

# Illicit Drug Policies and the Global HIV Epidemic

Effects of UN and National Government Approaches



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International Harm Reduction Development

# Illicit Drug Policies

## and the Global HIV Epidemic

Effects of UN and National Government Approaches

A working paper commissioned by the  
HIV/AIDS Task Force of the Millennium Project  
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Years after research has shown how swiftly injecting drug use can spread HIV—and how evidence-based approaches can effectively contain that explosive growth—countries with injection-driven epidemics continue to emphasize criminal enforcement over the best practices of public health.

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## Introduction

More than two decades of HIV have taught the world some clear lessons on how to successfully contain the virus. Effective HIV prevention includes not only the provision of tools such as condoms to help block HIV transmission, but also recognition of the ways in which HIV risk is shaped by and reduced through the engagement of multiple sectors of society. Community involvement—whether by sex workers in Thailand, gay men in the United States, clergy in Uganda, or human rights activists in Brazil—has proved central to mobilizing and sustaining successful efforts to stop the epidemic’s spread. Particularly important has been the involvement of people infected or at risk for HIV, and the creation by government and international agencies of an “enabling environment” that includes policies to protect affected individuals from discrimination, mechanisms for interaction between government and affected communities, and financial assistance for effective program design and delivery.

The HIV epidemic also offers more bitter lessons about the consequences of failure to support HIV prevention. Africa is paying an almost unimaginable human price for delay by local governments and international donors in directing political attention and resources to the epidemic there. The observation that AIDS

is a political crisis is also particularly apt today in countries where HIV infection is related primarily to injecting drug use. While HIV transmission through contaminated injection equipment is well documented, less attention has been paid to the ways that illicit drug policy and related issues, such as patterns of arrest of drug users or government stance toward provision of sterile injection equipment, shape global trends in HIV infection.

This report examines the intersection of global and national drug policy and HIV trends, with particular attention to those countries where the use of contaminated injection equipment is the primary mode of HIV transmission. Specifically, it highlights the two competing frameworks most commonly used to conceptualize drugs, drug users, and appropriate policy responses at the international and national levels: one regarding criminal enforcement as central, and the other relying on the best practices of public health.

The criminal enforcement and public health frameworks used to shape policy responses to drug use are not equally endowed or emphasized. Rather, far greater resources flow to the enforcement approach, which in turn directly and indirectly shapes the capacity of health care workers, nongovernmental organizations, and treatment programs to offer services to drug users without suspicion of undermining public order, violating moral norms, or contributing to unhealthy behavior. Even those measures offered as an alternative to incarceration in many countries—forced drug treatment, for example—rely upon a punitive, law enforcement approach to address problems related to injection drug use. Public health measures that do not require drug users to relinquish all claims to autonomy before receiving help, by contrast, or those that recognize that abstinence is not the only desirable outcome—such as needle exchange, substitution therapy, or overdose prevention—are frequently illegal, unfunded, or insufficiently supported at the national level. Many governments keep such efforts as perpetual “pilot programs,” effectively delaying for years the comprehensive approaches that can contain injection-related HIV transmission.

This report focuses primarily on developing nations with established HIV epidemics (>50,000 registered cases) where injecting drug users (IDUs) represent the majority of HIV infections. The limitations of this framework are many. HIV statistics are particularly unreliable when it comes to drug users, who frequently avoid testing or treatment settings for fear of incarceration or stigmatization. Political sensitivities make many governments reluctant to collect or report information about HIV, drug users, or both. Registered HIV cases frequently include only those drug users encountered by law enforcement, mandatory testing facilities or prisons

administered by ministries of security, justice, or internal affairs. Health ministries and assessments by outside epidemiologists suggest that such samples may underestimate actual cases by anywhere from two- to tenfold (USAID 2002; Hing 2003; Human Rights Watch 2003; U.S.-Russia Working Group 2003).

Nonetheless, five countries in the former Soviet Union and Asia—whose combined populations exceed one and a half billion—are already reporting established epidemics (>50,000 registered cases per country) in which the majority of cases are due to injection drug use. Like injection-driven HIV epidemics more generally, these—in Russia, China, Malaysia, Ukraine, and Vietnam—have grown at rates far higher than those associated with sexually transmitted epidemics. If current trends continue, dozens more nations—including both those who have yet to record more than a handful of AIDS cases and those who have successfully reduced infections among non-drug users but have been less successful in reaching IDUs—will soon join the list of those facing serious, injection-driven epidemics. IDUs are the majority of those infected in Tajikistan, Kazakhstan, Uzbekistan, Iran, Indonesia, and Nepal, all of which have registered fewer than 10,000 cases of HIV but report rapidly growing epidemics (CEEHRN 2002; Reid and Costigan 2002; UNAIDS 2002). Injection is now the predominant mode of transmission in most of Western and Eastern Europe, North Africa, and the Middle East (Strathdee and Poundstone 2003).

The good news is that interventions to stem HIV and other harms among injecting drug users have proven both easy to implement and highly effective. Participants in needle exchange programs show none of the ambivalence associated with behavioral initiatives to increase condom use: almost no drug user chooses to share needles if offered another option. Ongoing treatment with methadone, widely tested in developing and industrialized countries alike, has been shown to reduce both injection and social costs associated with drug use (Abdul-Quadar, Friedman et al. 1987; Ball and Ross 1991; Vanichseni, Wongsuwan et al. 1991; Ward, Mattick et al. 1994; Lindesmith Center 1997). More broadly, researchers evaluating the full spectrum of efforts to reduce drug-related harm—which include peer education, syringe exchange and safer injection rooms, methadone maintenance, overdose prevention—have demonstrated positive outcomes in countries from Australia, the United States, Belarus, and Thailand. Representatives of UNAIDS phrase it simply in their speeches and publications: “harm reduction works” (Cravero 2002; Hankins 2002).

The bad news is that evidence of effectiveness has so far proved little match for ideology. Years after gold-standard research has shown how swiftly injecting



drug use can spread HIV—and how evidence-based approaches can effectively contain that explosive growth—countries with injection-driven epidemics continue to emphasize criminal enforcement over the best practices of public health. If current epidemiological trends are any indication, the result may be one of the most tragic missed opportunities of the new millennium: the spread of an HIV epidemic in Asia and the former Soviet Union that will claim tens of millions of lives, and that could have been averted.

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UN agencies and bilateral and international donors should articulate criteria for equitable and effective responses to drug use and HIV against which national efforts might be judged.

The alternative—an internationally supported HIV/AIDS infrastructure that remains unresponsive and inaccessible to huge numbers of the people who need it most—will only perpetuate the growth of further infections, as well as stigma, illness, and death throughout Asia and the former Soviet Union.

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## Summary Recommendations

Participants in self-help programs for drug users have a saying about those who repeat familiar patterns of behavior and expect a different outcome: “If nothing changes, nothing changes.” Regrettably, the same insight applies to those formulating illicit drug policy. International organizations and national governments return again and again to the same tactics in addressing the twin problems of drug use and HIV infection, even as both climb steadily.

- ▶ Long after the scale and speed of HIV transmission through injection has become clear, the United Nations system continues to pursue parallel and contradictory policy recommendations regarding drug users and HIV prevention. The United Nations Office on Drugs and Crime (UNODC)<sup>1</sup> insists that it has no official position on harm reduction, and the International Narcotics Control Board (INCB) frequently condemns it as contributory to drug abuse and potentially illegal. The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), of which UNODC is

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1. The UN Office on Drugs and Crime (UNODC) was formerly named the UN Office for Drug Control and Crime Prevention (UNODCCP), and incorporates the activities of the United Nations Drug Control Programme (UNDCP) under its umbrella. For clarity, this document uses UNODC throughout.

a co-sponsor, say that the UN supports a full range of harm reduction efforts, including needle exchange programs and treatment with methadone. Even this support tends toward the rhetorical—WHO and UNAIDS, for example, have yet to object to overcriminalization of drug users by UN drug control entities, or to work with bilateral donors and recipient governments to bring a single harm reduction program to national scale.

- ▶ Every national government in Asia and the former Soviet Union with an established, injection-driven HIV epidemic (>50,000 registered HIV cases, with the majority among IDUs) imprisons large numbers of drug users, yet none systematically provides prisoners with the tools—condoms, sterile injection equipment, and methadone maintenance—most important to reducing risk of HIV infection while incarcerated.
- ▶ Every national government with an established, injection-driven epidemic has forced, abstinence-based “treatment” that fails to provide most drug users with tools needed for HIV prevention or care. This remains true despite repeated evidence that sex and drug use occur in forced treatment centers, that rates of HIV infection there are high, and that the overwhelming majority of those in forced treatment return to drug use after release.
- ▶ Every national government with an established, injection-driven HIV epidemic has endorsed the 2001 UN General Assembly Special Session (UNGASS) declaration of commitment on HIV/AIDS that includes support for the availability of sterile injection equipment and other harm reduction measures. To date, none save Vietnam, whose contribution is small, provides funding for syringe exchange programs. Legislation in many countries, including Vietnam, continues to use needle possession as grounds for arrest or forced institutionalization.
- ▶ Criminal enforcement approaches to drug policy have been emphasized at the expense of public health. National AIDS plans express theoretical support for interventions to drug users, when they mention them at all, yet drug users are denied fundamental human rights or access to even basic primary health care. HIV prevention efforts supported by the government in theory are in practice often undermined by harassment of drug users by police or public security forces.

While routinely viewed by law enforcement as a deviant minority, drug users in the eyes of HIV policy experts must be seen in many instances as a majority in need of immediate treatment and support. No template or universal approach can be

sufficient: national responses to HIV in countries with injection-driven epidemics, as elsewhere, must be tailored to local realities. Nonetheless, the global nature of the drug problem, and the global consequences of failure to respond effectively, makes concerted, coordinated policy and legal reform essential.

At a minimum, UN agencies and the growing number of bilateral and international donors acting to strengthen the global response to HIV should articulate criteria for equitable and effective responses to drug use and HIV against which national efforts might be judged. The alternative—the creation of an internationally supported HIV/AIDS infrastructure that remains unresponsive and inaccessible to huge numbers of the people who need it most—will only perpetuate the growth of further infections, as well as stigma, illness, and death throughout Asia and the former Soviet Union.

Specific recommendations include:

### **International Level Reform**

- ▶ *Addition of a fourth UN drug control convention explicitly supporting HIV prevention for drug users.* This convention should express support for the full range of strategies to reduce drug-related harm—including syringe exchange, safer injection rooms, substitution therapy, and peer outreach and education—as compatible with drug demand reduction and essential to HIV prevention.
- ▶ *Withdrawal of international support for UN drug conventions in the absence of timely reform.* While no single country can withdraw from UN conventions without fear of censure, joint withdrawal by countries committed to harm reduction would force recognition of the UN conventions' harmful effects.

Creation and adoption of new conventions, however, is a time-consuming and costly process. Shorter term recommendations include:

- ▶ *Adoption of a resolution by the UN Commission on Human Rights affirming the rights of drug users to HIV prevention and the need to amend existing UN drug control conventions.* Measures that prohibit IDUs from accessing the full range of appropriate HIV prevention measures violate basic precepts of human rights and the best practices of public health.
- ▶ *Creation of an international “memorandum of understanding” that expresses government commitment to harm reduction programs, summarizes legal arguments in support, and highlights conflicts with international law in need of immediate resolution.* Countries pursuing harm reduction are currently singled out for censure or left

to justify their approaches to entities such as the International Narcotics Control Board (INCB) and Commission on Narcotic Drugs (CND) without support from like-minded governments. This document, prepared with support of UNAIDS or WHO for signature by countries committed to harm reduction, would provide a united front, summarizing legal scholarship in favor of harm reduction and highlighting those aspects of the UN conventions in greatest need of clarification or reform.

- ▶ *Genuine UN system-wide coordination and consensus on harm reduction policy.* Previous efforts at “harmonizing” have been insufficient. Measures required include formal adoption of a supportive position on harm reduction by the UNODC and the CND, and clear legal justification for any INCB assertion that a particular harm reduction measure violates international drug control conventions.
- ▶ *Expansion of INCB monitoring and reporting to include analysis of drug treatment as well as illicit drug production and enforcement.* UN drug conventions call for provision of treatment for those using illicit drugs, and nations should be held as accountable for compliance with this requirement as they are for others contained therein. Focus should be on both quantity and quality of treatment.
- ▶ *Reclassification of methadone from Schedule I to a less restrictive category.* WHO should immediately propose, and the CND should approve, removal of methadone from the most tightly restricted category.
- ▶ *Addition of opioid substitution therapies to WHO essential drugs list, and inclusion of manufacturer and pricing information in surveys on HIV drugs and diagnostics.* With millions of IDUs infected with HIV, medications to help them avoid collateral infections or adhere to HIV therapies are essential and should be recognized as such.
- ▶ *Analysis of HIV treatment availability by route of HIV exposure, and measures to improve HIV treatment access for IDUs.* Better data collection is needed to ascertain the extent of discrimination against drug users in the provision of HIV care and to prioritize improved access to care for IDUs.

## National Level Reform

- ▶ *Inclusion of drug use issues in national AIDS plans, and of AIDS issues in national drug plans.* Lack of coordinated response hampers efforts to control drug use and HIV.

- ▶ *Repeal of mandatory imprisonment/institutionalization for possession of small amounts of illicit drugs.* Imprisonment and forced treatment expose detainees to psychological and health risks, including HIV, hepatitis C, and tuberculosis, and serve to accelerate HIV infection.
- ▶ *Decriminalization of drug use paraphernalia, adoption of legislation permitting purchase of syringes without prescription, and public education about the right to do so.* Drug users fear arrest even in countries where purchase of syringes is permitted. Penalties for possession of injection equipment, whether actual or perceived, encourage use of shooting galleries and professional injectors, and increase likelihood of HIV transmission.
- ▶ *Repeal of legislation or practices through which drug users are criminalized on the basis of addiction alone or past behavior.* Mass arrests based merely on suspicion of drug use or on the basis of “clean-up” campaigns conducted for political purposes should be prohibited. Legislation that criminalizes drug addiction per se or permits medical testing and punishment for evidence of past drug use should similarly be repealed.
- ▶ *Protection of confidentiality of IDUs and people with HIV in health care and drug treatment settings.* Information on HIV status or drug use history gained through the provision of medical care should not be shared with law enforcement or other governmental or nongovernmental agencies, or revealed to local community members.
- ▶ *Provision of HIV treatment and/or support to those with HIV in penal or treatment facilities.* If testing is used to inform staff or about the HIV-status of individuals in prison or drug treatment facilities, services and support—including treatment comparable to that available outside—should also be available.
- ▶ *End to punitive registration of IDUs and people with HIV.* Practices that publicly identify drug users and people with HIV, or that require them to submit to ongoing regulation or surveillance, are stigmatizing and counterproductive.
- ▶ *End to practices depriving drug users of due process while in police custody.* Denial of legal counsel, prolonged detention without a prompt hearing, extortion and use of drug withdrawal or its threat to coerce confession all violate human rights and basic standards of justice.
- ▶ *Involvement of health professionals in decisions about need for and length of drug treatment.* Course of treatment should be appropriate to the individual in

question, with decisions made by qualified health professionals rather than by arresting police officers, judges, local political officials, or on the basis of national “social evils” campaigns or forced treatment requirements.

- ▶ *Implementation of harm reduction and HIV prevention efforts, including syringe distribution, condom availability, and substitution therapy, in prison settings and for those recently released.* Whatever harm reduction programs are available outside of prisons should also be available inside. Given the key role played by penal institutions in the spread of HIV, special attention should be devoted to implementation of HIV prevention interventions in prisons even if they are unavailable in the country at large, and to HIV prevention and substance abuse treatment programs for those recently released from incarceration.
- ▶ *Creation of accessible drug-treatment that recognizes differences between casual and chronic use, and between users of different drugs.* Cannabis and heroin users, or those who use methamphetamine once and those who are chronically addicted, may share the same legal status, but their treatment needs are sharply different.
- ▶ *Scaling up, with financial support from governments, of the full spectrum of drug demand reduction and HIV prevention measures supported by UNAIDS and WHO.* These measures should include inpatient treatment, outpatient treatment, aftercare and rehabilitation, syringe exchange, overdose prevention, and opioid substitution therapy.
- ▶ *Adoption of minimum standards of care, based on best public health practice, in treatment and rehabilitation centers.* Services needed include medically assisted detoxification, psychological counseling, and humane and nonexploitative rehabilitation services.
- ▶ *Expansion of aftercare programs, including programs offering harm reduction services for active drug users, and abolition of punishments for relapse.* In the absence of adequate aftercare, policies that punish relapse into drug use with prison sentences or prolonged detention make drug treatment programs nothing more than precursors to imprisonment.
- ▶ *Analysis of HIV treatment availability for IDUs, and measures to end discrimination in treatment access.* Policies or practices that prohibit or discourage IDUs from equal access to HIV treatment—whether antiretroviral treatment or treatment for AIDS—related infections—are unethical and counterproductive.

