6 ISSUE PAPER FOR THE SESSION:
Human rights and drug policy in the run-up to the 2016 UNGASS on drugs

Background

HIV epidemics linked to use of illicit drugs remain among the fastest-growing and most intransigent in the world. As UNAIDS reports in the most recent global HIV overview, it is unlikely that the world will meet the 2015 goal for halving HIV transmission among people who use drugs.\(^1\) HIV burden remains high in this population. While there are very effective and affordable measures for prevention of HIV transmission linked to drug use, these interventions still reach a very small percentage of those who would benefit from them. Some 31 of the 35 countries reporting data to UNAIDS in 2013 indicated coverage of less than 10 percent in their opiate maintenance therapy programs, and only two of 32 countries indicated that they are able to supply at least 200 syringes per year per person, the cut-off recommended to ensure effectiveness of syringe programs.\(^2\)

People who use drugs are still systematically excluded from HIV treatment in many places. In addition, in many countries, those who need it do not have access to affordable, scientifically sound and humane treatment for drug dependence. As was noted in 2013 by the UN Special Rapporteur on Torture, some of the “treatments” that are provided to people who use drugs are cruel and inhuman, including “state-sanctioned beatings, caning or whipping, forced labour, sexual abuse and intentional humiliation.”\(^3\)

Practices in the health sector are also influenced by the deep criminalization of drug offenses, including minor infractions, which still characterizes the legal regime for drug use in most countries. Many national penal codes establish very harsh penalties for drug consumption itself as well as for possession of amounts for individual use and buying or selling of small amounts of drugs. Nonetheless, in the last few years, the movement to promote less repressive drug laws and policies has enjoyed some success. The purpose of this paper is to review the human rights imperative for improved responses to drug-related HIV epidemics and for drug law and policy reform, and to suggest ways in which UNAIDS can provide leadership in upcoming UN drug policy events.

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2 Ibid.
Harsh criminalization of drug offenses, human rights violations and HIV risk

In addition to facing cruel practices in the health sector, people who use illicit drugs are highly vulnerable to abusive policing and other human rights violations, many of which raise HIV risk directly or make it less likely that they will benefit from HIV services. It is no accident that some of the most uncontrolled HIV epidemics in drug-using populations are in places with the harshest criminalization of drug use.

Criminalization of drug offenses, including harsh custodial penalties for minor offenses, gives police leeway to crack down on people who use drugs. When people who use drugs live with persistent fear of arrest and detention, they are unlikely to seek the health services and social support they need. When the effectiveness of drug policing is measured by the number of arrests and detentions, as is often the case when laws are harsh, police may go so far as to target needle exchange sites and drug treatment facilities to meet arrest quotas. These barriers to use of essential HIV prevention services raise HIV risk and violate people's right to health services.

In some countries, drug paraphernalia laws make it a crime to possess syringes, even sterile syringes, a self-defeating policy with respect to HIV prevention. Some countries also define as a drug possession offense the possession of a syringe having trace elements of a drug in it. Such laws make it more likely that people will have to hide or share syringes and thus add to HIV risk.

Even in places where a significant percentage of HIV transmission is linked to drug use, people who use drugs are often systematically excluded from anti-retroviral therapy, a discriminatory and abusive exclusion that is most likely in the presence of repressive laws. Turning all people who use drugs into criminals gives health authorities one more reason to exclude them from care. "Treatment as prevention" measures that require high levels of participation of affected communities are unlikely to succeed in an environment of harsh drug law enforcement. In many countries, people who use drugs are registered as criminals when they seek health services, another barrier to HIV treatment and other life-saving care.

Where drug laws are harsh with respect to individual-level offenses, it is likely that people who use drugs will be in state custody at some time in their lives, often many times. People who use drugs and people with drug dependence

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are over-represented in prison populations in most countries. Relatively few countries in the world respect the human rights standard that health services offered to people in the community should be offered at least at the same level and quality to people in the custody of the state. This is particularly the case with respect to HIV prevention and treatment for drug dependence. In prisons around the world, prisoners have access to illicit drugs, but are denied access to clean injection equipment or evidence-based treatment for drug dependence, resulting in HIV and hepatitis C transmission and deaths from overdose. Many countries offer methadone maintenance therapy in the community but not in prisons. In spite of international standards recommending comprehensive harm reduction and HIV prevention activities in prison, custodial sentences for people who use drugs most often represent heightened HIV risk with no hope for treatment of either HIV or drug dependence. Exposure to tuberculosis and other infectious diseases only exacerbates their risk of illness and mortality.

