Harm Reduction and Human Rights

The Global Response to Drug-Related HIV Epidemics

HR2 | Harm Reduction & Human Rights

A Programme of the International Harm Reduction Association

About the International Harm Reduction Association and HR2

The International Harm Reduction Association (IHRA) is one of the leading international non-governmental organisations promoting policies and practices that reduce the harms from all psychoactive substances, harms which include not only the increased vulnerability to HIV and hepatitis C infection among people who use drugs, but also the negative social, health, economic and criminal impacts of illicit drugs, alcohol and tobacco on individuals, communities and society. A key principle of IHRA's approach is to support the engagement of people and communities affected by drugs and alcohol around the world in policy-making processes, including the voices and perspectives of people who use illicit drugs.

In 2007, IHRA established HR2, the Harm Reduction and Human Rights Monitoring and Policy Analysis Programme. HR2 leads the organisation's programme of research and advocacy on the development of harm reduction programmes and human rights protections for people who use drugs in all regions of the world.

IHRA is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

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The Global Response to Drug-Related HIV Epidemics

Damon Barrett, Catherine Cook, Rick Lines, Gerry Stimson and Jamie Bridge

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Published by
International Harm Reduction Association
Unit 704, The Chandlery
50 Westminster Bridge Road
London SE1 7QY
United Kingdom
Telephone: +44 (0)207 953 7412
E-mail: info@ihra.net
Website: www.ihra.net
Blog: www.ihrablog.net

Contents

Foreword by Anand Grover

UN Special Rapporteur on the Right to the Highest Attainable Standard of Health

Of the estimated 33 million HIV infections in the world, nearly 3 million or about 10 percent, are on account of injecting drug use. All these infections were and are preventable, but only if governments and authorities adopt the proven and workable strategies of harm reduction. These strategies involve needle and syringe distribution and condom promotion amongst drug users and their partners. These interventions prevent transmission of HIV and other infections. The efficacy of these interventions is beyond doubt, such that all key international organizations, including UNAIDS, WHO and UNODC have endorsed them.

Despite the proven efficacy of harm reduction interventions and endorsement by the UN bodies, uptake of these strategies, simply put, is thoroughly inadequate. This report points out that national responses to injecting drug-related HIV epidemics have been poor in many parts of the world and that there still remain seventy-six states with evidence of injecting drug use in which no harm reduction interventions are present.

Instead, around the world we see that punitive approaches are still being used to tackle illicit drug use and trafficking. These punitive strategies have had little impact on the illicit drug markets or drug trafficking, which is their intended target. The only real result has been to criminalize the drug user populations, who are forced to lead marginalized and criminalized lives, ill health being their only companion. These policies not only increase deleterious health effects and premature death for drug users, they also threaten to increase the HIV sero-prevalance in the general population. This alone should persuade governments that harm reduction strategies are in the public interest and that it is necessary to adopt them.

Apart from that, State Parties have obligations under international law and in particular under Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESR) to prevent epidemics. Therefore, states have an obligation under international law to pursue harm reduction strategies. Under the same provision, State Parties also are obliged to realize the right to highest attainable standard of health, particularly for marginalized communities, such as drug users. This means that drug user communities are entitled to, opioid substitution therapy and drug dependence treatment, both inside and outside prisons. This right has to be realized universally.

It is therefore imperative that international organizations, such as UNAIDS, ensure that harm reduction strategies become a central part of universal access programmes and that targets are set to monitor State Parties performance on the harm reduction front. Only by doing this will we ensure that precious lives are saved. There can be no room for complacency on that front. This report is part of the ongoing plea, which it eloquently makes, to adopt harm reduction universally. That plea needs to be heard and acted upon, sooner rather than later.

Anand Grover

1 Executive Summary

It is estimated that 15.9 million people inject drugs in 158 countries and territories around the world. The overwhelming majority live in low- and middle-income countries. Outside of sub-Saharan Africa, up to 30% of all HIV infections occur through injecting drug use. Despite this situation, the overwhelming evidence in favour of harm reduction as an effective HIV prevention strategy and the endorsement of UNAIDS, the World Health Organization and UN Office on Drugs and Crime, the global state of harm reduction is poor. This is especially true in countries where harm reduction services are needed most urgently.

A harm reduction approach – including the provision of needle and syringe exchange programmes and opioid substitution therapy – is endorsed and promoted by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) in numerous best practice guidelines and policy documents. UNAIDS, WHO and the United Nations Office on Drugs and Crime (UNODC) include both opioid substitution therapy and needle and syringe programmes within their Comprehensive Package of Interventions for HIV prevention, treatment and care for people who inject drugs, both inside and outside prisons.

Harm reduction is supported in policy or practice in at least eighty-two countries and territories around the world. Needle and syringe programmes are operating in seventy-seven countries around the world, and opioid substitution therapy is prescribed in sixty-three countries and territories. However, despite this widespread support, national responses to injecting drug-related HIV epidemics have been inadequate in many parts of the world, and there remain seventy-six states with evidence of injecting drug use in which no harm reduction interventions are present at all.