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UNAIDS estimates suggest that, outside Africa, more than one of every three new infections comes from sharing a contaminated needle.

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## 1. Epidemiology of Drug Use and Global HIV Infection

It is no accident that HIV/AIDS has emerged as the first major pandemic of the global economy: in many instances, HIV has been fueled by the same processes as globalization itself. The opening of national borders, increasingly rapid movement of goods and laborers between countries, and economic transitions and dislocations characteristic of the post-Cold War era have been accompanied by steady increases in drug use, sex work, and related HIV infection. The number of countries reporting HIV among injecting drug users has more than doubled in the past decade, from 52 in 1992 to 114 today (Strathdee and Poundstone 2003). While exact figures remain difficult to obtain, IDUs now account for as many as 10 percent of all global HIV infections (UNAIDS 2002). UNAIDS estimates suggest that outside of Africa, more than one of every three new infections comes from a contaminated needle. Individuals at greatest risk include those already among society's poorest and most marginalized: ethnic minorities, migrants, unemployed youth, and those exchanging sex for survival.



## Synergies of HIV and informal economies

Discussions of drug use and sex work often position them as the result of moral failings or existential crisis on the part of individuals unable to cope with rapid social change. This approach is historically consistent with HIV education approaches generally, which frequently produce accounts that range from the level of the microscopic (“AIDS is caused by a virus carried in blood and semen—it does not discriminate”) to the individual (“complacency causes people to have risky sex” or “despair causes people to inject drugs”). [See, for example, Centers for Disease Control and Prevention 2002; UNAIDS 2002]. The disproportionate toll of injection-driven HIV infection among the poor, however, and the distinct geography of injection drug use, suggest that uneven economic development must also be seen as a primary engine for drug use, sex work, and HIV transmission. Thus the frequently cited fact that there are thousands of teenage IDUs in the countries of the former Soviet Union is made more comprehensible by a corresponding, less often mentioned fact—by 1999, an estimated 18 million people in the region between the ages of 15-24 were unemployed and did not attend school (UNICEF-ICDC 1999). Spikes in syphilis and other sexually transmitted diseases that sharply increase risk of HIV infection, common in the countries of the former Soviet Union and in China, have followed privatization of health services and a demand—unmeetable for many—that people pay for their own health care (Brown and Rusinova 2000; Powell 2000; UNAIDS 2002).

The points of rapid economic transition are often those where HIV increases fastest. Sociologist Manuel Castells, describing the rise of financial and informational networks linking new elites across national borders, has noted the parallel emergence of what he terms “black holes,” areas with no access to key nodes on the network. Often subject to sharp reductions in government health and social services as the state redirects resources toward new economic priorities, people in these regions—whether in certain neighborhoods of capital cities, or in entire segments of countries or continents—turn instead to informal or “perverse” economies (Castells 1991): arms dealing, smuggling, illicit drugs, selling of sex, children, or even body organs. Through this lens, the spread of sex work and drug-trafficking in cities whose Soviet-era industrial base collapsed with the Soviet Union itself, or the widespread sale of blood by residents of counties in central China, can be seen as economic adaptation in regions left off the grid of global economic interchange. As perverse economies develop, so too do STD and HIV epidemics (Parker 2000).

Areas receiving a sudden influx of goods and labor similarly experience sharp increases in HIV and STDs. The Northern Shan State in Burma<sup>2</sup>, where as many as 500,000 migrant workers arrive each year to work in jade and ruby mines, is the site of widespread heroin use, sex work, and infection with STDs and HIV (UNAIDS/UNODCCP 2000; Reid and Costigan 2002). High HIV infection rates have been noted in many of the free trade zones of the newly globalized, post-Cold War economies, whether in the “free-economic zone” of Kaliningrad in Russia, the “special economic zone” linking Vietnam and Pianxiang City in China, or the “golden quadrangle” envisioned by the Asian Development Bank to strengthen economic relations and sharing of resources between Thailand, Laos, Burma, and China. As borders open, and transnational highways and trade agreements link countries and cities, drugs and sex workers are among those “goods” circulating with increasing speed. Again, as they move, so does HIV (Parker 2000).

The global movement of one internationally marketed commodity—heroin—is particularly important to understanding trends in IDU-related HIV infection. Technology able to trace the specific genotypes of HIV with which people are infected has made it clear that HIV epidemics closely follow drug trafficking routes out from Burma, Laos, and Afghanistan, the world’s three largest producers of opium (Zheng, Tian et al. 1994; Beyrer, Razak et al. 2000; Beyrer 2003). Increasingly, heroin trading, and the drug use and needle sharing that follow them, have come to represent a map of the hotspots of new HIV infections.

## **Injecting drug use and the global AIDS epidemic**

The world’s fastest growing HIV epidemics, and the majority of those identified as “next wave” epidemics poised to explode, are fueled primarily by injecting drug use.

- ▶ In the Newly Independent States of the former Soviet Union, where economic dislocation and newly open borders have been coupled with increased flow of heroin from neighboring Afghanistan, HIV infections have increased more rapidly than anywhere else in the world in recent years (UNAIDS 2000; UNAIDS 2001).
- ▶ In Central Asia, through which as much as half the narcotics produced in Afghanistan pass en route to markets in Russia and Europe, the HIV epidemic is relatively small but exploding. Almost as many HIV cases were detected in

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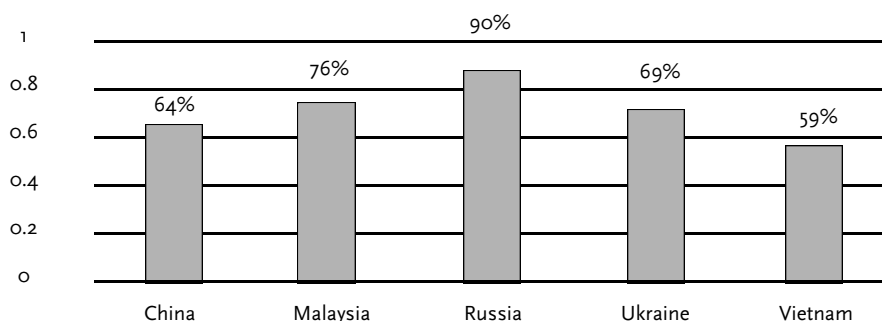
2. The name Myanmar is preferred by the current government of the country, while Burma is preferred by those who do not recognize the regime’s legitimacy. This publication uses Burma unless referring specifically to the Myanmar government.

Uzbekistan in the first half of 2002 than in the previous 10 years combined, and 60 percent of all cases are among IDUs (CEEHRN 2002; UNAIDS 2002). The Kazakhstan government estimates that there are 25,000 people living with HIV in the country, 80 percent of whom inject drugs (CEEHRN 2002; Human Rights Watch 2003).

- ▶ There are now an estimated 1.4 million people with HIV living in Russia and Ukraine—more than in all of North America. Ukraine, with as many as 400,00 infected, has become the first country in Europe to reach 1 percent HIV prevalence (Malinowska-Sempruch, Hoover et al. 2003). HIV cases in Russia tripled from 2000 to 2003. Virtually all those with HIV in both countries were infected in the past 10 years, and more than 80 percent of them are under age 30. More than 90 percent of those in Russia, and 69 percent of those in Ukraine, were infected through injection as of 2002 (CEEHRN 2002; USNIC 2002; Malinowska-Sempruch, Hoover et al. 2003; U.S.-Russia Working Group 2003, UNAIDS 2003).
- ▶ In China, a country deemed pivotal to the future of HIV in Asia (Piot 2001), the opening of borders and the flow of heroin up from the “golden triangle” of heroin producers in Burma, Thailand, and Laos have coincided with sharp spread of HIV. Today, the Chinese government estimates that as many as one million are HIV-infected, and UNAIDS places the upper boundary closer to 1.5 million. While the full scope of those infected due to faulty collection practices at blood centers in central China is yet to be assessed, an estimated 64 percent of HIV cases in the country are among IDUs. The number of officially registered drug users reached one million in 2002, and estimates suggest the number of drug users may be closer to three million. The vast majority are under 30. In the southern provinces of Yunnan, along the mountainous border with Burma, as many as 80 percent of IDUs are already HIV-positive (Asian Harm Reduction Network 2002; Reid and Costigan 2002; UNAIDS 2002; Human Rights Watch 2003; WHO Western Pacific Region 2003).
- ▶ In Vietnam, which produces a small amount of opium itself and borders the much larger heroin producer of Lao PDR, 59,200 HIV cases had been reported as of March 2002. Actual numbers were thought to be closer to 122,000. Some 59 percent of HIV cases were among IDUs in 2002 (Hing 2003).
- ▶ Malaysia, which shares a border with Burma and is a bridge for heroin bound for Australia, had its first reported case of HIV in 1986, and by 2002 had registered more than 51,000 infections. Seventy six percent of them were IDUs (Malaysian AIDS Council 2003).

- ▶ In Burma, the world's second largest producer of heroin, the majority of cases are not related to injection. The number of overall infections, however, and the fact that HIV prevalence of IDUs in some states is among the highest in the world, merits special consideration. In 2001, an estimated 90 percent of IDUs in the province of Myitkina were infected with HIV, and there are as many as 250,000 IDUs in the country. UNAIDS estimates that 510,000 adults were HIV infected by 2001, while other epidemiologists have concluded that as many as 687,000 are infected without even including IDUs and sex workers. Some 30 percent of total infections are thought to be the result of contaminated injection equipment (Reid and Costigan 2002; UNAIDS 2001; Beyrer, Razak et al. 2003; Dorabjee 2003).

FIGURE 1 IDUs as Percentage of All Registered HIV Cases, 2002, Countries with Established HIV Epidemics (> 50,000 HIV cases)



Sources: Chinese Centre for Disease Control and Prevention of the Government of the People's Republic of China, Malaysian AIDS Centre, CEEHRN (Russia, Ukraine), Vietnam Ministry of Health

## Speed of spread

Injection-driven epidemics are also distinguished by the extreme rapidity of their spread. Social and environmental factors perpetuate the isolation of drug users in small, isolated networks and encourage injection and sharing of needles. Law enforcement efforts restricting opium supplies lead users to shift to heroin use, or from smoking to injection. Criminalization of needle possession encourages use of shooting galleries or contaminated injection equipment. Social practices also shape injection: IDUs in Burma, Vietnam, and Malaysia use the services of professional injectors, while those in the former Soviet Union purchase pre-loaded, and

sometimes contaminated, syringes. IDUs in some cities prepare injectable solutions together, drawing their solution from a communal pot or a single large syringe. All of these practices may contribute to accelerated rates of HIV infection, or conversely, can offer opportunities for reduction of HIV risk (Ball 1998; Grund 2001; Ball and Crofts 2002; CEEHRN 2002; Rhodes, Mikhailova et al. 2003). While epidemics among IDUs have been successfully contained through measures such as provision of sterile injection equipment, early intervention is critical: once prevalence exceeds 5 to 10 percent among IDUs, overall infection rates frequently climb as high as 50 percent in fewer than five years (Rhodes, Stimson et al. 1999). The rapidity of spread among IDUs means that any delay in implementation of HIV prevention interventions carries particularly serious consequences.

- ▶ In Svetlagorsk, Belarus, one year after the first reported case of HIV, 67 percent of IDUs were estimated to be infected (Dehne and Kobyscha 2000).
- ▶ In St. Petersburg, Russia, prevalence among IDUs was estimated at 0.3 percent in 1998, but had risen to 19.3 percent by 2000 (Dehne and Kobyscha 2000).
- ▶ In Chiang Rai, Thailand, HIV prevalence among IDUs increased from 1 percent in 1988 to 61 percent in 1989 (World Bank 1997).
- ▶ In Temirtau, Kazakhstan, prevalence among IDUs went from 0 percent to 15 percent in a single year (UNAIDS 2002).
- ▶ In Ili prefecture (Xianjiang, China) reported rates of HIV infection among IDUs were 9 percent in January 1996. By August, 76 percent of IDUs were infected (UNAIDS/ UNODCCP 2000; Reid and Costigan 2002).
- ▶ In Manipur (India), the first case of HIV among IDUs was detected in 1989. Six months later, prevalence among IDUs had increased to 50 percent (World Bank 1997).

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Methadone remains a Schedule I drug, as it has since 1961, in spite of significant research showing its positive effect in decreasing rates of injection, HIV transmission, and criminal activity.

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## 2. Dis-United Nations: Competing Approaches to Policy on Illicit Drugs and HIV

Calls for global responses to the HIV/AIDS epidemic are increasingly framed in terms of *human rights*, and by emphasis on the importance of *evidence-based approaches*. The UNAIDS World AIDS Campaign in 2002-2003, for example, aimed at fighting HIV-related stigma, enjoined individuals and institutions to treat people with HIV with compassion rather than with hostility, and supported the rights of those infected to privacy, liberty of movement, equal access to education, housing, health care, and equality before the law (UNAIDS 2003). In a trend coincident with the new dominance of corporate-based philanthropies (the Bill and Melinda Gates Foundation) and “private-public partnerships” (the Global Fund to Fight AIDS, Tuberculosis and Malaria) in setting the global AIDS agenda, HIV policy papers routinely underscore the importance of “evidence-based” approaches, “proven effectiveness,” and “value added.” The hope is that appeals to science and free market principles will transcend the moralism that has made condoms, clean

needles and methadone, and the programs that provide them, the subject of so many years of conflict.

These assertions, however valid, must be measured against other, less discussed truths. As with the work of Sir Isaac Newton, whose age-of-reason breakthroughs coincided with alchemical experiments he conducted in a private laboratory, HIV prevention is in some important sense a project divided: exalting scientific principles even as it leaves other less-than-rational beliefs unquestioned. Indeed, for all the talk of evidence-based approaches, there is an insidious alchemy at work—a process by which certain people with HIV, or those at risk, are transmuted into something less than human, and thus deserving of something less than human rights. AIDS stigmatization is widely condemned when expressed in its crudest incarnations, as when Gugu Dlamini was beaten and stoned to death in KwaZulu Natal after disclosing her HIV status in 1998. Less examined are the more subtle acts of violence, common in the hallways of national governments or multilateral institutions, by which certain people are sentenced to death simply by being deemed unworthy of particular attention.

The tension elicited in most listeners by the phrase “the human rights of drug users”—and its absence in virtually all United Nations or national plans articulating HIV policy recommendations—suggest how rarely general statements about the rights of people with HIV have been extended specifically to IDUs. Rather, two other frameworks have defined national and international responses to injecting drug use, drug users, and HIV infection. The first of these is a *law enforcement framework* that seeks to track, restrict, or eliminate illicit drugs, and those who sell or buy them, from social circulation. In this framework, primary emphasis rests on supply of and demand for drugs—drug users are understood and responded to as participants in illegal patterns of exchange. Emphasizing criminalization and containment, this framework identifies police action, interruption of trafficking, and penal institutions such as prisons as pivotal to effective response. Even when drug treatment is offered, it is treatment cast in the mold of punishment: coercive, lacking in virtually all supportive services save the “service” of intense discipline and forced labor without compensation, and carrying severe penalties for relapse. Not surprisingly, relapse is the experience of the vast majority.

