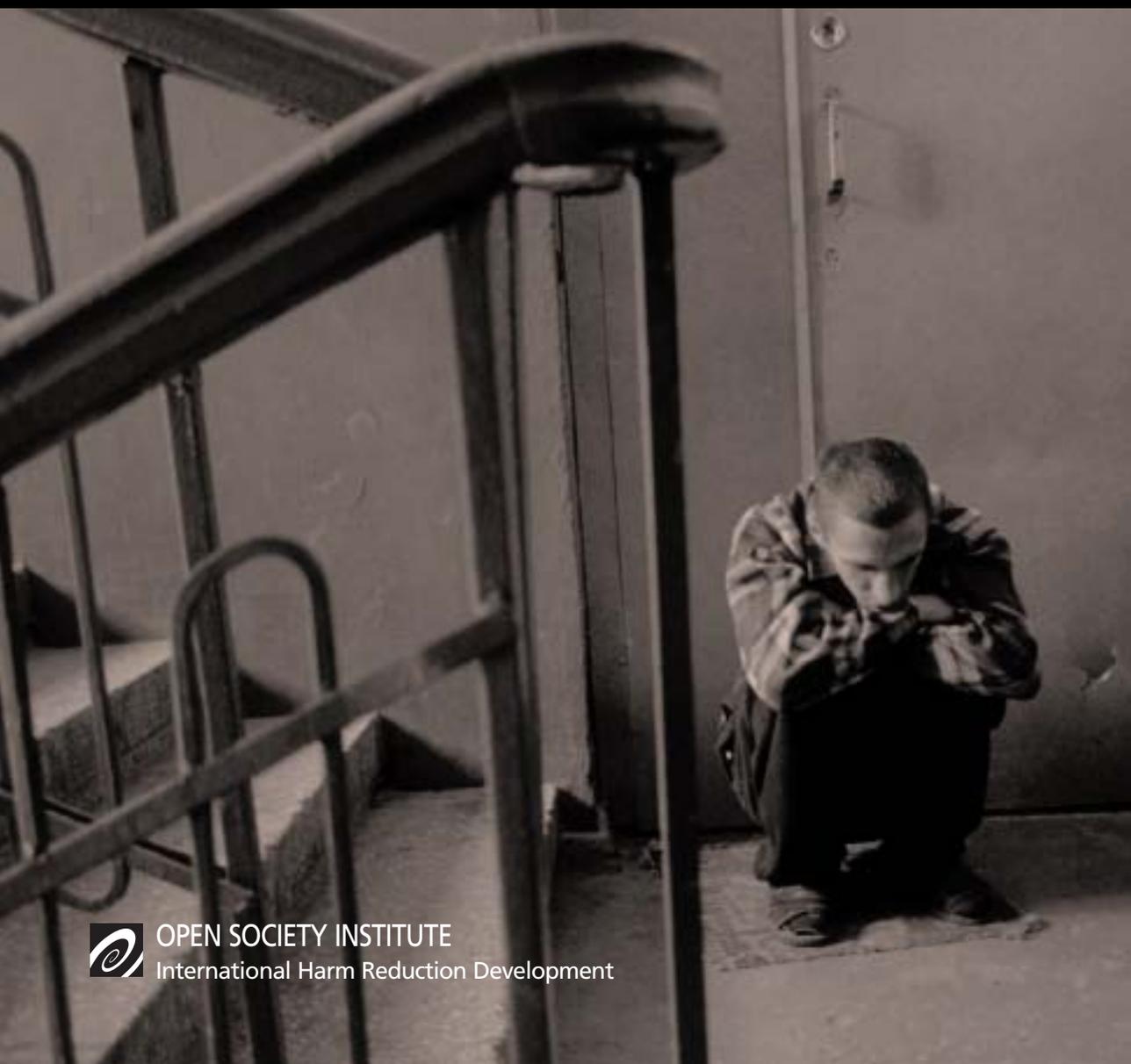


Protecting the Human Rights of Injection Drug Users

THE IMPACT OF HIV AND AIDS



OPEN SOCIETY INSTITUTE
International Harm Reduction Development

Protecting the Human Rights of Injection Drug Users

THE IMPACT OF HIV AND AIDS

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HARM REDUCTION
DEVELOPMENT

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The International Harm Reduction Development program (IHRD) supports local, national, and regional initiatives in Central and Eastern Europe, the Russian Federation, and Central Asia that address drug problems through innovative measures based on the philosophy of harm reduction. Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use—especially the risk of HIV infection. The approach places an emphasis on human rights, common sense, and public health. In practice, harm reduction encompasses a wide range of drug user services including needle and syringe exchange, methadone treatment, health education, medical referrals, and support services.

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The right to health includes the right to obtain health services without fear of punishment—impossible to achieve under the drug law regime in many countries.

Introduction

The human rights of drug users have too often been a casualty of the global “war on drugs.” Around the world, harsh national and international drug laws and repressive drug policies are implemented in a manner that makes the violation of drug users’ human rights inevitable. Undue repression of drug users by states not only represents bad human rights practice but also, in the era of HIV and AIDS, is potentially lethal as it drives drug users away from HIV prevention and AIDS treatment and care. Protection of the rights of injection drug users is thus both an urgent public health concern and a human rights imperative.

Injection drug use is a major risk factor for HIV in many parts of the world. Globally, an estimated 10 percent of new HIV infections and about one third of new infections outside of Africa are linked to injection drug use. In the former Soviet Union (fSU) and Eastern Europe alone, there are an estimated 4 million injection drug users, and in many countries of the region more than 70 percent of persons living with HIV are drug users. It is not surprising that this region is home to the world’s fastest-growing AIDS epidemic as HIV can spread at lightning speed through injection. In the United States, about one third of all HIV cases are linked directly or indirectly to injection drug use. In China, injection drug use is estimated to be the most important mode of HIV transmission. In addition to HIV, injection drug users are at high risk of numerous blood-borne diseases, including hepatitis B and C, and of lethal overdose.

