

Harm Reduction and Human Rights The Global Response to Injection-Driven HIV Epidemics

**Submission to the Office of the High Commissioner for Human Rights for
the biennial report on HIV/AIDS requested by Commission on Human Rights
Resolution E/CN.4/RES/2005/84**

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Summary and Recommendations

It is estimated that 15.9 million people inject drugs in 158 countries and territories around the world. The overwhelming majority (80%) live in low- and middle-income countries. Outside of sub-Saharan Africa, up to 30% of all HIV infections occur through injecting drug use. Despite this, the overwhelming evidence in favour of harm reduction as an effective HIV prevention strategy, and despite endorsements by UNAIDS, WHO and UNODC, the global state of harm reduction is poor, especially in those countries where such services are needed most.

Human rights abuses against people who use drugs, and which impede HIV prevention, treatment and care efforts, are widespread. These include denial of harm reduction services, discrimination in accessing antiretroviral therapy (ART), abusive law enforcement practices, disproportionate criminal penalties, and coercive and abusive drug dependence treatment. Moreover, vulnerable groups, including young people and women have not been a focus in HIV prevention strategies relating to injecting drug use.

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

The human rights entities within the UN system, in particular the Human Rights Council, have an important role to play in addressing these systemic gaps. We therefore recommend that:

The Human Rights Council

- Adopt a resolution on HIV and human rights at its tenth session, including a call for full access to harm reduction services and for an end to discriminatory and abusive practices against people who use drugs.
- Adopt a resolution on the 'protection of human rights while countering the world drug problem'.
- Consider the creation of a Special Rapporteur on HIV and Human Rights.
- Consider the creation of a Special Rapporteur on the protection of human rights while countering the world drug problem.
- Include a focus on drug policy during Universal Periodic Review

The Office of the High Commissioner for Human Rights

- Assist the UN Office on Drugs and Crime in mainstreaming human rights in its programmatic work, including the development of human rights impact assessments.
- Attend each session of the Commission on Narcotic Drugs, and in particular, the 2009 High Level Meeting of the Commission to be held in March.

The Human Rights Treaty Bodies and Special Procedures

- In accordance with their respective mandates (during country visits, periodic reporting procedures etc), focus on the impact of drug policy on human rights in order to highlight human rights issues and further the understanding of human rights obligations in this context.

Introduction by Professor Paul Hunt

Since the earliest days of the global HIV pandemic, people who inject drugs have been identified as one of the groups disproportionately affected by the virus. In the mid-1980s, harm reduction arose as a series of targeted, low-threshold interventions aimed at preventing the transmission of HIV through unsafe injecting practices. In the two decades since then, comprehensive harm reduction services, including needle and syringe exchange and opioid substitution therapy, have proven time and again to be remarkably effective responses to HIV.

Today, despite endorsement by all the relevant United Nations agencies, including UNAIDS, WHO and UNODC, and the overwhelming evidence in favour of harm reduction as an effective HIV prevention strategy, the global state of harm reduction is poor. Less than 5% of those in need have access to harm reduction services. Up to 10% of new HIV infections worldwide are attributable to unsafe injecting. When sub-Saharan Africa is excluded, this figure rises to 30%. The figure is significantly higher still in some regions and specific countries, often the same places where access to harm reduction services is most limited. All over the world, people who use drugs remain marginalised, stigmatised and criminalised, with increasing vulnerability to HIV and decreasing access to essential health care services. In such environments, the full guarantee of the right to the highest attainable standard of health for people who use drugs is impossible.

In seeking to reduce drug-related harm, without judgement, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health-based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs. Every state therefore has an obligation to implement, as a matter of priority, national comprehensive harm reduction services for people who use drugs.

**Professor Paul Hunt, former UN Special Rapporteur on the
Right to the Highest Attainable Standard of Health¹**

I. The Global State of Harm Reduction: The international response to injection driven HIV epidemics*

'By 2005, ensure: ... expanded access to essential commodities, including...sterile injecting equipment; harm reduction efforts related to drug use.'