The second approach is one that emerges from a *public health framework*, or more specifically, that school of public health able to recognize drug users as part of the deserving public. This approach focuses on risks rather than on the drugs themselves, considering both adverse health effects and the range of people affected. These include drug users as well as their sexual partners, their children, and their

extended families or communities. Similarly, this approach recognizes that all illegal drug use does not carry equal risk, identifies mediating factors that increase drug risk and related disease, and seeks to identify the tools and interventions that might best contain adverse health effects among the largest number of people. These include interventions for those drug users who are outside correctional or drug treatment systems, or those who have returned to drug use after a period of abstinence. In all countries, the majority of drug users remain outside treatment or penal systems.

These two frameworks often sit in uneasy relation to each other, both at the national level and within multilateral institutions charged with responding to drugs and HIV/AIDS. The tensions between the criminal enforcement and the public health approaches to illicit drugs and AIDS are particularly evident in the workings of the institution spearheading the international response to both the problems of drug trafficking and the skyrocketing rates of HIV infection: the United Nations.



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Neither WHO nor UNAIDS has worked with bilateral donors or recipient governments to bring a single harm reduction program to national scale in Asia or the former Soviet Union.

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### 3. International Policy Responses to Illicit Drug Use and HIV

#### UN Drug Control Initiatives: Drug Policy in the Context of Enforcement and Containment

##### **UN drug control conventions**

The unusual policy status of illicit drug use is made clear by the fact that it is one of the few public health issues to be governed by international agreements that direct signatories on how to regulate and respond to the problem. Three protocols known collectively as the UN Drug Conventions—the 1961 Single Convention on Narcotic Drugs as amended in 1972, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances—guide the global, and in many cases, national regulation of illicit drugs. One or more of these conventions, which carry the force of law, have been

ratified by 179 nations, including all those in the former Soviet Union and Asia where injecting drug use is the primary mode of HIV transmission.

The Single Convention of 1961 is so named because it replaced a patchwork of international agreements that had regulated international trade and use of drugs throughout the first five decades of the twentieth century (Walsh 1988; Bewley-Taylor 2002). Classifying more than 115 substances based on danger of abuse, dependence and medical benefit, the Single Convention mandated production of, trade in, or use of scheduled drugs exclusively for “medical and scientific” needs, set global targets for how much legal opium or coca needed to be produced to meet such needs, and required states to prevent production or diversion of drugs into illegal markets (United Nations 1971; Bewley-Taylor 2002). The 1971 convention expanded the roster of scheduled drugs by more than 100, adding LSD, methamphetamine, and a host of other more commonly prescribed psychotropics to the list of controlled substances (Room 2003). Licensing and targets for legal production of substances scheduled by the two treaties, as well as monitoring of efforts to prevent their diversion to illegal markets, is the responsibility of a “quasi-judicial” body known as the International Narcotics Control Board (INCB), a 13-member group of law enforcement, psychiatrists, pharmacologists, and other experts empowered by the 1961 convention (as amended in 1972) to assess how well countries were complying (INCB 2003).

The 1988 convention added “precursor chemicals” used for manufacture of illicit drugs to the list of controlled substances, and created a host of measures regulating fiscal matters such as money laundering and seizure of assets. More importantly, it expanded the scope of the conventions to clearly include restrictions on demand as well as supply. All signatories are required to criminalize “possession, purchase or cultivation of narcotic or psychotropic drugs for personal consumption.” The 1988 convention also requires that inciting someone else to use illicit drugs be made illegal (United Nations 1988).

## **UN drug conventions in theory and practice**

In theory, the language of the conventions is flexible enough to accommodate a range of public health responses to illicit drug use, and to allow countries to tailor responses to national realities (Bewley-Taylor 2002). The 1971 convention requires that parties not only act to discourage drug use, but also that they take all practicable measures “for the early identification, treatment, education, aftercare, rehabilitation, and social integration” of those who use illicit drugs (United Nations 1971). While requiring criminalization of drug possession for personal use, the 1988

convention does not specify what penalties must be attached, leading some to suggest that counseling or issuing of citations that are not recorded in permanent police records would fulfill the letter of the law (Krajewski 1999; Room 2003). In addition, the 1988 convention specifies the primacy of efforts to minimize human suffering related to drug use, and reiterates that treatment, education, aftercare, and rehabilitation are acceptable alternatives to punishment (United Nations 1988).

In practice, however, the entities charged with interpreting the conventions have routinely emphasized stringent enforcement and protection of the status quo. The INCB issues pointed criticisms in its annual reports of countries perceived to be doing too little to regulate drug diversion or production; quality and availability of drug treatment, by contrast, goes largely unmonitored and unmentioned (INCB 2001; INCB 2002). Western European measures to reduce criminal penalties for cannabis use, now adopted in Spain, Portugal, the Netherlands, and part of London, for example, have been criticized by the INCB as sending the wrong message and “endangering all eradication efforts, including those outside of Europe” (INCB 2002). The Board also objects strenuously to the proliferation of policies and messages “encouraging drug abuse,” which in its view include the publication of favorable research on use of cannabis in medical journals, the proliferation of popular songs about drugs, and even the inclusion of hemp in food or beverages, which they feel erroneously suggest that the plant might be “edible or nutritious” (INCB 1998). INCB members have gone as far as to suggest that politicians who campaign for more liberal drug policy may be liable for criminal prosecution for violation of convention restrictions against inducing or inciting illicit drug use (INCB 1998).

The INCB’s own language is carefully chosen. They refer only to drug abusers, emphasizing that all illicit drug use, by virtue of its legal status, is abuse. They describe those lost to addiction as “casualties,” suggesting that active drug users are in important ways as good as dead. They condemn “normalization” of any illicit drug, thus reinforcing the idea that drug abusers must be regarded per se as abnormal (INCB 2002). Recognizing that these are contested claims, they preemptively challenge experts who might differ, using quotation marks around phrases such as “medical marijuana” and “harm reduction” (INCB 1998; INCB 2002). Their analysis links interventions that in context need not necessarily be connected: syringe exchange is routinely paired with safer injection rooms, injection rooms to drug decriminalization, and decriminalization to drug legalization (INCB 1998; Schaepe 1999; INCB 2002; Room 2003).

While INCB members technically represent only themselves, governments find voice through the Commission on Narcotic Drugs (CND), the elected body responsible for guiding UN drug policy. Including European nations who have

strategically decriminalized petty drug use, CND meetings have begun to feature passionate debate in favor of less punitive approaches. To date, however, CND donors favoring zero-tolerance approaches, including the United States and Sweden, have ensured that the conventions are interpreted in the strictest possible light (Fazey 2003). U.S. unilateralism and longstanding American ambivalence to the United Nations combine to find strange synergy at CND meetings: because UN rules permit only fully-paid members to vote, and because the United States is behind on UN dues but too large a donor to be ignored, the CND has suspended voting in favor of a consensus process where objections from a single member state can stall proceedings for days (Fazey 2003). The result is reinforcement of the status quo. While drugs have been added to those scheduled by the conventions, the conventions themselves have remained unchallenged and unchanged.

The entity responsible for coordination of drug supply and demand reduction programs on the ground, the United Nations Office on Drugs and Crime (UNODC), dispatches millions of dollars annually and a wide range of scientific, military, and police experts to assist in international counternarcotics efforts. High-profile initiatives have included help in drafting strong laws on money laundering and asset seizure, arming counternarcotics forces, establishing special courts to prosecute narcotics trafficking or consumption, training and equipping guards at railway stations and national borders, and promoting the use of drug sniffing dogs (Lubin, Klaitz et al. 2002). UNODC also supports a range of drug demand reduction efforts, including drug education materials, training and support for community educators, as well as alternative development assistance to help farmers change from cultivation of opium poppies or coca to other crops. With a budget for supply reduction that has historically been nearly three times that of drug demand reduction (CND 1999), however, and more than \$1 billion spent separately by the U.S. government for counternarcotics operations including fumigation of fields with toxic herbicides and arming of local law enforcement with high-tech weapons of detection and destruction (ONDCP 2003; TNI 2003), these in many cases have been understood as alternatives that cannot be refused. In Central Asia, the UN also supported an experimental biochemical research program to engineer a new fungus capable of destroying the opium crops in Afghanistan (Lubin, Klaitz et al. 2002).

Similar scientific innovation has not been brought to bear on evaluation of drug control efforts. UNODC canceled internal evaluation of programs in 1997 (Lubin, Klaitz et al. 2002). Questionnaires to national governments focus on drug trends and measures undertaken to increase seizures or improve controls on money laundering, rather than on assessing whether these are making any difference (Transnational Institute 2003). UN drug control agencies themselves acknowledge

that both opium and coca production have increased significantly since the adoption of the 1988 convention (UNODCCP 2002). Efforts to reduce crop production have been consistently offset by technological advances enabling greater drug yield from plants harvested (UNODC 2003). Nor has evidence supported efficacy of demand reduction efforts such as the International Day Against Drugs, which the UN supports, and which countries from China to Thailand commemorate annually with bonfires of seized drugs, mass arrests, and public executions (Nakachol 1997; AP 2001; AP 2002).

Even without evidence of effectiveness, UN drug control entities have successfully guided UN member states toward the conclusion that the only strong response to drug use is a strongly punitive one. In 1994, a special UN advisory group on drug policy advanced a proposal for a United Nations General Assembly Special Session (UNGASS) on drugs, which some envisioned as an opportunity to consider alternative approaches to prevention and treatment and a review of the adequacy of definitions in the UN drug conventions (Transnational Institute 2003). When the proposal emerged from the homogenizing machinery of UN deliberations, however, suggestions for revision had been replaced by the language of affirmation. The Secretary General reported that the special session “could reiterate the importance of the international drug control treaties...and reaffirm their relevance and accuracy” (United Nations 1996). The UNGASS was convened in 1998 under UNODC director Pino Arlacchi’s slogan “A Drug Free World–We Can Do It!,” and secured pledges from participants to eliminate or significantly reduce drug trafficking and use by 2008 (INCB 1998; UN General Assembly 1998). While specifics of how this might be achieved were left to the discretion of individual countries, observers were alarmed to note that a subsequent UNODC report cited the drug demand reduction “successes” of Maoist China and Khomeini’s Iran without mentioning that those efforts had included trials without due process, and summary executions (Trebach 2002).

## **National interpretation of UN drug conventions**

Whether or not they are a cause or convenient excuse, UN drug conventions are used by national governments to justify highly punitive legal measures and failure to implement services for IDUs. Russia has pointed to the UN for explanation of its punitive drug policies, with Interior Minister Boris Gryzlov telling the State Duma that “Total prohibition of illicit drug use is not our own initiative...but rather a responsibility to implement the UN Drug Conventions of 1961, 1971, and 1988” (as cited in Malinowska-Sempruch, Hoover et al. 2003). Russian pharmacologist

Edouard Babayan, Russia's representative to the CND for nearly 30 years and current member of the INCB, has repeatedly referenced these two UN drug control bodies to support the Russian government's decision to keep methadone illegal in Russia (Levinson 2003). Similarly, a UN survey of government officials in seven Asian countries noted that one of the reasons given for lack of substitution therapy was the belief that methadone was prohibited by the spirit or letter of the conventions (UNAIDS/UNODCCP 2000).

There are of course governments who have forged ahead with substitution therapy, as well as with heroin prescription or safer injection rooms. All of these, however—including Australia, Germany, Great Britain, and the Netherlands—are members of the Western European and Other Governments (WEO) group that provides the bulk of UN finances, and so may feel themselves less vulnerable to censure. INCB commentary, in any event, has been clear and insistent that such measures are to be discouraged in all countries.

Governments have also used cooperation with UN drug control entities to suggest tacit or explicit approval of more widespread political repression. The Myanmar government, after a brutal suppression of Burma's pro-democracy movement that caused many countries to sever relations with the regime, reported with great fanfare the opening of a UN drug control office, and has since immortalized the collaboration in the massive Drug Elimination museum opened on the UN's International Day Against Drugs (Myanmar Central Committee for Drug Abuse Control 2003). The Taliban regime in Afghanistan requested, and received promises for, aid from UNODC, though the events of September 11, 2001 and their aftermath moved the UN agency to delay implementation (Armenta and Jelsma 2001). Most recently, at the height of a 2003 campaign that included mass arrests and what appeared to be extra-judicial execution of drug users, headlines in the Thai press announced that the UNODC director had praised Thailand's successful narcotic control efforts following a visit with Thai representatives (Thai Press Reports 2003; Xinhua News Agency 2003).

### **The UN drug conventions and reduction of drug-related harm**

The impact of the UN drug conventions—and the widespread incarceration and resistance to innovation justified in their name—requires special review in light of the HIV epidemic. Increasingly, advocates have questioned the adequacy of conventions regulating international response to drugs that reflect no awareness whatsoever of HIV (Malinowska-Sempruch, Hoover et al. 2003; Rossi 2003). The first two conventions predate the HIV epidemic entirely, and the third was approved

before widespread awareness of the role injection drug use would play in driving the epidemics of the former Soviet Union and Asia.

Legal analysts within and outside the UN system have noted that measures to reduce the spread of drug-related HIV infections, including distribution of clean syringes, can be interpreted as legal under the conventions, which call for alleviation of human suffering, exempt appropriate medical interventions from criminalization, and specify that demand reduction should aim both at preventing the use of drugs and at reducing adverse consequences of drug use (Bewley-Taylor 2002; INCB 2002; Fazey 2003). These interpretations, however, have been regularly rejected by the INCB, which as early as 1993 deemed harm reduction a “tertiary strategy” for prevention for demand reduction purposes (INCB 1993), and in 2000 expressed regret that harm reduction had “diverted the attention (and in some cases, funds) of Governments from important demand reduction activities such as primary prevention or abstinence-oriented treatment” (INCB 2000). Methadone remains a schedule I drug (“especially serious risk to public health and limited, if any, therapeutic usefulness”), as it has since 1961, in spite of significant research showing its positive effect in decreasing rates of injection, HIV transmission, and precisely the kinds of criminal activity the INCB is most interested in suppressing. The INCB has also been sharply critical of medical prescription of heroin undertaken by Switzerland, and threatened to revoke Australia’s ability to cultivate opium for medical purposes upon learning of plans to implement safer injection rooms to reduce risk of HIV and hepatitis C (Fazey 2003). Denmark reversed plans for safer injection rooms after INCB criticism. INCB Secretary Herbert Schaepe went as far as to compare injection rooms to opium dens in 1999, and to suggest that those implementing such interventions might be considered to be facilitating criminal offenses including drug possession and trafficking (Schaepe 1999).

In September of 2002, INCB asked UNODC legal experts to consider whether harm reduction measures were consonant with the conventions. The experts noted three important features of the conventions that could justify drug substitution therapy, safer injection rooms, and syringe exchange. First, all of these measures could be seen as medical treatment, and permissible under the conventions. Second, the conventions urged reduction of drug use and its adverse consequences, which clearly include HIV, thus potentially justifying measures to reduce infection. Finally, the conventions prohibited intentional incitement to or encouragement of drug use, and none of the harm reduction measures could be said to be performed with the intent of incitement of greater drug use (INCB 2002). Three months later, INCB President Philip Emafo stated in an official UNODC publication that “giving out of

needles” and “provision of rooms for drug abusers to inject themselves” amounted to inciting drug abuse, and was contrary to the conventions (Rahmy 2002).

The inadequacy of the conventions to address drug-related HIV infection has moved UN entities and outside observers to issue resolutions of concern and urge changes in course. A 2001 UN system-wide paper meant to “harmonize” the UN’s position on HIV prevention for drug users stated clearly that syringe exchange programs and opioid substitution therapy were acceptable parts of a wider package of drug prevention interventions (UN 2001), and UNODC subsequently began to offer limited support for both. In March 2002, the CND itself issued a resolution that expressed “alarm” about HIV, encouraged members states to consider HIV and hepatitis C, and to remember the need both for access to HIV treatment and sterile injection equipment when developing programs to reduce drug demand (CND 2002). A year later, just prior to the April 2003 CND session held to mark the halfway point between the 1998 UNGASS on drugs and the 2008 goal of significant and measurable drug reduction, Greece used its presidency of the European Union to convene a high-level meeting on international drug policy. Including representatives of the European and Greek Parliaments, NGO representatives, the European Commission, as well as researchers, scientists and UNODC staff, the conference affirmed the usefulness of the UN drug conventions, but noted that they could be improved by explicit support for harm reduction provisions and affirmation that drug users are not criminals but people in need of help and treatment (Hellenic Presidency of the European Union 2003).