These growing challenges and dangers have prompted the development of a number of proven and affordable services to reduce the harms of injection drug use. Syringe exchange pro-

grams that provide drug users with clean injecting equipment in exchange for used equipment have proven effective in many countries in decreasing needle sharing, getting dirty needles off the streets, and reducing HIV and hepatitis transmission. Syringe exchange services can also establish trusting relationships with injectors and lead them to other services, including other health care and addiction treatment programs, and information on HIV and other diseases.

Another important measure to reduce drug-related harm is substitution therapy. It provides opiate users with access to legal drugs that take the place of illicit narcotics. Methadone, which is used to help treat heroin addiction, is generally consumed orally, thus eliminating all of the risks associated with injection. Methadone maintenance therapy has a 30-year history of success in reducing the need for injection and is a central element of HIV prevention in many countries.

Unfortunately, too many countries focus their drug policies on criminalizing drug users and throwing them in jail, instead of treating drug use and addiction as a health problem and providing users with the health services they need. Only about 11 percent of injection drug users in the FSU and Eastern Europe have access to syringe exchanges. In the United States, 19 of the 50 states either ban outright or heavily restrict legal syringe exchanges. Methadone therapy remains illegal in numerous countries.

Some countries are content to restrict their drug control programs to criminal law measures. In many parts of the world, drug users can be incarcerated for long periods for consumption or possession of tiny amounts of narcotics. Drug users are regularly denied due process in the handling of criminal cases against them. They are often subject to widespread discrimination and stigma, marginalized by society, and denied access to basic services. They are vulnerable to a particular kind of torture as their addiction can be used against them as an instrument of coercion in police interrogations. In some countries, even though syringe exchange and substitution therapy services may exist, drug users cannot use them because they live virtually underground, in deep fear of the authorities and of government health facilities.

Necessary reform of repressive drug policies is a distant dream in many countries as entrenched police corruption deters change of an oppressive status quo. Government officials, legislators, and even civil society groups are rarely willing to take stands on behalf of mistreated drug users. Government antidrug awareness campaigns may further fuel public disdain through depictions of drug users as social demons or outcasts.

The right to health includes the right to obtain health services without fear of punishment—impossible to achieve under the drug law regime in many countries. As the UN Committee on Economic, Social and Cultural Rights has stated, policies that “are likely to result in...unnecessary morbidity and preventable mortality” are breaches of governments’ obligation to respect the right to the highest obtainable standard of health. Policies that impede access to clean syringes and opiate substitutes fit this description. In addition, prohibiting access to clean syringes or substitution therapy discriminates against persons with drug addiction as a class of

persons with a well defined disorder or disability. If the law denied syringes or medicines to insulin-dependent diabetics, the same kind of discrimination would occur, and no one would find it acceptable.

Much of the policy thinking that justifies criminalization of drug users rather than prioritizing humane health services for them is enshrined in United Nations conventions that have the force of international law. Three UN treaties on drug control—the Single Convention on Narcotic Drugs (ratified in 1961), the Convention on Psychotropic Substances (ratified in 1971), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (ratified in 1988)—form the basis for international coordination of drug control measures. Two of the treaties predate the AIDS epidemic, and the third predates the explosive global growth of injection drug use. It was surely never the intention of the framers of these treaties that they would impede the fight against AIDS but, tragically, this is part of their legacy. In the 1961 convention, methadone is classified as a “schedule 1” drug to which access should be strictly limited. Some countries use this provision to justify the illegality of methadone, thus denying injecting heroin users one of the most effective means to protect themselves from HIV and other harm.

The 1988 convention urges countries that are party to it to “adopt such measures as may be necessary to establish as criminal offences under its domestic law, when committed intentionally,” the possession of illicit drugs. Because this language is so vague, national governments have used it to justify a wide range of repressive antidrug policies that contribute to the marginalization of drug users from lifesaving health and harm reduction services. At the 1998 UN General Assembly Special Session on illicit drugs, member states reaffirmed the three conventions and agreed to work toward achieving “significant and measurable results” in reducing illegal drug consumption by 2008 (with a 50 percent reduction considered the formal target). That deadline has been criticized as unrealistic by many independent observers. Chasing this goal is likely to lead some countries to adopt draconian measures destined to fail in both reducing illicit drug use and controlling HIV.

Subsequent UN documents and statements have fortunately contained some language that can be construed as compassionate to drug users. The June 2001 declaration from the UN General Assembly Special Session on HIV/AIDS calls for “harm reduction efforts related to drug use,” though some member states objected to earlier language naming injection drug users as a population particularly in need of services and care. The 1998 UN International Guidelines on HIV/AIDS and Human Rights call on countries to review their laws with an eye toward legalizing and promoting syringe exchange and modifying laws that criminalize the possession and distribution of syringes.

Many UN member states, notably European Union states, Switzerland, Australia, and Canada, have demonstrated through scientifically sound policies that working respectfully with drug users and ensuring available services to reduce drug-related harm can stem HIV and

AIDS in this high-risk population. These experiences need to be shared widely and the legal and policy frameworks behind them understood.

The Open Society Institute and Human Rights Watch are pleased to have helped to organize the April 2004 discussion on the human rights of drug users documented in this publication. This parallel event at the sixtieth session of the U dN Commission on Human Rights was, to our knowledge, the first discussion of drug users' human rights to be part of the commission's formal session. It was held with the gracious support of the UN Special Rapporteur on the Right to Health, Professor Paul Hunt, and cosponsored by the government of Brazil.