Declaration of Commitment on HIV/AIDS, 2001
General Assembly Resolution S-26/2²

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

United Nations Secretary-General, Ban Ki Moon, 2007³

Injecting drug use and HIV epidemics

It is estimated that 15.9 million people inject drugs⁴ in 158 countries and territories around the world.⁵ The overwhelming majority (80%) live in low- and middle-income countries.⁶ Asia and Eastern Europe have the largest injecting populations, with the highest numbers residing in Russia, India and China.

Up to 10% of all HIV infections occur through injecting drug use and evidence suggests that over 3 million people who inject drugs are living with HIV.⁷ In much of Western Europe as well as Australia and New Zealand, where harm reduction initiatives are long established, HIV prevalence among people who inject drugs remains below 5%. But in some other areas, up to 80% of people living with HIV are likely to have acquired the virus through unsafe injecting.⁸ Countries as far reaching as China, Estonia, India, Kenya, Myanmar, Nepal, Thailand and Vietnam have HIV prevalence rates of over 50% among people who inject drugs.

The international response

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

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

Commitment. Guidelines for countries on scaling up responses towards universal access explicitly recommend the inclusion of targets related to needle and syringe exchange and OST.¹²

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

Harm reduction is supported in policy or practice in at least eighty-two countries and territories around the world. In recent years, countries across Asia, the Middle East and North Africa have introduced and in some cases, rapidly scaled up their harm reduction programmes. Needle and syringe exchanges are operating in seventy-seven countries around the world and opioid substitution therapy is prescribed in sixty-three countries and territories. However, there are still seventy-six states with evidence of injecting drug use where no harm reduction interventions are present at all. Even in those countries that have implemented a harm reduction response, coverage of services varies dramatically. Many countries have only very small scale pilot programmes reaching small numbers of people. Coverage levels sufficient to avert or reverse HIV epidemics have so far only been implemented in parts of Western Europe, Australia and New Zealand.¹⁴

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

Regional overviews†

Asia

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

However, coverage remains far below levels necessary to impact on HIV epidemics. In South-East Asia, only 3% of people who inject drugs have access to harm reduction programmes and

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

in East Asia this figure is 8%.¹⁷ NSP and OST sites are currently limited to pilot programmes in the majority of countries, reaching very small numbers.

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

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

Another key element of the response to drugs in Asia are compulsory drug treatment centres, often characterised by forced detoxification and forced labour. In some countries, entry into OST programmes is dependent on having spent a number of months in such a facility. Reports from numerous countries document a range of human rights concerns related to inadequate health care in compulsory drug treatment centres. For example:

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

Central and Eastern Europe and Central Asia

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

As a response to rapidly expanding HIV epidemics, almost all states in the region have needle and syringe exchange, and the majority of states (23 of 29) prescribe opioid substitution therapy for drug dependence. Russia and Ukraine combined are home to 90% of the region's injecting drug users, but the two countries have employed quite different responses. Largely enabled by a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria, Ukraine has rapidly increased access to NSP and buprenorphine maintenance therapy and, following enormous advocacy efforts, methadone prescription began in 2008. Russia is home to around 2 million people that inject drugs, but the use of opioid substitution for drug treatment is still prohibited and there are a meagre sixty-nine needle and syringe exchange sites across the vast country.

HIV prevalence in prisons is high in the region and a number of prisons have experienced a rapid increase in the incidence of HIV in a short time period. Harm reduction interventions are

currently reaching few prisoners in the region. Three countries have some prison-based needle exchange programmes (Armenia, Kyrgyzstan and Moldova) and eight countries prescribe opioid substitution therapy to some prisoners (Slovenia, the Czech Republic, Moldova, Poland, Albania, FYR Macedonia, Montenegro and Serbia). Inside and outside prison, access to ART for current or former injectors is disproportionately poor.

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

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

Caribbean

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

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

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

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

Latin America

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

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

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

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

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

Middle East and North Africa

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

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

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

Including Iran, seven countries have NSP and three have OST, but none are substantial enough to reach HIV prevention levels.

