Navigating Barriers to Harm Reduction Services

Understanding the challenges faced by communities and service providers

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Navigating Barriers: Access & Challenges to Harm Reduction Services in Southeast Asia

Overview


About AHRA
Context: Harm reduction in Southeast Asia
What is happening now?
Gaps & barriers
Best practices & integration opportunities
Community leadership & enabling environment
Recommendations
Q&A

About Southeast Asia Harm Reduction Association (AHRA)

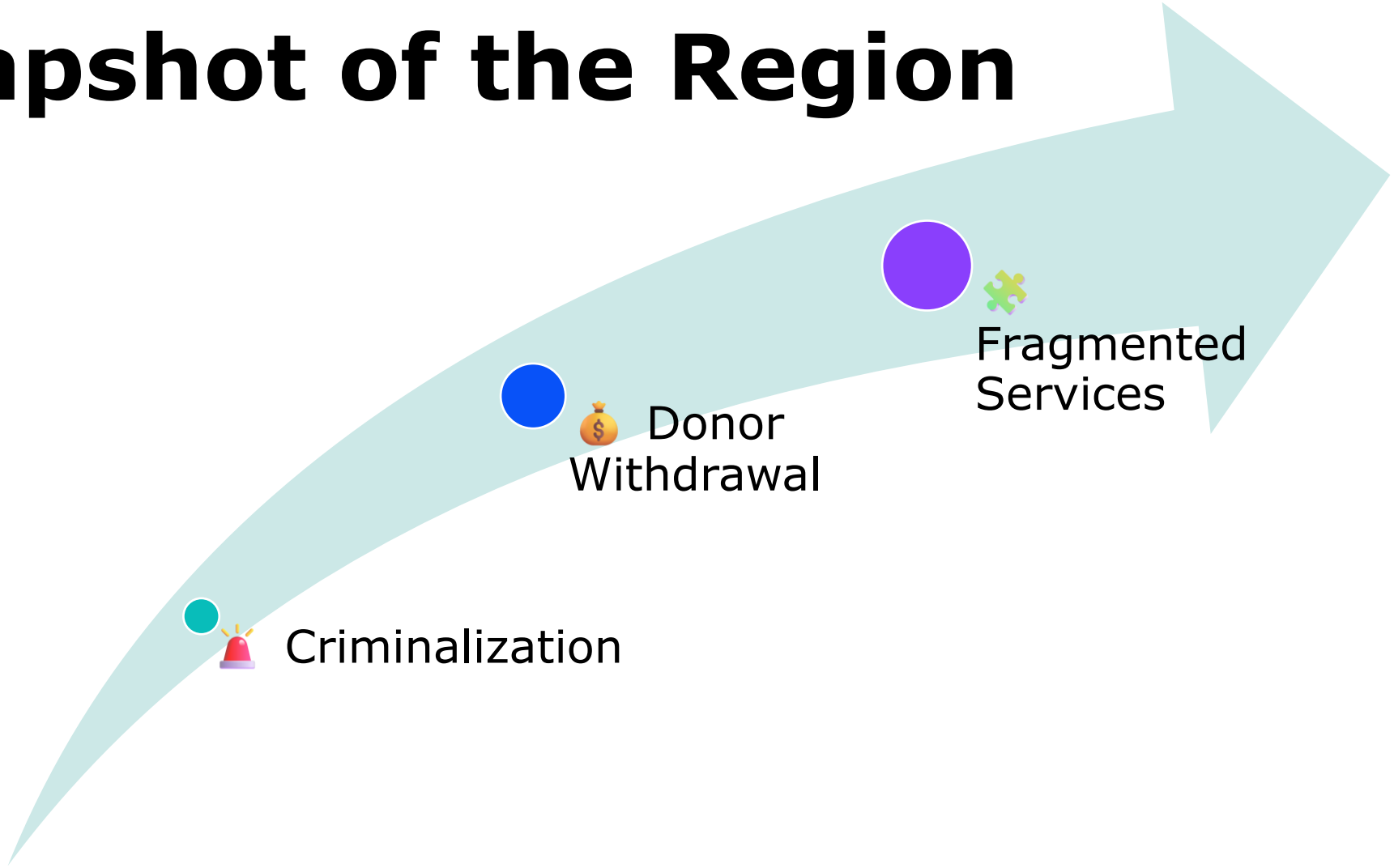
Regional network

Focus: harm reduction, cross-border advocacy, and community-led response

Capacity building and Technical support

Work across: Cambodia, Indonesia, Laos, Myanmar, Malaysia, Philippines, Thailand and Vietnam

