HIV, INJECTING DRUG USE AND HUMAN RIGHTS
A Human Rights Framework for HAARP’s Work in Vietnam, Cambodia and Laos

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1. Executive Summary

Recommended HAARP Human Rights Principles

Since its inception, HAARP has actively promoted principles of harm reduction in the work it supports in Vietnam, Cambodia and Laos. HAARP’s work has reflected a strong commitment to the rights of PWID, and the objectives of its projects have been consistent with internationally-accepted human rights principles.

In a difficult environment for harm reduction, HAARP can point to significant progress that has been made in improving access to HIV and drug treatment services for PWID, including expanded NSPs and support for community-based treatment. Overall, HAARP’s work has made a positive contribution to upholding the rights of PWID, and as such, has been a valuable counterweight to many existing national policies and practices around injecting drug use. However, it is important for HAARP to have clear principles to determine the basis upon which it is prepared to continue to fund work by governments and other local institutions in circumstances where the attitudes and practices of those institutions in relation to PWID are less than ideal from a human rights perspective.

Based on the attached report, it is recommended that the following key principles be used to direct decisions by HAARP in 2013-15:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Reference Documents</th>
<th>Recommended HAARP Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PWUD are entitled to be treated with dignity and respect, and to have the same rights as other individuals.</td>
<td>• Universal Declaration of Human Rights, Article 1 • International Covenant on Civil and Political Rights</td>
<td>HAARP’s promotion of harm reduction for PWUDs embodies this principle. HAARP should continue to support and advocate for policy responses that are respectful of PWUD and uphold their rights. Specific strategies should be developed at country level to support and guide this advocacy.</td>
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<tr>
<td>2. PWUD should not be subjected to compulsory detention or treatment</td>
<td>• Universal Declaration of Human Rights, Article 9 • International Covenant on Civil and Political Rights, Article 9 • UN Joint Statement on Compulsory Drug Detention and Rehabilitation Centres • Report of the Global Commission on HIV and the Law • From Coercion to Cohesion:UNODC • Australia’s National Drug Strategy 2010-2015</td>
<td>HAARP-funded services within compulsory treatment centres in Vietnam could be seen as indirectly supporting the national policy of detaining PWUD. No further work in these centres should be done by HAARP unless as part of “renovation” into voluntary treatment centres. HAARP should continue to advocate against compulsory detention and treatment in all countries in which it operates.</td>
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<td>3. PWUD should not be tested for HIV unless they receive appropriate pre and post-test counselling and give free and informed consent.</td>
<td>• UNAIDS/UNCHR International Guidelines on HIV/AIDS and Human Rights • Report of the Global Commission on HIV Law • UNODC/WHO Technical Paper on</td>
<td>HAARP support for services within compulsory treatment centres in Vietnam should be phased out unless appropriate HIV testing practices are adopted. Any ongoing work in closed settings should be reviewed to ensure</td>
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</table>
| **4.** HIV prevention, treatment and care should be available and affordable for all PWUD and integrated with drug treatment services, where appropriate. | Universal Declaration of Human Rights, Article 25  
International Covenant on Economic, Social and Cultural Rights, Article 12  
Report of the Global Commission on HIV Law  
WHO Continuum of care guidelines  
UNODC/WHO Technical Paper on HIV Testing and Counselling in Prisons and other Closed Settings | This is a primary focus of HAARP activities in all three countries. Where HIV services are not available to PWID, HAARP should explore opportunities to advocate for policy change. Consideration should be given to how best to sustain HIV services for PWID after HAARP comes to an end. |
| **5.** Treatment and rehabilitation services offered to PWUD should be evidence-based and aimed at reducing the harm associated with drug use. | UNAIDS/UNCHR International Guidelines on HIV/AIDS and Human Rights  
Report of the Global Commission on HIV Law  
UNODC report From Coercion to Cohesion  
Australia's National Drug Strategy 2010-2015 | While HAARP promotes an evidence-based harm reduction approach to drug use and funds services accordingly, there is limited in-country support for this approach. HAARP should continue to explore ways to build support for a harm reduction approach to drug use to increase the prospects of this approach being sustained after HAARP finishes. |
| **6.** HIV services and drug treatment and rehabilitation services for PWUD should be delivered in a way that is gender sensitive and avoids gender discrimination, either direct or indirect. | Universal Declaration of Human Rights, Article 1  
International Covenant on Economic, Social and Cultural Rights  
UNAIDS/UNCHR International Guidelines on HIV/AIDS and Human Rights  
Report of the Global Commission on HIV Law | There is differential treatment of female and male PWUD in some HAARP countries. HAARP should remain vigilant to ensure that the needs and concerns of female PWUD are addressed and that efforts are made to overcome any gender inequalities in this area. Specific efforts to find, reach and provide services for female PWID may be required. |
| **7.** Laws that criminalise drug use should be reviewed; they are likely to be ineffective and will obstruct effective harm reduction for PWUD | UNAIDS/UNCHR International Guidelines on HIV/AIDS and Human Rights  
Report of the Global Commission on HIV Law | This is a contentious issue in all three countries in which HAARP operates, and it is not HAARP’s role to dictate changes to domestic law. However, HAARP can and should advocate for changes to law and law enforcement policies where there is a public health rationale for these changes. HAARP should also consider prioritising initiatives, such as PCPI in Cambodia, that discourage the use of the criminal law against PWUD. |
| **8.** PWUD should be supported to participate actively and as equal partners in measures to address | Paris Declaration, 1994  
UNAIDS/UNCHR International Guidelines on HIV/AIDS and Human | This has also been a primary focus of HAARP activities to date. In the countries in which HAARP operates, |
HIV/AIDS.

<table>
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<tr>
<th>Rights</th>
<th>PWUD are highly stigmatised and marginalised. Active engagement with PWUD and support for PWUD organisations should continue to be a central focus of how HAARP works.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Report of the Global Commission on HIV Law</td>
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<tr>
<td>• Australia’s National Drug Strategy 2010-2015</td>
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9. Research involving PWUD should only be conducted if the research subjects have provided free and informed consent.

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<tr>
<th>Rights</th>
<th>Some HAARP-funded research involving PWID may have been undertaken without their informed consent. This is a significant risk for HAARP. Consideration should be given to whether future research funding should be made conditional on informed consent being obtained.</th>
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<tr>
<td>• World Medical Association: Declaration of Helsinki</td>
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<tr>
<td>• International Covenant on Civil and Political Rights, Article 7</td>
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2. Introduction

The HIV/AIDS Asia Regional Program (HAARP) is an 8-year (2007–2015) program aimed at supporting effective HIV prevention among people who inject drugs (PWID). The program initially operated in Burma, Cambodia, China, Laos and Vietnam. However, work in China and Burma are now being managed as part of AusAID’s other programs in those countries. Accordingly, HAARP’s work for the remaining phase of the program through to 2015 will be in Vietnam, Cambodia and Laos.

The guiding principle for HAARP’s activities in these countries has been the promotion of a harm reduction approach to injecting drug use. HAARP-funded projects have spanned service delivery, including needle and syringe and methadone programs, capacity-building of drug user networks and other local NGOs, and dialogue and advocacy with governments to build support for a harm reduction approach. HAARP has recognised and embraced the need to build the will and capacity of local governments to develop and sustain these policies and programs after HAARP ends in 2015.

In all the countries in which HAARP operates, there are particular challenges associated with working on drug use. All three countries utilise compulsory drug treatment centres to a greater or lesser extent, and have generally adopted a punitive, law enforcement approach to drug use rather than a harm reduction approach. PWID are highly stigmatised and marginalised both by the authorities and by the broader community, and there has been little recognition to date of either the rights of PWID or of the public health rationale for principles of harm reduction. As a result, many aspects of the prevailing national policies and practices around drug use have been significantly out of step with internationally accepted human rights principles.

Against this background, HAARP has attempted to work with the governments of Vietnam, Cambodia and Laos to introduce more effective HIV services for PWID and to promote greater acceptance of harm reduction principles. Inevitably, however, this has meant working within systems that are less than ideal from a human rights perspective. This is ethically uncomfortable for HAARP and raises questions about the extent to which it is appropriate to fund programs in these environments. While it is clear that HAARP has a valuable role to play in supporting service delivery and advocacy for PWID in these countries, it is also reasonable to establish a framework for what HAARP is and is not prepared to do, given the discordance between the human rights principles that HAARP wishes to uphold and the prevailing values and practices in the countries in which it works.

This report seeks to assist HAARP in defining the principles that should guide its work from a human rights perspective. It is based upon a review and analysis of relevant international human rights instruments, both those that establish overarching human rights obligations and those that have considered the application of these general human rights principles to HIV/AIDS, particularly in relation to injecting drug use. APMG Consultant Julie Hamblin and Director Dave Burrows conducted field trips to Vietnam and Cambodia in October-November 2012 to visit HAARP-funded projects and to meet with key stakeholders, including HAARP personnel, government officials, PWID, NGOs working on HIV and drug use and other donors. HAARP activities in each country were then reviewed to assess the extent to which there was reason to be concerned about these activities on human rights grounds. Based on this review, this report proposes a framework of human rights principles which it is suggested should guide future HAARP work.

The global response to HIV/AIDS has been framed by international human rights principles that have evolved over the past 60 years. The application of these principles to the particular challenges and tensions raised by HIV/AIDS has led to the development of internationally accepted principles that provide the foundation for a rights-based response to the HIV epidemic. While these principles are not always uncontested, particularly in countries such as the ones in which HAARP operates, there is overwhelming evidence that rights-based policy responses constitute best practice in terms of achieving effective and measurable outcomes for at-risk populations.

Over the years, there have been many international consultations and reports on human rights and HIV, as well as considerable research and thinking around what constitutes an effective rights-based approach. As the profile and context of the global HIV epidemic has evolved, so too has our understanding about the importance of having respect for human rights at the centre of the response in all policy areas. There is therefore an accumulated body of work that reflects a large measure of consensus at the international level about what constitutes an ethical response to HIV/AIDS that is consistent with accepted human rights standards.

The key reports, declarations and recommendations relevant to HIV/AIDS, human rights and injecting drug use are summarised in Annexure 2 to this report. In relation to HAARP activities, in particular, the following should be highlighted:

(a) General Human Rights Obligations

The foundation of international human rights is the Universal Declaration of Human Rights of 1948. The principles set out in the Universal Declaration remain the touchstone for human rights today. Among the principles relevant to injecting drug use and HIV are:

"Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in the spirit of brotherhood..."

"Article 9

No one shall be subjected to arbitrary arrest, detention or exile...

"Article 25

Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control..."

These high level human rights principles have been given more specific expression in a series of international covenants and conventions, beginning with the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), both adopted in 1966. For example, Article 7 of the ICCPR states that:

"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”

Article 10(1) further provides that:

"All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person'.

Similar high level protections are found in the ICESCR, such as an in Article 12 which recognises the right of every person "to the enjoyment of the highest attainable standard of physical and mental health".

Cambodia and Laos are signatories to both the ICCPR and ICESCR. Vietnam is not a signatory, but in 1982, acceded to both covenants, thereby indicating a willingness to be bound by them. Accordingly, the principles set out in both the ICCPR and ICESCR have application in all three countries in which HAARP operates.

(b) International Human Rights Framework for HIV/AIDS Policies and Programs

Over the past 25 years, considerable work has been done to take the high level human rights principles contained in the various international human rights covenants and conventions and apply these principles to the response to the HIV epidemic. Three international consultations on HIV/AIDS and Human Rights have been held – in 1989, 1996 and 2002 – and have led to the development of International Guidelines on HIV/AIDS and Human Rights. The current version of the International Guidelines, issued in 2006, establishes a clear human rights framework for HIV policies and programs, including in relation to injecting drug use. For example, Guideline 4 states that:

"States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups…

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 legalisation and promotion of needle and syringe exchange programs;

• the repeal of laws criminalising the possession, distribution and dispensing of needles and syringes".