None of these resolutions or small steps toward policy change, however, has the force of law. Nor apparently, have they carried sufficient force of persuasion. The April 2003 meeting of the CND was held as scheduled to review progress toward a drug-free world and to consider new strategies for progress, including proposals to support opioid substitution therapy and urge removal of legal obstacles to clean needle availability. Objections from the United States, as well as Russia, Ukraine, Malaysia, and a number of Arab states, torpedoed or tabled all language related to harm reduction. When the final resolutions were adopted, all mentions of substitution therapy or legalization of syringe exchange had been deleted (CND 2003). A separate resolution by the Commission issued a plea for UN member states to show enhanced cooperation with the INCB (CND 2003).

The INCB itself is not immune to change. In April of 2001, in a rebuke that some observers said had as much to do with U.S. recalcitrance on international treaties such as the Kyoto Protocol as with the war on drugs, UN members voted the U.S. representatives off both the Human Rights Commission and the International



Narcotics Control Board. The United States subsequently increased its pledges to UNODC by 45 percent, becoming the single largest supporter of UN drug control in 2003, and successfully fielded a candidate to replace a departing INCB delegate from Mexico. In the long run, however, shifting geopolitical dynamics may threaten the dominance of the zero-tolerance approach. The INCB report, due out in March of 2004, is expected to be more conciliatory toward harm reduction measures such as syringe exchange and substitution therapy.

## UN HIV Initiatives: Drug Policy in the Context of Public Health

As UN drug control entities urge governments to take punitive actions to deal with illicit drugs, other UN actors are assessing the problem through the lens of public health. Principal among these are the UN entities most concerned with HIV/AIDS prevention among IDUs—the World Health Organization and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Emphasizing the risks associated with drug use, rather than its legal status per se, WHO and UNAIDS focus less on use of recreational drugs, and more on drug injection and exchange of sex for drugs implicated in transmission of HIV, hepatitis C, and other infectious diseases. Drawing on social science literature, they emphasize a range of interventions, including harm reduction interventions, for reducing the spread of disease. Emphasizing vulnerability rather than criminality, they stress the importance of including those at risk—including active drug users—in formation and implementation of humane policy. “Experience tells us that cooperation with drug users gets better results than persecuting them,” noted UNAIDS director Peter Piot in his April 2003 address to the CND (Piot 2003).

How committed WHO and UNAIDS are to translating these principles into practice is unclear: neither, for example, has objected to overcriminalization of drug users by UN drug control entities, or convened an expert consultative group to identify perceived and actual tensions with UN drug control conventions or suggest strategies to resolve them. More importantly, neither WHO nor UNAIDS has worked with bilateral donors or recipient governments to bring a single harm reduction program to national scale in Asia or the former Soviet Union.

## Inconsistencies in UN policy recommendations

A superficial harmony has been forged at the rhetorical level throughout the UN system—all UN actors, for example, support “comprehensive” interventions for those using illicit substances, and urge “greater political commitment” to the problem. At the practical level, however, the difference in emphasis between United Nations drug control entities (e.g., INCB and CND) and health promotion entities (e.g., WHO and UNAIDS) results in sharp inconsistencies in policy recommendations. UNODC, a co-sponsor of UNAIDS since 1999 and a part of the drug control apparatus, hovers uncomfortably in between.

Among the most striking areas of inconsistency:

- ▶ *Substitution therapy.* The CND and INCB regard methadone, among the most affordable and best studied of available substitution therapies, as a schedule I substance with high abuse potential and limited medical use. UNODC drug demand reduction efforts for years included no support for opioid substitution therapy, though the agency now offers extremely limited support in a few countries. Representatives of UN health promotion agencies, by contrast, regularly advocate for substitution therapy under appropriate medical supervision as part of an effective response to HIV.
- ▶ *Harm reduction.* UN drug control representatives speak of harm reduction as linked to drug legalization efforts, remind governments that it is no substitute for drug demand reduction, or in UNODC’s case, avoid the term entirely. UN health promotion representatives stress that harm reduction is a scientifically tested approach that, while critical to helping to contain the spread of HIV, has yet to be sufficiently implemented by national governments.
- ▶ *Syringe exchange.* While supporting increased access to sterile injection equipment in a 2002 resolution, the CND torpedoed a resolution to remove legal obstacles to syringe exchange programs under pressure from the United States in 2003. UNODC was for years barred from funding needle exchange due to objections from the United States (Fazey 2003), and today offers only limited support. The INCB president has suggested that giving out syringes is equivalent to encouraging illicit drug use. UNAIDS and WHO, by contrast, have expressed consistent support for programs providing sterile injection equipment to reduce HIV infections.

- *International mandate.* Drug control entities refer regularly to the UNGASS on drugs, where participants agreed to significantly reduce or eliminate drug use by 2008, as proof of international consensus on drug control. Health promotion entities reference the 2001 UNGASS on HIV/AIDS, where all member governments of the UN endorsed specific efforts to reduce HIV transmission that included provision of sterile injection equipment and other harm reduction efforts.

**TABLE 1     Contrasting Approaches Within the United Nations**

<b>Drug Control</b>	<b>versus</b>	<b>Public Health</b>
<p>A drug-free world–We can do it!</p> <p>(Pino Arlacchi, Director, UN Office on Drug Control and Crime Prevention, 1998)</p>		<p>The total and immediate elimination of drug injecting is...unlikely to be an achievable goal.</p> <p>(WHO, <i>Principles for Preventing HIV Infection among Drug Users</i>, 1997)</p>
<p>The discussion on drug injection rooms and some other harm reduction measures has diverted the attention (and, in some cases, funds) of Governments from important demand reduction activities.</p> <p>(INCB <i>Annual Report</i>, 2000)</p>		<p>The translation of well-accepted harm reduction theory into harm reduction reality is held back by lack of social and political will.</p> <p>(Catherine Hankins, Associate Director, UNAIDS, 2002)</p>
<p>The term use or consumption should only be applied when it refers to the use or consumption of drugs for medical or scientific purposes....Drug abusers are therefore, by definition, neither consumers nor users.</p> <p>(INCB <i>Annual Report</i>, 2001)</p>		<p>Without the involvement of drug users themselves there can be no ongoing behavioral change and effective HIV prevention among that group. It is crucial to implement HIV preventive activities on the basis of the peer support principle, involving people from the drug using community.</p> <p>(UNODC, <i>Lessons Learned</i>, 2001)</p>

Drug Control	versus	Public Health
<p>To promote drug use illicitly through the giving out of needles...would to me amount to inciting people to abuse drugs, which would be contrary to the provisions of the convention.</p> <p>(INCB President Philip O. Emafo, 2002)</p>		<p>When working with people who inject drugs, it is important to focus on harm reduction as well as rehabilitation...[and to] adopt a multi-pronged approach including needle and syringe exchange...and substitution pharmacotherapy</p> <p><i>(Innovative Approaches to HIV Prevention, UNAIDS Best Practice Collection, 2000)</i></p>
<p>Based on the belief that the deliberate use of drugs for non-medical purposes leads to the destruction of the mind and the body, the Swedish drug control policy has as its objective a society that should be free of the evils of drug abuse...to achieve this ultimate goal, a drug free society, a variety of measures are applied...prevention, treatment, and repressive measures.</p> <p>(Ambassador H.S. Okun, Rapporteur of the INCB, 1998)</p>		<p>Laws and policies that prevent drug users from accessing services must be changed. Practices that instill fear and inflict punishment on people vulnerable to HIV infection must be transformed. Stigma and discrimination that drive drug users underground and undermine prevention efforts must be eliminated.</p> <p>(Kathleen Cravero, Deputy Director, UNAIDS, 2003)</p>
<p>UNDCP has yet to adopt an official position on harm reduction.</p> <p>(UNDCP Legal Affairs Section, 2002)</p>		<p>The United Nations fully endorses the fundamental principles of harm reduction: reaching out to injecting drug users, providing sterile injecting equipment and disinfectant materials, and providing substitution therapy</p> <p>(Catherine Hankins, Associate Director, UNAIDS, 2002)</p>

## HIV Treatment, Drug Users, and the UN

WHO's declaration of a "treatment state of emergency" in a special session of the United Nations General Assembly in September 2003, and the announcement of a plan to provide HIV treatment to 3 million people worldwide by 2005, sealed the increasingly irrelevant debate about whether international HIV efforts should prioritize prevention or treatment. With consensus supporting the notion that HIV prevention and treatment can and must complement each other, the question remains how to deliver the triple-combination antiretroviral therapy (ARV) considered the standard of care to countries that cannot afford it. The creation of the Global Fund to Fight AIDS, TB, and Malaria, price reductions for brand-name combination therapy through the UN's Expanded Access program, the manufacture and marketing of generic therapy for as little as \$300 a year, and increases in contributions by donor nations for scaled-up treatment efforts have all provided momentum for ARV in resource-poor settings than might have seemed unimaginable a decade ago. Given the relative lack of attention to questions of treatment access for drug users, transformation of the mechanisms to address the question of how to allocate HIV treatment to those in need is also urgently needed.

Policy guidance on the question of how best to offer HIV treatment to drug users is particularly important for countries with injection-driven epidemics, whose ambivalence about drug use may influence national commitment to HIV treatment more generally. UN drug control entities have remained silent on whether HIV treatment is part of the treatment or after-care envisioned by the drug control conventions, a stance consistent with their more general silence about the specifics or quality of treatment for addiction to be offered under the protocols. UN health entities have been clear about the efficacy of HIV treatment for injection drug users and their right to receive it, if vague on efforts to ascertain whether this is actually being done. WHO's guidelines for ARV treatment, for example, state unequivocally that treatment should be available for all, including users of injection drugs (WHO 2002). At the same time, the UN's surveys of treatment availability have not made any systematic effort to identify whether means of HIV infection has impacted access to treatment. Ethical and economic analysis of ARV provision frequently focuses on questions of socioeconomic status as determinant of treatment access, but rarely addresses specific questions raised by social attitudes toward IDUs (see, for example, UNAIDS/World Bank 1998). Given the large and rising share of infections attributed to IDU, and the growing commitment to scaling up treatment in developing countries, including those with injection-driven epidemics, this omission is a serious one.

Exploration by international policymakers of how the needs of IDUs might require reconceptualization of what HIV treatment is and how it is delivered has been similarly limited. Brazil's success in providing free ARV to IDUs along with the rest of its citizens has drawn worldwide acclaim, yet few UN guidelines exist about what mechanisms worked best to increase adherence to HIV regimens among IDUs and how applicable those mechanisms might be in other settings. Methadone maintenance has been shown to reduce injection and associated risk of pathogens like the hepatitis C virus, which progresses more quickly in the presence of HIV, and to reduce HIV risk behaviors (Wong, Lee et al. 2003). The World Health Organization has yet to add methadone, buprenorphine, LAAM, or any opioid substitution therapy to their list of essential medications (WHO 1998), and information about manufacture and price of substitution therapies has been unavailable in recent surveys on sources and prices of HIV drugs, which WHO conducts with UNICEF, UNAIDS, and Médecins sans Frontières (UNICEF, UNAIDS et al. 2002). At a minimum, reconceptualization of substitution therapies as HIV treatment and their inclusion on the Essential Medicines list would force welcome reexamination of the paradox that finds WHO supportive of substitution therapy but as yet unmotivated to initiate methadone's removal from the list of schedule I drugs enumerated by the UN drug conventions.

## Recommendations

### International Level Reform:

- ▶ *Addition of a fourth UN drug control convention explicitly supporting HIV prevention for drug users.* This convention should express support for the full range of strategies to reduce drug-related harm—including syringe exchange, safer injection rooms, substitution therapy, and peer outreach and education—as compatible with drug demand reduction and essential to HIV prevention.
- ▶ *Withdrawal of international support for UN drug conventions in the absence of timely reform.* While no single country can withdraw from UN conventions without fear of censure, joint withdrawal by countries committed to harm reduction would force recognition of the UN conventions' harmful effects.

Creation and adoption of new conventions, however, is a time-consuming and costly process. Shorter term recommendations include:

- ▶ *Adoption of a resolution by the UN Commission on Human Rights affirming the rights of drug users to HIV prevention and the need to amend existing UN drug control conventions.* Measures that prohibit IDUs from accessing the full range of appropriate HIV prevention measures violate basic precepts of human rights and the best practices of public health.
- ▶ *Creation of an international “memorandum of understanding” that expresses government commitment to harm reduction programs, summarizes legal arguments in support, and highlights conflicts with international law in need of immediate resolution.* Countries pursuing harm reduction are currently singled out for censure or left to justify their approaches to entities such as the INCB and the CND without support from like-minded governments. This document, prepared with support of UNAIDS or WHO for signature by countries committed to harm reduction, would provide a united front, summarizing legal scholarship in favor of harm reduction and highlighting those aspects of the UN conventions in greatest need of clarification or reform.
- ▶ *Genuine UN system-wide coordination and consensus on harm reduction policy.* Previous efforts at “harmonizing” have been insufficient. Measures required include formal adoption of a supportive position on harm reduction by the UNODC and the CND, and clear legal justification for any INCB assertion that a particular harm reduction measure violates international drug control conventions.
- ▶ *Expansion of INCB monitoring and reporting to include analysis of drug treatment as well as illicit drug production and enforcement.* UN drug conventions call for provision of treatment for those using illicit drugs, and nations should be held as accountable for compliance with this requirement as they are for others contained therein. Focus should be on both quantity and quality of treatment.
- ▶ *Reclassification of methadone from Schedule I to a less restrictive category.* WHO should immediately propose, and the CND should approve, removal of methadone from the most tightly restricted category.
- ▶ *Addition of opioid substitution therapies to WHO essential drugs list, and inclusion of manufacturer and pricing information in surveys on HIV drugs and diagnostics.* With millions of IDUs infected with HIV, medications to help them avoid collateral infections or adhere to HIV therapies are essential and should be recognized as such.

- ▶ *Analysis of HIV treatment availability by route of HIV exposure, and measures to improve HIV treatment access for IDUs.* Better data collection is needed to ascertain the extent of discrimination against drug users in the provision of HIV care and to prioritize improved access to care for IDUs.



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In China, “treatment” includes long hours of exercise, chanting of slogans like “Drugs are bad, I am bad,” and forced labor without pay to make goods for the growing tourist economy.

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## 4. National Policy Responses to Illicit Drug Use and HIV

Inconsistencies in addressing drug use and HIV/AIDS in the United Nations are reproduced at the national level, where government agencies and NGOs alike frequently talk past, rather than to, each other in articulating and implementing policy. Such inconsistencies are common even in countries with decades of experience in addressing the HIV epidemic: the U.S. Congress, for example, continues to prohibit federal funding for needle exchange even as commissions of public health experts have repeatedly recommended its implementation (Human Rights Watch 2003). How domestic U.S. prohibitions will impact its support for international responses to the epidemic is an open question—the United States Agency for International Development, for example, abruptly cancelled support for Brazilian HIV prevention programs in September 2003, raising suspicions that the U.S. was unhappy with the Brazilian openness to questions of sex and drug use (IPPF 2003). There is no question, however, that a divided approach to drug use and HIV is already common in countries with injection-driven epidemics, and that the split appears to be accelerating, rather than containing, the spread of HIV.

As on the international level, inconsistencies in national policies and programs return to tensions between prioritization of criminal enforcement or public health approaches. Treatment for drug users is frequently administered by ministries responsible for security or internal affairs, by officials with little knowledge of HIV or health interventions. Local decisions about treatment for substance use are often made by police or political leaders rather than by health professionals. Studies that include drug users conducted for purposes of HIV/AIDS prevention and treatment, including extensive qualitative research, is rarely considered in formulation of drug policy. Policies on drugs and HIV prevention are often developed separately, with neither coordination nor coherence. A UN study of seven Asian countries, for example, found that in only one, Vietnam, did the national drug plan mention HIV/AIDS issues explicitly (UNAIDS/UNODCCP 2000).