We were privileged to have the participation of a distinguished and highly experienced panel of experts whose remarks are reported here. Presenters highlighted the vulnerability of drug users to a wide range of human rights abuses and the importance of those abuses with respect to the AIDS epidemic. Professor Hunt highlighted social stigma against drug users in addition to abuses they may face in the criminal justice system, noting that drug users who are HIV-positive may be doubly stigmatized. He also noted particular examples of rights-friendly programs and policies that have proven to be useful in the fight against AIDS. Reflecting on his long experience in analyzing human rights abuses in the war on drugs, Aryeh Neier, president of the Open Society Institute, concluded that "there is no way to use the criminal law to deal with drugs, except in a very abusive way" and noted the intersection of repressive drug laws with racial discrimination and social marginalization. Emma Bonino, member of the European Parliament and former European Commissioner responsible for Humanitarian Aid, underlined the counterproductive nature of harsh drug laws to address the essentially victimless "crime" of drug use. She noted the increasing contradiction between the international legal regime of drug control and the policies of many European Union countries that are establishing legal protections for needle exchange and opiate substitution therapy.

Other speakers presented national experiences, both positive and negative. Fábio Mesquita, M.D., director of the health authority of the city of Sao Paolo, detailed the important role of harm reduction measures in Brazil's successful national response to HIV and AIDS. One of the important victories he noted was the simple realization that narcotic drug use should be addressed principally by public health policy and only secondarily as a matter of criminal law. Paisan Suwannawong of the Thai Drug Users' Network provided a moving personal perspective on the impact on drug users of the Thai government's 2003 "war on drugs," which resulted in over 2200 extra-judicial killings. In addition to these killings, the false arrests, black-listing, and forced enrollment into military-style "treatment" camps led already stigmatized drug users to flee from the few services that may have helped them to avoid HIV transmission and other harms. The Thai drug war is not only just one recent example of complete disregard for the human rights of drug users, but also a very striking one: despite the heinous nature of

the abuses in Thailand, the country has had international praise heaped upon it for its “model” national AIDS program.

It is our hope that this volume, like the session it records, will be useful in advancing the cause of protection, respect, and fulfillment of the human rights of drug users both in the United Nations system and beyond.

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October 2004

Effective programs and policies for combating drug addiction and HIV transmission can be put into practice around the world and often at reasonable cost.

Confronting HIV/AIDS and Respecting Human Rights

PAUL HUNT

The spread of HIV through injecting drug use is an increasingly serious public health problem in many parts of the world. Outside of Africa, around one-third of all new HIV infections are linked to drug use, an alarming number of which involve young people. In some countries in Eastern Europe and in parts of Asia, the great majority of new HIV transmission is among drug users. Globally, an estimated 10 percent of HIV/AIDS is attributed to injecting drug use, and the numbers are continuing to grow. The twin epidemics of drug use and HIV/AIDS are now spreading with unprecedented speed.

These issues have clear and pressing public health and human rights implications.

There is a particularly important need to address stigmatization of, and discrimination against, injecting drug users as barriers to the right to health and other human rights. For example:

- ▶ Drug users are often stigmatized and are vulnerable to repressive treatment by the criminal justice system in some countries. In many countries, drug addiction is treated primarily as a matter of criminal law rather than a health issue.

- ▶ Discrimination against drug users can hinder HIV prevention efforts: people will not seek HIV counseling, testing, treatment, and support if this means facing discrimination, lack of privacy or confidentiality, alienation or in some cases, the threat of incarceration.
- ▶ Lack of human rights protection makes it more difficult for drug users to cope with HIV/AIDS. Where drug addiction is met with HIV transmission, those affected can be doubly stigmatized and may suffer discrimination at multiple levels.
- ▶ Repressive or coercive public health measures, such as compulsory HIV testing, are often imposed on injecting drug users, who may be even more vulnerable in the context of the criminal justice system.

The human rights challenges are great. However, good practices do exist for addressing these issues. The following examples indicate that effective programs and policies for combating drug addiction and HIV transmission can be put into practice around the world and often at reasonable cost.

- ▶ In Bangladesh, an HIV/AIDS prevention program provides outreach services for injecting drug users, including needle exchange services, peer education, condom promotion, and user-friendly treatment for sexually transmitted infections. As a result of these interventions, prevalence among injecting drug users was measured at 7 percent in 2003, as opposed to the projected estimate of 60 percent.
- ▶ In Ukraine, needle exchange projects are now reaching about 20 percent of all drug users, following recent widespread information campaigns and open debate on the issues.
- ▶ In the United States, clean-needle services in the state of California have resulted in a drop in the percentage of new injecting drug users and a massive decrease in needle-sharing.

To be effective, human rights sensitive public health strategies should include harm reduction initiatives, as well as commitments to:

- ▶ reviewing antidiscrimination laws to ensure that persons affected by HIV/AIDS and members of vulnerable groups, including drug users, are protected against discrimination;
- ▶ ensuring available and accessible treatment and rehabilitation services for drug

users, together with appropriate HIV-related information, education and support;

- ▶ reviewing drug control legislation and practices, to ensure that they do not hinder HIV prevention efforts by perpetuating the stigmatization and marginalization of drug users; and
- ▶ ensuring the participation of injecting drug user communities in the development and implementation of programs and policies—consistent with the human right to participate.

These are not easy discussions. Some of these initiatives will be controversial in some societies. Yet confronting the issues that HIV/AIDS poses to international human rights law and pragmatic public health goals demands difficult policy decisions. And such decisions must include ensuring respect for the human rights of drug users who have become one of the most vulnerable and marginalized groups affected by HIV/AIDS.

The law enforcement approach to drugs has had disastrous results that include systematic violations of human rights.