The rights-based approach set out in the International Guidelines on HIV/AIDS and Human Rights has been adopted in other high level pronouncements, notably the Paris Declaration of 1994 and declarations made by the United Nations General Assembly Special Sessions on HIV/AIDS (UNGASS) in 2001, 2006 and 2011. The most recent UNGASS declaration, the Political Declaration on HIV and AIDS 2011, was a commitment by all the member States of the United Nations to intensify their efforts to eliminate HIV and AIDS, including the following:

• commit to ensure that national prevention strategies comprehensively target populations at higher risk and that systems of data collection and analysis about these populations are strengthened, and to take measures to ensure that HIV services, including voluntary and confidential HIV testing and counselling, are accessible to these populations so that they are encouraged to access HIV prevention, treatment, care and support;

• commit to intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health care, employment and social services, provide legal protection for people affected by HIV..., and promote and protect all human rights and fundamental freedoms, with particular attention to all people vulnerable to and affected by HIV...
commit to national HIV and AIDS strategies that promote and protect human rights, including programs aimed at eliminating stigma and discrimination against people living with and affected by HIV, including the families, including by sensitising the police and judges, training health care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support”.

Most recently, the Global Commission on HIV and the Law, established at the request of UNAIDS, released a detailed report in July 2012 entitled “Risks, Rights and Health”. The report was based on more than 1,000 submissions from individuals and organisations from 140 countries and a series of regional consultations around HIV/AIDS, law and human rights. The recommendations of the Global Commission cover the full spectrum of HIV policy issues, but in relation to drug use specifically, the report states:

"3.1 Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence based treatment for drug dependence. Countries must:

3.1.1 Shut down all compulsory drug detention centres for people who use drugs and replace them with evidence based, voluntary services for treating drug dependence.

3.1.2 Abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.

3.1.3 Repeal punitive conditions such as the United States Government’s Federal Ban on funding of needle and syringe exchange programs that inhibit access to HIV services for people who use drugs.

3.1.4 Decriminalise possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful for society.

3.1.5 Take decisive action, in partnership with the UN, to review and reform relevant international laws and bodies in line with the principles outlined above, including the UN International Drug Control Conventions; Single Convention on Narcotic Drugs (1961); The Convention on Psychotropic Substances (1971); The Convention Against the Elicit Traffic in Narcotic Drugs and Psychotropic Substances (1988); and the International Narcotics Control Board."

These recommendations are backed up by the Joint Statement on Compulsory Drug Detention and Rehabilitation Centres, issued by 12 United Nations agencies in March 2012. This Statement calls on States that operate compulsory drug detention and rehabilitation centres to close them without delay and to release the individuals detained. Upon release, appropriate health care services should be provided to those in need of such services, on a voluntary basis, at community level. These services should include evidence-informed drug dependence treatment; HIV and TB prevention, treatment, care and support; as well as health, legal and social services to address physical and sexual violence and enable reintegration.

Where a State is unable to close compulsory drug detention and rehabilitation centres rapidly, the Joint Statement calls for the following immediate steps:

- A process to review the detention of those in the centres to ensure there is no arbitrary detention and that any detention is conducted according to relevant international standards of due process and provides alternatives to imprisonment. This review will allow the identification of those who should be released immediately and those who should be referred for voluntary, evidence informed treatment programs within the community;
• A process to review conditions in compulsory drug detention and rehabilitation centres with a view to immediately improving those conditions so as to meet relevant international standards applicable in closed settings, including access to quality and evidence-informed health care, social and education services, and the elimination of inhumane and degrading treatment and forced labour, until the centres are closed;

• Provision of health care services pending closure of the centres, including for treatment of HIV and other sexually transmitted infections, TB and opportunistic infections, as well as health and legal services to respond to physical and sexual violence;

• Judicial and other independent oversight and reporting over the review enclosure process of the centres; and

• Moratoria on further admission in to compulsory drug detention and rehabilitation centres of people who use drugs, people who have engaged in sex work and children who have been the victims of sexual exploitation."

These reports, declarations, guidelines and other documents provide clear guidance on the principles that should underpin HIV policies and programs if they are to conform to internationally accepted human rights standards. In the context of injecting drug use, the key elements of a rights based approach can be seen to be (as a minimum):

• No compulsory detention or treatment for PWUD.

• Availability of voluntary community-based drug and rehabilitation services.

• Availability of clean needles and syringes and other HIV prevention, treatment and care services.

• Access to voluntary and confidential HIV counselling and testing, linked to available HIV treatment.

• Repeal punitive laws that impose criminal sanctions on drug use.

• Strengthen efforts to overcome the stigmatisation and marginalisation of PWUD.

(c) AusAID's Human Rights Framework

AusAID's own Human Rights Framework affirms that human rights are a high priority for the Australian Government, with civil and political rights ranking equally with economic, social and cultural rights. Emphasis is placed on the creation of durable institutional capacity to promote and protect human rights, and on consultation and cooperation with partner countries on human rights initiatives. The Framework also states that aid conditionality based on human rights concerns would only be used in extreme circumstances since it can jeopardise the welfare of the poorest and may be counterproductive.

The AusAID Framework provides a secure and robust basis for a human rights review of HAARP activities. It demonstrates the Australian Government's commitment to a consistent and principled approach to human rights issues in relation to its aid program, and a recognition of the importance of addressing these issues through dialogue and consultation with its development partners. Making this approach explicit, by testing HAARP activities against accepted human rights principles in the area of injecting drug use, is an appropriate and effective way of implementing the AusAID Human Rights Framework in practice.
4. **Best Practice in relation to Harm Reduction and Injecting Drug Use**

Scientific evidence supports a comprehensive package of structural, biomedical and behavioural interventions as the optimal HIV prevention strategy for reducing HIV incident infections among PWID. The WHO, UNODC, UNAIDS *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* is increasingly being used by countries as a framework for developing a comprehensive package of core public health interventions and as a guiding resource for setting targets and identifying key indicators to monitor the availability, coverage, quality and impact on HIV prevalence of the comprehensive prevention package.

There is strong evidence that these interventions, implemented in a variety of settings (including in prisons), are effective in reducing risk behaviours, preventing HIV infections, and accessing essential care and treatment services for PWID. The *Technical Guide* has been explicitly endorsed by the UN in multiple venues including the Commission on Narcotic Drugs, the UNAIDS Program Coordinating Board, and the Economic and Social Council (ECOSOC) of the UN General Assembly. It is cited as the basis for the PEPFAR 2010 Guidance on work with people who inject drugs and is the foundation for the recently released US CDC/DHHS guidance on integrated health services for PWID.

The core interventions, as outlined in the *Technical Guide*, should include a combination of the following HIV prevention interventions and strategies and, as the PEPFAR guidance states, they should be carried out in a manner consistent with human rights obligations:

- Community-based outreach;
- NSPs;
- Opioid substitution therapy (OST) and other drug dependence treatment;
- HIV counselling and testing (HCT);
- ART for IDUs living with HIV;
- Prevention and treatment of sexually transmitted infections (STIs);
- Condom programs for IDUs and their sexual partners;
- Targeted information, education and communication (IEC) for IDUs and their sexual partners;
- Vaccination, diagnosis and treatment of viral hepatitis; and
- Prevention, diagnosis and treatment of tuberculosis.

The Australian Government’s *Sixth National HIV/AIDS Strategy 2010-2013* states that “ensuring a supportive and enabling environment to both maintain and expand access to harm reduction and peer-based services and programs will help prevent further increases in HIV infection rates among people who inject drugs”. Needle and syringe programs are clearly supported under the strategy as is the need to improve access to primary health care and to reduce the level of discrimination experienced by people who inject drugs as a result of stigma within the healthcare system.

In terms of addressing HIV among PWID in prisons, the AIDS Strategy acknowledges that Australia’s eight jurisdictions have different policies and practices, but concludes that “it is essential that the full range of BBV and STI prevention strategies be maintained in Australian custodial settings, including:

- increasing the provision of, and access to, bleach and disinfectants where no safer alternatives are provided for decontaminating spills, surfaces or equipment
- easily accessible education and counselling—including peer education and support on HIV and STIs, hepatitis B, hepatitis C and injecting drug use—as a fundamental health promotion technique to support risk reduction practices

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2 The U.S. President’s Emergency Plan for AIDS Relief Comprehensive HIV Prevention for People Who Inject Drugs, Revised Guidance Washington, DC 2010
3 Centers for Disease Control/ Department of Health and Human Services Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services Atlanta 2012
increasing access to drug treatment programs, including opioid pharmacotherapy programs which have reduced BBV transmission in custodial settings, as well as detoxification and drug rehabilitation programs.

These measures are based on international evidence which the UN Office on Drugs and Crime (UNODC) has assembled in its global guidance document on addressing HIV in prisons[^4]. The purpose of this document is to provide a Framework for mounting an effective national response to HIV in prisons that meets international health and human rights standards, prioritises public health, is grounded in best practice, and supports the management of custodial institutions. The fundamental principle underlying this guidance is that countries should “provide prisoners with prevention, care, treatment, and support for HIV/AIDS that is equivalent to that available to people in the community outside of prison”.

Drug treatment, including opioid substitution treatment, is addressed in Australia’s National Drug Strategy 2010-2015, which states that “the overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010–2015. This encompasses the three pillars of:

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community
- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs
- **harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The three pillars apply across all drug types.”

Specifically addressing drug treatment in the Demand Reduction pillar, the Strategy states that:

“Successful support for longer-term recovery after treatment requires strategies that are focused on the whole individual and look across the life span. While different people will have different routes to recovery, support for recovery is most effective when the individual’s needs are placed at the centre of their care and treatment. Treatment service providers can help individuals recover from drug dependence, help the individual access the internal resources they need (such as resilience, coping skills and physical health) and ensure referral and links to a range of external services and support (such as stable accommodation, education, vocational and employment support and social connections).”

One of the key principles to be continued under the National Drug Strategy is:

“In designing treatment services, it is important to recognise that drug users are not a homogenous group. Treatment services should incorporate a principle of consumer involvement in planning and operations. Treatment interventions should also be tailored to the varying needs of individuals (including the potential for access to substance-specific treatment and services).”

This approach is echoed by UNODC in its landmark report *From Coercion to Cohesion*[^5], which states that:

“Many countries provide long-term residential treatment for drug dependence without the consent of the patient that is in reality a type of low security imprisonment. Evidence of the therapeutic effect of this approach is lacking, either compared to traditional imprisonment or to community-based voluntary drug treatment. It is expensive, not cost-effective, and neither benefits the individual nor the community. It does not constitute an alternative to incarceration because it is a form of incarceration. In some cases, the facilities become labour camps with unpaid, forced labour, humiliating and punitive treatment methods that constitute a form of extrajudicial punishment. It is [^4]: UNODC/WHO/UNAIDS. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response NY 2006*

[^5]: UNODC *From Coercion to Cohesion: Treating drug dependence through health care, not punishment NY 2010*
argued that the use of any long-term treatment for drug use disorders without the consent of the patient is in breach of international human rights agreements and ethical medical standards.”

Both Australia’s current HIV and Drugs Strategies, and global guidance on best practice in addressing HIV among PWID, reflect the rights-based approaches described earlier in this framework and the evidence basis for individual-oriented, non-coercive drug treatment approaches that are at odds with compulsory drug treatment of any type.

5. The Regional Context

(a) Vietnam

According to Vietnam’s UNGASS report, the HIV epidemic in Vietnam is concentrated among key populations, though there are signs that it may have begun to stabilise over the last two years, with a decrease in HIV prevalence among key populations at higher risk, people who inject drugs (PWID) and female sex workers (FSW) in some provinces, while prevalence trends remain stable or have increased in other provinces. According to 2011 sentinel surveillance, HIV prevalence among PWID and FSW remains high, at 13.4% and 3% respectively; IBBS data indicate that prevalence among men who have sex with men (MSM) also remains high, at 16.7%. The overall adult HIV prevalence (ages 15-49) remained at 0.45% in 2011. There were estimated to be between 135,000 and 335,000 PWID in Vietnam in 2011 (UNGASS Report).