Strikingly, failure to adequately address IDU issues extends even to government AIDS centers and planning bodies in countries with injection-driven epidemics. Even in countries with a majority of HIV cases among IDUs, many national AIDS plans make only passing reference to drug users or methods to reach them. Hospitals or health clinics providing care to people with HIV frequently decline—explicitly or through practice—to make services available to active or former drug users, or report those seeking health care to law enforcement authorities. Plans to deliver or scale up treatment, similarly, do not include explicit policies addressing how former and active drug users will be incorporated into treatment, thus potentially excluding the majority of those in need (UNAIDS/UNODCCP 2000; CEEHRN 2002; Reid and Costigan 2002).

## National Drug Policies in the Context of Enforcement and Containment

Local realities shape HIV/AIDS epidemics, making generalization across populations or regions difficult. Consideration of drug policy is similarly complex, since national and international responses to illicit drug use can be understood in terms of a number of distinct yet overlapping political dimensions. Drug control efforts may be viewed, for example, as market interventions, designed to shape national or international access of some commodities relative to other competing products (Szasz 1996; Musto 1999; Room and Paglia 1999). Drug policy may be seen as state regulation of social norms, an effort to set standards for the way that citizens feel, think, or perform (Szasz 2003). Understandings of drugs are culturally situated:

a highly controlled substance in one country may be available over the pharmacy counter in another, and standards of what constitutes normal and deviant use are similarly culturally specific (Weil and Rosen 1993; Musto 1999). Finally, drug policy is frequently expressive of other policy concerns entirely, a means of establishing the standing of the state relative to a range of national or international forces seeking to undermine or reinforce it.

However varied their causes, policy responses in countries confronting sharp increases in heroin use and HIV infection reveal important commonalities. Severely punitive legislation and harsh public rhetoric regarding illicit drug use is common in virtually all countries now facing injection-driven epidemics. Particularly important for patterns of HIV transmission and stigmatization alike are laws mandating imprisonment for purchase of small amounts of drugs (e.g., quantities for personal use), mass institutionalization of drug users in forced treatment centers, and policies that extend power of government surveillance by blurring lines between public health and law enforcement. While these do not have a cause-and-effect relation to HIV rates per se—many countries with similar penalties and practices have not faced skyrocketing rates of HIV infection—they clearly stigmatize drug use, deter users from coming forward for help and hamper prevention programs.

### **Punitive legislation and HIV infection among IDUs**

Many countries with injection-driven epidemics have responded to increases in drug use and HIV infection by strengthening criminal penalties for drug-related crimes. Some countries criminalize possession of injection equipment, or make drug users liable to detention or imprisonment on suspicion of addiction itself. More commonly, criminal statutes require *imprisonment or institutionalization for purchase or possession even for small amounts of illicit substances* (e.g., amounts for personal use), and apply severe penalties to possession of both “hard” and “soft” drugs. Injection of cocaine and heroin are thus equated with smoking of cannabis or consumption of Ecstasy, in spite of the fact that these behaviors vary greatly in their health risks and social costs.

A similar pattern is seen in *application of severe penalties to low-level “traffickers.”* The term heroin trafficking describes a range of practices, from producers and distributors who maintain private militias and fleets of trucks to Central Asian women who may carry 100 grams of someone else’s heroin over a border to earn U.S. \$20. Production of synthetic drugs—which requires no agricultural product and far less apparatus than heroin production—is similarly varied, including large factories producing millions of tablets annually in Burma and cottage industries producing

several thousand in Thailand. Legal penalties frequently do not make such distinctions, setting thresholds for trafficking penalties so low that small-scale dealers or producers are punished as severely—and far more frequently—than industry kingpins.

Policies may be later revised as the scope of the HIV epidemic and the limits of enforcement become evident. Ukraine, for example, passed legislation in 1996 allowing for sale of injection equipment in pharmacies and providing protection against discrimination for people with HIV. These changes, however, often exist only on paper, with local law enforcement continuing to threaten, stigmatize, and punish drug users and their families.

- ▶ China has made its drug laws increasingly stringent over the past two decades, with the government identifying severe punishment as one of the “outstanding characteristics” of its reform (PRC Ministry of Foreign Affairs 2002). “Treatment” for most is highly coercive. Drug users can be detained for up to 15 days by police, and/or sent to forced detoxification centers for “re-education.” Those who relapse—by all estimates the overwhelming majority—face imprisonment in forced labor camps under even harsher conditions. Legal penalties include no less than seven years imprisonment for producing or possessing 10 grams of heroin (approximately a three-week supply)<sup>3</sup>, and production or possession of more than 50 grams of heroin is punishable by death (UNAIDS/UNODCCP 2000; Reid and Costigan 2002; U.S. State Department 2002; Human Rights Watch 2003).
- ▶ Russia sharply intensified criminal penalties for drug possession in the mid-to-late 1990s. In 1996, using a chart drafted by longtime CND and INCB member Edouard Babayan, officials revised downward by a factor of fifty the amounts of illicit drugs required for mandatory imprisonment. The new chart recognized only “large” and “extra large” doses of heroin or cocaine, and made purchase of small amounts of either (.005 grams of heroin, or one-hundredth of a daily dose) punishable by five to seven years imprisonment. Purchase of more than 0.1 gram of cannabis (approximately a matchbox full) carries a sentence of up to five years. In theory, judges also retain the right to mandate addicts who do not appear to be a danger to society to forced treatment rather than prison.

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3. Doses of heroin vary by individual, length of use, drug purity, etc., making it difficult to classify personal use. Swiss doctors prescribing pharmaceutical grade heroin to addicts (Uchtenhagen, Dobler-Mikola et al 1999) have noted that .5 gram daily is an average dose for an experienced user. Doses for those using street-quality heroin, which is cut with adulterants, are usually larger, though this varies by country.

In practice this option has been progressively replaced by incarceration, or incarceration followed by a requirement for forced treatment. Changes to penalties and judicial practices were approved in late 2003, when the Duma included relaxed penalties for small-scale drug possession and shifted authority for mandatory treatment of prisoners to penitentiary medical boards. The effects of the changes are not yet clear, though the Babayan chart is set for revision in March 2004 (Levinson 2003; MHG 2003).

- ▶ Vietnam enables police to detain those found in possession of drugs, and to commit them to compulsory rehabilitation centers where they can remain for up to five years. While users who can afford to enter private treatment may do so voluntarily, fees are prohibitive for most IDUs. Users who relapse after several efforts at “re-education”—again, the vast majority—are sentenced to prison for up to two years, and additional relapses result in two to five years more in prison. Possession of needles can be grounds for arrest, and sharing of injection equipment can be considered drug promotion and punished by imprisonment. Young (under 18-years old) drug users who relapse receive a year of mandatory detention and forced labor. Possession of more than 600 grams heroin is punishable by death. (UNAIDS/UNODCCP 2000; VCHR 2000; Vu Doan Trang 2001; Reid and Costigan 2002)
- ▶ Malaysia’s drug laws, among the most stringent in Asia since 1952, have been repeatedly revised since to increase penalties and decrease due process in the courts. It is illegal to carry injection equipment without a prescription, and possession of even a needle may result in up to two years imprisonment. Possession of any amount of any illicit drug, including cannabis, results in whipping and no less than five years in prison. As little as 5 grams of heroin (10 days supply) can result in a life sentence, and possession of 15 grams or more is assumed to be trafficking and carries a mandatory sentence of death unless proven otherwise. Suspected addicts can be detained for 14 days by police and forced to submit to a urine test. A positive test results in up to two years of mandatory institutionalization in a military-style boot camp facility (Harring 1991; UNAIDS/UNODCCP 2000).
- ▶ Burma criminalizes addiction itself, and authorities do not require possession of drugs or paraphernalia to convict drug users. Those who use illicit drugs are required to register with the authorities and turn themselves in for treatment. Any who fail to do so are liable for three to five years in prison (UNAIDS/UNODCCP 2000).

- ▶ Ukraine's drug law reforms from 1996-2001—described by the U.S. State Department as “solid” and “in line with the 1988 convention” (U.S. State Department 2002)—include forced treatment at a narcological clinic for those suspected of drug use, and up to five years in prison for those in possession of “large” doses of illicit drugs. As in Russia, the table used by Ukraine to determine penalties recognizes virtually all doses of heroin as “large” or “extra-large,” so that purchase of 1.0 gram (approximately two daily doses) yields up to five years in prison (U.S. State Department 2002; Kucheruk 2003).

### **War on drugs campaigns and HIV infection among IDUs**

Harsh penalties in countries with injection-driven HIV epidemics are often matched with campaigns against drug use and users conducted in the court of public opinion. “War on Drugs” efforts common in these countries include stigmatizing media coverage, public beatings of drug users, and public executions.

- ▶ Malaysia has the goal of a “drug-free society by 2015.” High-ranking government officials have repeatedly termed drugs “public enemy number one,” labeled “every addict a potential pusher,” and launched a highly-visible campaign that has included high-profile roundups of drug users, floggings of anyone convicted of possession, and public execution of those who traffick in “dadah” (illicit drugs). President Mahathir has termed drug users “not human” and “already dead.” Large posters with graphic images of hangman’s nooses and carrying slogans such as “Dadah Means Death,” and “Dadah Kills” line the corridors of airports, schools, and offices. Newspaper and television coverage includes regular anti-drug public service announcements, as well as photographs and headlines such as “Mother of Five to Hang for Trafficking in Heroin.” In June 2003, the government announced a new “Social Evils” campaign, with drugs and sex workers principal targets of enforcement. (Schwartz 1987; Harring 1991; Kuppusamy 2003).
- ▶ Vietnam launched a “Social Evils” campaign focusing on drugs, pornography, and prostitution in 1993, with high-ranking officials issuing regular calls for its renewal or intensification for a decade. Most recently, the government announced an intensified assault against drug users in March 2003 (Xinhua News Agency 2003). Families and local communities have been encouraged to identify drug users for detoxification and “reeducation.” Billboards show piles of skulls and dark figures with slogans like “AIDS, Drugs, and Prostitutes,” or a large red fist crushing stick figures with the slogan “Stopping Harmful Culture

and Social Evils Is The Responsibility of the Whole Society.” Newspapers have reported closure of shooting galleries, and arrests of prostitutes, drug users, and drug traffickers. The “Social Evils” campaign has been accompanied by increasing numbers of executions, including public executions: in 1996, 13 traffickers received the death penalty, but in 2000, six times as many were executed (Reid and Costigan 2002; Xinhua News Agency 2003).

- ▶ China launched a “people’s war” against drugs in 1990, including an aggressive and highly publicized crackdown against suspected drug traffickers, and a nationwide education campaign in favor of a “socialist-spiritualist” civilization cleansed of “the six evils.”<sup>4</sup> Thousands of Chinese attend public trials of drug traffickers held in cinemas and stadiums across the South, which commonly include anti-drug speeches by government officials, the public burning of confiscated drugs in enormous cauldrons, and the pronouncement of death sentences to chants of “kill, kill” from the audience. Some 7,000 drug offenders were sentenced to death or life imprisonment between 1991 and 1995 alone. A 1998 exhibit about the evils of drug use has been seen by an estimated 168 million Chinese (UNAIDS/UNODCCP 2000; Yongming 2000; U.S. State Department 2002; Human Rights Watch 2003).
- ▶ In Ukraine, which has the highest HIV prevalence in Europe, anti-drug user campaigns have frequently emphasized the idea that “drug users are spreading it to the rest of us.” There is a tradition of zero-tolerance toward drug users, with derogatory terms such as “tvarj konchennaya” (creature) or “zhivotnoje” (animal) used to describe HIV-infected IDUs, and media reporting that “AIDS...is a sanitary inspector, which helps rid society of people who have led an immoral way of life” (DLHPRN 2002; Viyenski and Dvoryak 2002; Lezhentsev 2003). While legislation passed in the late 1990s allows for voluntary, confidential HIV testing and the current president designated 2002 as the year for action against AIDS, strongly negative sentiment against drug users continues. Antidrug posters show children being devoured by the “dragon” of drugs, and a popular “real-life” crime show on television features regular stories linking cannabis use to violent crime and features cannabis users alongside murderers and rapists (Lezhentsev 2003).
- ▶ Russian policies have been matched by a strong component of public shaming of drug users and hostility toward programs serving them. One of the most

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4. See Yongming 2000. The six evils were drugs, pornography, trafficking in women, secret societies, superstition, and gambling.

popular television shows, “Coma,” has proposed that drug users be kept away from children by putting them in concentration camps. In the oblast (province) of Ekaterinburg, the governor recently launched a campaign to collect signatures mandating the death penalty for drug users. City Without Drugs, one of the province’s most prominent substance abuse facilities, has taken alleged drug dealers, torn their pants off, jabbed them repeatedly in the buttocks with syringes, and then dragged the alleged dealers through the streets for townspeople to spit on. Drug users have had signs hung around their neck and been similarly paraded for public ridicule. The leader of these initiatives has recently been elected to the Duma. In Moscow, Mayor Luzhkov has said that there is no need for syringe exchange programs or street outreach, since problematic injection drug use does not exist (Levinson 2003; Melnikov 2003).

### **CASE STUDY** *Thailand, “Successful” HIV Prevention, and the War on Drugs*

Tensions between the law enforcement and public health frameworks for responding to drug use are manifest even in countries saluted by the UN for their HIV prevention efforts. Thailand, for example, regularly cited for its successful response to the AIDS epidemic (UNAIDS 2001; Ainsworth, Beyrer et al. 2003; UNICEF 2003), also demonstrates how easily prevention “success” can exclude those with a history of drug use. The Thai government has been widely praised for its 100 percent Condom Programme, which in the early 1990s helped stem rising rates of infection by requiring quality control in the manufacture of condoms, distributing approximately sixty million condoms annually free of charge to sex establishments, and working with all provincial governors, chiefs of police, and chief medical officers to ensure national commitment to the program. Supplemented by such measures as alternative career development for young women in sex work, the program helped to sharply increase condom use, reduce sexual transmission of HIV and other STIs, and lower HIV prevalence by as much as fourfold (Nelson, Eiumtrakul et al. 2002). Thailand is also the first developing nation to have implemented an effective perinatal prevention initiative to stop transmission of HIV, delivering short-course zidovudine to more than two thirds of HIV-infected pregnant women in prenatal care, and to nearly 9 in 10 of their infants (Amornwichee, Teeraratkul et al. 2002).

Instead of strong HIV prevention programs for drug users, however, the Thai government has offered them an iron fist. In February 2003, the governing Thai Rak Thai (Thais Love Thais) party launched a “war” on the growing problem of methamphetamine use that has included arrest quotas for provincial police, and mass roundups of alleged



drug dealers and addicts. By April, Thai newspapers were reporting that police—armed with government blacklists and offered a percentage of assets seized—had taken more than 40,000 drug traffickers into custody. Some 230,000 Thais were reportedly forced into treatment in less than three months, with police conducting forced urine tests in nightclubs and bars (Macan-Markar 2003). Television broadcasts were soon filled not only with pictures of drugs and money seized, but with images of the large numbers of Thais—more than 2,700, the majority of them ethnic minorities—shot to death during the crackdown. Officials have accepted responsibility for fewer than 60 of these deaths, claiming that most resulted from drug dealers killing each other to prevent incriminating testimony. Thai and international human rights observers charge the murders—accomplished with the neat efficiency of professional gunmen, sometimes as victims were returning from police interrogation—were systematic, extrajudicial executions (Macan-Markar 2003).

While Thai authorities have declared the war on drugs a “beautiful success” (Agence France Presse 2003), its effect on programs serving drug users—including HIV prevention and research efforts—has been immediate and negative. A study led by researchers at Chiang Mai University found that 37 percent of drug users visiting rehabilitation clinics had stopped attending after the government crackdown, and were likely to have returned to injection and risk of HIV infection (Razak, Jittiwutikarn et al. 2003). Programs providing risk reduction information to drug users in the south report that many clients were too afraid to participate (Suwannawong and Kaplan 2003). Fear of blacklisting and indiscriminate arrests have also swelled the ranks of rehabilitation centers with non-drug users, including parents who have incarcerated themselves to clear their family name, and those swept up without cause.