Abuses in the Name of Law and Order

ARYEH NEIER

I have had an opportunity to try to deal with the problem of the human rights of drug users for about 40 years. When I started work for the American Civil Liberties Union in 1963, Nelson Rockefeller was the governor of New York State. Some of my earliest battles, as director of the New York branch of the American Civil Liberties Union, focused on fighting what came to be known as the Rockefeller drug laws. These laws, which still prevail in New York, make the state where I live one of the most punitive places anywhere in dealing with drug users. My experience with the Rockefeller drug laws showed me how dealing with drugs through the criminal justice system operates. In subsequent years, I found overwhelming similarities in drug law enforcement efforts throughout the world.

As a result, I have come to believe that there is no way to use the criminal law to deal with drugs, except in a very abusive way. If one is going to use the criminal law, one has to conduct arbitrary searches and engage in practices such as entrapment. It is quite natural for law enforcement agencies to identify drugs with particular minorities within different societies, and therefore to engage in racial profiling. It is natural for law enforcement to engage in violations of privacy, to access confidential medical records or conduct invasive body cavity searches.

Another characteristic of the effort to control drugs through law enforcement is that it often punishes the status of being a drug user. In some countries, such as Myanmar (Burma), the status of being a drug user is per se a crime. In countries such as Malaysia, drug users, or

suspected drug users, may be subject to mandatory testing such as urinalysis to determine if they have used drugs, and are punished if they test positive. Here, too, it is the status of being a drug user that is punished. In many places, the criminal law imposes punishments on those who possess quantities of drugs for their own use. Effectively, in all of these examples it is the status of being a drug user that is punished. Yet from the standpoint of the rule of law and in human rights, punishment of status is always improper. It is a form of cruel and unusual punishment. But it is an inevitable part of the process of enforcing the criminal law against drug use.

Why is this the case? I think the reason is not very difficult to find. The nature of drug crimes differs from other crimes in that there is no complainant. No one has said to the law enforcement authorities, "I have been victimized by that person. I complain." Or, "I witnessed that person committing a crime." When there are witnesses in drug cases, they are law enforcement officers themselves, or those who are coerced to testify by law enforcement in order to receive a lesser punishment for themselves, or escape punishment altogether. Without a complainant, law enforcement must resort to arbitrary searches and violations of privacy to enforce the criminal law against drugs.

Racial profiling is also something that goes with the enforcement of laws against drugs. In the United States, it is widely known that the use of marijuana among nonwhites and whites is approximately the same. Yet a greatly disproportionate number of all those arrested for possession of marijuana are black. In many of our states, 90 percent or more of those in jail or prison for marijuana are black. The reason is that law enforcement, in dealing with drugs, works on the basis of probabilities. Law enforcement officials arbitrarily assume that there is a higher probability that a black will be in possession of drugs than a white, and so they stop more blacks and engage in more searches. If you stop more people and engage in more searches, you will find more drugs among those people you stop and search. Therefore, you will have a higher proportion of blacks in prison. The law enforcement assumption, based on racial prejudice, is reinforced by law enforcement practice and by the number of blacks who are actually brought to court and prosecuted and punished.

There are other factors that seem to me to exacerbate the problems of law enforcement in dealing with drugs. One is that the persons who are the targets of law enforcement have no significance in society. They are looked down upon; they are stigmatized; they are drug users. Therefore, it does not matter when they complain or when they protest about the way in which they are treated. It becomes much easier to victimize them because they don't have political power. The stigma of being a drug user denies them the political capacity to protest against the abuses that they suffer.

Another factor of equal significance in exacerbating the consequences of abusive law enforcement practices is that drug crimes inspire corruption. The law enforcement process drives up the cost of drugs. Drug dealers, who bear the risks and expenses of running an ille-

gal business, increase the prices of drugs ever higher to make a suitably large profit. As a result, there is a lot of money in the drug business. It becomes very tempting for those who are engaged in law enforcement to get some of this money for themselves. Since the only complainants are law enforcement officials, they have complete discretion in determining which cases to pursue, increasing the likelihood that corrupt officials will base their decisions on what is most financially rewarding to them.

In the United States, in our federal government, we have a special agency for enforcing the law against drugs, the Drug Enforcement Agency. Our main federal law enforcement agency, the FBI, the Federal Bureau of Investigation, does not deal with drugs. The reason is this: J. Edgar Hoover, who was FBI director for some 50 years, refused to enforce the law against drugs because he wanted to convey the impression that the Federal Bureau of Investigation was incorruptible. He knew that if the FBI enforced the laws against drugs, FBI agents would be corrupted. So, bureaucratically, he resisted taking on the enforcement of laws against drugs, forcing the United States government to create a separate agency, the Drug Enforcement Agency, which indeed has been very corrupt in dealing with drugs.

Corruption exacerbates the problem of law enforcement abuses. Individual law enforcement officers who are corrupt are the most abusive officers. They don't respect themselves and don't respect anybody whom they deal with.

All these problems with law enforcement are compounded enormously in the era of HIV/AIDS. National laws and international treaties dealing with drugs were conceived either before the HIV/AIDS pandemic or without regard to HIV/AIDS. Yet we know that a large part of the HIV/AIDS pandemic is attributable to injecting drug use. Injecting drug use accounts for about one third of new cases outside Africa. In the countries of the former Soviet Union, in parts of Asia and in Iran, overwhelmingly, the problem of HIV/AIDS is attributable to injecting drug use. In the former Soviet Union, the HIV/AIDS epidemic is actually growing at a faster rate than in Africa. Today in Russia there are generally estimated to be about a million and a half persons who are HIV positive. In Ukraine, which, among former Soviet countries, probably has the highest ratio of those who are HIV positive, the total number is about 400,000 persons.

The law enforcement approach tends to get in the way of, or actually prohibit, the use of effective means of dealing with the HIV/AIDS pandemic. In places where needle and syringe exchange is possible, there is often harassment by law enforcement officials. It may range from raids on syringe exchange facilities in Uzbekistan to practices in the United States and elsewhere of targeting anyone in the vicinity of a syringe and needle exchange. The consequence is to frighten drug users away. Also, if drug users who carry their own syringes are subject to search, arrest, and prosecution, they will be deterred from carrying their syringes when they purchase drugs. Instead, they will use syringes that have been used by others, which, of course, contributes to the spread of HIV/AIDS.