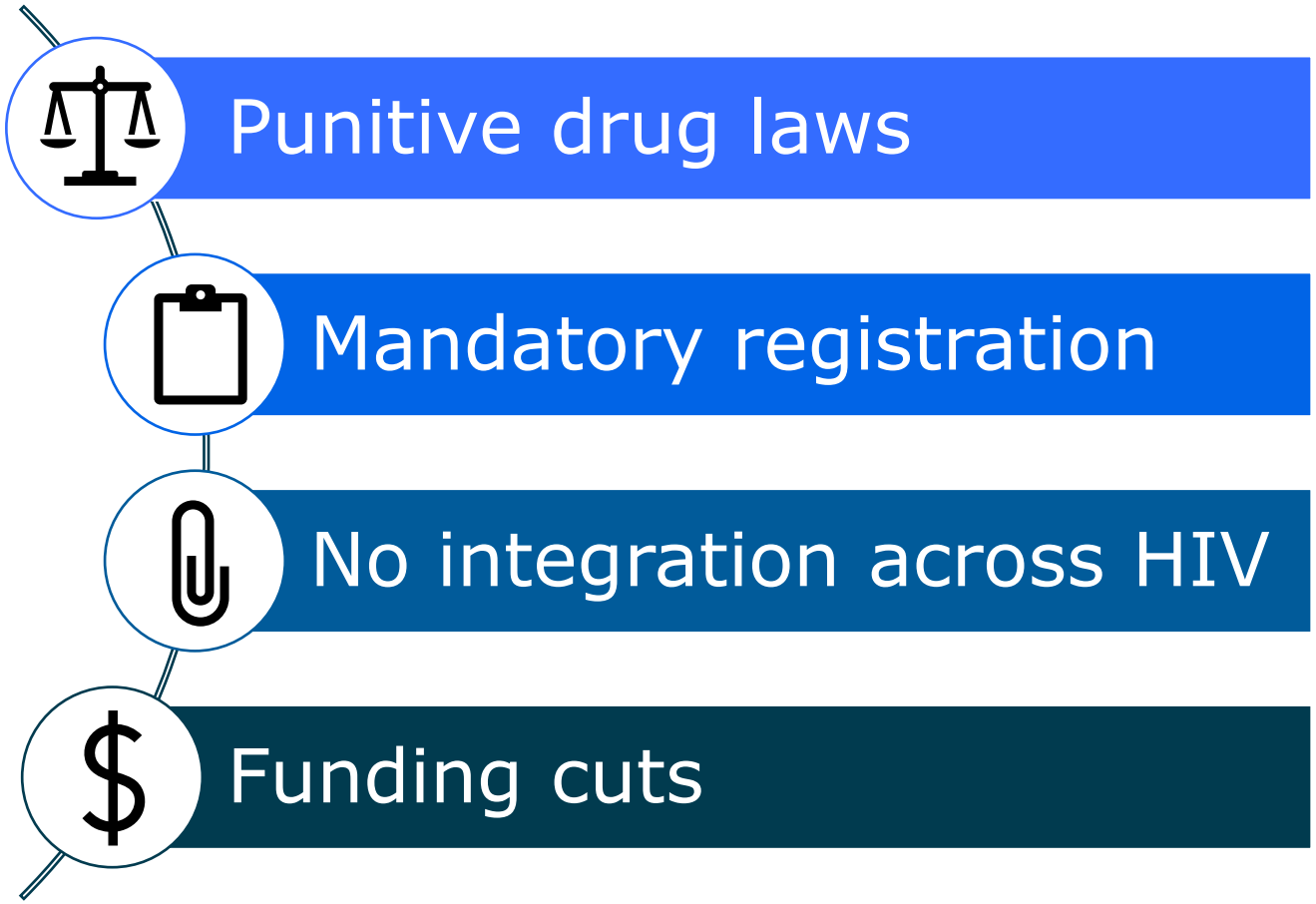
Snapshot of the Region



The Situation in Border Areas

- Crackdowns targeting PWUD, sex workers, LGBTQIA+, and undocumented Myanmar refugees
- Mobility, lack of legal status, and language barriers → restricted access to health services