In the context of HIV prevention for IDUs in Thailand, the war on drugs may be the latest in a long series of missteps. A pilot needle exchange program in the north has been discontinued. Long-term methadone treatment, in spite of a trial demonstrating efficacy more than a decade ago (Vanichseni, Wongsuwan et al. 1991), remains technically illegal and largely unavailable outside of Bangkok. The 100 percent Condom Programme has not been implemented in prisons, whose population grew sharply due to a five-fold increase in drug-related incarcerations between 1992-1999, and where studies show both high rates of HIV-infection and significant numbers of seroconversions behind bars (Beyrer, Jittiwutikarn et al. 2003). The amount of methamphetamine required for criminal charges of possession was revised downward three times between 1999-2001. Until mid-2003, the Thai policy on implementation of antiretroviral therapy (ARV) explicitly forbade injection drug users from receiving therapy. While the government has agreed to change the policy, IDUs continue to face severe discrimination

in health care settings, or to avoid them for fear of being reported to the police (Kaplan 2003).

Rates of HIV infection among drug users, meanwhile, show no sign of decline. While HIV incidence among soldiers, pregnant women, and STD clinic patients has fallen sharply since 1995, no decrease has been noted among Thai IDUs. In 1995, an estimated 32 percent of IDUs were HIV-infected. By 2001, this had risen to 50 percent (Reid and Costigan 2002). A study of military recruits in the north found that the percent of HIV-infected with a history of injection rose from 1 percent in 1991 to more than 25 percent in 1998 (Nelson, Eiumtrakul et al. 2002).

Prime Minister Thaksin publicly declared Thailand drug free and concluded the war on drugs in honor of the King's Birthday in December 2003. Arrests and forced drug testing, however, continue. Whether through execution or HIV infection while incarcerated, the price paid by drug users may include their lives.

## **Overly broad powers of arrest and surveillance**

The existence of laws does not necessarily say much about their enforcement. Countries including the Netherlands, Spain, Portugal, and Great Britain, for example, have relaxed arrests for violation of drug prohibitions, making distinctions between cannabis and other drugs, between private and public use, and between personal use and commercial production. In countries with injection-driven HIV epidemics, however, sharp expansion in arrests and increased powers of surveillance, rather than relaxation of regulation, appear to be the norm.

Police practices on the local level, in fact, play a critical role in undermining efforts to reduce HIV infection among drug users even when policy seeks to increase their access to services. A law allowing syringes to be purchased over the counter is of little use when drug users fear arrest at the pharmacy. The best-designed harm reduction programs are undermined if police officers linger nearby waiting to beat up, arrest, or extort drug users seeking help. Often, workers in programs serving drug users are themselves arrested, or humiliated by police. In St. Petersburg, Russia, for example, police took condoms away from outreach workers, crushed their sterile syringes, and forced them to tear up and eat the identification cards they issued to drug users (Tsekhanovich 2002).

Widespread arrests, or roundups of “drug abusers” who are then imprisoned or compelled to enter mandatory treatment, are common to virtually all countries with injection-driven epidemics. Whether tied to the arrival of foreign dignitaries,

the start of an international exposition, or a desire to rally popular support, these roundups frequently include not only all in possession of drugs, but all suspected to be drug users on the basis of appearance, needle marks (“tracks”), social association or geographical location. Because drug users are anxious to avoid long periods of institutionalization and subsequent stigmatization—and because they are already regarded as morally suspect—they are particularly vulnerable to extortion from police, a pattern common in many countries with injection-driven epidemics.

- ▶ There were 100,000 drug-related convictions in Russia in the first year following passage of harsher penalties for drug possession, and the number of those imprisoned for drugs increased five-fold between 1997–2000. Pre-detention centers were so full that inmates had to sleep in shifts, or fainted en masse from lack of oxygen. Even after amnesties and sharp restriction of pretrial detention, as many as 850,000 remain imprisoned in Russia, with as many as 20 percent—and 40 percent of women prisoners—detained on drug charges (Levinson 2003; MHG 2003).
- ▶ In China, the “People’s” war against drugs and other evils—and door-to-door visits by police—have resulted in sharp increases in imprisonment, registration of drug users, and forced detoxification. More than 230,000 drug users were arrested in 1998 alone, and numbers of registered addicts increased from 70,000 in 1991 to 680,000 in 1999. More recently, sweeps have reportedly filled forced treatment facilities far beyond capacity, with inmates sleeping on the floor, next to buckets of sewage that serve as toilets, or sharing quarters with pigs or other livestock (Liu 1996; Yongming 2000; Human Rights Watch 2003).
- ▶ In Vietnam, more than two-thirds of all those tried on drug charges in 2000 received terms of 7 to 20 years (Reid and Costigan 2002). The ongoing Social Evils campaign has been accompanied by construction of centers for the rehabilitation of prostitutes and drug users in every province, and construction of many new forced treatment centers in Ho Chi Minh City. Since 2001, roundups of more than 27,000 drug users have filled treatment centers to overflowing.

## **Blurring the line between health care provision and social regulation**

Frequently, arrest is followed by registration of drug users by the government, and monitoring by police or community members. Drug users who can afford it in many countries turn to private treatment facilities, where they avoid public scrutiny and registration of their names in official records. For many IDUs, however, the fees

or paperwork required for entry into such facilities prove prohibitive. Further, once labeled as drug users in the public system, few have any means of removing their names from the lists. Those who test HIV positive are also registered. This results in what sociologist Irving Goffman (1974) called the creation of a “spoiled” identity—a stigmatized status that is applied to drug users as a group even in the absence of particular behaviors—and a pattern which seriously impedes efforts to reach drug users with HIV prevention and treatment. Programs from Malaysia to Ukraine to Vietnam report that drug users and their families, fearing legal punishment or harassment, have refrained from seeking services, treatment for overdoses, or counseling (Open Society Institute 2001).

***Police or political leaders given power to decide who goes into treatment and for how long.***

- ▶ In China, suspicion of drug use is sufficient to result in police detention and forced re-education. Police decide not only who goes into forced detoxification, but how long they remain. Community leaders can expel drug users from villages, force them into the custody of the Public Security Bureau, or seize their property or that of their families (Reid and Costigan 2002; Human Rights Watch 2003).
- ▶ In Vietnam, community “focal points” identify drug users and issue criticism at the workplace or at the local level. If drug use continues, focal points can order drug users into compulsory treatment (Reid and Costigan 2002).

***Punitive use of medical tests and procedures.***

Blood and urine tests are demanded, even without evidence of drug use, and punishment delivered based on the results.

- ▶ In Malaysia, police can administer a forced urine test. Those who test positive are sent to treatment for up to two years (Reid and Costigan 2002).
- ▶ In Russia, the Moscow City Duma recently proposed mandatory drug testing of all homeless people and sex workers, and recommended that businesses routinely test employees. When advocates objected that such testing violated the constitution, a deputy replied that “democracy is incompatible with public health” (CEEHRN 2003; Levinson 2003).

Blood drawing has been used as a threat in Burma prisons, where lack of sterile collection equipment in medical facilities makes inmates aware of and afraid of HIV infection (Beyrer 1998).

HIV testing is used punitively, or as a surveillance measure with no benefit to patients.

- ▶ In China, residents of forced treatment facilities are tested for HIV, but never told the results (Human Rights Watch 2003). Those who test HIV-positive at hospitals or other health care facilities face discrimination including eviction and confinement without treatment in hospitals. In some provinces people with HIV are banned from swimming pools and forbidden to marry (Human Rights Watch 2003).
- ▶ In Vietnam, a survey of government rehabilitation facilities found that while most detainees were tested, four of five centers did not inform residents of their HIV test results. Patients with HIV are discharged from drug treatment when they become sick (Vu Doan Trang 2001; Higgs 2003).
- ▶ In Ukraine and Russia, HIV testing without consent—though forbidden by law—is performed on IDUs and sex workers in narcological centers and pre-trial detention centers. Those testing positive are reported to public health authorities, made to sign a declaration of understanding about criminal penalties if they knowingly infect someone, but are often not provided with any information about treatment or immune system monitoring (CEEHRN 2002; Malinowska-Sempruch, Hoover et al. 2003).
- ▶ In Russia and Malaysia, drug users are tested for HIV upon arrival at prisons. Once inside, those with HIV are segregated, but no HIV treatment is provided. Malaysian rehabilitation centers also test and separate those with HIV (Reid and Costigan 2002; Kamarulzaman 2003).

### *Registration of drug users and people with HIV*

- ▶ In Russia and Ukraine, state narcologists register drug users and compare their lists with those kept by police. Registered users are required to report at regular intervals to police and/or narcology facilities. Ukraine forbids registered addicts from holding driver's licenses, and bars registered people with HIV from a variety of occupations, including food preparation. Russian drug users registered at narcology clinics must report regularly for up to five years, with clinics able to demand urine tests. IDUs who have received a suspended court sentence, primarily those suspected of drug use but not carrying drugs at the time of their arrest, must be registered with police and report monthly to answer questions. They must also notify police of any travel plans, and submit to home inspections upon request (CEEHRN 2002; Kucheruk 2003; Melnikov 2003).
- ▶ Community “focal points” keep names of drug users in Vietnam, along with type of drug, route of administration, treatment history, and progress toward

abstinence. Names are passed from the community level to departments dealing with social evils in the Department of Labour, Invalids, and Social Affairs, and from there to the National Drugs Committee in Hanoi (UNAIDS/UNODCCP 2000).

- ▶ In China, neighbors, family members, and coworkers are encouraged to monitor known drug users closely, and can invoke forced treatment or put drug users into the custody of the public security bureau (Yongming 2000; Human Rights Watch 2003).
- ▶ In Burma, drug users must register—with their parents in attendance—to enter treatment, and must subsequently carry cards that identify them as drug users. Once on the list, it is unclear how one's name is removed (UNAIDS/UNODCCP 2000).

### **Concentration of drug users in prisons and mandatory treatment facilities**

In countries with injection-driven HIV epidemics, there is perhaps no more powerful key to HIV prevention—or more powerful factor in HIV transmission—than prisons and forced rehabilitation centers. Vastly overcrowded, forcing together drug users of different ages and HIV status, and sharply limiting access to HIV prevention materials such as condoms or syringes without eliminating the behaviors that transmit HIV, these facilities in effect act as engines of HIV infection. Featuring little or no HIV care, and exposing inmates or residents to a range of other infectious diseases including tuberculosis, they frequently add penalty of illness or death to the sentences mandated for drug offenses.

Segregation of those who are HIV positive, a common strategy in facilities from Russian prisons to Malaysian rehabilitation centers, is often the single answer to HIV prevention in forced treatment facilities or prisons. Authorities claim that this approach protects inmates from further infection and shields those who are HIV positive from exposure to both violence and pathogens from other inmates. In addition to violating international human rights conventions forbidding discriminatory segregation, this “solution”—like the incarceration or institutionalization of drug users itself—often offers the appearance of effectiveness without demonstrated result. HIV testing, even when routine, is not universally applied in most centers or prisons, and is in any event unable to detect those infections that have occurred recently. Repeated studies documenting significant rates of seroconversion behind bars further testify to the fact that prisoners infected with HIV frequently share living quarters—and risk behavior—with those who are not. In some cases, the placement of HIV-infected patients in cells with inmates with other, highly contagious

diseases such as tuberculosis suggests that the intent of HIV testing has more to do with protection of prison staff than with increasing the safety of inmates themselves (MHG 2003).

Penal reform, including reform of drug demand reduction efforts that rely on forced treatment at the expense of more effective and less punitive interventions, thus becomes critical to effective efforts at HIV control. At the level of the institutional setting, reform requires interventions from condom distribution to staff training to substitution therapy. Here too, the tension between public health and law enforcement is evident. Officials at prisons and treatment facilities—charged with enforcing restraint from the sex or drug use that commonly transmit HIV—fear that efforts to prevent HIV will be synonymous with acknowledgement that inappropriate behaviors are occurring, and decline to implement them. Risk behaviors themselves are often criminalized, adding time to the sentences of those caught engaging in them (MHG 2003).

Conditions in prisons and treatment facilities that increase vulnerability to HIV infection include:

*High rates of HIV infection.* Data on how many HIV-infected people there are in prisons and rehabilitation centers is difficult to obtain, either because governments have discontinued the mandatory HIV testing of prisoners that WHO has declared ineffective and unethical (Ukraine) or because the results from such mandatory tests are not made public (Burma). Nonetheless, even the limited data available show growing concentrations of drug users in prisons and disproportionate rates of HIV infection in residential treatment centers.

- ▶ In Vietnam, a study found that between 40-80 percent of those in five forced treatment centers were HIV positive (Vu Doan Trang 2001).
- ▶ In Russia, an estimated 20 percent of the country's HIV cases have passed through the prison system. Rates of HIV among prisoners have increased by nearly 200 times between 1996 and 2000 (Roschupkin 2003).

*Continued risk behaviors for HIV.* While prisons and mandatory treatment facilities alike maintain that drug use or sex does not occur—one Malaysian treatment center, for example, explained to a visiting researcher that they “leave the lights on” to deter sexual liaisons—available evidence shows continuing risk behaviors for HIV. Tattooing, widely reported in prisons and forced treatment centers in many countries, carries risks for HIV. Reports of sex between detainees, or between detainees and staff, are not uncommon, and treatment for STDs is limited. Perhaps most importantly, repeated studies have found that injectable drugs circulate in

prisons, and anecdotal reports suggest their presence in many forced treatment and rehabilitation facilities (Bich San and Huy Dung 2002; Human Rights Watch 2003). Injection equipment is scarce, highly prized, and almost always shared (Malinowska-Sempruch 2001; Reid and Costigan 2002; Beyrer, Jittiwutikarn et al. 2003; Crofts 2003; MHG 2003).

- ▶ In one study in a Russian prison, more than 25 percent of inmates became infected while behind bars. A larger study of seven prisons found that 26 percent of IDUs in prison had injected in the past month, and that 13.5 percent began injection while incarcerated. Ten percent of respondents in this larger study reported penetrative sex with other prisoners (CEEHRN 2002; MHG 2003).
- ▶ In Malaysian prisons, injection equipment is used many times. A study in one prison found that HIV prevalence among inmates increased by 80 percent in a single year (Reid and Costigan 2002).

*Transmission of other blood- or air-borne diseases.* Hepatitis C, more infectious than HIV and highly prevalent among IDUs in all countries with injection-driven epidemics, is spread through tattooing as well as the use of contaminated injection equipment. Tuberculosis, the world's major killer of people with HIV, spreads quickly in the damp, poorly ventilated quarters common to many prisons. In Russia, for example, TB incidence has trebled in the past decade, with prisoners and ex-prisoners accounting for half of the more than 130,000 cases reported in 2000. Transfer between prisons, or release from incarceration, frequently interrupts treatment and helps lead to the development of multiple-drug-resistant tuberculosis (MDR-TB) that is untreatable with the two most powerful and affordable TB drugs. Of the estimated 30,000 prisoners with TB released from prisons each year in Russia, one in four has MDR-TB. Those infected with TB by someone with the MDR variety—including other prisoners, family members, or community members—are themselves resistant to treatment with available drugs (Drobniewski, Balabanova et al. 2002; MSF 2003). MDR-TB, and tuberculosis outbreaks in prisons, have also been reported in China and Burma (Wise 1998; Liu, Jiang et al. 2002; Phyu, Ti et al. 2003).