The law enforcement approach, driven by the policies of the United Nations

Commission on Narcotic Drugs, has discouraged the use of methadone. Russia has a million and a half people already suffering from HIV/AIDS, almost all attributable to injecting drug use, yet the government prohibits the use of methadone, which reduces injection drug use. This prohibition on methadone, based on the law enforcement approach promoted by a UN agency, greatly accelerates the problem of HIV/AIDS in Russia.

There are countries that have not yet suffered a major HIV/AIDS epidemic, but I think one can predict that they will suffer from this epidemic unless they are able to adopt more sensible drug policies. The Iranian government says that it has 1,200,000 regular injection drug users. At this point, HIV/AIDS has not become an epidemic in Iran. Fortunately, the Iranian authorities seem open to more enlightened policies than those that are being pursued in countries such as Russia and Ukraine. But it is urgent that they should actually be able to implement such policies without the interference of UN agencies, which have derailed sensible policies elsewhere.

The law enforcement approach to drugs has had disastrous results that include systematic violations of human rights. There is no way to conduct law enforcement in dealing with drugs except in a manner that produces such abuses. In the age of HIV/AIDS, law enforcement abuses directly endanger the lives not only of drug users but also of large segments of the general population. The HIV/AIDS epidemic in these countries may begin with drug users but cannot be confined to them. Ultimately, the whole community is victimized.

We should oppose policies and laws that seek to establish criminal responsibility where there is no victim.

Crimes Without Victims: Appropriate Policy Responses to Drug Use

EMMA BONINO

Current drug policies—the result of three UN conventions that more or less establish a total prohibition on anything related to drugs—are counterproductive and simply don't work. There are many ways to show how the three conventions are ineffective. Yet for the first time to my knowledge, we are tackling the issue by examining the human rights of drug users. It is a new and worthwhile perspective to analyze the repercussions that the policies embedded in the conventions have on vulnerable groups such as drug users.

The human rights perspective is also important because it helps reveal the contradictions faced by the United Nations as it seeks to protect and expand human rights while also acting as the international community's guarantor of conventions to control licit and illicit drugs.

It is of particular importance to bring debate about the effectiveness of UN drug policies to its specialized agencies. I see schizophrenia and contradictions in the UN's establishment of international drug conventions that result in unforeseen consequences which then require analysis by specialized UN agencies.

I am convinced that those who inject drugs, whether willingly, unwillingly, desperately, happily, or for whatever reason, should not be treated as criminals. They should not be sentenced to prison. They should not be forced to live at the margins of society. Their actions do not have a direct impact on another person. I strongly believe that we should oppose policies

and laws that seek to establish criminal responsibility where there is no victim. One of the basic guidelines in defining a crime is whether an action has a victim. Individuals using drugs on themselves definitely do not meet this definition. Yet if you implement the prohibition convention, individual drug use becomes a criminal act. Criminalizing personal use of drugs is a major barrier to a sensible approach to the problems of drugs *per se*.

In several countries in Europe, there is an awareness that the conventions do not work at all, and that they foster human rights abuses. These states are adopting different policies and initiatives to address the issue in ways that were unforeseen by the conventions and even run contrary to them. So you have the prohibitions of the conventions on one hand, while on the other, you have European states that are putting up policies which contradict the convention in order to limit the harm that prohibition creates. Instead of addressing the issue of prohibition itself, we pursue a schizophrenic course by trying to be more effective in tackling the consequences of prohibition.

A number of countries, mainly in Europe, continue to modify their legislation to facilitate treatment, often through harm reduction, but also by acknowledging the human rights of drug users, and the need for rehabilitation of drug users and addicts. In the last five years, we have seen a 34 percent increase in the availability of substitution treatment in the European Union and Norway. This means that 400,000 people now receive substitution treatment in sixteen European countries. Over 60 percent of these people, around 250,000, receive treatment at facilities in Spain, France, and Italy. The biggest rise in treatment has been in countries with low initial provisions such as Greece, Ireland, Portugal, Finland, and Norway. Methadone is by far the most common treatment substance used, which indicates that the legal framework of prohibition continues to have bad consequences that European countries are trying to reduce through different treatment policies.

Let me stress that this contradiction continues to grow. For instance, in its 2004 report, the International Narcotics Control Board stigmatized needle exchange, saying it is a violation of the UN conventions. So we are in a situation in which, frankly, there is no rule of law which seems to apply. You have an international legal framework, and then you have national policies that are in violation of the conventions, but are implemented either to support the human rights of the drug users and addicts or guide harm reduction efforts. Thus we have many countries developing national policies without having the courage to challenge the international conventions.

I would also like to stress the importance of emphasizing the human rights of drug users. The common belief is that drug users don't deserve anything. But, again, that is fantastic, because if you go to EU statistics on marijuana or hashish use, you will find that 20 percent of adults in the European Union have used cannabis-based drugs at least once in their lifetime. What are we going to do with this 20 percent of the population? Put them all in jail? And if you go even deeper into figures for young people between the ages of 15 and 34, these percentages

are even higher, with 44 percent in Spain, indicating that almost half of the population, apparently, should be in jail. In France, the ratio is 40 percent; in the UK, 42 percent; and in Denmark, 44 percent.

So, all in all, these examples highlight that we are living in a situation where the law has very little to do with real life. Implementation is selective and often depends on where you were born; if you are black or white; or if you happen to be in Italy soon after the referendum or three years later when the law has been reversed. So you can be a criminal or not a criminal depending on often unstable motivations that can change from one year to the next.