- Local clinics require documentation → migrants refuse care for fear of arrest/deportation

Key Barriers

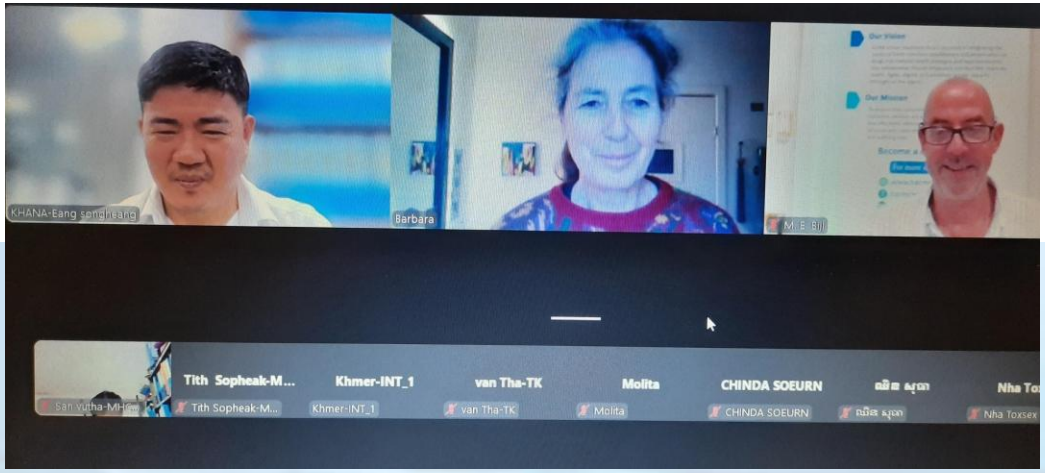


Impact on Communities

- 40% of Myanmar refugees lack access to HIV/TB/STI services
- Increased HIV vulnerability, overdose risk, mental health distress
- Peer networks operating without resources and without safety