*Failure to provide HIV prevention.* With drug users a sizable percentage of those incarcerated in all countries with injection-driven epidemics (UNAIDS/UNODCCP 2000; Cohen 2003; MHG 2003), the lack of HIV prevention interventions also represents a missed opportunity of enormous proportion. Residents of forced treatment centers, too, are a “captive population” that could benefit from HIV



prevention interventions. The importance of HIV prevention information and techniques in the forced treatment context is made particularly clear given the relapse rates reported by government run treatment centers in all countries with injection driven epidemics. In every case, official statistics themselves estimate that two-thirds or more of those treated return to drug use. In some cases, such as with female IDUs in southern China or methamphetamine users in Vietnam or short-term treatment in Russia and Ukraine, estimated relapse rates are as high as 90-100 percent (Reid and Costigan 2002; Viyenski and Dvoryak 2002; Levinson 2003). Nonetheless, most prisons and substance abuse treatment centers, even if they offer information about HIV prevention measures, fail to give detainees the tools needed to implement them. No government in countries with established injection-driven epidemics (>50,000 registered cases) in Asia or the former Soviet Union offer syringe exchange or substitution therapy in prisons, in spite of strong evidence in Europe, Australia, and elsewhere of the practicability and efficacy of this approach (Dolan and Wodak 1996; Dolan, Rutter et al. 2003). While a few forced rehabilitation facilities programs offer chemically assisted detoxification, none offers the long-term substitution therapy demonstrated to achieve strongest results in helping opiate users return to work or abstain from injection (Abdul-Quadar, Friedman et al. 1987; Ball and Ross 1991; Vanichseni, Wongsuwan et al. 1991; Ward, Mattick et al. 1994; Lindesmith Center 1997). A select number of prisons (e.g., in Russia and Ukraine) offer inmates bleach for cleaning syringes or even sterile syringes, and a few treatment centers (e.g., in Yunnan, China) offer instructions on cleaning injection equipment. These efforts, however, are funded primarily by foreign donors rather than local governments, and are not widespread (Open Society Institute 2001; Reid and Costigan 2002). No government programs in Asia provide condoms in prisons (Beyrer, Jittiwutikarn et al. 2003), and condom availability is limited in Russia and Ukraine. While some forced treatment centers have begun to provide instruction on condom use and bleaching needles, most provide neither sterile injection equipment nor, in most countries, condoms.

*Lack of treatment or support for HIV-infected detainees.* Lack of specialized interventions for those with HIV, similarly, represents a missed opportunity. Prisons and treatment facilities that segregate those with HIV offer them no special medical treatment, and in many places exercise greater reluctance in the provision of basic medical care (CEEHRN 2002; Crofts 2003; MHG 2003). As noted earlier, treatment facilities in Russia, Ukraine, Vietnam, and China test drug users without informing them of the results, and/or without providing them information about or access to immune system monitoring, antiretroviral treatment, or treatment of opportunistic

infections considered the standard of care by WHO (Reid and Costigan 2002; Human Rights Watch 2003). Prophylaxis for deadly AIDS-related infections such as pneumocystis carinii pneumonia—obtainable for U.S. \$11 per patient per year (UNAIDS 2000)—is also not provided.

*Inadequate plans for return of drug users or prisoners to local communities.* An estimated 70-95 percent of drug users in forced treatment centers return to drug use after their release, and prisons experience a constant influx and outflow of inmates convicted of drug offenses. Given these realities, institutional failure to provide effective drug or HIV prevention carries significant implications for communities at large. Indeed, if penal institutions act as an engine of HIV infection, the constant circulation of inmates and forced treatment detainees acts as a distributor, dispersing those infected without supporting them in sustaining behavior change. The Russian prison system, for example, moved to reduce overcrowding with a badly needed amnesty that released 220,000 prisoners in 2000, as well as reforms to the criminal code which sharply limited pre-trial detentions from 2002 onward (Abramkin 2003). Few or no provisions, however, were made for job training, or for aftercare for those with TB or HIV. Today, one quarter of Moscow's homeless—among those at highest risk for drug use, HIV, and sex-for-drugs transactions—are former prisoners (MSF 2003). Government-supported aftercare for drug users in countries with injection-driven epidemics, similarly, offers only abstinence-based programs, if any at all. This continues in spite of overwhelming evidence that the vast majority of those served by the programs return to active drug use following treatment. With prison sentences common in many countries for those who relapse following one or several experiences of mandatory treatment (UNAIDS/UNODCCP 2000; Reid and Costigan 2002), abstinence-only approaches tend to prevent drug users from admitting to active drug use or from seeking services to cope with its adverse effects. Increasingly, governmental response to the apparent insufficiencies of forced treatment has been to extend the length of detention. Vietnam, for example, which doubled the detention period for drug users in mandatory treatment from six months to a year in 2001, proposed to extend it to five years in 2003 (Reid and Costigan 2002; Voice of Vietnam 2003). In Malaysia, the government has said that it will contemplate extending detention for relapsers to 13 years, as is done in Singapore (Harring 1991; Reid and Costigan 2002). In the absence of HIV treatment or prevention interventions, the result may well be increased infections and illness within treatment centers, and increased reluctance by other drug users to interact with nongovernmental organizations or health care facilities for fear of prolonged detention.

## FOCUS Public Health Principles to Combat HIV/AIDS and Drug Abuse

How can governments move beyond a punitive framework to articulate programs that decrease health risks for drug users, their families and society? Best practices of public health have articulated a number of key principles useful in reducing risks for the many not living in the “drug free” world promised by the criminal enforcement framework.

1. Focus on risks associated with drug use, rather than on the fact of its illegality.
  - a. While all illicit drug use may be illegal, not all is identical in terms of risk: interventions should concentrate on riskiest behaviors in health terms.
2. Recognize that risk is often relational, rather than merely individual.
  - a. Interventions should focus on social practices and relations, as well as on individual drugs or drug users.
    - i. IDU-related HIV, for example, comes from contaminated injection equipment rather than from injection per se, and will be reduced by elimination of needle sharing even if drug use continues.
    - ii. Since laws and social practices such as use of shooting galleries or professional injectors structure the risk associated with drug use, interventions should also focus on these influences.
3. Move beyond the binary of drug abusing/drug-free in gauging success.
  - a. Incremental risk reduction by active drug users-the decision to continue to smoke heroin rather than to begin injecting, for example-can also reduce adverse health outcomes.
  - b. Increased condom use, or reduction of number of sex or drug-sharing partners, can reduce transmission of HIV and hepatitis even if active drug use continues.
4. Prioritize evidence-based approaches over ideological ones.
  - a. Interventions should be based on demonstrated efficacy in reducing risk of drug use and HIV risk.
    - i. If abstinence-based treatment yields high relapse rates, additional interventions to reach relapsers are needed.
    - ii. Provision of sterile injection equipment has been shown in repeated studies to decrease needle sharing and HIV transmission without encouraging drug use.
    - iii. Substitution therapy, particularly methadone maintenance, has been shown to reduce social costs of drug use, including HIV infection and other injection-related harm.

5. Seek to have the largest impact on the largest number of people at risk.
  - a. If drug users outside of treatment or prison settings outnumber those inside, interventions should not be limited to the institutional frame.
    - i. Methadone maintenance treatment, for example, can be delivered to large numbers of opiate addicts without institutionalization or incarceration.
    - ii. Targeted interventions (e.g., provision of clean needles to professional injectors, work with drug dealers to eliminate preparation of solutions in common pots, legal reform to allow for pharmacy-based sale of syringes) may protect more people than syringe distribution to individual users on the streets.
6. Create integrated services addressing both drug use and HIV.
  - a. Rather than drug use interventions unable or unwilling to deal with HIV, or HIV services that refuse to address drug use, interventions should have some capacity to deal with both.
  - b. HIV prevention and care are complementary: drug users need counseling and interventions to protect themselves from HIV, but also access to effective treatment.
  - c. Health care provision to drug users may include collateral services, such as assistance in obtaining official documents necessary for integration into larger health care system.

Sources: (O'Hare, Newcombe et al. 1992; Ball 1998; Drucker 1999; Rhodes, Stimson et al. 1999; Burrows 2001; Ball and Crofts 2002; Elovich and Wolfe 2003; Rhodes, Mikhailova et al. 2003).

## National Drug Policies in the Context of Public Health

Countries with injection driven epidemics have mobilized significant resources—law enforcement efforts, political declarations, community commitment, and widespread expansion of penal and forced treatment facilities—to isolate and contain drug use and users. Efforts to contain risks of HIV infection among drug users, however, have received significantly less funding, and have been markedly less successful.

## **Provision of sterile injection equipment**

More than 20 years into the HIV epidemic, and long after the epidemic exploded among IDUs across Asia and the former Soviet Union, no government with an injection-driven epidemic except Vietnam provides national funds for distribution of sterile injection equipment. Many governments continue to claim that availability of needles in pharmacies or the absence of drug use problems make this unnecessary, even as evidence shows high rates of needle sharing, and steadily climbing HIV prevalence among IDUs (Bich San and Huy Dung 2002; Reid and Costigan 2002; Human Rights Watch 2003). In countries where syringe exchange programs operate, such as Russia and Ukraine, they do so with local government permission and limited financial support (Open Society Institute 2001). Coverage is intermittent and vastly incommensurate with need—Moscow, for example, has no needle exchange programs. China has a small social marketing effort for needles in Guangxi province, and offers only a few needle exchange programs, situated in for-fee clinics, in Yunnan (Reid and Costigan 2002). Vietnam—while acknowledging harm reduction explicitly in its national AIDS plan and providing limited funding to syringe exchange programs—has yet to repeal legislation criminalizing syringe possession. The strength of the social evils campaign in rural areas, as well as the mass roundup of 10,000 drug users in Ho Chi Minh city in 2003 (Bich San and Huy Dung 2002; Voice of Vietnam 2003), have severely hampered efforts to implement syringe exchange on a national level. Malaysia and Burma, where even past evidence of drug use is sufficient for institutionalization or incarceration, have no government supported syringe availability programs, though the Myanmar government has recently permitted international organizations to explore provision of sterile injection equipment in provinces where rates of HIV infection among IDUs are highest (Dorabjee 2003).

### **CASE STUDY   Syringe Exchange in Bangladesh**

Bangladesh shares much with its nearest neighbors in Asia and the Indian subcontinent—a sharp rise in the number of IDUs in the past decade, a marked lack of treatment facilities for drug users, and steep increases in HIV infections due to contaminated injection equipment. Unlike many other countries, though, Bangladesh has explicitly acknowledged the usefulness of harm reduction strategies in its national AIDS plan since 1997, and since 1998 has had a nongovernmental program offering clean syringes,

HIV education, primary health care, and other services to a substantial number of active drug users (Beg 1999). Offering services in Dhaka, Rajshahi, and three other towns with high concentration of IDUs, the program—run by CARE Bangladesh and known as SHAKTI—is credited with helping Bangladesh avoid the high overall HIV prevalence common to IDUs in many Asian urban centers (UNAIDS 2001; Dorabjee 2002).

With only 200 treatment slots in a country with an estimated 22,000 opiate users (Dorabjee 2001), Bangladesh has not relied on abstinence-only treatment to stem the spread of blood-borne viruses. SHAKTI works to prevent HIV infection, hepatitis C, or other injection-related harms even among individuals who continue active drug use. The SHAKTI syringe exchange program (SEP) provides clean injection equipment to IDUs, and has documented an 83 percent return rate on syringes distributed. Other SHAKTI services include drop-in centers where drug users can rest, socialize or seek health care, a police training program that successfully reduced rates of assaults on drug users and arrests of those using the SEP, and counseling to help heroin smokers from switching to injecting (Burrows 2001; Dorabjee 2002). HIV and primary care education is provided by PROCHESTA, a drug user outreach and peer educator group in Dhaka, with plans to form similar groups in other cities (Beg 1999; Dorabjee 2002).

While not country-wide, SHAKTI's reach is substantial—an estimated 74 percent of known IDUs in Dhaka and Rajshahi have been reached by one or more SHAKTI interventions. Nearly 6 of 10 IDUs connected to the program used condoms to protect their sexual partners in the past year, a percentage sharply higher than that reported in cities with no such programs (Dorabjee 2002). Independent evaluation has confirmed sharp decreases in needle sharing as a result of the syringe exchange program. Particularly pronounced effects were noted in Rajshahi, where professional injectors were among those receiving sterile syringes (Hossain 2000; Jenkins, Rahman et al. 2001).

Bangladesh is not exempt from problems in HIV prevention, including persistent harassment by police and local gangs toward sex workers, men who have sex with men, drug users, and outreach workers. (Human Rights Watch 2003). In 2002, users of needle exchanges reported reluctance to seek help from programs following the arrest of outreach staff, and front-page articles announced record increases in prevalence among injectors in June 2003 (Daily Star 2003; Human Rights Watch 2003). Nonetheless, overall rates of prevalence among IDUs—at 4 percent among injectors of black market buprenorphine—remain far lower than those of Bangladesh's neighbors. SHAKTI is now lobbying the government for a pilot substitution therapy program, in the hope of continuing momentum toward containing Bangladesh's HIV epidemic before it passes the tipping point.

## Substitution therapy

Adequate substitution therapy (without limits on duration of treatment, and at sufficient dose to relieve symptoms) remains illegal or unavailable to the vast majority of IDUs in all countries with injection-driven epidemics. Ukraine registered methadone as a legal drug in 2002 but has not yet begun to supply it, instead treating a limited number of people with low doses of buprenorphine: length of treatment and dosage are as yet unevaluated (CEEHRN 2002). China has begun a few pilot methadone programs in the south, though these generally do not provide treatment for longer than three weeks (Reid and Costigan 2002), and are in danger of the perpetual pilot status that in many countries is synonymous with lack of genuine government commitment. Chinese authorities generally feel that Chinese medicines may be more appropriate than methadone maintenance treatment (UNAIDS/UNODCCP 2000). In Russia, methadone remains illegal and the target of attack by forces ranging from the leading government pharmacologist to the country's Christian Scientist minority (Levinson 2003). Vietnam has very limited pharmacy availability of buprenorphine and a few pilot methadone programs supported by WHO, but shows no evidence of commitment to expanding them. Malaysia has announced plans for a pilot methadone program, and the Myanmar government has recently begun to explore the possibility of providing methadone or buprenorphine through international NGOs. Neither country has programs yet in place.

### **CASE STUDY    Methadone on Demand: The Hong Kong Model**

Though tens of thousands of Hong Kong residents are dependent on opiates, levels of HIV among IDUs there are far lower than those found in neighboring countries or other parts of China. The widespread availability of methadone is thought to be the major reason why.

Hong Kong authorities have demonstrated commitment to methadone since before the HIV/AIDS epidemic, opening the first methadone clinic in 1972 (ACAN 2000), and continuing to support low-threshold methadone detox and longer-term methadone maintenance treatment ever since. The region has 20 operational methadone clinics (Reid and Costigan 2002), and is the only place in Asia or the former Soviet Union where methadone maintenance treatment is easily available upon demand. Advertisements in the mass media have emphasized not only the importance of drug prevention, but also the availability of help for those with heroin problems.

Accessibility is the key to Hong Kong's methadone treatment approach. In contrast to the United States and Western Europe, where entrance into methadone treatment frequently requires protracted paperwork, waiting lists, and referrals, treatment in Hong Kong is generally available the same day it is requested (ACAN 2000). The fee for treatment has remained unchanged for years at HK \$1 (less than U.S. \$0.80) per day. Clinics are open seven days a week and are open early and late to serve the estimated 40 percent of clients who maintain full time employment (Newman 1985; Webb 1996; ACAN 2000). The responsiveness of the methadone program to local market changes is demonstrated by fluctuations in demand—as heroin prices increase in the region, the number of enrollees also increases (Newman 2003).

Again in contrast to the United States, where methadone program staff are subject to rigid educational demands and certification requirements, Hong Kong clinics have historically been supervised by a physician but staffed by Auxiliary Medical Service volunteers whose regular occupations may range from shoe salesman to housewife to bank clerk. Working for a nominal fee, these volunteers have enabled clinics to operate at extended hours with minimal expenses (Newman 1985). Patients, too, are less strictly monitored than in the United States: while urine tests are collected to assess general program effectiveness in limiting heroin use, these have never been used to disqualify patients from participation (Newman 1985).

Other modes of treatment in Hong Kong include residential treatment and forced abstinence-based treatment for prisoners, for whom methadone is not available. While overall rates of HIV among IDUs in Hong Kong remain far lower than elsewhere in China, the number of HIV cases among IDUs jumped more than six-fold between 1999-2001 (ACAN 2000; Reid and Costigan 2002). Still, absolute numbers of those infected are small, with the Hong Kong Director of Health reporting only about 250 new HIV infections annually. The Hong Kong government has reaffirmed its commitment to ongoing, accessible methadone treatment, and strengthening of counseling and HIV reduction measures for those attending the clinics (ACAN 2000).

### **Abstinence-based “treatment”**

Forced, abstinence-based treatment can be imposed on drug users in all countries with injection-driven epidemics. The imposition of treatment through law enforcement in most countries, however, is matched neither by commitment to comprehensive services nor by funding to provide them, creating an unmettable demand. In Russia, fewer than half of state narcology clinics received funding needed to operate in 2000 (Itar News Service 2000). In Malaysia, the law mandates two years



of aftercare for those completing mandatory treatment for drug use—in 1996, however, there were only 350 slots for approximately 40,000 drug users who needed them (UNAIDS/UNODCCP 2000).