Reconciling drug laws with reality is also important for human rights and the rule of law: every citizen should know what the rules are and how to follow them. Right now, many citizens are uncertain about the rules on drugs. You can be arrested or not depending on a variety of reasons that frankly have nothing to do with the law or should be the construct of citizen and state or citizen and institution.

I think it's important that we think and work together to create some type of coalition of willing states. We already have some representatives and I understand, for instance, that in Vancouver, Canada, a project for distributing heroin started just recently. With some pushing and prodding, we can get more pragmatic governments to pursue drugs and human rights issues at more of the agencies and conferences organized by the UN and the international community.

I welcome this human rights approach. If we can join it with policy discussions on HIV and other issues in regions like Latin America, or Asia, or even in specialized UN agencies, then I think we can do much to change the chaotic and contradictory situation in which we currently live.

In 2002, the Brazilian Congress legalized needle exchange programs (NEPs) nationwide, and Brazil now has almost 300 NEPs, all supported by the federal government. These programs have had impressive results in offering comprehensive services to intravenous drug users, their sexual partners, and their children.

Health Care, Not Warfare: Brazilian Responses to the Drug Problem

FÁBIO MESQUITA

“In time of war the first casualty is truth.”

—Boake Carter during World War II.

Unfortunately, this statement remains incredibly relevant when applied to the current “War on Drugs,” which, in fact, could be more appropriately phrased as a “War on Drug Users.”

The policy guiding the current war was established by former U.S. President George H. Bush in 1989, and was supposed to be limited to U.S. domestic affairs. Yet, studies have shown that the policy had international applications as well. These analyses indicate that the motivation for the new “War” was the end of the “Cold War” and the necessity to maintain profits for the arms industry. A war on drugs could also act as a new instrument for geopolitics, providing new rules for interventions in strategic regions throughout the world.

Even if we ignore all these “motivations,” the consequences of this war have been confirmed by researchers, journalists, and social scientists all over the world and cannot be

ignored: the “War on Drugs” has resulted in millions of people in jail for possession or use of drugs; violations of basic rights; and a host of social, economic, and health problems.

Besides the spirit of the “War on Drugs,” the three UN drug control conventions—the Single Convention on Narcotic Drugs (1961); the Convention on Psychotropic Substances (1971); and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)—have significantly influenced policies in countries throughout Latin America, including Brazil.

As a medical doctor and member of the directorate of the public health system in Sao Paulo, Brazil’s largest city with almost 11 million inhabitants, I have had firsthand experience with the health consequences of drug war policies and international conventions on Brazil and how we are dealing with them. Brazil is part of the developing world and marked by many substantial social inequalities, including consistent violations of human rights on many fronts. However, in conjunction with other concerned public officials and activists, I have been working hard over the last 15 years to overcome abuses of drug users, based on the bad influence of the “War on Drugs” and the UN conventions in our region. Our efforts to change public health and drug policies are by no means finished, but they are definitely heading in the right direction.

The world’s coca supply is produced in Latin America, with Peru, Bolivia, and Colombia as its primary producers. Brazil’s role was initially as a trafficking route to take cocaine to the best markets: North America and Europe. However, in the 1980s, Brazil also developed into a local market for cocaine consumption, with port cities playing a key role in this process. Cocaine use increased rapidly, and growing numbers of injecting cocaine users prompted the quick spread of HIV/AIDS. Like many countries, Brazil was tremendously affected by AIDS in the 1980s, and injection drug use played a critical role in driving the epidemic.

By 1989, the city of Santos, on the coast of the State of Sao Paulo (the main harbor in South America), faced the highest number of HIV/AIDS cases in Brazil in proportion to the population. Almost 50 percent of our cases were due to injecting drug users. Looking at the international experience, we found that a comprehensive program addressing the health problems of drug users would be the best way to prevent the spread of suffering within this population. Harm reduction was a compelling approach at that time, and it fit well with our commitment to promoting and maintaining public health.

Shortly after receiving local government approval from the city of Santos, we launched Brazil’s first needle and syringe exchange program (NEP) in 1989 through the local department of public health. State prosecutors responded by issuing a criminal suit against me, as a director of the STD/AIDS Program, as well as my colleague, the head of the public health department. The suit was based on the Brazilian legislation at that time, which was modeled on the 1988 UN Convention principle establishing that “inciting someone else to use drugs is illegal.” The lawsuit delayed our prevention strategy for many years. In 1993, an NGO from Santos, IEPAS, established the first Brazilian-based outreach workers project, and finally, in 1995, the University of Bahia in the city of Salvador launched the first NEP tolerated in Brazil.

Despite the subsequent delays, the initial events in 1989 helped establish a deep debate in Brazil about the necessity to support harm reduction projects. This debate eventually led to political support and federal funding in 1993 and 1996 for many harm reduction projects. Financial support came also from two international agreements between the Brazilian government, the UNODC, and the World Bank. In 1998, the first law on harm reduction was approved in the State of Sao Paulo, followed by approval in two other states, Santa Catarina and Rio Grande do Sul. In 2002, the Brazilian Congress legalized NEPs nationwide, and Brazil now has almost 300 NEPs, all supported by the federal government. These programs have had impressive results in offering comprehensive services to intravenous drug users, their sexual partners, and their children. They have also provided significant HIV/AIDS and harm reduction data for international publications. Between 1998 and 2003, the number of harm reduction projects in Brazil increased from 8, serving 1200 drug users, to 279, serving over 145,000 users. HIV Seroprevalance among IDUs dropped significantly: going from 63 percent in 1992 to 42 percent in 1999 in Santos; and, in Salvador, from 49.5 percent in 1996 to less than 8 percent in 2000. Nationally, the levels declined from 52 percent to 41.5 percent between 1998 and 2000.