Government policy on drug use in Vietnam has slowly moved towards a harm reduction approach over the past two decades. In 2011, some level of needle-syringe programs (NSP) was available in 60 of Vietnam’s 69 jurisdictions, while 49 provinces carried out outreach through 3,875 PWID peer educators, and 6,900 PWID accessed methadone from 41 clinics in nine provinces. However, the government’s main policy related to PWID is to detain them in compulsory drug treatment (06) centres, generally called 06 centres or Treatment – Education – Labour Centres. There are now 119 06 centres in Vietnam.

The HAARP Vietnam Country Program aims to establish a comprehensive package of services for PWID including:

- strengthening and expansion of existing harm reduction services including needle and syringe exchange programs, condom provision, voluntary counselling and testing, behaviour change
- referral to primary health care services and antiretroviral provision
- methadone maintenance therapy.

The program has worked in communities and closed settings, such as 06 centres, detention (pre-trial) centres and prisons in the program’s three currently under-serviced provinces: Tuyen Quang, Hoa Bin and Bac Can. In addition, HAARP aims to strengthen Vietnam’s multisectoral approach to management and delivery of harm reduction interventions involving health, law enforcement and social affairs agencies. It is building capacity at central and provincial levels to better deliver integrated services and manage a comprehensive service model. HAARP has also developed and strengthened civil society groups through an Innovation Fund that provides small grants for advocacy, research, job creation and micro-credit, peer networking and self help groups, and anti-stigma measures and campaigns.

HAARP has partnered with the Vietnam Administration of HIV/AIDS Control (VAAC) of the Ministry of Health, the Standing Office of Drugs Control (SODC) of the Ministry of Public Security and the Department for the Prevention of Social Evils (DSEP) of the Ministry of Labour, Invalids and Social Affairs (MOLISA).

In discussions with HAARP partners and other stakeholders at both the national and Tuyen Quang provincial level, it was evident that AusAid’s contribution to policy and practice of harm reduction has been substantial over the life of the project. Most HAARP activities fit easily within the framework described at the end of this

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document. The work which was clearly most controversial was the assistance provided to date through HAARP to HIV prevention inside 06 centres. On a visit to one such centre at Tuyen Quang, it was revealed that a usual “treatment duration” was two years or 104 weeks, of which actual drug treatment (of any kind) was provided only for the first week. For the following 103 weeks, inmates provided labour without payment in a variety of activities ranging from raising pigs, cattle and geese (with plans for a fish farm); growing vegetables and a tea plantation; to dynamiting a rock face on the centre’s property and smashing the rock into gravel – at this last task, most inmates worked for five hours each day. Despite the sales of meat and gravel, the 06 centre Director stated that inmates would receive only basic food and few medications if AusAID support was withdrawn. The HIV prevention activities provided through HAARP, in addition to medications for one week of drug treatment, were a large mural of a condom on a water tank (advising inmates to have safe sex), and regular loudspeaker messages about HIV prevention.

As noted in the above Australian, UN and global documents on harm reduction, treatment of the type provided in the 06 centres is ineffective, inefficient, may be counter-productive and is certainly not tailored to the individual needs of the drug users. As noted by UNODC above, “any long-term treatment for drug use disorders without the consent of the patient is in breach of international human rights agreements and ethical medical standards”.

It should be noted that the Government of Vietnam is responding to issues surrounding 06 centres by preparing a Roadmap for Renovation of these centres. An informally translated recent draft of this roadmap calls for changing 17 of the 119 06 centres into voluntary drug treatment centres and closing or otherwise changing the purpose of 24 further 06 centres by 2015. In the following five years, a further 59 centres would be closed or changed to other duties, leaving 17 compulsory drug treatment centres in the country. By investing in and supporting these renovation plans, HAARP can ensure a consistent approach to promote community-based drug treatment and access to HIV prevention, treatment and care for all PWID, and to advocate for an evidence-based harm reduction approach to injecting drug use in Vietnam.

Another activity of potential controversy is the work HAARP has funded in prisons and detention centres. This work includes peer education, training and education of prison staff, information materials and the same type of loudspeaker messages described above; as well as HIV counselling and testing and research. There was no evidence of human rights issues in HAARP’s work in these custodial settings – beyond the issue of whether drug users should be in community drug treatment rather than prison or detention centres – but there are risks for HAARP if funds are provided to the Ministry of Public Security without the ability of HAARP staff and consultants to supervise/evaluate these activities.

HAARP support for peer education, and drop-in centres (called Lotus Clubs) which provide HIV counselling and testing, are linked closely with HIV treatment and care. While there remain major challenges to initiate and maintain PWID on ART, evidence was found of active PWID receiving ART and of fewer barriers against active PWID receiving treatment than some neighbouring countries. There was insufficient time to visit MMT programs supported by HAARP in Vietnam, but all stakeholders agreed that HAARP has played an excellent role in assisting these poorer provinces to participate in methadone treatment.

HAARP has worked on policy issues surrounding harm reduction in Vietnam but is regarded by other stakeholders – such as UNODC, UNAIDS and USAID contractors – as playing a minor role at present in discussions such as the drafting of the Road Map for Renovation of 06 centres. A sustained strategic investment in policy work on this topic is likely to be highly effective. It should also be recognised that planned support by HAARP for networks of representatives of PWID or PWUD not only abides by human rights principles but fits well with Australia’s Drug Strategy principle to “incorporate a principle of consumer involvement in planning and operations”.

(b) Cambodia

The profile of drug use in Cambodia is unusual, in that while there are large numbers of people who use amphetamines, injecting drug use is relatively rare. It was estimated in 2007 that there were around 2,000 PWID in Cambodia, with 85% of these in Phnom Penh. HIV prevalence among PWID at that time was estimated.
at 24.4%, though a more recent estimate has put it as high as 29%. This demonstrates the importance of effective HIV prevention, treatment and care programs for PWID in Cambodia, notwithstanding their relatively low number.

Much of the Government policy on drug use in Cambodia is couched in harm reduction terms, but this does not always accord with the practice on the ground. There are currently 13 government-operated drug treatment and rehabilitation centres where drug users can be detained involuntarily for extended periods of time. While the treatment and rehabilitation centres are often promoted by the Government and law enforcement authorities as being preferable to sending drug users to prison, the compulsory nature of the treatment centres for many PWUD means that they are a form of imprisonment in any event. It also seems that the centres offer little by way of actual treatment or rehabilitation services.

Cambodia’s drug law expressly recognises the benefits of a harm reduction approach by providing that police can refer a drug user to a treatment program as an alternative to criminal prosecution. However, PWUD and NGOs working with PWUD report that there are several practical obstacles to the implementation of this approach in practice. First and foremost, there are very few community-based treatment programs in Cambodia (none in many regions), so PWUD arrested by the police can only be referred to a compulsory treatment and rehabilitation centre, which differs little from imprisonment. Second, the law is unclear around what quantity of drugs is considered to be for personal use, with the result that possession alone is often taken as evidence that the person is supplying and not merely using drugs, leading inevitably to criminal prosecution. Third, where a PWUD has been referred by police to a treatment program and is subsequently arrested again for drug use, the law makes criminal prosecution mandatory. Since many treatment programs provide little practical assistance to PWUD to avoid ongoing drug use, this expectation that referral to a treatment program should result in a “cure” is not a realistic one.

There are also many anecdotal reports of police violence towards PWUD as well as police bribery and corruption around their arrest and detention. PWUD who are sent to compulsory treatment and rehabilitation centres report that their release often depends on money being paid to the authorities in charge.

The Government of Cambodia has recently sought the assistance of UNODC to close down some of the compulsory drug treatment and rehabilitation centres in favour of community based treatment. This is an encouraging development, but will require adequate resourcing of community based treatment options.

The other significant factor affecting law enforcement practices around drug use in Cambodia is the Village and Commune Safety Policy, which was introduced by the Government of Cambodia in August 2010. The stated intention of the Policy is to improve public safety and reduce crime by eliminating certain practices, such as theft, sex work, drug use and “gangsterism”, from local communities. Supporters of the Policy say that one of its aims is to encourage initiatives, such as alternative income generation programs, to support people who engage in this conduct. In practice, however, it seems that the immediate impact of the Policy has been a police crackdown on crime, including drug use. Prison numbers are said to have increased by 50% in the two years since the Policy was introduced, and the perception of PWUD is that they are now more likely to be arrested and imprisoned because of the pressure on police to be seen to be implementing the Policy.

Given the experience of most PWUD in Cambodia, there is reason to be concerned about the extent to which their rights are ignored or abused. As noted above, compulsory detention in treatment centres remains common, and few PWUD have access to effective, evidence-based treatment and rehabilitation. Police attitudes to PWUD are generally hostile, with PWUD often facing punitive criminal sanctions. They are also a highly stigmatised and marginalised group within the broader community. In fact, the Village and Commune Safety Policy is said to have a large measure of community support because public opinion favours “zero tolerance” of practices such as sex work and drug use.

Against this background, HAARP’s support for a harm reduction approach to injecting drug use in Cambodia is an important counterweight to prevailing policy and practices around drug use. The objectives of the HAARP Country Program for Cambodia are:

7 Centre for Mental Health & Drug Dependence, Ministry of Health, Phnom Penh, April 2012
• to expand access to HIV (and associated infectious diseases) prevention information, services and commodities for people who use illicit drugs, those at risk of illicit drug use, their sexual partners and families, and to increase access to primary health care for illicit drug users.

• to contribute to creating an enabling environment (including related law, policy, quality surveillance, research, advocacy and community engagement) which supports interventions to prevent and treat HIV in illicit drug users.

• to develop capacity of the Government and implementation partners (including monitoring and evaluation capacity).

The principal HAARP activities in Cambodia consist of:

• A methadone maintenance therapy (MMT) program operating out of the Khmer Soviet Friendship Hospital in Phnom Penh. WHO Cambodia assists the Cambodian Ministry of Health (MOH) to operate this program. Treatment numbers have fluctuated since the program commenced operation in 2010, but there are currently approximately 140 PWID enrolled. MOH has indicated a willingness to take over responsibility for the MMT program once HAARP funding ends in 2015.

• Support for Friends International and its local NGO partner, Mith Samlanh, to implement a needle and syringe program (NSP) for PWID in Phnom Penh, to assist with the referral of PWID to the MMT program, and to provide social support and counselling to MMT patients.

• Support to the Khmer HIV/AIDS NGO Alliance (KHANA) and Korsang (a local NGO that works specifically with drug users) to provide community HIV counselling and outreach to drug users in Phnom Penh, and for KHANA to introduce NSPs in two provincial centres.

• Support for Family Health International (FHI) to develop a national training curriculum on harm reduction for law enforcement officers and to integrate the curriculum into existing police training programs.

• Building on the work done by FHI on police training, HAARP is also supporting the Police Community Partnership Initiative (PCPI) which promotes ongoing consultation and discussion around harm reduction and law enforcement issues related to drug use between the police, local authorities, health services and representatives of the drug user community. PCPI is being piloted in Phnom Penh with the intention of expanding the initiative into key provincial areas if it is shown to be effective.

The establishment of Cambodia’s first MMT program is a significant achievement for HAARP, and an important contribution to effective harm reduction in Cambodia. Similarly, HAARP’s support for NSPs in Phnom Penh, with plans to expand into two additional provinces, ensures that these services are available for Cambodian PWID. Operational challenges remain, particularly around the level of recruitment of PWID into the MMT program, and NSP licensing: needle and syringe provision can only be carried out with specific licences issued by the Government of Cambodia and there have been significant problems in ensuring that appropriate organisations receive licences. However, HAARP-funded programs have demonstrated that community-based treatment for drug users in Cambodia can be viable and effective.