At its twelfth meeting in March 2011, the Reference Group expressed serious concern about the many human rights violations occurring in compulsory drug detention centres (CDDCs), including the denial of effective HIV prevention and treatment, care and support in many of the centres. It agreed that UNAIDS and other UN agencies should pursue a strategy aimed at closure of the centres, as soon as possible, while continuing to work to secure protections against abuses until the centres are closed. Members emphasized that CDDCs exist for a number of reasons, including for financial reasons (as “moneymakers”), to get “undesirable” people off the streets, to uphold “morality” and to deal with what are considered as “social evils”. The Reference Group expressed concern that UN efforts in South-East Asia currently seemed to focus nearly exclusively on helping countries develop treatment alternatives, neglecting to address the other reasons why these centres exist and neglecting to highlight the serious human rights violations occurring in the centres. They urged UNAIDS and UNODC never to be silent about the human rights abuses in the centres since such silence comes dangerously close to being complicit with the centres. The Reference Group asked that a more comprehensive strategy be developed urgently and that UN agencies devote adequate staff time and resources to implementing this strategy. Since then, UNAIDS, together with 11 other UN agencies, developed a joint statement on compulsory drug detention centres. While there has been progress in recent years, most of the concerns expressed by the Reference Group in 2011 remain valid and action by UNAIDS and other UN agencies remains critical, as recommended by the Reference Group.

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Human rights groups have documented the police practice of interrogating or coercing confessions on people who are in a state of drug withdrawal while in detention. The UN Special Rapporteur on Torture has condemned this practice, a form of torture specific to people who use drugs. Intensive policing and crackdowns can raise the risk of HIV and other harms, not only by making it less likely that people will seek services, but also by breaking up what may be relatively safe injection networks, by causing rushed injections leading to vascular accident, by causing people to switch from smoking to injecting drugs because of the quicker effect of injection, and by causing unsafe disposal of syringes.

In places where opiate use is widespread, it is clear that access to low-threshold methadone therapy and other effective treatments can dramatically lower HIV risk by eliminating the need for injection and can also reduce crime and stabilize the lives of patients. In spite of long-standing endorsement of such treatment by WHO, UNODC and UNAIDS, many countries have failed to ensure access to opioid maintenance therapy, with disastrous consequences for HIV transmission.

Prohibitionist policies have cost the world trillions of dollars, but they have not reduced the supply or demand for illicit drugs, which are more abundant, cheaper and purer than ever before. The frequency or intensity of drug supply seizures and interdictions bear no relationship to the supply of drugs available for purchase on city streets. Prevention programmes that preach abstinence to young people fail because they exaggerate the effects of recreational drug use or they do not account for the real pressures that motivate people to experiment with or sustain drug use. A dent can be made most effectively in drug demand by ensuring those with problematic addictions — whose use accounts for a large percentage of demand — have easy access to treatment and care. But those with heavy use are also in most countries the most likely to be in prison or otherwise marginalized by criminalization. The fear of criminal sanctions is thus at the heart of the failure of demand reduction efforts. Ineffective drug policies overall are a major impediment to the success of global efforts to rein in HIV.

**A key moment for drug policy reform**

In spite of the many countries that cling to drug control policies dismissive of scientific evidence and human rights, a global movement for reform of drug policy has gained strength in recent years. Largely in response to growing injection-linked HIV during the 1980s and 1990s, a number of European countries have seen the value of giving harm reduction and high-quality drug-related health services a central place in drug policy-making. The Global Commission on Drug Policy, comprised of former heads of state and other notable persons, including former UN Secretary-General Kofi Annan, has drawn global attention to the senselessness of ineffective drug policies and called for new approaches. Decades of drug-related gang violence and
organized crime have spurred Latin American governments and civil society — and even sitting heads of state — to call publicly for a reconsideration of the dominant repression-based paradigm of drug policy. Many Latin American countries have joined European countries in decriminalizing individual-level drug offenses and developing accessible and affordable harm reduction services.

In Africa, where most national drug laws are very harsh — imposing long prison sentences for minor offenses — a new African Union drug strategy for 2013-2017 recognizes the importance of drug control that respects the human rights of marginalized people who use drugs. For the first time, African Union policy calls for member states to endeavor to find alternatives to incarceration for drug consumption and minor offenses. A new West Africa Commission on Drugs, convened with the help of Kofi Annan and chaired by former Nigerian president Obasanjo, will release a report in May 2014 that is likely to call for more human rights-friendly drug laws and policies in the sub-region and should be helpful in opening up new drug policy debates.

The Commission on Narcotic Drugs (CND), in which debate on any subject is limited by procedural rules, remains a difficult environment for serious consideration of drug policy reform, though it is the UN’s chief drug policy-making body. Nonetheless, in recent years the Commission has passed resolutions to support alternatives to incarceration for some drug infractions. In addition, in 2011, some 26 countries formally protested the continued exclusion of harm reduction measures from CND documents and debates. In the annual sessions in 2012 and 2013, several countries in their formal interventions urged the CND to endorse less repressive measures and more attention to health and social services for people who use drugs, though these statements generally do not appear in the CND official record.