In addition to the 1998 and 2002 decisions, two other pieces of legislation currently awaiting final approval may facilitate the work of health authorities in helping drug users. The first is a Presidential Decree (already approved by all ministries and waiting for the signature of Brazilian President Luis Inacio Lula da Silva), and a new bill before Brazil's congress that avoids prison for possession or use of drugs. These developments are the result of an internal fight in the Brazilian government with support for the legislation coming from the health, justice, human rights, and culture ministries, and opposition coming from agencies representing the government's conservative wing like the National Secretariat on Drugs and the Civil Affairs Cabinet.

In addition to this drug legislation, the government is also pursuing a number of other important initiatives addressing drug treatment and drug users with HIV/AIDS. In 1991, the city of Santos followed up on its pioneering 1989 harm reduction efforts by being the first Brazilian city to purchase zidovudine (AZT) to treat AIDS. In 1996, it was also the first city in Brazil to provide HAART therapy for all AIDS clients who needed it with no exception, including drug users. In February 1996, Santos also had the first legislation obligating the government to provide HAART therapy. In November of the same year, the Brazilian congress enacted a national law on the provision of and rights to HAART therapy. The law is based on principles of universal access established by Brazil's constitution, its health law, and the public health care system. By the end of 2003, 128,000 AIDS patients had received HAART therapy, about 25 percent of whom were injecting drug users. Based on the Brazilian government's policies for producing generic HAART, the initial annual cost per client dropped from over U.S. \$4,800 in 1997 to \$1,000 in 2004.

A second initiative was the introduction of prevention and treatment for hepatitis B and C in the public health services in some parts of Brazil. Established over the last four years, this

program includes vaccination for hepatitis B, laboratory tests including genotyping, education, and offers treatment to drug users and others with hepatitis. As is well known, injecting drug use is currently the main source of new hepatitis C infections worldwide. The program is expected to expand and be guided by experience gained from efforts to control HIV/AIDS.

Finally, a remaining gap for harm reduction efforts to overcome (besides extending the work into prisons) is the lack of options for drug users who want to quit using drugs by undergoing treatment. This may be due to the fact that almost 100 percent of the injection drug use in Brazil involves cocaine, for which no substitution therapy currently exists. It would be wonderful if there were substitutes such as methadone, but substitution therapy for cocaine is still only at the research stage. However, there have been many tentative attempts to find approaches other than abstinence, which, in the case of cocaine, are mainly based on psychological therapies. Most of the development and application of these therapies is conducted at public universities carried out with public money.

It is clear that in Brazil we have not totally dealt with the problems faced by drug users, and that drug user issues are surrounded by much internal organizational fighting. We do not have a national drug users' organization, and it remains difficult for drug users to have their needs and issues acknowledged. We also need to better organize the health services to address the problem of cocaine overdoses, which continues to undermine our system. However, as a doctor, I'm sure that the best approach to deal with the consequences of drug use is through public health instead of law enforcement.

In the near future, I would love to hear from my colleagues in places such as India, China, the former Soviet Union, and the United States about the progress they have made in alleviating suffering, saving lives, and controlling the health consequences of drug use in their countries. I would also love to hear about how much of this success was strongly supported by the United Nations and its improved drug conventions of the future.

For the moment, however, I look forward to working with others in Brazil and beyond who want to make public health harm reduction approaches feasible and available for all!

It is common for drug users to be denied access to village loan funds; common for them to be wrongly charged for village crimes; and even common for them to be denied the right to be cremated or buried according to their religious beliefs.

We Are Part of the Solution, Not Part of the Problem: Drug Users Struggle for Rights in Thailand

PAISAN SUWANNAWONG

My name is Paisan Suwannawong, and I am 38 years old. I come from Bangkok, Thailand, where I am the director of the Thai AIDS Treatment Action Group and a founding member of the Thai Drug Users' Network.

I am also a former injecting drug user, and have been HIV-positive for 13 years. Like many other injectors, I am also infected with hepatitis C. Most of the other people I used drugs with 10 or 15 years ago are dead, and I am here to talk about what killed them.

At least half of all injecting drug users in Thailand are HIV-infected and constitute the fastest-growing group of new infections. These numbers have not decreased for more than a decade because of a total lack of political commitment to the health and safety of injectors. The sexual transmission of HIV, however, has been reduced dramatically. In just 10 years, the number of new infections per year decreased from approximately 140,000, to just 20,000 in 2003.

Stigma and discrimination in our society, often fueled by government attitudes, are equally deadly. It is common for drug users to be denied access to village loan funds; common

for them to be wrongly charged for village crimes; and even common for them to be denied the right to be cremated or buried according to their religious beliefs.

Provision of substandard treatment or outright denial of any health care services to drug users is also widespread. Last month, my friend, an HIV-positive drug user, went to a local police hospital for care. The doctor refused to treat him and told him to go home and die. In fact, he died of AIDS two weeks later in wretched pain. Despite the high HIV prevalence among injecting drug users, those considered by the state to have “high risk behaviors” are excluded from life-saving AIDS drugs that every other Thai may receive. Also, AIDS is not covered by Thailand’s universal health care plan.

In addition to being ravaged by HIV/AIDS, drug users are being attacked and killed by the government. In February 2003, Thailand’s prime minister, Thaksin Shinawatra, announced the beginning of the most violent war on drugs in Thai history. In the first three months, over 2000 people, including children, were murdered for allegedly being involved with drugs. Most of the victims were members of ethnic minorities in the border areas. Thaksin offered monetary awards to officials who met their arrest and drug seizure targets, and threatened to fire anyone who did not. He proclaimed that “Anyone who fails to cooperate will be regarded as an enemy of the state,” and billboards sprung up around the country describing people using or selling drugs as a threat to national and family security.