HAARP’s advocacy work around harm reduction and its efforts to build the capacity of NGOs that support PWUD are particularly important from a human rights perspective. By consistently arguing for a harm reduction approach to injecting drug use on public health grounds, HAARP and its implementation partners have been able to temper support for some of the more punitive law enforcement approaches to drug use, particularly following the introduction of the Village and Commune Safety Policy. The Police Community Partnership Initiative is a good example of how HAARP can promote discussion and debate within Cambodia that can help to steer the thinking of government and law enforcement authorities in the direction of a rights-based harm reduction approach. HAARP’s support for KHANA, Korsang and Mith Samlanth is also crucial in assisting them to advocate effectively for the rights of PWUD.
HAARP does not work in any of Cambodia’s compulsory drug treatment and rehabilitation centres, either directly or indirectly. The consistent thrust of all the programs HAARP funds in Cambodia is to promote community-based drug treatment and access to HIV prevention, treatment and care for all PWID, and to advocate for an evidence-based harm reduction approach to injecting drug use. While there remain considerable obstacles to achieving acceptance of this approach, HAARP’s contribution overall is clearly a positive one.

(c) Lao PDR

It was not possible to visit Lao PDR during the preparation of this report in order to review HAARP projects and meet with key stakeholders. National estimates of the number of injecting drug users determined in 2010 that there were only 1,150 PWID among a total of 12,000 opiate users in the country.

The risk of HIV infection from injecting drug use was previously unrecognized in Lao PDR, but a rapid assessment and response survey conducted in 2010 in two northern provinces showed that 17% of 46 injecting drug users (IDUs) were HIV positive. Moreover, HIV prevalence in Vietnamese IDUs across the border was 42%.

Based on the project documentation, the HAARP Laos Country Program is working to develop a broad range of demand-driven harm reduction services integrated within the village health system infrastructure, on a pilot basis in 4 districts of 2 provinces next to Vietnam, including:

- provision of IEC materials for drug users, their sexual partners and their families
- health centres and outreach by peer educators to deliver services
- peer outreach networks among different sub-groups of drug users
- referral mechanisms for drug users and their families to access primary and sexual health services
- and, harm reduction training institutionalised in the national police and health training curriculum.

Research on the efficacy of tincture of opium (TO) for heroin users as substitution therapy or long-term treatment will be started in 2013. Long-term treatment of opium users began recently but is not under HAARP and has not been assessed: TO for short-term detoxification (4 weeks) of opium users under UNODC direction has been reviewed.

The objectives of HAARP in Laos are to:

- improve coordination and collaboration in support of Laos harm reduction policies that prevent HIV among drug users.
- strengthen technical and management capacity to deliver effective services and support to drug users.
- increase awareness and understanding of drug use and HIV issues by policy makers to enhance responses.

Much of HAARP’s work in Laos is in advocacy at the national level, and service delivery in the remote provinces of Phongsaly and Huaphan. For service delivery, HAARP is supporting outreach and provision of primary health care in 25 villages in four target districts; these were selected as pilot sites during Phase 1 of the project from 2009-2012. Activities are being carried out under three main areas:

1. **Harm reduction advocacy** - Creating an enabling and supportive policy environment for implementation at all levels

2. **Needle syringe program (NSP) service delivery at 25 fixed sites (health centres) and via outreach** - Establishing (and scaling up) comprehensive HIV and harm reduction services: distribution of needle, syringe, alcohol swabs and condoms; referral of PWIDs and their families / partners to auxiliary services for primary health care, VCT, and STI/TB counselling, diagnosis and treatment at health centres; and pharmacotherapy (or opioid substitution treatment, OST).

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8 Lao PDR Commission for Drug Control and Supervision Lao PDR National Drug Control Master Plan 2009-13 Vientiane 2009
3. **Capacity building for harm reduction** - Capacity building of local stakeholders to deliver services

Also underway is the development of a referral system linking outreach at villages to HIV/STI/TB clinical services at health centres, district hospitals and provincial hospitals. However, there are several important considerations to its implementation. The National HIV/AIDS Program in Laos is mainly funded by the Global Fund on AIDS, TB and Malaria however, ART is only accessible from nearby priority provinces, and funding for HIV testing kits by HAARP are being explored. The four target districts are also closer to Vietnam, which is more accessible for major health treatment among those who can afford it, including NSP. Furthermore, collaboration by HAARP with other programs, such as the ADB HIV Mitigation Program at the two pilot provinces, will be crucial since the Lao government has little experience in HIV prevention interventions at district level and more so in providing ART. Because providing substitution therapy using methadone or buprenorphine is deemed costly given the low client base of heroin users, HAARP will instead explore the efficacy of tincture of opium among a sample of clients. HAARP in Lao PDR will also contribute towards identifying other hotspots for HIV and drug use beyond the pilot areas, and in exploring the replication of its pilot NSP model under the National HIV/AIDS Program.

The main human rights implications of HAARP’s work in Laos relate to the inclusion of voluntary counselling and testing in the above activities, which is preferably accessed at village health centres and district hospitals given inaccessible conditions. Most global guidance suggests that the more members of most-at-risk populations can be counselled and tested for HIV, the easier it will be to design programs to meet the needs of people living with HIV. But, in these remote districts and villages of Laos, provision of HIV testing without the possibility of linking HIV-positive individuals to care can lead to severe problems.

Without trained health and support staff to assist those who discover that they are HIV-positive, suicide and severe depression can become common. Reported deaths among PWID are not rare, including a peer educator and one client in early 2012; the latter was suspected of having advanced HIV disease but was not confirmed. It is therefore suggested in the next section that testing only be carried out where those found to be HIV-positive can have a reasonable expectation of at least some psychological, medical and social assistance.

Prevailing policy practices around drug users also impact the effective implementation of NSPs at villages. For instance, each village aims to qualify for the ‘Cultural Village Model’ where, among others, drug using (or trafficking) does not exist. While this limits access to drug users, village heads are kept from fully supporting the harm reduction interventions. If the family can afford, it is general practice to send drug users for detoxification at health centres or district treatment facilities. According to HAARP clients, detoxifying a drug user at home is also common and family members tend to their needs during withdrawal. Absence of clinical supervision at these settings can easily lead to relapse, and any risk of HIV transmission is not being prevented. Unlike urban areas however, arrest or harassment of drug users at villages in Laos is not a routine practice. Arguing for a public health approach to harm reduction for injecting drug users is therefore constrained by social, geographical and infrastructural limitations that keep people living in remote areas from using facility-based health care. Outside of Vientiane, the capacity of health staff to provide any kind of HIV (or health) service is generally low. HAARP must carefully consider the fundamental conditions and resources for health of the community in order to effectively address HIV/AIDS prevention, treatment and care needs of drug users and their families at the pilot areas.
6. Human Rights Principles to guide HAARP’s Work

As discussed above, there is a strong international consensus, backed by extensive and well-documented research, about what kinds of policies and programs will result in effective HIV harm reduction for PWID. It has been consistently demonstrated that an approach that upholds the rights of PWID rather than attempting to use the force of the criminal law against them is appropriate not only from a human rights perspective but also because it results in better public health outcomes.

It is evident that HAARP, in both its design and implementation, has sought to give effect to “best practice” principles of harm reduction. However, there are challenges in doing so in the countries in which HAARP operates, because these principles are sometimes significantly out of step with prevailing national policies and practices on drug use. As a result, decisions must be made about the extent to which it is ethically appropriate for HAARP to fund work by governments and other local institutions on drug use in circumstances where the attitudes and practices of those institutions in relation to PWID are less than ideal from a human rights perspective. On the one hand, it can be argued that HAARP can have a positive influence on moderating those attitudes and practices, thereby improving the lives of PWID while at the same time reducing the harmful impact of HIV. On the other hand, if HAARP continues to provide support to governments whose drug policies are inconsistent with accepted human rights standards, there is a risk that HAARP might be seen to be complicit in those human rights abuses.

Given the positive impact of many HAARP activities to date, there is a compelling argument that HAARP should continue its efforts to support effective harm reduction for PWID in Vietnam, Cambodia and Laos for the remaining term of the project. Nonetheless, it is appropriate to set parameters for what HAARP should or should not do based on the need for adherence to certain fundamental human rights principles. This is particularly important during the final phase of the project, since arrangements need to be put in place for the ongoing support and management of HAARP initiatives in each country once HAARP comes to an end.

Based on the principles and experience discussed in this report, the following are proposed as human rights principles to guide future work by HAARP in Vietnam, Cambodia and Laos. We have generally used the term “PWUD” or “people who use drugs” as this encompasses people who inject drugs and the principles should be used for all drug users, not just injectors.

Principle 1

**PWUD are entitled to be treated with dignity and respect, and to have the same rights as other individuals.**

This is a fundamental principle that underpins all international human rights instruments. It is also at the heart of effective harm reduction relating to HIV and drug use, which emphasises the importance of giving PWUD the means, capacity and power to protect themselves and others from HIV infection and to receive HIV care, treatment and support.

HAARP’s support for a harm reduction approach to drug use in the countries in which it operates embodies this principle. At the operational level, and if preferred by communities, the establishment of drug user networks and support for NGOs run by and advocating for PWUD affirms respect for the rights and dignity of PWUD. In all its programs, HAARP should continue to advocate for policy responses that are respectful of PWUD and not punitive or discriminatory. National advocacy plans are recommended for each country.

Principle 2

**PWUD should not be subjected to compulsory detention or treatment**

Vietnam, Cambodia and Laos all utilise compulsory detention and treatment of PWUD to some extent. Vietnam is embarking on a process of “renovation” of its compulsory treatment centres, and Cambodia has indicated a willingness to close some of its centres in favour of community-based treatment, so there are encouraging indications of a move away from compulsory treatment in these countries. For the time being,
though, HAARP must operate in contexts in which this aspect of the prevailing drug policy is problematic from a human rights perspective.

This is not a significant concern in Cambodia and Laos, where HAARP does no work associated with the compulsory drug treatment centres and provides strong support for voluntary community-based treatment, both through its advocacy work and by funding community-based treatment options. The situation is more troubling in Vietnam where HAARP does fund programs that operate within the compulsory treatment centres. Apart from work to assist the proposed “renovation” of these centres, HAARP should no longer support programs in 06 centres. The UN Joint Statement on Compulsory Drug Detention and Rehabilitation Centres, referred to earlier in this report, provides guidance on what measures are appropriate during the transitional phase - for example, ensuring that people within the centres have access to health and social services, including HIV prevention, treatment and care, and eliminating all forms of forced labour.

Given the stated intention of Vietnam and Cambodia to modify their use of compulsory drug treatment centres, there is scope for HAARP to influence the direction of this change through dialogue with government and advocacy work more broadly. HAARP should actively explore opportunities for constructive engagement around this issue.

**Principle 3**

*PWUD should not be tested for HIV unless they receive appropriate pre and post-test counselling and give free and informed consent.*

There are a number of circumstances in which PWUD appear to be subjected to mandatory HIV testing in the countries in which HAARP operates, including in prisons and in some of the compulsory treatment centres. Where HAARP funds programs within these institutions, consideration should be given to phasing out support unless HIV testing practices are changed. Any programs operating in closed settings should be reviewed to ensure they comply with the UN Joint Statement on Compulsory Drug Detention and Rehabilitation Centres and other applicable UNODC guidelines.

In its other activities, such as peer outreach for PWID and support for community-based treatment, HAARP has actively promoted the availability of voluntary HIV counselling and testing for PWID.

**Principle 4**

*HIV prevention, treatment and care should be available and affordable for all PWUD and integrated with drug treatment services, where appropriate.*

This has been a primary focus of HAARP activities in all three countries. Indeed, in some instances, services such as methadone maintenance therapy and needle and syringe programs have been established solely as a result of HAARP support.

The coverage of HIV services for PWID remains incomplete in all three HAARP countries, and dramatically so in some instances. While there are clearly limits on how much more HAARP can do to support service provision, there may be further opportunities for advocacy in this area.

As HAARP moves into its final phase, consideration also needs to be given to how HIV services for PWID will be sustained once HAARP comes to an end.