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

Sub Saharan Africa

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

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

Responses to HIV in the region currently include little focus on people who inject drugs. Mauritius, where an estimated 17,000—18,000 people inject drugs, is the only country where needle and syringe exchange is operating. Limited OST is prescribed in South Africa and Mauritius. No prisoners in the region have access to either needle and syringe exchange or OST.

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

II. Harm Reduction and Human Rights

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

United Nations Secretary-General, Ban Ki Moon, 2008²³

Harm Reduction and the right to health

Individuals who use drugs do not forfeit the right to the highest attainable standard of health. In recent years, UN human rights monitors have specifically connected the provision of harm reduction interventions as necessary for states to be compliant with the right to health under Article 12 of the *International Covenant on Economic, Social and Cultural Rights*. For example, in its November 2006 Concluding Observations on Tajikistan, the UN Committee on Economic, Social and Cultural Rights expressed concern at 'the rapid spread of HIV in the State party, in particular among drug users, prisoners, [and] sex workers', and specifically called upon the government to 'establish time-bound targets for extending the provision of free...harm reduction services to all parts of the country.'²⁴ In 2007, the Committee raised similar concerns in its report on Ukraine, stating it was 'gravely concerned about the high prevalence of HIV/AIDS epidemic in the State party, including among...high risk groups such as sex workers, drug users and incarcerated persons...and the limited access by drug users to substitution

[‡] Directly injecting a recent heroin injector's blood to ease withdrawal symptoms.

therapy.’²⁵ The Committee recommended that the government ‘make drug substitution therapy and other HIV prevention services more accessible for drug users.’²⁶

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

Criminal law and abusive law enforcement impeding HIV prevention efforts

‘Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider:

- *the authorization or legalization and promotion of needle and syringe exchange programmes;*
- *the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes’*

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

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

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

In Georgia, for example, drug crackdowns in 2007 resulted in 4% of Georgia’s male population receiving a drugs test, many under forced conditions. Thirty-five per cent of these went on to be imprisoned on a drug-related charge.³² In Thailand, the ‘war on drugs’, which in 2003 resulted in over 2,800 extrajudicial killings, has had a lasting impact on drug users’ access to

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

fundamental health care services. Studies reported a significant decline in the number of people seeking treatment for drug use during the war on drugs, and that a significant percentage of people who had formerly attended drug treatment centres went into hiding, in some cases sharing syringes because sterile syringes were difficult to obtain.³³

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

The perceived threat from law enforcement in these countries is entirely legitimate. Both countries have some of the most stringent drug control legislation in the world. Both allow for administrative detention, without trial, in forced detoxification centres. In China, for example, according to government policy, the local police may subject a drug user to between three and six months detention in a forced detoxification centre, and repeat offenders to re-education through labour centres (RELC) for one to three years. In each case, such detention is administrative and without trial or other semblance of due process. The most recently available data from 2005 indicate that there were approximately 700 mandatory drug detoxification centres and 165 re-education through labour centres in China, housing a total of more than 350,000 people. Detainees in drug detention centres reported being housed in unsanitary and overcrowded conditions. Investigations by others have also described extreme ill-treatment in the name of 'rehabilitation', such as the administering of electric shocks while viewing pictures of drug use. A 2004 survey found that 9 percent of 3,213 Chinese heroin users had taken extreme steps such as swallowing glass to gain a medical exemption from forced treatment.³⁶ Moreover, both countries retain the death penalty for drug offences and both actively execute those convicted of drug trafficking.³⁷

Discrimination against people who use drugs in accessing ART

'No-one should be stigmatised or discriminated against because of their dependence on drugs.'