In fact, beyond the tight restrictions on entrance and exit, little can be said of state-sponsored programs except that they are closer to prisons than to treatment facilities and that they fail to resolve issues of drug use in the majority of instances. Relapse after forced treatment exceeds 60 percent in all countries with injection-driven epidemics, and in many instances exceeds 90 percent. Staff vary widely in knowledge and training, and few standards exist for any aspect of care provided. Common deficiencies include:

*Inconsistent and ineffective detoxification.* Most treatment centers offer only herbal medicines or “cold turkey” approaches.

- ▶ In Russia, detoxification often consists of being locked in a bare cell until withdrawal symptoms subside (Open Society Institute 2001).
- ▶ In China, those going through withdrawal at forced detox centers are offered nothing but herbal formulations manufactured on and untested outside the premises (Human Rights Watch 2003).
- ▶ In Malaysia, detoxification is two weeks in an eight-by-twelve foot cell that frequently holds two or three other drug users (Schwartz 1987).
- ▶ In Ukraine, state standards for detoxification are ignored, with narcologists using an irregular mixture of medications and psychological techniques (Viyenski and Dvoryak 2002).

*Undifferentiated approach for both casual and heavy drug use.* Virtually all drug treatment facilities require casual and chronic users to go through the same “treatment.” Users of different drugs also receive the same treatment.

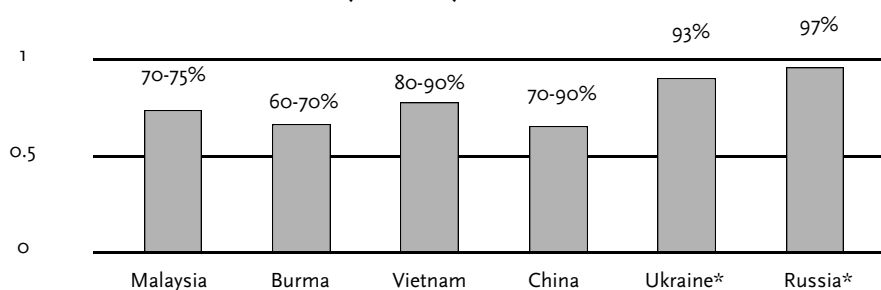
*Forced labor and punitive “trainings.”* Treatment is often an exercise in physical endurance, psychological humiliation, or exploitation.

- ▶ In Yunnan, China, “treatment” includes long hours of exercise, chanting of slogans like “Drugs are bad, I am bad,” and menial work for no pay. In addition to tending to thousands of animals and acres of farmland without compensation, men are forced to make gems, while women are made to embroider scarves for sale to the tourists who represent the fastest growing segment of the Yunnan economy (ASIAINFO News 2001; Human Rights Watch 2003).

- ▶ In Malaysia, “treatment” includes hours of military drills in the hot sun, religious instruction, strict searches of personal belongings and a demand for discipline so severe that some inmates have rioted. While treatment models have changed little for more than a decade, the government has recently announced a new national rehabilitation program in which drug users will be sent to work at palm oil plantations for token wages (Schwartz 1987; Loh 2003).
- ▶ In Vietnam, rehabilitation includes forced labor for no reimbursement. Increasingly, rehabilitation facilities are expected to achieve self-sufficiency or even profitability through cultivation of vegetables or production of small handicrafts sold by the government. In July 2003, officials announced plans to construct new industrial complexes where as many as 8,000 drug users will live and labor for up to five years (VCHR 2000; Crofts 2003; Voice of Vietnam 2003).

*Experimental medical procedures* are carried out on drug users. In St. Petersburg, for example, physicians are reportedly drilling holes into the brains of relapsing drug addicts to reduce cravings (Tsekhanovich 2002). Other unproven but common procedures include rapid detox using insulin shock in Russia, and provision of herbal formulations claimed to cure AIDS in China (Tsekhanovich 2002; Human Rights Watch 2003).

FIGURE 2 Estimated Percentage of Drug Users Who Relapse Following Abstinence-based Treatment, by Country, 2002



Sources: UNAIDS/UNODCCP (Malaysia, Burma/Myanmar, Vietnam, China), Viyenski and Dvoryak (Ukraine), Levinson (Russia)

\* Short-term, mandatory treatment

## HIV treatment for IDUs

Prevention and treatment of HIV at the national level are mutually supporting rather than competing goals. As the example of Brazil (see page 64) suggests, people are motivated to be tested for HIV or to protect others from infection precisely when there is some evidence that society's commitment to the issue of HIV/AIDS includes provision of treatment and support for those infected. Other arguments in favor of integrating treatment and prevention include growing evidence that treatment reduces both vertical (mother-to-child) and horizontal transmission, that treatment preserves human lives, social infrastructure, and the economic productivity necessary for sustained prevention efforts, and that—contrary to longstanding assertions to the contrary—compliance with treatment regimens is achievable even in resource-poor countries (Berkman 2001; Orrell, Bangsberg et al. 2003).

The issue of HIV treatment for drug users, including triple combination antiretroviral therapy (ARV), is one that is countries with injection-driven epidemics have yet to effectively address. While HIV treatment to date has been too limited to draw strong conclusions—of the more than 3.5 million estimated to have HIV in countries with injection-driven epidemics, fewer than 1,200 people are on ARV—preliminary evidence suggests that a history of drug use is applied explicitly or in practice to exclude IDUs from treatment. In Russia, where IDUs accounted for more than 90 percent of cumulative HIV cases registered by 2002, AIDS service programs in St. Petersburg and Moscow reported that none of those on ARV are IDUs (CEEHRN 2002). In the leading HIV clinic in Kuala Lumpur, where the government provides one of the three ARV drugs used in combination and asks patients to pay for the other two, former IDUs—75 percent of all HIV cases in the country—are only 20 percent of those receiving treatment (Kamarulzaman 2003). None are current drug users. In Yunnan, the epicenter of the Chinese IDU epidemic, only 300 patients were receiving triple-combination ARV—through a U.S.-funded research project—and treatment of opportunistic infections is also sharply limited. In some parts of the province, AIDS clinics are padlocked shut and beds are empty (Human Rights Watch 2003). In Ukraine, where IDUs were 69 percent of cumulative registered HIV cases in 2002, they were only 20 percent of those receiving triple-combination ARV, with AIDS centers reportedly placing drug users after all others in line for medication (CEEHRN 2002).

Without explicit measures to ensure access, scaling up of treatment—however laudable—is also likely to exclude drug users or to offer them substandard care. In China, for example, the government announced in 2003 that it would offer treatment with two domestically produced versions of AIDS drugs to 3,000 people with

HIV (Human Rights Watch 2003). All of these, however, are in Henan, where infections are primarily related to blood collection practices, not in provinces where IDUs are most heavily concentrated. Russia treats the vast majority of HIV patients with monotherapy, in spite of WHO guidelines establishing triple combination therapy as the standard of care. Vietnam has recently moved to manufacture and make available combination therapy that includes only two drugs, at a price higher than the triple-combination regimen available in nearby Thailand (Saigon Times 2003). While the extent to which the injection-driven nature of HIV/AIDS epidemics shapes national commitment to HIV treatment provision is uncertain, the danger that treatment needs will be ignored, or implemented in such a way that those without a history of drug use receive superior care, remains clear. China, Russia, Ukraine, and Myanmar have received grants from the Global Fund for support in treating and preventing HIV. The approved applications, however, include few specifics about how IDUs will be included in expanded HIV treatment efforts.

The problem may lie in part with donor nations, many of which have not articulated effective policies to ensure access to treatment for their own IDUs. HIV/AIDS treatment patterns in countries with injection-driven epidemics echo a larger global discomfort with offering care to active drug users. Even analyses of HIV treatment by NGOs focused on countries with injection-driven epidemics have tended to obscure IDU-specific treatment issues behind more general calls for ARV (Human Rights Watch 2003; U.S.-Russia Working Group 2003). U.S.-based groups admittedly are seeking to increase treatment for the greatest number of people, and operate in a country that bans funding for needle exchange and has a system of medical education that continues to demonstrate pervasive prejudice against IDUs with and without HIV (Elovich and Wolfe 2003). Nonetheless, it is essential that the mistakes of the donors not be repeated in countries whose treatment efforts they support.

The inordinate share of HIV cases attributable to IDU in Asia and the former Soviet Union makes addressing questions specific to HIV treatment for IDUs particularly urgent in these regions. What kinds of changes to services, whether in clinic operation hours or consolidation of medications into fewer pills, work best to increase adherence to HIV treatment regimens among IDUs in different countries? What frameworks beyond “drug user or not” can be developed to help guide equitable distribution of HIV medications when not all can be treated? What particular treatment interventions will work best in prisons, or for those on methadone? For those with hepatitis C? What reforms of policy and practice are needed at AIDS centers and other treatment providers to ensure that drug users are included among those who receive care?

These questions, ignored or answered de facto by marginalization of drug users in many nations, are central to the development of an effective response in countries with injection-driven epidemics. Without concerted attention and ethical guidelines, it is conceivable that international donors and national governments will constitute an AIDS service structure that denies care to the majority of those infected with HIV.

## **CASE STUDY   Treating HIV-Infected IDUs in Brazil**

Building on international assistance from the World Bank and a commitment to accessible health care and human rights that pre-dated the HIV epidemic, Brazil's government guaranteed all citizens free access to antiretroviral drugs in 1996. Coupled with aggressive HIV prevention efforts, the results have demonstrated what prevention experts have termed "the clearest example of the potential synergy between prevention and treatment initiatives," (Global HIV Prevention Working Group 2003) and a demonstrable reduction in both AIDS cases and HIV infection among injection drug users.

With the second largest number of HIV cases in the Western hemisphere and a growing percentage of HIV cases attributable to injection-IDU—related infections grew from 18% of all infections in 1998 to 25% in 2000 (Latin American Harm Reduction Network 2003)—the Brazilian government has supported a wide range of harm reduction programs and interventions serving drug users. Prisons offer condoms to inmates, as well as rooms for visits with partners, including unmarried partners. After a period of police harassment of harm reduction workers under federal law prohibiting incitement of drug use, municipal and local governments have supported harm reduction and syringe exchange programs, in some cases passing their own legislative reforms to authorize syringe exchange efforts. In Porto Alegre, drug users involved with the outreach program serve on local government councils. Bars and restaurants collect used injection equipment, and distribute sterile needles. Residents in the poorest neighborhood volunteer their houses as exchange points at hours when mobile teams are unavailable (Bastos 2000). Drug users are also referred to an extensive network of treatment facilities (UNODC 2003).

Maintaining that treatment and prevention fuel each other, and that availability of treatment is an essential component to reversing AIDS-related stigma, the government offers ARV to all people with HIV, including drug users. Prices have been negotiated with drug companies, and in some cases the government has manufactured generics itself. Rates of adherence to triple combination therapy have been comparable to those in the United States or Western Europe.

Results in prevention and treatment have exceeded those in more developed countries. AIDS mortality among drug users—and people with HIV more generally—has dropped by 50 percent since 1996, and opportunistic infections by 60-80 percent. The government estimates that treatment availability has prevented as many as 360,000 hospital admissions between 1997-2001, for a savings of more than \$1 billion (Global HIV Prevention Working Group 2003). The percentage of IDUs among total AIDS cases has fallen from over 30 percent in 1991 to less than 12 percent in 2000 (UNODC 2003). A study of five harm reduction projects found that up to 60 percent of IDUs who participated in the projects for six months were consistently using their own injection equipment (Caiffa 2000). In a national survey, condom use among IDUs rose from 42 percent in 1999 to 65 percent in 2000 (UNAIDS 2002).

## Recommendations

### National level reform

- ▶ *Inclusion of drug use issues in national AIDS plans, and of AIDS issues in national drug plans.* Lack of coordinated response hampers efforts to control drug use and HIV.
- ▶ *Repeal of mandatory imprisonment/institutionalization for possession of small amounts of illicit drugs.* Imprisonment and forced treatment expose detainees to psychological and health risks, including HIV, hepatitis C, and tuberculosis, and serve to accelerate HIV infection.
- ▶ *Decriminalization of drug use paraphernalia, adoption of legislation permitting purchase of syringes without prescription, and public education about the right to do so.* Drug users fear arrest even in countries where purchase of syringes is permitted. Penalties for possession of injection equipment, whether actual or perceived, encourage use of shooting galleries and professional injectors, and increase likelihood of HIV transmission.
- ▶ *Repeal of legislation or practices through which drug users are criminalized on the basis of addiction alone or past behavior.* Mass arrests based merely on suspicion of drug use or on the basis of “clean-up” campaigns conducted for political purposes should be prohibited. Legislation that criminalizes drug addiction

per se or permits medical testing and punishment for evidence of past drug use should similarly be repealed.

- ▶ *Protection of confidentiality of IDUs and people with HIV in health care and drug treatment settings.* Information on HIV status or drug use history gained through the provision of medical care should not be shared with law enforcement or other governmental or nongovernmental agencies, or revealed to local community members.
- ▶ *Provision of HIV treatment and/or support to those with HIV in penal or treatment facilities.* If testing is used to inform staff or about the HIV-status of individuals in prison or drug treatment facilities, services and support—including treatment comparable to that available outside—should also be available.
- ▶ *End to punitive registration of IDUs and people with HIV.* Practices that publicly identify drug users and people with HIV, or that require them to submit to ongoing regulation or surveillance, are stigmatizing and counterproductive.
- ▶ *End to practices depriving drug users of due process while in police custody.* Denial of legal counsel, prolonged detention without a prompt hearing, extortion and use of drug withdrawal or its threat to coerce confession all violate human rights and basic standards of justice.
- ▶ *Involvement of health professionals in decisions about need for and length of drug treatment.* Course of treatment should be appropriate to the individual in question, with decisions made by qualified health professionals rather than by arresting police officers, judges, local political officials, or on the basis of national “social evils” campaigns or forced treatment requirements.
- ▶ *Implementation of harm reduction and HIV prevention efforts, including syringe distribution, condom availability, and substitution therapy, in prison settings and for those recently released.* Whatever harm reduction programs are available outside of prisons should also be available inside. Given the key role played by penal institutions in the spread of HIV, special attention should be devoted to implementation of HIV prevention interventions in prisons even if they are unavailable in the country at large, and to HIV prevention and substance abuse treatment programs for those recently released from incarceration.
- ▶ *Creation of accessible drug-treatment that recognizes differences between casual and chronic use, and between users of different drugs.* Cannabis and heroin users, or those who use methamphetamine once and those who are chronically addicted, may share the same legal status, but their treatment needs are sharply different.

- ▶ *Scaling up, with financial support from governments, of the full spectrum of drug demand reduction and HIV prevention measures supported by UNAIDS and WHO.* These measures should include inpatient treatment, outpatient treatment, aftercare and rehabilitation, syringe exchange, overdose prevention, and opioid substitution therapy.
- ▶ *Adoption of minimum standards of care, based on best public health practice, in treatment and rehabilitation centers.* Services needed include medically assisted detoxification, psychological counseling, and humane and nonexploitative rehabilitation services.
- ▶ *Expansion of aftercare programs, including programs offering harm reduction services for active drug users, and abolition of punishments for relapse.* In the absence of adequate aftercare, policies that punish relapse into drug use with prison sentences or prolonged detention make drug treatment programs nothing more than precursors to imprisonment.
- ▶ *Analysis of HIV treatment availability for IDUs, and measures to end discrimination in treatment access.* Policies or practices that prohibit or discourage IDUs from equal access to HIV treatment—whether antiretroviral treatment or treatment for AIDS—related infections are unethical and counterproductive.



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More than two decades of HIV have taught the world clear lessons on how to successfully contain the virus. While HIV transmission through contaminated injection equipment is well documented in many countries, less attention has been paid to the ways that illicit drug policies, including patterns of arrest of drug users and rules around provision of sterile injection equipment, shape global trends in HIV infection. National governments and the UN must adopt approaches based on the best practices of public health, while minimizing the damage caused by aggressive illicit drug policies that do little to control and prevent HIV transmission.



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