In 2012, advocacy in the UN General Assembly by several Latin American presidents led to a resolution to advance the date of the planned UN General Assembly Special Session on the global drug regime from 2018 to 2016. The 2016 UNGASS is a crucial opportunity for bringing HIV and human rights issues to the fore in global drug policy-making. The previous UNGASS on drugs in 1998 completely neglected HIV, though it was well known by that time that drug-related HIV transmission was virtually out of control in several countries. The 1998 UNGASS with the theme — “A drug free world – we can do it” — produced a self-congratulatory endorsement of global prohibition that dismissed a large body of evidence that repressive policies were both ineffective with respect to drug supply and demand and harmful to national HIV responses. The voices of HIV leaders in the UN and in civil society were virtually silent, an experience that should not be repeated.

The main official preparatory activities for the 2016 UNGASS are centered on a high-level segment of the 2014 annual CND session in March. The text of the ministerial declaration to emerge from that session is already in heated discussion in Vienna, and so far mentions of harm reduction continue to be
excluded from the text by a coalition of states including Russia, Canada and the US. Although the declaration will not be the only way to influence the UNGASS debate, it is disheartening that in 2013-2014, the battle continues over whether to even mention harm reduction, particularly when the Declaration of Commitment of the HIV/AIDS UNGASS in 2001 so clearly spelled out the responsibility of states in this regard. Some states have also actively sought to limit participation of civil society in the high-level segment and the UNGASS.

Potential key messages and recommendations

1. **There has never been a more crucial moment for UNAIDS leadership on removing punitive drug laws and policies that are clear barriers to the success of HIV responses.**

2. **UNAIDS at CND 2014:** The presence of the UNAIDS Executive Director at the high-level segment would have a potentially game-changing impact, and it appears that Michel Sidibé is planning to attend. The UNAIDS Reference Group on HIV and Human Rights supports his attendance and encourages him to make a bold statement, highlighting the many unfulfilled commitments of the international community for harm reduction services and protection of the rights of people who use drugs. In particular, it would be useful for the Executive Director to highlight the connection between criminalization of drug use and minor possession on the one hand and HIV risk on the other, as well as to highlight the devastating consequences with respect to HIV of mass incarceration of minor, non-violent offenders, with no attention to ensuring harm reduction and other services for those in state custody. He might also mention that “treatment as prevention”, which is so much a part of the hope for HIV responses, is a distant dream for people who have to worry constantly about being searched, arrested, detained, registered publicly as criminals and abandoned by their communities, all of which is reinforced by repressive laws.

3. **UNAIDS leadership in UN drug policy-making:** All UN agencies that work on aspects of drug policy encourage national governments to establish drug control mechanisms that ensure the place of health and social service sectors around the table along with police and security officials. But the UN itself does not adequately reflect a multisectoral approach in its management of the global drug control regime. Policy-making is dominated by voices that readily dismiss public health and human rights concerns. The steward of the UN drug conventions, the International Narcotics Control Board, is chronically dismissive of harm reduction. The Secretary-General’s attempt in recent years to establish a UN-wide drug panel, co-convened by the Department of Political Affairs and UNODC, floundered in the failure to find common ground in intersectoral approaches. UNAIDS, as the chief proponent of the powerful
evidence of the connection between ill-conceived drug policies and HIV and as an inherently intersectoral body, has a leadership responsibility to improve drug policy-making in the UN system. The UNAIDS Executive Director should urge the Secretary-General to continue to pursue a system-wide drug policy-making mechanism that puts health, economic development, human development and human rights on a par with drug law enforcement.

4. **UNAIDS and the 2016 UNGASS:** It would be a terrible failure for the global HIV response as well as for drug policy reform if the 2016 UNGASS fails to address the link between drug policy and HIV and fails to recognize the harms to human rights of people with HIV and people who use drugs in the current regime. UNAIDS should do everything possible to ensure that HIV and human rights concerns are adequately reflected in both the debate and the official declaration of the UNGASS. It should also do everything possible to ensure the involvement of civil society from the HIV and human rights sectors in the UNGASS debates and preparatory processes. It would be useful for UNAIDS in advance of the UNGASS to articulate, in a user-friendly way, some clear positions that embody the evidence on decades of HIV-related harms inflicted by repressive drug policy and to seek support of UNAIDS Co-sponsors so that a strong voice for rights-friendly global drug policy can be part of the debate.

5. **UNAIDS and the West Africa Commission on Drugs:** The endorsement of the UNAIDS Executive Director of a report calling for less repressive drug laws and policies in his own home region would be very valuable. While the content of the West Africa Commission’s report is not yet finalized, it is likely to include a call for decriminalization of drug use. The Reference Group could urge the Executive Director to read the report and enter into the debates that it will open.

6. **UNAIDS and compulsory drug detention centres:** The Reference Group welcomes the joint statement developed by 12 UN agencies, but urges UNAIDS to follow up on all of the recommendations the Reference Group issued in its report on the 12th meeting in March 2011.

This issue paper was prepared by Joanne Csete and edited by Ralf Jürgens, to facilitate discussion at the Reference Group’s December 2013 meeting.

Please see the Summary and Recommendations report of the Reference Group’s Fifteenth Meeting for an overview of the discussion at the meeting and the Reference Group’s recommendations.