United Nations Secretary-General, Ban Ki Moon³⁸

In many countries where people who use drugs represent a significant, or even a majority, of those living with HIV, their access to treatment is disproportionately low relative to other people living with HIV. In Russia, for example, where people who use drugs are the majority of the population in need of antiretroviral treatment, they have often been excluded from government AIDS treatment programmes. In 2004, for example, the chief physician of St. Petersburg's City Health Committee reported that active drug users were not considered a good risk for AIDS treatment.³⁹ International experience, however, has demonstrated that with adequate support, people who use drugs can adhere to antiretroviral treatment regimens and benefit from other HIV care at rates comparable to non-drug users.⁴⁰

Although national laws and HIV/AIDS policies may in principle recognise the right to non-discrimination in access to ART, in practice, drug users still face serious obstacles in obtaining

equal access to necessary care. A recent study by WHO Europe showed that in many countries, access to ART for people who use drugs is not proportionate to HIV rates among them, with eastern European countries having the lowest rates of access in the region. According to WHO, 'In eastern European countries, where IDUs are the majority of reported HIV cases, relatively few IDUs receive ART and, where they do, only few are current injectors when they initiate treatment.'⁴¹ The figures showed that while there were significant improvements in access to antiretrovirals in western European countries from 2002—2005, in eastern Europe, more than 70% of reported HIV cases were in the IDU transmission category between 2002 and 2005, but the rates of access to ART increased from only 14% to 38%. Furthermore, figures for active injectors are even lower. Limited data from seven reporting eastern European countries at the end of 2005 on the injecting status of those accessing ART suggested that, on average, only 15% of reported people who inject drugs on ART were current drug injectors when they initiated treatment.⁴² According to WHO, the figures showed a clear inequity in access to treatment for HIV for injecting drug users.⁴³

These figures are mirrored in other parts of the world. In China, figures from 2006 showed that while 48% of HIV cases were injecting drug users, this group represented only 1% of those accessing ART. In Malaysia, the figures were 75% of HIV cases versus 5% who had access to ART.⁴⁴

Lack of focus on young people who use drugs**

'Injecting practices using unsterilized instruments further increase the risk of HIV transmission...In most countries, children have not benefited from pragmatic HIV prevention programmes related to substance use, which even when they do exist have largely targeted adults.'

UN Committee on the Rights of the Child, 2003⁴⁵

In some countries, children initiate drug injecting as early as age 12. In many others, the age of first injection is between the late teens and early twenties. Consequently, this time in some young people's lives can be one of specific vulnerability to HIV transmission. Despite this, however, there has been a consistent lack of focus on this vulnerable group in HIV prevention discussions and policy decisions relating to injecting drug use.

There are important differences between young people and adults who inject drugs, which may put young people at increased risk of HIV transmission, as well as a range of other harms. For example:

- Early age injecting drug use is associated with high levels of HIV risk behaviours. For example: young people who inject drugs are often poorly skilled injectors and poor injecting practices are passed on through observation and learning; novice or occasional injectors are often unaware of injection related health threats and prevention measures; a number of studies show that young people are more inclined to borrow and to share injecting equipment, than adults who inject drugs
- Young people have less economic security and access to resources. Many resort to crime or sex work to pay for drugs. Financial barriers may hamper obtaining clean injecting equipment and increase re-use and sharing.

** This section is largely taken from PC. Grund & S. Merkinaite, Young People and Drug Use in Selected Countries of Central and Eastern Europe, Vilnius, Eurasian Harm Reduction Network (EHRN), 2008 (Forthcoming)

- Young people often feel resilient and invulnerable to harm and may have difficulties connecting long term consequences with current behaviours
- Many young people are insufficiently aware of their rights, and do not know how to access health services. Many young people starting to inject or who are occasional users do not identify themselves as being 'drug users' in need of assistance and therefore may not seek out services that do exist
- Young people often lack trust in institutions and confidence in service providers. They have limited skills in navigating 'institutions', and fear losing their independence, being criminalized for their substance use or being forced into treatment
- Traditional gender roles are often amplified in the drug scene. Women injectors face distinguished gender related risks for injection related harm, in particular at the onset of their drug injecting careers
- Lastly, communities of young injecting drug users are often smaller and more underground as a result of the additional stigma faced by young people, resulting in reduced visibility of the issues that are particular to young people and injection drug use.⁴⁶

However, identifying and reaching people who inject drugs as a 'hidden population' is notoriously difficult. Reaching young people within this group presents an even greater challenge. While data quality varies from country to country, in many, data on injecting drug use are not disaggregated by age, and the numbers of young people injecting, becoming infected with HIV, or accessing drug dependence treatment and harm reduction services are largely unknown.