**Principle 5**

*Treatment and rehabilitation services offered to PWUD should be evidence-based and aimed at reducing the harm associated with drug use.*

Again, this has been a primary focus of everything HAARP has done. A measure of HAARP’s success will be the extent to which there is in-country support for a harm reduction approach to drug use once HAARP comes to
an end. Ongoing advocacy for a harm reduction approach will be crucial during the remaining life of HAARP, and consideration should be given to whether HAARP’s efforts in this regard can be intensified.

Principle 6

_HIV services and drug treatment and rehabilitation services for PWUD should be delivered in a way that is gender sensitive and avoids gender discrimination, either direct or indirect._

While there is no overt gender discrimination in the availability of services for PWUD in any of the HAARP countries, there are differences in the ways in which male and female PWUD are treated. This is particularly the case in Vietnam where only male PWUD are sent to the 06 centres. Female PWUD are sent to the 05 centres, which it appears are otherwise usually reserved for female sex workers. There may also be more subtle, indirect discrimination against female PWUD where they do not feel comfortable to access services due to a lack of sensitivity to gender considerations in the way in which the services are delivered.

A number of HAARP projects specifically recognise the importance of gender sensitivity. In both its service provision and its ongoing advocacy work, HAARP should remain vigilant to ensure that the needs and concerns of female PWUD are addressed and that efforts are made to overcome any gender inequalities in this area.

Principle 7

_Laws that criminalise drug use should be reviewed; they are likely to be ineffective and will obstruct effective harm reduction for PWUD._

This is a contentious issue in all three countries in which HAARP operates, and it is not HAARP’s role to dictate changes to domestic law. However, HAARP can and should advocate for changes to law and law enforcement policies where there is a public health rationale for these changes. There is an effective example of this in Cambodia, where HAARP has actively sought to ameliorate the harmful impact on PWUD of the Village and Commune Safety Policy by supporting the Police Community Partnership Initiative that seeks to generate discussion and understanding between the police, local authorities, health services and NGOs representing PWUD about the adverse consequences of the Policy on HIV prevention efforts.

With HAARP coming to an end by 2015, there is a limited time within which to attempt to shift thinking around the use of the criminal law against PWUD in the countries in which HAARP operates. Consideration should be given to prioritising initiatives in all three countries that promote different and less punitive approaches to law enforcement in relation to drug use.

Principle 8

_PWUD should be supported to participate actively and as equal partners in measures to address HIV/AIDS._

HAARP has been active in supporting drug user networks and NGOs that work with PWUD. This is particularly important because of the level of stigma associated with drug use and the resulting marginalisation of PWID. There are significant practical challenges to effective NGO participation in all three countries, and building the capacity of local NGOs has very appropriately been a key focus of HAARP’s work. This should continue.

Principle 9

_Research involving PWUD should only be conducted if the research subjects have provided free and informed consent._

This is a particular issue where HAARP supports research involving PWID but does not have sufficient oversight to ensure that the informed consent of research participants is obtained – this may happen in prisons or detention centres, for example. This is a significant risk for HAARP. Consideration should be given to whether ongoing funding can and should be made conditional on the re-design of research in order to ensure compliance with the requirement to obtain free and informed consent.
These principles are summarised in table form in the Executive Summary at the beginning of this report.

7. Conclusion

There is much for HAARP to be proud of in the work done so far in Vietnam, Cambodia and Laos. In a difficult environment for harm reduction, progress has been made in improving access to HIV and drug treatment services for PWID, including expanded NSPs and support for community-based treatment. While considerable obstacles remain to achieving optimal coverage for these services, HAARP can take credit for having successfully supported and promoted harm reduction initiatives for PWID, sometimes in circumstances where no such services existed previously.

The planning and design of HAARP clearly reflects a strong commitment to the rights of PWID and is entirely consistent with internationally-accepted human rights principles. Any human rights concerns in relation to HAARP activities arise not because of the nature of those activities themselves but because of the environment within which HAARP operates. The process of dialogue and negotiation with local development partners, that is a necessary and appropriate element of development assistance, inevitably requires a degree of tolerance on the part of HAARP for different values and attitudes towards PWID. The important issue for HAARP is to establish clearly the extent to which it is prepared to support work in contexts where existing policies and practices affecting PWID are not in accord with what HAARP considers to be appropriate human rights standards.

This report has concluded that HAARP’s work, in the main, makes a positive contribution to upholding the rights of PWID. By promoting a harm reduction, rights-based approach to drug use and HIV, HAARP has been a valuable counterweight to existing national policy. As HAARP enters its final phase, it is perhaps even more important for it to continue to work in countries where principles of harm reduction are still to be fully embraced. Overall, HAARP’s work improves adherence to human rights standards in these countries, and should be applauded for this.

This report does, however, recommend certain principles that need to be observed to ensure that HAARP remains a positive influence in promoting a rights-based approach to injecting drug use, and avoids the risk of being seen to condone policies and practices that are inconsistent with respect for human rights. The intention and design of HAARP already reflect these principles. The critical issue is to ensure that in its final implementation phase, HAARP remains true to these principles notwithstanding its challenging operating environment, and re-focuses its work in some areas in order to do so. It is hoped that this report will assist this process.
Annexure – Relevant Human Rights Documents

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## 1. Global Level

### 1.1 International Human Rights Commitments

**The Universal Declaration of Human Rights, 1948 (United Nations, 1948)**

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<th>Preamble</th>
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<td>Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people, Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law, Whereas it is essential to promote the development of friendly relations between nations, Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom, Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms, Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge, Now, therefore, The General Assembly, Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.</td>
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<th>All Articles are relevant, but specifically:</th>
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<td><strong>Article 1</strong></td>
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<td>All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.</td>
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<td><strong>Article 2</strong></td>
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<td>Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.</td>
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<td><strong>Article 7</strong></td>
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<td>All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal</td>
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<td>Article 9</td>
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<td>No one shall be subjected to arbitrary arrest, detention or exile.</td>
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<th>Article 21</th>
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<td>1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.</td>
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<td>2. Everyone has the right to equal access to public service in his country.</td>
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<td>3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.</td>
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<th>Article 25</th>
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<tr>
<td>1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.</td>
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<tr>
<td>2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.</td>
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**Preamble**
The States Parties to the present Covenant,
Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Recognizing that these rights derive from the inherent dignity of the human person, Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights, Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms, Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant, Agree upon the following articles:

**All Articles are relevant, but specifically:**

**Article 7**
The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:
a. Remuneration which provides all workers, as a minimum, with:
   i. Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;
   ii. A decent living for themselves and their families in accordance with the provisions of the present Covenant;

b. Safe and healthy working conditions;

c. Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;

d. Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays.

### Article 11

1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.

2. The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:
   a. To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources;
   b. Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need.

### Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy
development of the child;

b. The improvement of all aspects of environmental and industrial hygiene;

c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.


Preamble

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

All Articles are relevant, but specifically:

Article 1

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic cooperation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.

3. The States Parties to the present Covenant, including those having responsibility for the administration of Non-Self-Governing and Trust Territories, shall promote the realization of the right of self-determination, and shall respect that right, in conformity with the provisions of the Charter of the United Nations.

Article 9

1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No
one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.
2. Anyone who is arrested shall be informed, at the time of arrest, of the reasons for his arrest and shall be promptly informed of any charges against him.
3. Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release. It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and, should occasion arise, for execution of the judgement.
4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.
5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.

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<th>Article 17</th>
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<tr>
<td>1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.</td>
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<td>2. Everyone has the right to the protection of the law against such interference or attacks.</td>
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<th>Article 26</th>
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<td>All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.</td>
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**World Medical Association Declaration of Helsinki (WMA General Assembly, 2001)**

The World Medical Association has developed the Declaration of Helsinki as a statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects.

**All principles are relevant, but specifically:**

- It is the duty of the physician in medical research to protect the life, health, privacy, and dignity of the human subject.
- The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol. This protocol should be submitted for consideration, comment, guidance, and where appropriate, approval to a specially appointed ethical review committee, which must be independent of
the investigator, the sponsor or any other kind of undue influence. This independent committee should be in conformity with the laws and regulations of the country in which the research experiment is performed. The committee has the right to monitor ongoing trials. The researcher has the obligation to provide monitoring information to the committee, especially any serious adverse events. The researcher should also submit to the committee, for review, information regarding funding, sponsors, institutional affiliations, other potential conflicts of interest and incentives for subjects.

- The research protocol should always contain a statement of the ethical considerations involved and should indicate that there is compliance with the principles enunciated in this Declaration.

- 20. The subjects must be volunteers and informed participants in the research project.

- The right of research subjects to safeguard their integrity must always be respected. Every precaution should be taken to respect the privacy of the subject, the confidentiality of the patient’s information and to minimize the impact of the study on the subject’s physical and mental integrity and on the personality of the subject.

- In any research on human beings, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail. The subject should be informed of the right to abstain from participation in the study or to withdraw consent to participate at any time without reprisal. After ensuring that the subject has understood the information, the physician should then obtain the subject’s freely-given informed consent, preferably in writing. If the consent cannot be obtained in writing, the non-written consent must be formally documented and witnessed.
1.2 Global Human Rights Frameworks for HIV Interventions

The Paris Declaration, 1994 (UNAIDS, 1994)

During the 1994 Paris AIDS Summit a joint commitment was made by all Governments and Representatives present. We, the Heads of Government or Representatives of the 42 States assembled in Paris on 1 December 1994 Solemnly Declare:

All are relevant, but specifically:

- our obligation as political leaders to make the fight against HIV/AIDS a priority,
- our obligation to act with compassion for and in solidarity with those with HIV or at risk of becoming infected, both within our societies and internationally,
- our determination to ensure that all persons living with HIV/AIDS are able to realize the full and equal enjoyment of their fundamental rights and freedoms without distinction and under all circumstances,
- our determination to fight against poverty, stigmatization and discrimination,
- our determination to mobilize all of society - the public and private sectors, community based organizations and people living with HIV/AIDS - in a spirit of true partnership,
- our appreciation and support for the activities and work carried out by multilateral, intergovernmental, non-governmental and community-based organizations, and our recognition of their important role in combating the pandemic.

Undertake in our national policies to:

- protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS, through the legal and social environment,
- fully involve non-governmental and community-based organizations as well as people living with HIV/AIDS in the formulation and implementation of public policies,
- ensure equal protection under the law for persons living with HIV/AIDS with regard to access to health care, employment, education, travel, housing and social welfare,
- intensify the following range of essential approaches for the prevention of HIV/AIDS:
  i. promotion of and access to various culturally acceptable prevention strategies and products, including condoms and treatment of sexually transmitted diseases,
  ii. specific risk-reduction activities for and in collaboration with the most vulnerable populations, such as groups at high risk of sexual transmission and migrant populations.

Millennium Development Goals, 1994 (UNAIDS, 1994)

In September 2000, 189 heads of State and Government gathered to reaffirm their commitment to the United Nations. Out of this meeting the General Assembly adopted the
United Nations Millennium Declaration which outlined commitments to values and principles; peace, security and disarmament; development and poverty eradication; protecting common environment; human rights; democracy and good governance; protecting the vulnerable; meeting the special needs of Africa; and, strengthening the United Nations (UN General Assembly 55th Session, Agenda Item 60, 2000). The declaration led to the development of the Millennium Development Goals (MDGs), a series of 8 time-bound goals with sub-goals which has been adopted by all 191 UN member states.

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<th>All Goals are relevant, but specifically:</th>
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**GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES**

**Target 6.A:** *Have halted by 2015 and begun to reverse the spread of HIV/AIDS*
- The spread of HIV appears to have stabilized in most regions, and more people are surviving longer
- Many young people still lack the knowledge to protect themselves against HIV
- Empowering women through AIDS education is indeed possible, as a number of countries have shown
- In sub-Saharan Africa, knowledge of HIV increases with wealth and among those living in urban areas
- Disparities are found in condom use by women and men and among those from the richest and poorest households
- Condom use during high-risk sex is gaining acceptance in some countries and is one facet of effective HIV prevention
- Mounting evidence shows a link between gender-based violence and HIV
- Children orphaned by AIDS suffer more than the loss of parents

**Target 6.B:** *Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it*
- The rate of new HIV infections continues to outstrip the expansion of treatment
- Expanded treatment for HIV-positive women also safeguards their newborns

**UNGASS Declaration of Commitment (DoC) on HIV/AIDS, 2001** *(United Nations, 2001)*

In 2001 all UN member states adopted the UNGASS DoC- “Global Crisis—Global Action” with the goal of reversing the HIV/AIDS epidemic. The Declaration contained time-bound commitments.