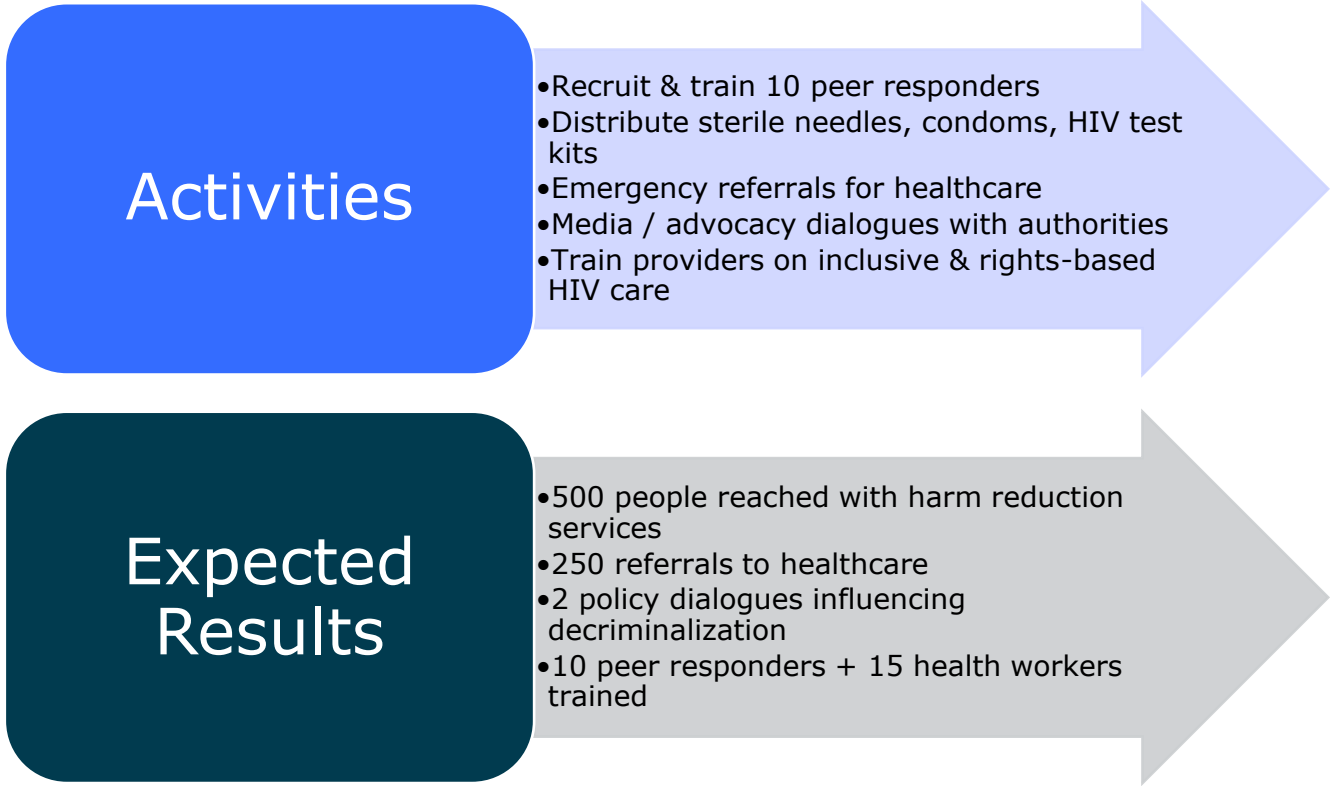
AHRA Approach

- Regional coordination
- Capacity building
- Advocacy + documentation (data to policy)
- Youth leadership