While significant progress has been made in other areas of the HIV response, the vast majority of people who use drugs – a marginalised and largely criminalised population – have been the last to benefit from HIV prevention, treatment and care services. For example, in Russia, where there is an estimated 2 million people who inject drugs, the use of opioid substitution therapy is prohibited and there are only sixty-nine needle and syringe exchange sites across the entire country. In the region of South-East Asia, only 3% of people who inject drugs have access to harm reduction programmes. In East Asia, this figure is 8%. In other regions, such as Latin America and the Caribbean, the link between non-injecting drug use and HIV is increasingly apparent, but remains largely unaddressed in the HIV response. Perhaps most challenging of all is the prospect of increasing injecting drug use in Sub-Saharan Africa, which could

exacerbate epidemics in countries where HIV prevalence is already very high, as well as rapidly expanding epidemics in countries which have so far remained relatively less affected.

Individuals who use drugs do not forfeit the right to the highest attainable standard of health. In recent years, UN human rights monitors, including the UN Committee on Economic, Social and Cultural Rights and UN Special Rapporteur on the Right to Health, have specifically connected the provision of harm reduction interventions as necessary for states to be compliant with the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights. The inadequacy of the harm reduction response in many countries therefore represents a failure in both public health and human rights terms.

Moreover, human rights abuses against people who use drugs, which often further impede access to HIV prevention, treatment and care efforts, are widespread in countries around the world. These human rights violations include denial of harm reduction services, discrimination in accessing antiretroviral therapy (ART), abusive law enforcement practices, disproportionate criminal penalties (including the death penalty for drug offences in some countries) and coercive and abusive treatment of people who use drugs under the guise of drug dependence treatment.

Despite the connections between drug control, human rights and HIV, the United Nations drug control and human rights regimes have developed in what the former UN Special Rapporteur on the Right to Health has described as 'parallel universes'. UN drug control bodies rarely discuss human rights, and the human rights bodies and mechanisms, in turn, have rarely focused on drug policy. The result is an international system and policy environment where significant human rights violations, many impeding HIV prevention efforts, fall between these two separate regimes, unaddressed and largely ignored.

2 The Global State of Harm Reduction: The international response to drug-related HIV epidemics*

Estimates from 94 low- and middle-income countries show that the proportion of injecting drug users receiving some type of prevention services was 8 per cent in 2005, indicating virtual neglect of this most at-risk population.

United Nations Secretary-General, Ban Ki-Moon, 2007[1]

2.1 Drug use and HIV epidemics

It is estimated that 15.9 million people inject drugs[2] in 158 countries and territories around the world.[3] The overwhelming majority (80%) live in low- and middle-income countries.[4] Asia and Eastern Europe have the largest injecting populations, with the highest numbers residing in Russia, India and China.

Up to 10% of all HIV infections occur through unsafe injecting drug use and evidence suggests that over 3 million people who inject drugs are living with HIV.[5] In much of Western Europe, as well as Australia and New Zealand, where harm reduction initiatives are long established, HIV prevalence among people who inject drugs remains below 5%. However, in some other regions, up to 80% of people living with HIV are likely to have acquired the virus through unsafe injecting.[6] Countries as diverse as China, Estonia, India, Kenya, Myanmar, Nepal, Thailand and Vietnam have HIV prevalence rates among people who inject drugs of over 50%.

Where data are available, studies have shown that young people often represent a significant proportion of injecting drug users. In some countries, children initiate drug injecting as early as age 12, while in many others the age of first injection is between the late teens and early twenties. In a study among clients of needle exchange programmes and voluntary counselling and testing in four Georgian cities (Tbilisi, Zugdidi, Gori and Batumi), 16.8% of the respondents were under 25. A study among out-of-treatment injecting drug users in Budapest (1999—2000) found that 16% of the participants were aged 15—19, and 45% aged 20—24. In 2006 in Ukraine, it was estimated that 43% of the people injecting drugs in Kiev city, 20% in Poltava oblast, 36% in Odessa oblast and 47% in the oblast of Dnipropetrovsk were younger than 24 years.[7] Given these factors, UNAIDS has estimated that approximately 45% of all new HIV infections are among those under age 25.[8]

* This section summarises some of the key findings of Cook C & Kanaef N (2008) The Global State of Harm Reduction. Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association. London, UK. (Hereafter, The Global State of Harm Reduction). The report was produced by the International Harm Reduction Association, in collaboration with harm reduction networks and independent researchers around the world, in 2008.

Injecting drug use by women is an area of growing concern in many parts of the world. There is also a substantial overlap between commercial sex work and injecting drug use reported in several regions. Though precise data on women who use drugs are rarely available, women have been estimated to represent about 40% of drug users in the United States and some parts of Europe, 20% in Eastern Europe, Central Asia, and Latin America, between 17-40% in various provinces of China, and 10% in some other Asian countries.