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<th>All commitments are relevant, but specifically:</th>
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- By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable
groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic; and,

- By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen and community-based care, including that provided by the informal sector, and healthcare systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; and improve the capacity and working conditions of health-care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care.

**Political Declaration on HIV/AIDS, 2006 (UN General Assembly, 2006)**

In June 2006 Heads of State and Government and representatives of States and Governments participated in the comprehensive review of the progress achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS. UN Member States reaffirmed their commitment to achieving the goals set out in the DoC and developed the Political Declaration on HIV/AIDS which contained a set of political commitments.

**All commitments are relevant, but specifically:**

**Heads of State and Government and representatives of States and Governments:**

- Commit ourselves to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;

- Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status;

- Commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal
Protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic;

Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, 2011 (United Nations, 2011)

The United Nations High Level Meeting on HIV/AIDS was held on 8-10 June 2011 in New York to review the progress achieved in meeting the commitments of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. The Political Declaration on HIV and AIDS saw the 193 Member States of the United Nations commit to redouble efforts to achieve universal access for HIV prevention, treatment, care and support by 2015 with a view to fulfilling Millennium Development Goal 6.

All commitments are relevant, but specifically:

- Commit to ensure that National prevention strategies comprehensively target populations at higher risk and that systems of data collection and analysis about these populations are strengthened and to take measures to ensure that HIV services, including voluntary and confidential HIV testing and counselling are accessible to these populations so that they are encouraged to access HIV prevention, treatment, care and support;

- Commit to intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health care, employment and social services, provide legal protections for people affected by HIV, including inheritance rights and respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms, with particular attention to all people vulnerable to and affected by HIV;

- Commit to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV and to consider their review in accordance with relevant national review frameworks and time frames;

- Commit to national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, including by sensitizing the police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support;
The report examines the ways in which human rights, and specifically the right to health, can add value to development policies. Mr Grover sets out the ‘right to health framework’, by means of which the right to health is to be implemented. The framework focuses on participation, community empowerment, and vulnerable populations. Mr Grover illustrated the benefits of this framework through presentation of case studies in which it has been successfully applied to limit the spread of HIV/AIDS. He argued that the failure to adopt a human rights approach to HIV/AIDS can result in the marginalization and stigmatization of those living with the disease, which in turn has a detrimental effect on efforts to reduce infection rates. Mr Grover also notes that development approaches to health tend to rely on easily quantifiable data and evidence-based evaluation, which can result in neglecting less easily quantifiable strategies, such as capacity-building.

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<th>All recommendations are relevant:</th>
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<tr>
<td>(a) States take steps to ensure that the right to health framework is integrated into health-related development programming, particularly in respect of the health-related MDGs and social determinants of health;</td>
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<td>(b) States take measures to ensure that information on the right to health framework, including the need for transparency, accountability and participation of individuals and communities in decision-making that has a bearing on their health, is disseminated and its use promoted in development-related areas;</td>
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<td>(c) The United Nations continues its efforts to provide more guidance in respect of human rights-based approaches and to provide best-practice examples of operationalization of human rights-based approaches;</td>
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<td>(d) The United Nations continue to design and implement human rights based approaches to development issues, and build its own capacity and that of States and other actors to incorporate human rights, and the right to health framework, into their development operations;</td>
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<tr>
<td>(e) Organizations adopting a human rights-based approach in respect of development make use of independent, well-designed qualitative evaluation to assess the outcomes of their interventions, and publicize these evaluations to encourage dialogue and cooperation amongst agencies working at the intersection of development and rights and vulnerability;</td>
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<tr>
<td>(f) Efforts be made to improve tools to measure the impact of human rights-based approaches to development interventions with the support of relevant international bodies such as UNDP and OHCHR, taking into account that to achieve realization of rights is an end in itself;</td>
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<tr>
<td>(g) Measures be taken to ensure that human rights priorities and goals are not neglected as a consequence of an overreliance on easily quantifiable data in the evaluation of development interventions.</td>
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1.3 Global Human Rights Framework for HIV in relation to Harm Reduction and Drug Use

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<th>International Labour Organization Convention on Forced Labour (No.29) (ILO, 1932)</th>
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<td>According to the International Labour Organization (ILO) Convention on Forced Labour (No. 29), forced or compulsory labour “shall mean all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily.” The term forced labour in international law does not cover “any work or service exacted from any person as a consequence of a conviction in a court of law” if certain preconditions are met.[38] However, people held in drug detention centres in these four countries have not been detained due to a conviction in a court of law.</td>
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<th>Declaration of Commitment on HIV/AIDS (UN Assembly, 2001)</th>
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<td><strong>Recommendations on People Who Use Drug:</strong></td>
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<td><strong>Article 49:</strong> By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programs in public, private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS;</td>
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<tr>
<td><strong>Article 50:</strong> By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programs for migrants and mobile workers, including the provision of information on health and social services;</td>
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<td><strong>Article 51:</strong> By 2003, implement universal precautions in health care settings to prevent transmission of HIV infection.</td>
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<td><strong>Article 52:</strong> By 2005, ensure: that a wide range of prevention programs which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of culture, aimed at reducing risk – taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;</td>
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<tr>
<td><strong>Article 62:</strong> By 2003, in order to complement prevention programs that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programs that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons.</td>
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The purpose of the report is to introduce key ethical principles and to discuss how they can be applied in epidemiological research on drug use. Major ethical challenges for drug epidemiology are identified, along with the important questions and issues that investigators should consider in addressing those challenges. In recognition of the increasing application of drug epidemiological methods in developing countries, where institutional ethics systems may not be the norm, the report also provides suggestions about ethics approval processes that may be used in such contexts. The report aims to enhance the capacity of researchers in developing countries to carry out data collection on illicit drug use in an ethical manner. It is intended as a starting point for the development of an ethical framework for drug epidemiology and also as a resource that investigators may utilize when taking the initiative to develop ethically sound solutions to the dilemmas they face locally.

Relevant paragraphs include:

On ethical issues in drug epidemiological research
- Investigators should consider how existing ethical guidelines (developed in a particular cultural context) can be applied in developing countries that may have either very different or no research traditions and may not have established a form of institutional or independent ethics review.
- Major ethical challenges exist for drug use epidemiological research, many of which remain unresolved, leaving open the possibility of serious ethical breaches. Significant issues exist in the following areas: capacity and limits of consent; confidentiality, privacy and protection from legal hazards; safety; opportunistic research; communication of study findings; and researcher training and understanding of the social, economic and political context in which their work is conducted.
- The ethical challenges posed by epidemiological research on drug use are amplified when attempting to conduct comparative epidemiological studies across different cultures, in particular in jurisdictions with little or no research tradition and none of the institutional infrastructure for ethical oversight.
- The conduct of drug epidemiology requires flexibility and pragmatism on the part of investigators and a commitment to identifying ethically sound solutions to the dilemmas they face locally.

On the Ethical review of drug epidemiological research:
Careful analysis is needed in considering the ethics of epidemiological research on drug use. Principles that have evolved in biomedical research provide a starting point for discussion on how existing moral principles and practical ethical standards can be applied in local settings.
- In most developed countries, the preferred method of independent ethics review of research is the institutional ethics committee. In countries where institutional ethics systems do not exist, a minimum standard of ethical review for all research with human subjects should be considered.
- Where independent ethics review systems do not exist
Investigators, in consultation with research stakeholders, may choose to develop a local hierarchy of ethics review options. Key factors include existence of local networks of experience and expertise; available local resources for establishment and ongoing support; and professional and other institutional endorsement and support.

Checklists of ethical issues and key questions are a valuable tool for assisting researchers and other stakeholders in assessing the ethical acceptability of epidemiological research on drug use. Issues that should be considered are requirement for ethical review; study design; informed consent; confidentiality and privacy; potential harm; benefits; participant payment; health and safety; dissemination and disclosure; and monitoring.

**International Guidelines on HIV and Human Rights (UNAIDS, 2006)**

UN health and drug control agencies—including UNAIDS, WHO, UNODC and INCB—have endorsed and promoted a wide range of interventions for the prevention, treatment, and care of HIV among people who use drugs, including opioid substitution therapy and ensuring access to and use of needle and syringe exchange programs, as essential components of HIV/AIDS programs for people who use drugs. Yet punitive laws, policies and practices keep many drug users from receiving these lifesaving services, even in countries where they are legal.

Research in several countries has established that criminal laws proscribing syringe possession and associated policing practices targeting people who use drugs increase the risk of HIV in both direct and indirect ways. This reality is reflected in the International Guidelines on HIV and Human Rights, which state that:

“**States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.**

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.”

**Declaration of Commitment and the Political Declaration on HIV/AIDS (CND, 2008)**

The Commission on Narcotic Drugs has endorsed the Declaration of Commitment and the Political Declaration on HIV/AIDS (and thereby indirectly the harm reduction words contained in them):

- 2008: CND Resolution 51/14 Promoting coordination and alignment of decisions between the Commission on Narcotic Drugs and the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS

- 2006: CND Resolution 49/4 Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users. More generally, the Commission on Narcotic Drugs has reaffirmed that countering the world drug problem must be carried out in full conformity with human rights and
fundamental freedoms:

- 2008: CND Resolution 51/12 Strengthening cooperation between the United Nations Office on Drugs and Crime and other United Nations entities for the promotion of human rights in the implementation of the international drug control treaties.

- "The Commission on Narcotic Drugs, (…) 1. Reaffirms that countering the world drug problem is a common and shared responsibility that must be addressed in a multilateral setting, that it requires an integrated and balanced approach and that it must be carried out in full conformity with the purposes and principles of the Charter of the United Nations and other provisions of international law and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms and on the basis of the principles of equal rights and mutual respect; 2. Requests the United Nations Office on Drugs and Crime to continue, within its existing mandate, to work closely with the competent United Nations entities, including the United Nations human rights agencies;” 3. Requests the Executive Director of the United Nations Office on Drugs and Crime to report to the Commission at its fifty-third session on the implementation of the present resolution."

**UN Special Rapporteurs on the Right to Health and on Torture (UN Special Rapporteur, 2008)**

The UN Special Rapporteurs on Torture and on the Right to the Highest Attainable Standard of Health have concluded that State failure to ensure access to harm reduction measures violates State obligations to protect the right to health, and amount to cruel, inhuman and degrading treatment of people who use drugs. They have thus urged the CND Chair and Vice-chairs to ensure that the outcome documents for the March 2009 CND make a strong commitment to harm reduction. See Letter to CND Chairperson Ms Selma Ashipala-Musavyi from Manfred Nowak, Special Rapporteur on the question of torture, and Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, December 10, 2008. Their position reflects earlier statements by the Special Rapporteur on health supporting harm reduction measures.

**Relevant paragraphs include:**

"Harm reduction is an essential HIV prevention measure endorsed by the General Assembly in the Declaration of Commitment on AIDS in 2001 and in the Political Declaration on AIDS in 2006. We have reviewed the Chairperson’s draft annex, dated 4 November 2008. Given the General Assembly’s endorsement and the global HIV pandemic, we are, however, concerned that it fails to include any reference to harm reduction services. In order for member states to live up to their human rights obligations, and to ensure UN system-wide coherence, we believe that the annex should be amended to include specific language supporting comprehensive harm reduction measures."