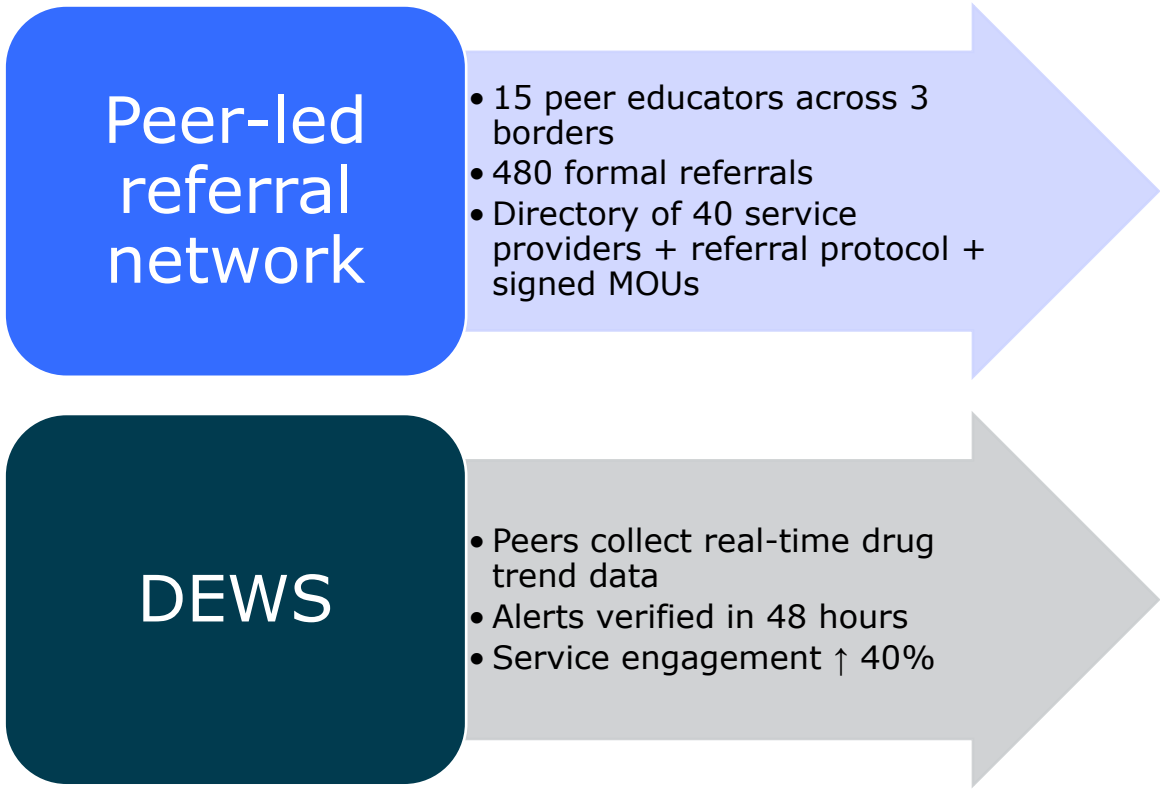
AHRA Emergency Response (RRF)

Goal: Rapid harm reduction service restoration



AHRA OSF Project

Goal: Cross-border, duplicable harm reduction system



Integration Opportunities

Area	Integration Approach
Substance use literacy	Peer educators + simple materials
Overdose / overamp	Distribution of naloxone; stimulant overamp protocol
Sexual health	HIV/STI + PrEP referral pathway
Mental health	Basic psychological first aid + referral
Socio-legal support	Paralegal volunteers + case management

Best Practices in the Region

- **Peer-led outreach** (Myanmar, Indonesia) – harm-reduction kits, safer-use education, overdose awareness.
- **Mobile / community methadone** (Vietnam) – rural coverage with basic mental-health screening.
- **Integrated clinic models** (Malaysia) – OST + HIV/TB/SRH under one roof.
- **Inclusive DICs** (Thailand, Philippines, Myanmar, Malaysia) – stigma-free spaces with psychosocial & legal support.
- **ATS-focused peer initiatives** (Indonesia, Myanmar, Thailand) – safer-smoking kits, hydration, stress care.
- **Mental-health integration** (Vietnam, Cambodia & regional pilots) – counselling + referral within harm-reduction services.

Community Leadership

- **Peers co-design and lead services** — from outreach to planning and evaluation.
- **Fair pay and formal recognition** — peers as equal professionals.
- **Community data ownership** — networks manage and use evidence for advocacy.
- **Integrated peer support** — bridging harm-reduction, mental, and sexual health.
- **Policy voice** — peers drive decriminalization and rights-based reform.

Lesson: Community-led, evidence-driven leadership makes harm reduction sustainable and effective.

What’s Needed (Policy & Environment)

To scale community-led harm reduction:

- Replace punitive raids with health-first policing
- Government co-financing for harm reduction, domestic funding, social contracting
- Remove mandatory registration for OST/needle syringe program
- Recognition of community-led organizations as service providers

Key Takeaways

- **Community-led harm reduction** - delivers trust, reach, and impact.
- **Capacity building** - turns participation into leadership.
- **Integration** - strengthens efficiency, continuity, and person-centred care.
- **Peer networks** - are essential partners in policy and service delivery.
- **Data and evidence** - must guide decisions, not ideology.
- **Governments must shift** - from punitive control to **health and rights-based governance**.
- **Regional collaboration** - amplifies voice, learning, and sustainability.

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Any Questions?

Thank You!