2.2 The international response

Introducing comprehensive harm reduction interventions, including needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST) is an effective method of preventing HIV transmission and improving the lives of people who inject drugs. Harm reduction has been described as 'an essential programmatic action for HIV prevention'[9] and a 'clear example of human rights in practice'.[10] This approach is endorsed and promoted by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) in numerous best practice guidelines and policy documents. UNAIDS, WHO and the United Nations Office on Drugs and Crime (UNODC) include both opioid substitution therapy and needle and syringe exchange programmes within their Comprehensive Package of Interventions for HIV prevention, treatment and care for people who inject drugs, both inside and outside prisons.[11] In 2006, the commitment of UN Member States to work towards universal access to HIV prevention, care and treatment services by 2010 was enshrined in the Declaration of Commitment. Guidelines for countries on scaling up responses towards universal access explicitly recommend the inclusion of targets related to needle and syringe exchange programmes and OST.[12]

Despite this widespread support, national responses to injecting drug-related HIV epidemics have been inadequate in many parts of the world. While significant progress has been made in other areas of the HIV response, the vast majority of people who use drugs – a marginalised and largely criminalised population – have been the last to benefit from HIV prevention, treatment and care services.[13]

Harm reduction is supported in policy or practice in at least eighty-two countries and territories around the world. In recent years, countries across Asia, the Middle East and North Africa have introduced and, in some cases, rapidly scaled up their harm reduction programmes. Needle and syringe exchange programmes are operating in seventy-seven countries around the world, and opioid substitution therapy is prescribed in sixty-three countries and territories. However, there remain seventy-six states with evidence of injecting drug use in which no harm reduction interventions are present at all. Even in those countries that have

implemented a harm reduction response, coverage of services varies dramatically. Many countries have only very small scale pilot programmes reaching small numbers of people. Coverage levels sufficient to avert or reverse HIV epidemics have thus far only been implemented in parts of Western Europe, Australia and New Zealand.[14]

The lack of harm reduction interventions within prisons is particularly striking. Needle and syringe exchange programmes are available to a proportion of prisoners in only eight countries around the world, despite the clear evidence that such programmes can be implemented effectively and safely in the prison environment. Opioid substitution therapy is prescribed to some prisoners in only thirty-three states, and is often restricted to those who have already begun receiving OST prior to imprisonment, thereby missing an important HIV prevention and drug treatment opportunity for people during incarceration.[15]

2.3 Regional overviews*

Asia

Significant developments in policy and practice in parts of Asia have signalled a shift towards harm reduction in recent years. Fifteen of twenty-four Asian states are now supportive of harm reduction in policy and/or practice. In thirteen countries, needle and syringe exchange programmes are operating. Opioid 'substitution therapy programmes appear to be entering a new era of acceptance in some parts of Asia',[16] with thirteen countries now prescribing either methadone or buprenorphine for drug dependence. Since May 2008, Cambodia and Bangladesh have also begun prescribing OST and the trend of establishing and rapidly increasing harm reduction programming looks set to continue in many states over the coming years, for example in China and Taiwan.

However, coverage remains far below levels necessary to have an impact on HIV epidemics. In South-East Asia, only 3% of people who inject drugs have access to harm reduction programmes and in East Asia this figure is 8%.[17] NSP and OST sites are currently limited to pilot programmes in the majority of countries, reaching very small numbers.

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* These regional overviews outline the current response to drug-related HIV epidemics in regions where harm reduction has not been a long-established approach and therefore exclude Oceania, North America and Western Europe. That does not imply that there do not exist considerable gaps and barriers in these regions.

The lack of a supportive legal and policy framework for an effective response to drug-related harms is a major barrier in much of the region. Several states have national legislation prohibiting possession and/or provision of needles and syringes, methadone and/or buprenorphine. In some cases, these legal prohibitions extend even to NGO functioning. Legal ambiguities and contradictory policies also impede the scaling up of harm reduction in the region.

Drug use is highly criminalised in many Asian countries. Fifteen of approximately thirty states in the world which retain the death penalty for drug offences are in Asia.[18] People convicted of drug-related offences, including drug possession, make up a large proportion of prison populations. Harm reduction in prisons remains very limited. No Asian prisons have needle and syringe programmes, and only four of 378 Indonesian prisons prescribe OST to prisoners.

Another key element of the response to drug policy in Asia are compulsory 'drug treatment' centres, often characterised by arbitrary detention without due process of law, followed by forced detoxification and forced labour. In some countries, entry into OST programmes is dependent on having spent a number of months in such a facility. Reports from numerous countries document a range of human rights concerns related to inadequate health care in compulsory drug treatment centres.

For example:

- Lack of access to anti-retroviral treatment (ART) for detainees has been reported in compulsory 'treatment' centres in China, Malaysia, Cambodia and Vietnam (where it has also been reported that treatment for tuberculosis is also unavailable).
- Lack of access to HIV prevention measures – including methadone – has also been reported in countries including Vietnam and Malaysia, despite the fact that in some cases high risk behaviours for the sexual and intravenous transmission of HIV have been documented.
- Forced or involuntary testing for HIV of persons in compulsory 'treatment' centres has been reported in China, Malaysia and Vietnam.[19]

Central and Eastern Europe and Central Asia

Following a rapid increase in injecting drug use during the 1990s, Central and Eastern Europe and Central Asia witnessed the fastest growing HIV epidemics in the world. Since 2001, the number of people living with HIV in the region has more than doubled, from 630,000 to 1.6 million.