My friends who had not used drugs in over a decade found that their names were on local police blacklists. Often, people were shot point-blank after visiting the local police station for an interview regarding their blacklist status. Hundreds of thousands of people were forced into military boot camps for rehabilitation, including elderly mothers who were allowed in to clear their children’s names. One survey demonstrated the lack of any therapeutic benefit of these camps. Drug users themselves fled their provinces in fear for their lives. Service providers could no longer reach their drug-using clients.

The prime minister’s crackdown was characterized by false arrests and charges, wrongful seizure of assets, unfounded accusations and blacklisting, lack of due process, and countless extrajudicial executions. A week after Thaksin announced his so-called “victory” against drugs in Thailand, my friend “Noi,” like so many other poor, small-time drug users, was murdered by the police. His family remains too scared and hopeless to demand an investigation.

Recently, the lieutenant general of the Thai police said, “The war on drugs will never end, as long as drugs continue to flow into our country.” Yet there has never been a society free of drugs, and we must learn to deal with the problems that drugs can cause in an intelligent and compassionate manner. The most dangerous unresolved conflict is between public health and law enforcement approaches to drugs. When political leaders use the national drug problem as a campaign platform and try to conquer it by any means necessary, the whole nation suffers in the long term as drug use, sales, and trafficking are only temporarily suppressed. In fact, at the height of the drug war, prices for a majority of drugs remained stable in most regions. In cases where the war on drugs did reduce supplies or increase prices, many people simply

resorted to using other drugs, leading to dangerous new risks. The crackdown also scared people away from seeking treatment, for fear of being identified as a user or seller and potentially murdered.

This climate of hostility and intolerance led to the formation of the Thai Drug Users' Network to promote the rights, health, and safety of drug users. As long as our peers continue to die, uninformed, unsupported, unhealthy, untreated, and now as the unprotected scapegoats of a dangerous political regime, we will promote our needs to the government and society.

We believe we are part of the solution, not the problem. We want to work equally with all sectors of the government to comprehensively and holistically address the needs of people involved with drugs, using a rights-based approach focusing on the dignity and inherent worth of all individuals. Yet as long as we are seen as criminals in the eyes of our political leaders and communities, we can never be healthy.

On behalf of the Thai Drug Users' Network I enjoin you to help stop the violence and the export of Prime Minister Thaksin's dangerous model, and to help start promoting equal treatment and rights for drug users as a crucial part of healthier and more egalitarian societies.

About the Contributors

Paul Hunt

UN Special Rapporteur on the Right to Health

Paul Hunt was appointed the UN Special Rapporteur on the Right to Health for a three-year term in 2002. Prior to this, he served as director of the Human Rights Centre and as an independent expert on the UN Committee on Economic, Social and Cultural Rights. Hunt's work as a diplomat, as general secretary at the National Council of Civil Liberties in London, and as an adjunct professor at the University of Waikato, Aotearoa/New Zealand, has resulted in numerous publications and articles on economic, social, and cultural rights in Africa, Europe, the Middle East, and the South Pacific.

Aryeh Neier

President, Open Society Institute

Before joining the Open Society Institute and the Soros foundations network as president in 1993, Aryeh Neier spent 12 years as executive director of Human Rights Watch, of which he was a founder. Prior to that, he worked for the American Civil Liberties Union for 15 years, including eight as national director. Neier has served as an adjunct professor of law at New York University, and he has lectured at many colleges and universities in the United States and abroad. Neier's activities and his numerous publications have focused on investigating human rights abuses, establishing accountability, and bringing to justice those who have committed crimes against humanity.

Emma Bonino

Member of the European Parliament and former European Commissioner for Humanitarian Aid

In addition to representing Italy in the European Parliament, Emma Bonino is also a visiting professor at the American University in Cairo, Egypt. She has served as European Commissioner for Humanitarian Aid and on the board of the International Crisis Group. A cofounder of the Transnational Radical Party, Bonino has used nonviolent strategies to add dynamism and impact to her party's political campaigns for almost 30 years. She is committed to challenging discrimination and has led campaigns focusing on divorce and abortion rights as well as the regulation and legalization of narcotics.

Fábio Mesquita**Director of Health Programs, City of Sao Paulo Public Health Department, Brazil.**

Fabio Mesquita, M.D., is director of the of Sao Paulo Public Health Department's Health Programs Sector. Mesquita has served as vice-president of the International Harm Reduction Association, and has directed Sao Paulo's STD/AIDS program as well as the prevention and human rights units of Brazil's national program on AIDS. He has also worked as a consultant for UNESCO, UNAIDS and WHO. Mesquita has been one of Brazil's leading advocates for harm reduction and the rights of drug users and has published numerous books and articles on public health issues in English, Portuguese, and Spanish.

Paisan Suwannawong**Director, Thai AIDS Treatment Action Group**

Paisan Suwannawong is the founding director of the Thai AIDS Treatment Action Group (TTAG), which he established after five years as Chairman of the Thai Network of People Living with HIV/AIDS (TNP+). He is also a founding member of the Thai Drug User's Network (TDN), a group of leading advocates for the health and human rights of drug users. With Suwannawong's leadership, TDN received a \$1.3 million grant from the Global Fund to Fight HIV, Tuberculosis and Malaria to establish new harm reduction services in Thailand. In recognition of their accomplishments, TDN received the 2004 International Award for Action on HIV/AIDS and Human Rights from the Canadian HIV/AIDS Legal Network and Human Rights Watch.

Unduly strict interpretation of UN drug control treaties directly undermines HIV prevention efforts by discouraging countries from implementing effective, realistic, and compassionate public health policies. The analyses and experiences shared by this volume's contributors indicate that international bodies like the UN Commission on Narcotic Drugs and national governments must give greater consideration to the human rights, including access to treatment, of injection drug users. By incorporating a human rights perspective into the process of reforming the laws and treaties governing drugs, the UN and national governments could do much to improve access to treatment and better protect the health of those at risk for HIV transmission, especially injection drug users.

