 71.2% of reported HIV cases from 1986 to December 2008 were IDUs (Edwards, 2009).

By this time the core beliefs of the state coalition had metamorphosed to include harm reduction. When the methadone replacement therapy was begun, the issue of NSEP was not even raised by the MAC. It was the deputy prime minister who asked if it should not be on the cards as well. Marina Mahathir remarked, “A year ago, it would have been unimaginable” (TA Report, 2005).

It was again the NGO fraction within the newly formed harm reduction coalition that suggested a way out. It offered to run a pilot NSEP programme to take the heat from conservative opponents provided the government agreed to finance it. A pilot scheme was launched in 2006 in three states (Reid et al., 2007). As the initiative matured government health clinics became involved in it on a small scale. As of December 2008, 12,230 IDUs were registered with the NGO-run programmes and just 253 IDUs with government health clinics. The National Strategic Plan on HIV/AIDS was launched in 2006 with RM100 million allocated for a five year period. Of this, RM43.1 million was set aside to fund the NSEP (Edwards, 2009).

As anticipated, a vigorous debate did erupt; for example, the Mufti of the state of Perak condemned the harm reduction programme as “it brought no benefit to the addict or society”. The Mufti of the state of Penang expressed the fear that the free availability of needles and condoms would increase drug addiction and encourage sexual promiscuity (Utusan Malaysia Website, 2008). ABIM, an influential Malay Muslim youth movement, went further and handed a memorandum to the Ministry of Health strongly opposing the pilot harm reduction initiative (ABIM, no date). A key opposition leader from the Islamic PAS party held that prostitution was the root cause of drug addiction and HIV infection and urged the government to close down all the massage parlours, karaoke lounges and social escort services that were all fronts for prostitution (Bardan, 2005).

By now, more medical practitioners and academics lent their voice in favour of harm reduction. For example, IKIM, an Islamic think tank, justified harm reduction as an approach that “allows for something that is normally unacceptable in preventing something more harmful”. Iran, Pakistan and Bangladesh were held out as Islamic countries that adopted it in the face of a serious HIV/AIDS situation (Shaikh Mohd, 2005).

The power of the state led by a Prime Minister with solid Islamic credentials, the fragmentation of the Muslim lobby, and the strong support of the NGOs backed by academics and medical practitioners worked to mute the protests of the pro-prohibition coalition. The weakened and fractured religious lobby therefore could not sustain the protest.

Surprisingly there was no serious opposition from enforcement agencies, at least on policy. The endorsement and support from the highest level of government, coupled with sustained briefings by the NGOs to the leadership of these agencies resulted in revised standard operating procedures incorporating a more sympathetic approach to drug use. The head of a state enforcement agency asserted during the course of our interview, “In a centralised bureaucracy like ours, when the head turns the tail also falls in place.” However, harm reduction and punitive drug policies coexisted uneasily and the sporadic reports of raids on participants of the MMT and the NSEP programmes suggest that the tail is apt to go out of line occasionally.

The use of public funds to support harm reduction initiatives has always been controversial (Nissaramanesh et al., 2005) but more so in a society that had criminalised drug taking and where religious reservations are strong. Again, the government leveraged on the NGOs. They were inducted and conferred with a frontline role in widening the initiative. This strategy proved beneficial on several counts. Since the initial moves towards harm reduction were pioneered by the NGOs, it seemed logical to get them to lead the widening process as well. They were closest to the ground, had intimate links with drug users and instilled confidence in drug dependents to conform to treatment, counselling, supervision and therapy protocols. Finally – and not any less importantly – the active involvement of NGOs in the frontline work of the harm reduction allowed the authorities to remain in the background, supervising and financing the effort, whilst avoiding a direct confrontation with remaining groups unconvinced about the programme. The adoption of harm reduction also signalled a shift in the modus operandi of implementing drug policy from a centralised top-down effort to a more participatory process.