As a response to rapidly expanding HIV epidemics, almost all states in the region have needle and syringe programmes, and the majority of states (23 of 29) prescribe opioid substitution therapy for drug dependence. Russia and Ukraine combined are home to 90% of the

region's injecting drug users, but the two countries have employed quite different responses. Largely enabled by a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria, Ukraine has rapidly increased access to NSP and buprenorphine maintenance therapy. Following enormous advocacy efforts, methadone prescription was initiated in 2008. Russia is home to around 2 million people who inject drugs, but the use of opioid substitution for drug treatment is still prohibited and there is a meagre sixty-nine needle and syringe exchange sites across the vast country.

HIV prevalence in prisons is high in the region and a number of prisons have experienced a rapid increase in the incidence of HIV in a short time period. Harm reduction interventions are currently reaching few prisoners in the region. Three countries have some prison-based needle and syringe programmes (Armenia, Kyrgyzstan and Moldova) and eight countries prescribe opioid substitution therapy to some prisoners (Slovenia, the Czech Republic, Moldova, Poland, Albania, FYR Macedonia, Montenegro and Serbia). Inside and outside prison, access to ART for current or former injectors is poor.

The average age of people injecting drugs in this region is especially low. Neglected by public policy and underserved by harm reduction and drug treatment services, young injectors are extremely vulnerable to HIV and other blood borne viruses.

European Union membership has had a positive influence on drug legislation in several countries, with a reduction in penalties and terms of imprisonment and/or improvement to prison conditions. In general, there are indications that harm reduction will continue to increase in the region, but inadequate government commitment and an emphasis on drug law enforcement over drug treatment and harm reduction remain major obstacles.

Caribbean

After sub-Saharan Africa, the Caribbean is the region of the world most affected by HIV and AIDS. The virus is predominantly sexually transmitted and, with the exception of the Dominican Republic, Cuba and the US territory of Puerto Rico, injecting drug use is rare in the region. However, recent research highlights a link between non-injecting drug use and sexual HIV transmission in several Caribbean countries, with HIV prevalence estimates among crack cocaine smoking populations reaching those found among injecting populations elsewhere. Crack cocaine is widely available on most islands, due to drug transhipment routes, and its use is reported to be 'extensive'.[20]

Only in Puerto Rico, where the majority of new HIV cases are associated with injecting drug use, are both OST and NSP available. Elsewhere in the region, abstinence-based, high-threshold services are the predominant response. One HIV/STI clinic in Saint Lucia provides targeted services to street-involved crack

cocaine users.
As in other regions, drug use is highly criminalised in the Caribbean, and the US-supported 'war on drugs' has resulted in large numbers of people being incarcerated for drug-related offences. HIV prevalence is elevated within prison populations and prisoners have limited access to HIV prevention, treatment and care. Methadone maintenance prescribing has been piloted successfully in some Puerto Rican prisons. Condom distribution in prisons is particularly controversial in many Caribbean countries due to the severe stigma surrounding homosexuality.

Despite the evidence that drug use is playing a role in HIV epidemics in the Caribbean, national drug and HIV policies remain largely unrelated.

Latin America

HIV predominantly affects marginalised populations in this region, including people who inject drugs. Injecting drug use is associated with new infections in Argentina, Brazil, Chile, Northern Mexico, Paraguay and Uruguay. Cocaine and its derivatives are the most commonly injected drugs in this region, with the exception of Northern Mexico and parts of Colombia, where heroin is used. There is also evidence of elevated HIV prevalence among non-injecting drug users in Argentina.

Five countries are supportive of harm reduction in policy and/or practice. Needle and syringe programmes are available in five countries, although the vast majority operate in Brazil and Argentina. Mexico, with substantially more heroin users than other Latin American countries, is the only state which prescribes opioid substitution therapy, although coverage is low.

Where harm reduction services exist, the heavy stigma surrounding drug use, as well as a fear of arrest, often deter people from accessing them. HIV programmes targeting people who inject drugs exist in Argentina, Brazil, Mexico and Paraguay, although these are limited. The most recent global estimates of the number of current or former injectors receiving ART found that the vast majority were in Brazil (30,000).[21] However, misconceptions, uncertainties and stigmatising views held by health workers limit access to life-saving ART for people who inject drugs in much of Latin America. In many countries, it is advised that drug users receive abstinence-based drug treatment prior to initiating ART.

There is no access to harm reduction in prisons within Latin America.

This region has been under immense political pressure from the US government to reduce drug cultivation and production. This has overridden public health responses to drug use and has in many cases violated the human rights of local farming communities cultivating coca crops.

Middle East and North Africa

The marginalised and criminalised populations of men who have sex with men and injecting drug users are most affected by HIV in this region. Injecting drug use is fuelling HIV epidemics in Iran and Libya and contributes to those in Algeria, Israel, Morocco, Syria, and Tunisia.

Drug-related offences result in severe penalties in this region, including the death penalty in nine countries, and prison populations include many people with a history of drug use. Elevated HIV prevalence is reported in prison populations in Yemen, the United Arab Emirates and Libya, although data on HIV in prisons are unavailable in much of the region.

Several countries in this region fall along heroin transhipment routes from Afghanistan. The impact of this is most pronounced in Iran, where it is estimated that 1.2 million people smoke, inject or ingest opiates (2.8% of the population). Faced with a growing HIV epidemic among people who inject drugs, the Iranian government has embraced a harm reduction approach and dramatically scaled up access to both NSP and OST. Iran is also one of the eight countries worldwide where needle and syringe programmes are available in prisons, although only in five of 200 institutions.