Where data are available, studies have shown that young people often represent a significant proportion of injecting drug users. In a study among clients of needle exchange programmes and voluntary counselling and testing in four Georgian cities, for example, Tbilisi, Zugdidi, Gori and Batumi, 16.8% of the respondents were under 25. A study among out-of-treatment injecting drug users in Budapest (1999—2000) found that 16% of the participants were aged 15—19, and 45% aged 20—24. In 2006 in Ukraine, it was estimated that 43% of the people injecting drugs in Kiev city, 20% in Poltava oblast, 36% in Odessa oblast and 47% in the oblast of Dnipropetrovsk were younger than 24 years.⁴⁷

Given these factors, that UNAIDS has estimated that approximately 45% of all new HIV infections are among those under age 25,⁴⁸ and given the links between drug use and sexual transmission among young people, there is an urgent and immediate need to focus on identifying young people who inject drugs and ensuring access to youth friendly, age appropriate and comprehensive harm reduction services - often the first step in a continuum of care for young people who use drugs.

Lack of focus on gender and drug use^{††}

Injecting drug use by women is an area of growing concern in most countries of the world, yet existing prevention and treatment services are for the most part inadequate and based on male-centred and abstinence models. Expansion and redesign of services for girls and women is necessary if the harms related to drug use, including HIV, are to be reduced. As a basis for such approaches, there is a pressing need to understand the differences in drug use between males and females and between different groups of women and girls.

Though precise data on women who use drugs is rarely available, women have been estimated to represent about forty percent of drug users in the United States and some parts of Europe, twenty percent in Eastern Europe, Central Asia, and Latin America, between seventeen and forty percent in various provinces of China, and ten percent in some other Asian countries.

Gender shapes the experience of drug use and its associated risks. There is a growing body of literature on gender differences with respect to risks and harms associated with injecting drug use, including HIV transmission. These differences relate to the way in which women inject (or are injected), to levels of high-risk sexual behaviour, such as commercial sex work, transactional sex, and to other factors such as stigma and discrimination.⁴⁹ As a result, in the EU, for example, HIV prevalence among female injecting drug users is higher than those among men.⁵⁰

Many of the social factors influencing HIV transmission among women who inject drugs relate to gender dynamics and the imbalance of power structures between men and women.

- Women who inject drugs have been found to share equipment more than men in some studies.
- Women who inject drugs are more likely than men to be in a relationship with another injecting drug user. Sharing of equipment often occurs within relationships, and in this context women are significantly more likely to report borrowing needles from regular sex partners than are males.
- A number of studies have found that sharing injecting equipment and unprotected sex are perceived as less risky by women than men in 'trusting' relationships. The injecting process is often dictated by the dynamics of power and control with women having constrained power over safe drug use.
- Male partners are more likely to inject first, with women receiving shared needles last, and women tend to be injected by others more often than men.

In some parts of the world, there is also a substantial overlap between commercial sex work and injecting drug use. For those who become sex workers primarily to support their drug use, commercial sex work has much in common with transactional sex, with the same absence of genuine choice in the face of urgent need. Drug-using sex workers often engage in higher risk

^{††} This section is has been drafted with input from Diane Riley of the Women's Harm Reduction Network, and with sections taken from two reports of the International Harm Reduction Development Program of the Open Society Institute: "Women's Health and Harm Reduction: Communities working together to save lives", October 2008, and "Women, Harm Reduction and HIV", September 2007 Available at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/women_20071012/footnoted_20071015.pdf and http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/women_20070920/women_20070920.pdf

forms of sex work. This is largely because of the financial pressures imposed by poverty and the need to support their own – and sometimes their partners’ – drug use, and because people who inject drugs are seen as undesirable and at high risk of HIV, and are therefore often excluded from brothels in many places. HIV prevalence among sex workers who inject drugs is higher than it is among either non–sex worker injecting drug users or non-injecting sex workers.