Discussion

The evolution of the Malaysian drug policy was presented as the outcome of competing perspectives between the state, the Muslim religious lobby and the NGOs in the drug policy subsystem. External events such as the poor outcomes from the prohibition programmes and the outbreak of HIV/AIDS amongst drug users split the state alliance and resulted in a new partnership between the policy making subgroups within the state and the NGOs but brought no immediate change in policy. It was the failure to meet the Millennium Development Goal (MDG) with respect to HIV/AIDS in 2005 that opened the door for change. It helped highlight harm reduction as an initiative that could forestall an impending public
health emergency. It therefore fell on the Ministry of Health to lead the final charge for a policy shift and it did so successfully. Fortunately, the state partnership with NGOs (under the MAC) that had drawn the latter into the policy subsystem allowed them to take advantage of the situation and enable change in a variety of ways. First, NGOs played a central role in educating their partners in the state coalition on the benefits of harm reduction by providing international evidence in support; this further whittled down resistance against change. Second, they garnered the backing of local academics and encouraged research in the local setting. Third, the medical fraternity was convinced to join in the advocacy. Fourth, they weakened the religious lobby through direct engagement and gained the support of more progressive elements within it to justify harm reduction on religious grounds. Finally, and most importantly, they played a frontline role in implementing the harm reduction programmes and, in the process, deflected remaining criticisms from Islamic groups away from the state. In short, NGOs not only laid the groundwork to precipitate change in the core beliefs of the state but also were already in partnership with the state to take advantage of the opportunity provided by the failure to meet the MDG; they became the visible, frontline implementers of the key harm reduction initiatives.

It is too early to evaluate the impact of harm reduction introduced tentatively in 2006 but preliminary results are encouraging. More Malay heroin dependents are now coming forward to seek treatment, setting aside their fear of being detained by enforcement authorities (Chawarski, Mazlan, & Schottenfeld, 2006). Furthermore, the number of new HIV/AIDS cases recorded a decline from 7000 in 2002 to 4900 in 2006 and this has been attributed to harm reduction efforts (Cruz, 2008).

Nevertheless, significant challenges remain. Adeeba Kamarulzaman, an academic and medical practitioner who led the MAC as its second President, hopes that at least 60% of drug users will have access to these harm reduction services but noted that the scope and reach had not covered even a fraction of this target (Edwards, 2009).

Being caught carrying needles and syringes is still sufficient cause to be subjected to mandatory testing and forced rehabilitation. In fact, under Section 37 of the Dangerous Drugs Act 1952, possession of any equipment associated with drug use can result in up to 2 years imprisonment though this has not always enforced strictly (Commission of Law Revision, Malaysia, 2006). In any event, this runs contrary to the spirit of the NSEP that encourages drug users to bring in used syringes and needles for exchange. It is imperative therefore to harmonize drug control laws so that they are consistent with the spirit and objectives of harm reduction. Cracking down on drug users and forcing them into rehabilitation seriously sets back voluntary participation in the NSEP and allied counselling services (Kamarulzaman, 2009; Hammett et al., 2007; Hathaway & Tousaw, 2008; Nissaranamehs et al., 2005; Sarang, Stuijkyte, & Bykov, 2007). The NSEP programme has succeeded in building a bond between the NGOs administering it and the drug users benefiting from it. NGOs are thus in a unique position to leverage on this goodwill to convince drug users to voluntarily seek treatment from the growing medical fraternity already involved in affirming such services. If successful, Malaysia would reap the twin dividends of reduced harm and reduced incidence of drug use achieved through strictly voluntary means. This would be a significant additional contribution to the arsenal of programmes associated with harm reduction.

Finally, efforts at educating the public on the rationale and objectives of harm reduction must be continuous. The acceptance of harm reduction can never be taken for granted. For instance, Canada, a mature secular country, that instituted harm reduction as early as 1987 appears to be reverting back to the enforcement centred approach with the Health Minister declaring that “Enforcement is harm reduction” (Hathaway & Tousaw, 2008).

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Conflict of interest statement

None.

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