Seven countries, including Iran, have NSP and three have OST, although none have responses sufficient to meet the needs.

Across the region there is a low awareness of risks associated with injecting drug use. Few NGOs are working on harm reduction in the region, and in several countries' restrictions on NGO functioning further limit the harm reduction response from civil society.

Sub Saharan Africa

The majority of new HIV diagnoses in sub-Saharan Africa are attributable to sexual transmission, but the influence of drug use and of drug injecting is becoming increasingly evident in many countries.

Although data on drug use in the region are limited, injecting has been reported in thirty-one of forty-seven sub-Saharan African states. Where data are available, they suggest high HIV prevalence among people who inject drugs. Needle and syringe sharing is common, and extremely risky practices such as 'flashblood'* have been reported in Tanzania and Zanzibar. As in other regions, women who inject drugs are particularly vulnerable to HIV infection. A Kenyan study, for example, found that six of every seven female injectors were living with HIV.[22]

Responses to HIV in the region currently include little focus on people who inject drugs. Mauritius, where an estimated 17,000—18,000 people inject drugs, is the only country where needle and syringe programmes are operating. Limited OST is

* Directly injecting a recent heroin injector's blood to ease withdrawal symptoms.

prescribed in South Africa and Mauritius. No prisoners in the region have access to either needle and syringe programmes or OST.

In sub-Saharan Africa, injecting drug use could exacerbate epidemics in countries where HIV prevalence is already very high, as well as rapidly expand epidemics in countries which have so far remained relatively less affected. Experiences from Asia and Eastern Europe illustrate the importance of timely interventions to mitigate the rapid escalation of epidemics among key populations and the wider population.

3 Harm Reduction and Human Rights

There will be no equitable progress in HIV prevention so long as some parts of the population are marginalized and denied basic health and human rights – people living with HIV, sex workers, men who have sex with men, and injecting drug users.

United Nations Secretary-General, Ban Ki-Moon, 2008[23]

3.1 Harm Reduction and the right to health

Individuals who use drugs do not forfeit the right to the highest attainable standard of health. In recent years, UN human rights monitors have specifically connected the provision of harm reduction interventions as necessary for states to be compliant with the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights.

In its November 2006 Concluding Observations on Tajikistan, the UN Committee on Economic, Social and Cultural Rights expressed concern at 'the rapid spread of HIV in the State party, in particular among drug users, prisoners, [and] sex workers', and specifically called upon the government to 'establish time-bound targets for extending the provision of free…harm reduction services to all parts of the country.'[24] In 2007, the Committee raised similar concerns in its report on Ukraine, stating it was 'gravely concerned about the high prevalence of HIV/AIDS epidemic in the State party, including among…high risk groups such as sex workers, drug users and incarcerated persons…and the limited access by drug users to substitution therapy.'[25] The Committee recommended that the government 'make drug substitution therapy and other HIV prevention services more accessible for drug users.'[26]

One of the strongest statements in this regard was made in 2007 by the then UN Special Rapporteur on the Right to Health, Professor Paul Hunt, following his mission to Sweden. In his report on Sweden's compliance with its obligations under Article 12, the Special Rapporteur stated that harm reduction is not only an essential public health intervention, but that it 'enhances the right to health' of people who inject drugs.[27] Stating that the provision of harm reduction programmes was 'an important human rights issue', Professor Hunt said was 'very surprised' at the small number of needle exchange programmes in Sweden, and 'emphasis[ed] that the Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes'.[28]

3.2 Criminal law and abusive law enforcement impeding HIV prevention efforts

Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider:
the authorization or legalization and promotion of needle and syringe exchange programmes;
the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes

International Guidelines on HIV and Human Rights, Guideline 4(d)

The consequences of prioritising the criminalisation of drugs and people who use them over protecting and promoting health come into stark focus in the context of the global HIV pandemic.[29] Research in several countries, for example, has established that criminal laws proscribing syringe possession and associated policing practices targeting people who use drugs increase the risk of HIV and other adverse health outcomes in both direct and indirect ways.[30] The fear of arrest or police abuse creates a climate of fear for people who use drugs, driving them away from life-saving HIV prevention and other health services, and fostering risky practices.

In some countries, many people who inject drugs do not carry sterile syringes or other injecting equipment, even though it is legal to do so, because possession of such equipment can mark an individual as a drug user, and expose him or her to punishment on other grounds.* Police presence at or near government sanctioned harm reduction programmes (such as legal needle exchange sites) drives people away from these services out of fear of arrest or other punishment.[31]

In Georgia, for example, drug crackdowns in 2007 resulted in 4% of Georgia's male population being tested for drugs, many under forced conditions. Thirty-five per cent of these went on to be imprisoned on a drug-related charge.[32] In Thailand, the 2003 'war on drugs' that resulted in over 2,800 killings has had a lasting impact on drug users' access to fundamental health care services. Studies reported a significant decline in the number of people seeking treatment for drug use during the 'war on drugs', and that a significant percentage of people who had formerly attended drug treatment centres went into hiding, in some cases sharing syringes because sterile syringes were difficult to obtain.[33]