Ill-informed and punitive policies, stigma, and lack of access to accurate information jeopardise the health of women drug users and their children. For example, in some countries, women living with HIV who also use drugs are pressured or coerced to abort or to give up their children to the care of the state, and are denied accurate information about prevention of mother to child transmission or drug use and treatment during pregnancy. Myths and misconceptions about drug dependence treatment mean that pregnant women who use drugs are often denied access to OST despite these being safe during pregnancy and the proven effectiveness of OST in preventing HIV transmission. The stigma of drug use during pregnancy also encourages women to conceal their drug use from health care providers, similarly limiting their access to harm reduction information and specialised care.

The UN Office on Drugs and Crime, in collaboration with UNAIDS has very recently released a briefing paper entitled ‘Women and HIV in Prison Settings’. Globally, female prisoners represent about five per cent of the total prison population, but this proportion is increasing rapidly, particularly in countries where levels of drug use are high. The briefing notes that ‘both drug use and HIV infection are more prevalent among women in prison than among imprisoned men’ and that ‘women in prison are vulnerable to gender-based sexual violence; they may engage in risky behaviours and practices such as unsafe tattooing, injecting drug use, and, are more susceptible to self-harm.’ Prison settings, however, ‘do not usually address gender-specific needs’. The briefing recommends a comprehensive list of HIV prevention, treatment and care measures, including the provision of sterile injecting equipment, and opioid substitution therapy for women who use drugs.⁵¹

Despite the particular needs of women in the context of drug use, harm reduction and HIV, few women’s health services worldwide incorporate harm reduction, and women who inject drugs are shut out of mainstream health and social services that can directly or indirectly help them with the challenges they face. Moreover, international policy discussions have failed to focus on women who use drugs.

III. UN System-Wide Coherence: ‘Parallel universes’ of human rights and drug control

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

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

Taken from every region of the world the human rights indictment in the ‘war on drugs’ is long.⁵² Ranging from cruel, inhuman and degrading treatment to executions for drug offences, and from chemical spraying over rural villages to denial of essential HIV prevention and treatment services, the global fight against drugs has impacted negatively across borders and across human rights protections.⁵³

The influence of the international drug control conventions, and indeed the international drug control system that has been built around them, should not be underestimated. The conventions adopt a restrictive and punitive approach to drug users with little acknowledgement of human rights obligations. It has been noted that 'whether or not they are a cause or a convenient excuse, the UN drug conventions are used by national governments to justify highly punitive legal measures and failure to implement services for IDUs'.⁵⁴ Very often the stigmatisation and marginalisation of drug users is most extreme in those countries where harm reduction services are needed most.

The International Narcotics Control Board (INCB), the treaty body of the drug conventions, has a long record of neglect in relation to HIV prevention measures,⁵⁵ while making no commentary on abusive drug policies in its annual reports. The Commission on Narcotic Drugs, meanwhile, has never condemned human rights abuses in drug policy and has focused on human rights only once in its sixty year history, with an extremely controversial resolution adopted in 2008 at its 51st session.⁵⁶ And at the programmatic level, the UN drug control programme within UNODC has not incorporated human rights into its activities, conducting no human rights impact assessments, for example, despite the risk of complicity in human rights abuses.

This neglect of human rights in drug policy is not, however, limited to the drug control entities. The former Commission on Human Rights never adopted a resolution calling for the protection of human rights while 'countering the world drug problem', and the Human Rights Council has not yet considered this global human rights issue. This is a significant gap given that every year the General Assembly adopts a resolution reaffirming that countering the world drug problem must be carried out in full conformity with the Charter of the United Nations and, in particular, with fundamental human rights.⁵⁷

There are no guidelines from the Office of the High Commissioner for Human Rights (OHCHR) on mainstreaming human rights in UN drug control policies, and little co-operation between OHCHR and UNODC on drug control programmes. At the same time, the human rights treaty bodies and special procedures have focused on drug policy on only very few occasions.

Indeed, the United Nations drug control and human rights regimes have developed in what have been described as 'parallel universes'.⁵⁸ The drug control entities rarely discuss human rights and the human rights bodies and mechanisms, in turn, have rarely focused on drug policy. The result is an international system and policy environment where significant human rights violations, many impeding HIV prevention efforts, fall between these two separate regimes, unaddressed and largely ignored.