In many instances, particularly in those states with extremely repressive drug laws, perceived threats from law

* A survey of drug users in five Russian cities, for example, found that 40% routinely did not carry injection equipment, in part out of fear of attracting police attention. Jean-Paul C. Grund, 'Central and Eastern Europe', in HIV AND AIDS: A GLOBAL VIEW, Karen McElrath, (ed) (Westport, Connecticut: Greenwood Press, 2002), pp. 41-67.

enforcement drive people who use drugs away from HIV prevention programmes. A recent study of HIV prevention efforts along the border between China and Vietnam showed clearly the delicate balance between law enforcement and HIV prevention efforts.[34] Interviews with peer educators and people who inject drugs undertaken during the study indicated that 'crackdowns and elevated enforcement activities from late 2003 into 2004 resulted in arrest of many IDUs…and drove others underground or prompted them to leave the area at least temporarily'.[35] This is despite the fact that the project had gained the official support of the police and government agencies.

The perceived threat from law enforcement in these countries is entirely legitimate. Both countries have some of the most stringent drug control legislation in the world. Both countries retain the death penalty for drug offences and both actively execute those convicted of drug trafficking.[36] Both also allow for administrative detention, without trial, in forced detoxification centres.

In China, for example, government policy empowers local police to subject a person who uses drugs to a period of three to six months detention in a forced detoxification centre. Repeat offenders may be detained in re-education through labour centres (RELC) for one to three years. In each case, such detention is administrative and without trial or other semblance of due process. The most recently available data from 2005 indicate that there were approximately 700 mandatory drug detoxification centres and 165 re-education through labour centres in China, housing a total of more than 350,000 people.

Detainees in drug detention centres reported being housed in unsanitary and overcrowded conditions. Investigations have described extreme ill-treatment in the name of 'rehabilitation', such as the administering of electric shocks while viewing pictures of drug use. A 2004 survey found that 9% of 3,213 Chinese heroin users had taken extreme steps such as swallowing glass to gain a medical exemption from forced treatment.[37]

3.3 Discrimination against people who use drugs in accessing ART

> ***No-one should be stigmatised or discriminated against because of their dependence on drugs.***
>
> **United Nations Secretary-General, Ban Ki-Moon[38]**

In many countries where people who use drugs represent a significant, or even a majority, of those living with HIV, their access to treatment is disproportionately low relative to other people living with HIV. In Russia, for example, where people who use drugs are the majority the population in need of antiretroviral treatment (ART), they have often been

excluded from government AIDS treatment programmes. In 2004, the chief physician of St. Petersburg's City Health Committee reported that active drug users were not considered a good risk for AIDS treatment.[39] International experience, however, has demonstrated that with adequate support, people who use drugs can adhere to antiretroviral treatment regimens and benefit from other HIV care at rates comparable to non-drug users.[40]

Although national laws and HIV/AIDS policies may in principle recognise the right to non-discrimination in access to lifesaving antiretroviral therapy, in practice people who use drugs still face serious obstacles in obtaining equal access to necessary care. A recent study by WHO Europe showed that, in many countries, access to ART for people who use drugs is not proportionate to HIV rates among them, with eastern European countries having the lowest rates of access in the region. According to WHO, 'In eastern European countries, where IDUs are the majority of reported HIV cases, relatively few IDUs receive ART and, where they do, only few are current injectors when they initiate treatment.'[41]

The WHO figures showed there were significant improvements in access to antiretrovirals in western European countries from 2002—2005. However, in eastern Europe, rates of access to ART increased from only 14% to 38% among people who use drugs, this despite the fact that more than 70% of reported HIV cases were in the IDU transmission category from 2002—2005.

Figures on ART access for active injectors are even lower. Limited data from seven reporting eastern European countries at the end of 2005 on the injecting status of those accessing ART suggested that, on average, only 15% of reported people who inject drugs on ART were current drug injectors when they initiated treatment.[42] According to WHO, the figures showed a clear inequity in access to treatment for HIV for injecting drug users.[43]

These figures are mirrored in other parts of the world. In China, figures from 2006 showed that while 48% of HIV cases were people who inject drugs, this group represented only 1% of those accessing ART. In Malaysia, 75% of HIV cases were among people who inject drugs, while only 5% of injectors had access to ART.[44]

4 UN System-Wide Coherence: 'Parallel universes' of human rights and drug control

We will not enjoy development without security, we will not enjoy security without development, and we will not enjoy either without respect for human rights.

Former United Nations Secretary-General, Kofi Annan, 'In Larger Freedom'

Taken from every region of the world, the human rights indictment in the 'war on drugs' is long.[45] Ranging from cruel, inhuman and degrading treatment to executions for drug offences, and from chemical spraying over rural villages to denial of essential HIV prevention and treatment services, the negative impact of the global fight against drugs has been felt across borders and across human rights protections.[46]

The influence of the UN drug control conventions, and indeed the international drug control system that has been built around them, should not be underestimated. The conventions adopt a restrictive and punitive approach to drug users with little acknowledgement of human rights obligations. It has been noted that 'whether or not they are a cause or a convenient excuse, the UN drug conventions are used by national governments to justify highly punitive legal measures and failure to implement services for IDUs'.[47] Very often the stigmatisation and marginalisation of people who use drugs is most extreme in those countries where harm reduction services are most needed.