The human rights entities within the UN system, in particular the Human Rights Council, have an important role to play in addressing these systemic gaps.

The UN General Assembly's 20th Special Session on the World Drug Problem met in 1998, setting objectives centred on the achievement of significant and measurable reductions in the supply of and demand for illicit drugs over a ten year period. In 2008, the Commission on Narcotic Drugs began the process of reviewing the progress made. The delegates to the 2008 CND confirmed that a 2 day, high-level, political meeting will be held in March 2009 in Vienna, which will agree the framework for the next phase of UN drug policy.⁵⁹

The 2008/9 review process therefore presents a significant opportunity to begin to address the current human rights weaknesses in the system. This is not the sole responsibility of the

Commission on Narcotic Drugs, the INCB and the UNODC. The human rights entities within in the United Nations must, within their respective mandates, take this opportunity to begin to focus on the human rights aspects of international drug policies, including their impact on HIV prevention, treatment and care for people who use drugs.

IV. Recommendations

Human Rights Council

- Adopt a resolution on HIV and human rights at its tenth session, including a call for full access to harm reduction services for those who need them in order to guarantee the right to the highest attainable standard of health, and for an end to discriminatory and abusive practices against people who use drugs.
- In accordance with its mandate to mainstream human rights in the work of the UN, adopt a resolution on the 'protection of human rights while countering the world drug problem' to provide policy guidance to the Commission on narcotic Drugs, the UNODC and the INCB.
- Consider the creation of a new mandate of Special Rapporteur on HIV and Human Rights.
- Consider the creation of a new mandate of Special Rapporteur on the protection of human rights while countering the world drug problem.
- Include a focus on drug policy during Universal Periodic Review

Office of the High Commissioner for Human Rights

- Assist the UN Office on Drugs and Crime in mainstreaming human rights in its programmatic work, including the development of human rights impact assessments.
- The Office of the High Commissioner for Human Rights should attend each session of the Commission on Narcotic Drugs. A high level representative of the OHCHR should, in particular, attend and make a statement at the 2009 High Level Meeting of the Commission on Narcotic Drugs to address the human rights aspects of the next ten year strategy for international drug control.

Human Rights Treaty Bodies and Special Procedures

- In accordance with their respective mandates (during country visits, periodic reporting procedures etc), focus on the impact of drug policy on human rights in order to highlight human rights issues and further the understanding of human rights obligations in this context.

ENDNOTES

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- ³ Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: focus on progress over the past 12 months, Report of the Secretary General, UN Doc No A/61/816, 20 March 2007, para 53
- ⁴ Mathers B, Degenhardt L, Phillips B, Wiessing L, Hickman M, Strathdee S, Wodak A, Panda S, Tyndall M, Toufik A, Mattick RP and the Reference Group to the United Nations on HIV and injecting drug use. The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *The Lancet* 2008, Volume 372
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- ²² National AIDS Control Council (2008) UNGASS Country Progress Report – Kenya
- ²³ Remarks on the handover of the report of the Commission on AIDS in Asia. United Nations Headquarters (New York), 26 March 2008
- ²⁴ Committee on Economic, Social and Cultural Rights, 'Concluding Observations: Tajikistan', (24 November 2006) UN Doc No E/C.12/TJK/CO/1, para 70.
- ²⁵ Committee on Economic, Social and Cultural Rights, 'Concluding Observations: Ukraine', (23 November 2007) UN Doc No E/C.12/UKR/CO/5, para. 28.
- ²⁶ *ibid.*, para. 51.
- ²⁷ 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Mission to Sweden' (28 February 2007) UN Doc No A/HRC/4/28/Add.2 para 60.
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- ²⁹ See Elliott et al 'Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control Policy' *Health and Human Rights: An International Journal*, Vol. 8, No. 2, 2005
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⁴⁰ See, for example, Matt Curtis, ed., 'Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice' (New York: Open Society Institute, 2006), pp. 25-35. .

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⁴² Bollerup et al, 2005, op.cit.

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