The International Narcotics Control Board (INCB), the independent monitoring body established under the drug conventions, has a long record of neglect in relation to HIV prevention measures,[48] while making no commentary on abusive drug policies in its annual reports. The UN Commission on Narcotic Drugs, meanwhile, has never condemned human rights abuses in drug policy and has focused on human rights only once in its sixty year history, with an extremely controversial resolution adopted at its 51st session in 2008.[49] At the programmatic level, the UN drug control programme within UNODC has not incorporated human rights into its activities. For example, UNODC does not conduct human rights risk assessments of its drug enforcement activities, even when those activities take place in states with problematic human rights records.

This neglect of human rights in drug policy is not, however, limited to the drug control entities. There are no guidelines from the Office of the High Commissioner for Human Rights (OHCHR) on mainstreaming human rights in UN drug control policies, and little co-operation between OHCHR and UNODC on drug control programmes. At the same time, the human rights treaty bodies and special procedures have focused on drug policy on only very few occasions.

The former UN Commission on Human Rights never adopted a resolution calling for the protection of human rights while 'countering the world drug problem', and the UN Human Rights Council has not yet considered this global human rights issue. This is a significant gap given that every year the UN General Assembly adopts a resolution reaffirming that countering the world drug problem must be carried out in full conformity with the Charter of the United Nations and, in particular, with fundamental human rights.[50]

The United Nations drug control and human rights regimes have developed in what have been described as 'parallel universes'.[51] The drug control entities rarely discuss human rights and the human rights bodies and mechanisms, in turn, have rarely focused on drug policy. The result is an international system and policy environment where significant human rights violations, many impeding HIV prevention efforts, fall between these two separate regimes, unaddressed and largely ignored.

The UN General Assembly's 20th Special Session on the World Drug Problem met in 1998, setting objectives centred on the achievement of significant and measurable reductions in the supply of and demand for illicit drugs over a ten year period. In 2008, the Commission on Narcotic Drugs began the process of reviewing the progress made towards these objectives.[52] The 2008/9 review process presents a significant opportunity to begin to address the current human rights weaknesses in the system. This is not the sole responsibility of the Commission on Narcotic Drugs, the INCB and the UNODC. The human rights entities within in the United Nations must, within their respective mandates, take this opportunity to begin to focus on the human rights aspects of international drug policies, including their impact on HIV prevention, treatment and care for people who use drugs.

ENDNOTES

1 Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: focus on progress over the past 12 months, Report of the Secretary General (20 March 2007) UN Doc No A/61/816, para 53.

2 Mathers B, Degenhardt L, Phillips B, Wiessing L, Hickman M, Strathdee S, Wodak A, Panda S, Tyndall M, Toufik A, Mattick RP and the Reference Group to the United Nations on HIV and injecting drug use 'The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review' (2008) The Lancet 2008 vol 372.

3 Cook C and Kanaef N (2008) Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics. London: International Harm Reduction Association, p 12.

4 Aceijas C, et al 'Global overview of Injecting drug use and HIV infection among injecting drug users' (2004) AIDS 18:2295—2303.

5 ibid.

6 Joint United Nations Programme on HIV/AIDS and World Health Organization (2007) AIDS epidemic update.

7 ibid.

8 Joint United Nations Programme on HIV/AIDS (2008) 2008 Report on Global AIDS Epidemic.

9 Joint United Nations Programme on HIV/AIDS (2005) Intensifying HIV prevention: UNAIDS policy position paper, 32.

10 P Hunt in Cook and Kanaef, p 3, op. cit.

11 World Health Organization, UN Office on Drugs and Crime and UNAIDS (January 2008 – draft for review). Technical guidance for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.

12 ibid.

13 Joint United Nations Programme on HIV/AIDS (2008) 2008 Report on Global AIDS Epidemic.

14 See Cook and Kanaef, op. cit.

15 ibid.

16 Reid G, Devaney ML and Baldwin S 'Harm Reduction Programmes in the Asia-Pacific Region' (2008) Drug and Alcohol Review 27:95—98.

17 Prasada Rao, J.V.R., Director, UNAIDS Regional Support Team, Asia Pacific (2008) Speech given at the opening ceremony of the 1st Asian Consultation on the Prevention of HIV Related to Drug Use, Goa, India, 28 January.

18 Lines, R (2007) The Death Penalty for Drug Offences: A Violation of International Human Rights Law. London: International Harm Reduction Association.

19 Case reports taken from Open Society Institute (2009, forthcoming) Abuses in the Name of Treatment: Reports from the Field. New York: Open Society Institute.

20 Day M for the Caribbean Drug Abuse Research Institute (2007). Cocaine and the risk of HIV infection in the Saint Lucia.

21 Aciejas C, et al. 'Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the "Treating 3 million by 2005. Making it happen. The WHO strategy"' (2006) Addiction 101(9):1246—1253(8).

22 National AIDS Control Council (2008) UNGASS Country Progress Report – Kenya.

23 Ban Ki-Moon (2008) Remarks on the handover of the report of the Commission on AIDS in Asia at United Nations Headquarters, New York, 26 March.

24 UN Committee on Economic, Social and Cultural Rights 'Concluding Observations: Tajikistan' (24 November 2006) UN Doc No E/C.12/TJK/CO/1, para 70.

25 UN Committee on Economic, Social and Cultural Rights 'Concluding Observations: Ukraine' (23 November 2007) UN Doc No E/C.12/UKR/CO/5, para 28.

26 ibid para 51.

27 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and

mental health, Paul Hunt, Mission to Sweden' (28 February 2007) UN Doc No A/HRC/4/28/Add.2, para 60.

28 ibid para 62.

29 See Elliott R, et al 'Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control Policy' (2005) Health and Human Rights: An International Journal vol 8 no 2.

30 See Burris S, et al 'Addressing the "Risk Environment" for Injection Drug Users: The Mysterious Case of the Missing Cop' (2004) The Milbank Quarterly vol 82 no 1:131—135.; Pollini R, et al 'Syringe Possession Arrests are Associated with Receptive Sharing in Two Mexico-US Border Cities' (2007) Addiction vol 103:101—108; Csete J (2007) Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs. Toronto: Canadian HIV/AIDS Legal Network.

31 See also studies cited in Burris (2004) op. cit. as well as Human Rights Watch reports 'Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against AIDS' (2006) p 34—40.; 'Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation' (2004) p 28—31.; 'Fanning the Flames: How Human Rights Abuses Are Fuelling the AIDS Epidemic in Kazakhstan' (2003) p 32—34.; 'Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights' (2004) p 36—42.

32 Otiashvili, D (2008) 'Georgian Drug War – Ignoring Evidences, Neglecting Human Rights'. Presented at the International Harm Reduction Association's 19th Annual conference in Barcelona, Spain, 14 May.

33 'Not Enough Graves, p 36—37, op.cit.. Researchers have also found that the government crackdown on drug users was likely to discourage drug users from obtaining HIV testing and other medical services. Tassanai Vongchak et al 'The influence of Thailand's 2003 "war on drugs" policy on self-reported drug use among injection drug users in Chiang Mai, Thailand' (2005) International Journal of Drug Policy no 16: 15–121.

34 Hammett T, et al 'Law Enforcement Influences on HIV Prevention for Injecting Drug Users: Observations from a cross-border project in China and Viet Nam' (2005) International Journal of Drug Policy 16:235—245.

35 ibid p 242.

36 Lines (2007) op. cit.

37 See Human Rights Watch, International Harm Reduction Association and Asia Catalyst (2008) Submission to the UN Committee against Torture, 30 September 2008. Available at http://www2.ohchr.org/english/bodies/cat/docs/ngos/HRW_IHRA_AC_China_41.pdf

38 Ban Ki-Moon (2008) Message on the International Day against Drug Abuse and Illicit Trafficking, 26 June 2008.

39 Human Rights Watch (2004) Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation, p 45, op. cit.

40 See, for example, Curtis M (ed) (2006) Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice. New York: Open Society Institute, p 25—35.

41 Bollerup A, Donoghoe M, Lazarus J & Matic SV (2005) 'Access to HAART for injecting drug users in the WHO European Region 2002–2005'. For a more detailed analysis see Donoghoe et al, 'Access to HAART for injecting drug users in the WHO Europe Region 2002—2004' (2007) International Journal of Drug Policy 18:271—280.

42 Bollerup et al (2005), op.cit.

43 ibid.

44 Aceijas et al (2006), op. cit.

45 Hunt P (2008) Human Rights, Health and Harm Reduction: States' amnesia and parallel universes. London: International Harm Reduction Associaton.

46 See generally Barrett D, et al (2008) Recalibrating the Regime: The need for a human rights based approach to international drug policy. London: Beckley Foundation Drug Policy Programme/International Harm

Reduction Association.

47 Wolfe D (2004) 'Alchemies of Inequality: The United Nations, Illicit Drug Policy and the Global HIV Epidemic' in Malinowska-Sempruch K and Gallagher S (eds) War On Drugs, HIV/AIDS and Human Rights. New York: International Debate Education Association, p 171.

48 Csete J and Wolfe D (2007) Closed to Reason: The International Narcotics Control Board and HIV/AIDS. Toronto: Canadian HIV/AIDS Legal Network/Open Society Institute.

49 Commission on Narcotic Drugs 'Strengthening cooperation between the United Nations Office on Drugs and Crime and other United Nations entities for the promotion of human rights in the implementation of the international drug control treaties' (2008) Resolution 51/12. For a commentary on the drafting of the resolution see http://www.ihrablog.net/2008/04/life-of-human-rights-resolution-at-un.html .

50 See, for example, UNGA Res 61/183 (13 March 2007), UN Doc A/RES/61/183 and UNGA Res 60/178 (22 March 2006) UN Doc A/RES/60/178.

51 Hunt (2008) Human Rights, Health and Harm Reduction: States' amnesia and parallel universes, op. cit.

52 For more information see the website of the International Drug Policy Consortium (www.idpc.info) and the Transnational Institute Drugs and Democracy Programme (www.ungassondrugs.org).

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