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“Harm reduction is essential to the progressive realization of the right to the highest attainable standard of health for people who are using drugs, and indeed, communities affected by drug use. Moreover, the Committee Against Torture, the Special Rapporteur on Torture, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, and the European Court of Human Rights all have raised concerns that the failure to provide adequate health services to detainees may contribute to conditions amounting to cruel, inhuman and degrading treatment.

The failure to ensure access to harm reduction measures – both inside and outside prisons – puts injection drug users at unnecessary and avoidable risk of HIV and other blood-borne infections. We consider that such failure violates State obligations to respect, protect, and fulfil the right to the highest attainable standard of health, and may amount to cruel inhuman and degrading treatment of this vulnerable and marginalized population.

Principles of Drug Dependence Treatment (WHO, UNODC, 2008)

This discussion paper aims to encourage Governments and other partners to take concerted action for the implementation of evidence-based drug dependence treatment services, which respond to the needs of their populations. Given the scale of the problem in most societies and the limited resources available, a clear and coherent approach to service planning is required. There is a need to develop services that can reach the maximum number of individuals and have the greatest impact at lowest cost. This is most likely to be achieved with broad community-based health care services that can work with individuals in their own communities over longer periods of time. While the present document recommends actions to promote each of the nine principles, these will need to be prioritized to respond to the local situation and circumstances and implemented in progressive steps in accordance with resource availability and stages of development of the treatment system.

All principles are relevant:

Principle 1: Availability and accessibility of drug dependence treatment

Drug dependence and its associated social and health problems can be treated effectively in the majority of cases if people have access to continuum of available and affordable treatment and rehabilitation services in a timely manner. To this end, all barriers limiting accessibility to treatment services need to be minimized for people to have access to the treatment that best fits their needs.

Principle 2: Screening, assessment, diagnosis and treatment planning

Patients affected by drug use disorders often have multiple treatment needs across a range of personal, social and economic areas that cannot be addressed when taking into consideration only their addictive symptoms in a standardized way. As for any other health care problems, diagnostic and comprehensive assessment processes are the basis for a personalized and effective approach to treatment planning and engaging the client into treatment.
<table>
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<tr>
<th>Principle 3: Evidence-informed drug dependence treatment</th>
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<tr>
<td>Evidence-based good practice and accumulated scientific knowledge on the nature of drug dependence should guide interventions and investments in drug dependence treatment. The high quality of standards required for approval of pharmacological or psychosocial interventions in all the other medical disciplines should be applied to the field of drug dependence.</td>
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<tr>
<th>Principle 4: Drug dependence treatment, human rights, and patient dignity</th>
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<tr>
<td>Drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination.</td>
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<th>Principle 5: Targeting special subgroups and conditions</th>
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<tr>
<td>Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialized care. These groups with specific needs include adolescents, women, pregnant women, people with medical and psychiatric co-morbidities, sex workers, ethnic minorities, and socially marginalized individuals. A person may belong to more than one of these groups and have multiple needs. The implementation of adequate strategies and provision of appropriate treatment for these patients often require targeted and differentiated approaches regarding contacting services and entering treatment, clinical interventions, treatment settings and service organization that respond best to the needs of these groups.</td>
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<th>Principle 6: Addiction Treatment and the Criminal Justice System</th>
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<td>Drug related crimes are highly prevalent, and many people are incarcerated for drug related offences. These include offences to which a drug's pharmacologic effects contribute; offences motivated by the user’s need for money to support continued use; and offences connected to drug distribution itself. A significant proportion of people going through criminal systems worldwide are drug dependent. In general, drug use should be seen as a health care condition and drug users should be treated in the health care system rather than in the criminal justice system where possible. Interventions for drug dependent people in the criminal justice system should address treatment as an alternative to incarceration, and also provide drug dependence treatment while in prison and after release. Effective coordination between the health/drug dependence treatment system and the criminal justice system is necessary to address the twin problems of drug use related crime and the treatment and care needs of drug dependent people.</td>
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<th>Principle 7: Community involvement, participation and patient orientation</th>
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<tr>
<td>A community based response to drug use and dependence can support and encourage behavioural changes directly in the community. This might imply a paradigm shift from a directive to a more cooperative form of service delivery, for which the active</td>
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involvement of local stakeholders (governmental and non-governmental organizations, private sector, community leaders, religious organizations, and traditional healers), community members (families) and the target populations is needed to establish ownership and an integrated network of community-based health care services.

**Principle 8: Clinical governance of drug dependence treatment services**
A drug dependence treatment service requires an accountable, efficient and effective method of clinical governance that facilitates the achievement of its goals. Service organization needs to reflect current research evidence and be responsive to service user needs. Its policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and target population.

**Principle 9: Treatment systems: policy development, strategic planning and coordination of services**
A systematic approach to drug use disorders and patients in need of treatment, as well as to planning and implementation of services require a logical, step-by-step sequence that links policy to needs assessment and treatment planning and implementation, to monitoring and evaluation.

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The aim of these guidelines is to provide a strategic approach to reducing morbidity and mortality related to TB and HIV among at-risk drug users and their communities in a way that promotes holistic and person-centred services. In particular, health services should provide treatment adherence support for drug users. Comorbidity, such as hepatitis infection, should not be a barrier to obtaining TB and HIV treatment services. Prisoners with HIV, TB or drug dependence need to have the same access to treatment and care as the civilian (general, non-incarcerated) population, as should drug users who are migrants, homeless or otherwise marginalized. In addition, continuity of care on transfer in and out of places of detention is essential.

**Relevant sections include:**

- HIV services should:
  - consider methods of reaching drug users living with HIV who may not currently be using their services;
  - be equipped to identify and manage people living with HIV who use and/or inject drugs or should establish a referral link with services for drug users to do so;
  - carry out intensified TB case-finding, especially among drug users with HIV who are at particular risk of TB;
  - test for TB among all drug users living with HIV and consider isoniazid preventive therapy for all those without active TB (see the section on preventing TB through isoniazid preventive therapy);
  - implement an infection control plan for all service settings to
reduce the risks of TB infection among people living with HIV and personnel; and

- promote continuity of care in a drug user’s care package, including TB treatment and drug treatment, such as opioid substitution therapy.

### From coercion to cohesion: treating drug dependence through health care, not punishment (UNODC, 2009)

The aim of this draft discussion paper, “From coercion to cohesion: Treating drug Dependence through health care, not punishment”, is to promote a health-oriented approach to drug dependence. The International Drug Control Conventions give Member States the flexibility to adopt such an approach. Treatment offered as an alternative to criminal justice sanctions has to be evidence-based and in line with ethical standards. This paper outlines a model of referral from the criminal justice system to the treatment system that is more effective than compulsory treatment, which results in less restriction of liberty, is less stigmatizing and offers better prospects for the future of the individual and society. Drug dependence treatment without the consent of the patient should only be considered a short-term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific standards as voluntary-based treatment. Human rights violations carried out in the name of “treatment” are not compliant with this approach.

### Thematic Briefings on Human rights and Drug Policy (IHRA, 2010)

The briefing papers are intended to provide a basic overview of some of the core human rights issues related to drug control efforts and to show how they interconnect, and to spark a discussion of how international human rights law can be engaged to address a range of human rights concerns raised by drug enforcement laws, policies, and practices.

**Relevant Briefing include:**

**Briefing 4: Compulsory Drug Treatment**

**Human rights principles and compulsory drug treatment**

- Drug dependence treatment is a form of medical care, and therefore must comply with the same standards as other forms of health care. In developing and implementing effective drug dependence treatment programs, human rights must be respected and protected. These rights include the right of people who use drugs to enjoy the highest attainable standard of physical and mental health; patient rights, including confidentiality and the right to receive information regarding one’s state of health; the human rights principle of informed consent (including the ability to withdraw from treatment); and the right to non-discrimination in health care and to be free from torture or other cruel, inhuman or degrading treatment.

**Medically inappropriate treatment**

- States that are parties to the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* have recognized the right of every person to enjoy “the highest attainable standard of physical and mental health” (Article 12). The Committee on Economic, Social and Cultural Rights
(CESCR) has stated that a state’s health facilities, goods and services should be available, acceptable, accessible and of good quality. Forms of supposed “treatment” and “rehabilitation” such as detention, forced labour, forced physical exercises and military drills do not meet the requirement under international law that drug dependence treatment be culturally and ethically acceptable, scientifically and medically appropriate, and of good quality. Elements of supposed “treatment” and “rehabilitation” may also constitute torture or cruel, inhuman or degrading treatment or punishment. The Convention Against Torture establishes a clear legal obligation on state parties to investigate credible allegations of torture and cruel and inhuman treatment or punishment and to hold perpetrators accountable.

**Compulsory treatment as a matter of course and ‘en masse’**

- International human rights standards require that medical treatment be based on free and informed consent, which includes the right to refuse medical treatment. The right to informed consent to treatment is integral to the rights to health, to privacy and bodily integrity, and freedom from torture and cruel, inhuman and degrading treatment or punishment.

- According to the CESCR, “The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body... and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation... obligations to respect [the right to health] include a State’s obligation to refrain (...) from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases.

- UN agencies (including UNAIDS, WHO, UNICEF and UNDP), and the Global Fund for AIDS, Tuberculosis and Malaria have acknowledged reports of illegal detention and human rights abuses (including torture) in several countries. They have called for the closure of compulsory drug detention centres and their replacement with community and evidence based, voluntary drug treatment that respects human rights standards.

- The UN Office on Drugs and Crime has also recognized that where systems of supposed drug “treatment” and “rehabilitation” force people into treatment as a matter of course and en masse, such systems violate international human rights standards. According to UNODC, “With respect to drug treatment, in line with the right to informed consent to medical treatment (and its “logical corollary”, the right to refuse treatment), drug dependence treatment should not be forced on patients. Only in exceptional crisis situations of
high risk to self or others can compulsory treatment be mandated for specific conditions and for short periods that are no longer than strictly clinically necessary. Such treatment must be specified by law and subject to judicial review. . . . Under no circumstances should anyone subject to compulsory treatment be given experimental forms of treatment, or punitive interventions under the guise of drug-dependence treatment.”

Global Commission on HIV and the Law (UNDP, 2012)

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations, the Commission forcefully calls for governments, civil society and international bodies to:

- Outlaw all forms of discrimination and violence directed against those who are vulnerable to or living with HIV or are perceived to be HIV positive. Ensure that existing human rights commitments and constitutional guarantees are enforced.
- Repeal punitive laws and enact laws that facilitate and enable effective responses to HIV prevention, care and treatment services for all who need them. Enact no laws that explicitly criminalize HIV transmission, exposure or non-disclosure of HIV status, which are counterproductive. Work with the guardians of customary and religious law to promote traditions and religious practice that promote rights and acceptance of diversity and that protect privacy.
- Decriminalize private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.
- Prosecute the perpetrators of sexual violence, including marital rape and rape related to conflict, whether perpetrated against females, males, or transgender people.
- Abolish all mandatory HIV-related registration, testing, and forced treatment regimens. Facilitate access to sexual and reproductive health services and stop forced abortion and coerced sterilization of HIV-positive women and girls.
- Reform approaches towards drug use. Rather than punishing people who use drugs but do no harm to others, governments must offer them access to effective HIV and health services, including harm reduction programs and voluntary, evidence-based treatment for drug dependence.
- In matters relating to HIV and the law, offer the same standard of protection to migrants, visitors and residents who are not citizens as is extended to citizens. Restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country should be repealed.
- Enforce a legal framework that ensures social protection for children living with and affected by HIV and AIDS. Laws must protect guardianship, property and inheritance rights, and access to age-appropriate, comprehensive sex education, health and reproductive services.
- Develop an effective IP regime for pharmaceutical products. Such a regime must be consistent with international human rights law and public health needs, while safeguarding the justifiable rights of inventors.

Recommendations on People Who Use Drug:

- 3.1 Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary,
evidence-based treatment for drug dependence. Countries must:

- Shut down all compulsory drug detention centres for people who use drugs and replace them with evidence based, voluntary services for treating drug dependence.

- Abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.

- Repeal punitive conditions such as the United States government’s federal ban on funding of needle and syringe exchange programs that inhibit access to HIV services for people who use drugs.

- Decriminalise the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society.

- Take decisive action, in partnership with the UN, to review and reform relevant international laws and bodies in line with the principles outlined above, including the UN international drug control conventions: the Single Convention on Narcotic Drugs (1961); Convention on Psychotropic Substances (1971); the Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) and the International Narcotics Control Board.

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<td><strong>United Nations entities call on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community.</strong></td>
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<td>The UN entities which have signed on to this statement call on States that operate compulsory drug detention and rehabilitation centres to close them without delay and to release the individuals detained. Upon release, appropriate health care services should be provided to those in need of such services, on a voluntary basis, at community level. These services should include evidence-informed drug dependence treatment; HIV and TB prevention, treatment, care and support; as well as health, legal and social services to address physical and sexual violence and enable reintegration. The UN stands ready to work with States as they take steps to close compulsory drug detention and rehabilitation centres and to implement voluntary, ambulatory, residential and evidence-informed alternatives in the community. Where a State is unable to close the centres rapidly, without undue delay, we urge that the following be established immediately:</td>
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<td>• a process to review the detention of those in the centres to ensure that there is no arbitrary detention and that any detention is conducted according to relevant international standards of due process and provides alternatives to imprisonment. This review will allow the identification of those who should be released immediately and those who should be referred for voluntary, evidence-informed treatment programmes within the community;</td>
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<td>• a process to review conditions in compulsory drug detention and</td>
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rehabilitation centres with a view to immediately improving those conditions so as to meet relevant international standards applicable in closed settings, including access to quality and evidence-informed health care, social and education services, and the elimination of inhumane and degrading treatment and forced labour, 3 until the centres are closed;

| • provision of health care services pending closure of the centres, including for treatment of HIV and other sexually transmitted infections (STIs), TB and opportunistic infections, as well as health and legal services to respond to physical and sexual violence; |
| • judicial and other independent oversight and reporting over the review and closure process of the centres; and |
| • moratoria on further admission into compulsory drug detention and rehabilitation centres of people who use drugs, people who have engaged in sex work and children who have been the victims of sexual exploitation. |
| • States increasingly acknowledge the concerns associated with these compulsory drug detention and rehabilitation centres, including their lack of effectiveness in preventing relapse, their high costs, and their potential negative impact on efforts to ensure universal access to HIV prevention, treatment, care and support. We note with appreciation that some countries are in the process of scaling down the number of such centres and building greater capacity for voluntary, evidence-informed, community-based approaches. These positive steps are critical to expanding understanding and building support for an approach to drug dependence, sex work and child sexual exploitation that is based on available scientific and medical evidence ensures the protection of human rights and enhances public health. |
| • sharing of information and good practices on voluntary, evidence-informed and community- and rights-based programs for people who use drugs, those who engage in sex work, and children who have been victims of sexual exploitation; |
| • dialogue with policy-makers to increase support for voluntary, evidence-informed and rights-based treatment and programs for drug dependence; |
| • multisectoral collaboration among law enforcement, health, judiciary, human rights, social welfare and drug control institutions to assist in developing frameworks of action to support voluntary and community-based services for people who use drugs, those who engage in sex work and children who have been victims of sexual exploitation; and |
| • establishment of services to address the root causes of vulnerability (e.g. Poverty, gender inequality and the lack of |
TreatNet Quality Standards for Drug Dependence Treatment and Care Services (UNODC, 2012)

TREATNET promotes diversified and accessible quality drug dependence treatment and care services, including HIV/AIDS prevention and care. TREATNET began in 2005 with 20 treatment centres worldwide, and in its current phase is being implemented in 27 countries in five regions.

The goals:
- Increase access to quality drug dependence treatment services
- Reduce the negative health and social consequences of drug use and dependence
- Create local ownership and sustainability by involving staff from national and local government agencies, universities and treatment centres in project countries

Strategy:
- Advocacy: Raising awareness of drug dependence as a health disorder that requires a multidisciplinary and comprehensive approach
- Capacity-building: Provide training on evidence-based drug dependence treatment for health and social service providers, based on the UNODC TREATNET Training Package (Training of Trainers approach)
- Service Improvement: Create community-based treatment networks involving health and social services

Relevant Sections:

Human rights

The commitment to protect human rights and the general application of the Universal Declaration of Human Rights in all treatment procedures are considered a precondition for all sites participating in the TREATNET programme. This aspect also includes the protection of the patient/client’s rights through:
- Anonymity and confidentiality
- No compulsory treatment (add reference to the compulsory treatment document)
- Informed consent
- Contact with family and relatives
- Voluntary HIV testing
- Prohibition of physical and psychological coercion
- Transparent procedures for complaints

Good practice in drug dependence treatment and care

All TREATNET sites need to implement good practices in drug dependence treatment as described below. Even though it is not a precondition to join the project, the following set of good practices represents the basis for the future development and improvement of all drug dependence treatment centres.
- Patient/client is priority: The prior concern of all staff members should be the health and well-being of the patient/client. The best way to act accordingly is to establish a partnership between the service providers and the patient/client. Moreover, health protection and health promotion are priority concerns, as well as the counteraction of stigma, discrimination and social exclusion.
• Team work: A multi-disciplinary team is considered most appropriate for (patients) with substance use disorders, because such teams boost the potential to address the various needs and problem areas of this specific target group. The team members should have clearly defined competencies, which would be periodically appraised and the opportunity for further ongoing professional development would be granted. The relevant links with professional bodies and regular supervisory processes should be ensured for governance.

• Written policies and standard operating procedures (SOPs): Evidence-based guidelines for diagnosis and treatment and on how to conduct the treatment procedures should be available at every site in order to guide the staff, provide useful instructions for daily routine and serve quality assurance. The scope of the institutional policy should include guidelines on the provision of comprehensive and effective services. It should also define the rights of patients/clients and their caregivers, and it should provide guidance for social re-integration of patients/clients.

• Data management: Data protection and security is essential. Careful acquisition, management and documentation of data are of utmost importance for both patients/clients and staff. Confidentiality has to be ensured at all times, so data must only be accessible to staff. Respecting relevant policies concerning data management is considered a precondition.

• Monitoring and evaluation have to follow structured procedures, since they play an essential role in drug dependence treatment.

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The guide presents research-based principles of addiction treatment that can inform drug treatment programs and services in the criminal justice setting.

The publication discusses 13 principles proven through research to help criminal justice organizations tailor treatment programs to better serve their populations. All principles are relevant, but specifically:

- Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
- Treatment must last long enough to produce stable behavioural change.
- Assessment is the first step in treatment.
- Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
- Drug use during treatment should be carefully monitored.
- Treatment should target factors that are associated with criminal behaviour.
- Criminal justice supervision should incorporate treatment.
planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.

- **Continuity of care is essential for drug abusers re-entering the community.**
- Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

## 2. Regional Level

### 2.1 Regional Commitments on HIV and Human Rights

Redefining AIDS in Asia (Report of the Commission on AIDS in Asia, 2008)

Commissioned by UNAIDS and presented to Mr. Ban Ki-moon on 26 March 2008

Redefining AIDS in Asia cemented Asia’s commitment to focusing on MSM and key population focused HIV programs. The Commission undertook research into Asia’s pandemic and produced recommendations for effective action. The report found that HIV knowledge among surveyed groups of MSM was poor and calls for an urgent scale-up of interventions focused on MSM to prevent the transmission of HIV and to ensure greater access to HIV services.

All findings and recommendations are relevant, but specifically:

- The vast majority of HIV infections in Asia occur during three high-risk behaviours (unprotected commercial sex, the sharing of contaminated injecting equipment, and unprotected sex between men) and one ostensibly ‘low-risk’ behaviour (sex between wives and their HIV-infected husbands).

- Leaders should ensure that an ‘enabling environment’ for prevention, care and impact mitigation is established. Legislatures and institutions must address legal or institutional restrictions that undermine effective programmes. Non-governmental and community organizations, working with Government entities, need to develop strategies to convince the public to support appropriate efforts. Some of those interventions form an intrinsic part of the HIV response and should be funded accordingly.

- HIV-related stigma and discrimination continue to undermine Asia’s response to the epidemic—whether by sanctioning inaction or encouraging the harassment and maltreatment of people affected by the epidemic. Leaders must show greater resolve in challenging the ignorance and prejudice that surround the epidemic, and in supporting legislative and other changes that can reduce stigma and discrimination.

- Engagement of affected communities in planning, implementing and assessing HIV responses is weak. Because of the marginalization of people most at risk and the stigma experienced by people living with HIV, AIDS policies and programmes need to be informed by engagements with the
affected communities. At present in Asia, the involvement of such key populations in national HIV responses is weak and, in many places, tokenistic.

- Address legal barriers to effective prevention in most at-risk populations. Sex work, the use of narcotics, and sex between men is illegal in many countries. In Asia, where these behaviours are at the centre of the HIV epidemics, such legal provisions should not be allowed to hinder potentially effective efforts to control HIV. Countries should repeal punitive laws that criminalize sex between men.

- Governments are advised to shift their focus from punitive legislation towards policies providing protection for vulnerable people who are at high-risk of HIV infection, as well as for service providers and their beneficiaries. Rather than try to address HIV risk and transmission among groups most at risk as a legal issue, health-enhancing services should be made available or improved—such as sexual health services for sex workers and their clients, and men who have sex with men and harm reduction programmes for injecting drug users.

- Governments have a duty to ensure that a comprehensive package and continuation of effective treatment services (that is, first- and second-line antiretroviral drugs) is accessible to those who need it.

- Governments must assume responsibility for ensuring that free antiretroviral therapy is available and accessible to all who need it. Community organizations, including those representing most-at-risk groups and people living with HIV, should be involved in designing, implementing and monitoring this undertaking.

ESCAP Resolution 66/10: Regional call for action to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific, 2010 (UN Economic and Social Commission for Asia and the Pacific 66th Session, 19 May 2010)

The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) was established in 1947 is the regional arm of the UN. There are 58 member countries in the region including Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. ESCAP focuses on issues in the region that are most effectively addressed through regional cooperation. In 2010 ESCAP Resolution 66/10 was adopted by all Member States. The Resolution emphasized the political commitment to meeting the MDGs and the 2001 Declaration of Commitment on HIV/AIDS and called upon members and associate members to accelerate the implementation of the Political Declaration on HIV/AIDS. By adopting the Resolution Member States agree to meet the commitments and recommendations set forward.

All are relevant, but specifically:

- Calls upon all members and associate members:
  - To ground universal access in human rights and undertake measures to address stigma and discrimination, as well as
policy and legal barriers to effective HIV responses, in particular with regard to key affected populations;  

*Requests the Executive Secretary:*

- To support members and associate members in their efforts to enact, strengthen and enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against people living with HIV and AIDS and other key affected populations, and to develop, implement and monitor strategies to combat stigma and exclusion connected with the epidemic.

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**ESCAP Resolution 67/9: Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS** (UN Economic and Social Commission for Asia and the Pacific 67th Session, 19-25 May 2011)

Following the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS ESCAP met in Bangkok on 19-25 May 2011 to discuss the regions commitment to addressing the HIV epidemic. By adopting the Resolution Member States agree to meet the commitments and recommendations set forward.

**All are relevant, but specifically:**

- *Calls upon* members and associate members to further intensify the full range of actions to reach the unmet goals and targets of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS by:
  - Developing national strategic plans and establish strategic and operational partnerships at the national and community levels to scale up high-impact HIV prevention, treatment, care and support to achieve 80 per cent coverage for key affected populations with a view of the universal access target;
  - Initiating, as appropriate, in line with national priorities, a review of national laws, policies and practices to enable the full achievement of universal access targets with a view to eliminate all forms of discrimination against people at risk of infection or living with HIV, in particular key affected populations;
  - Increasing the effectiveness of national responses by prioritizing high-impact interventions for key affected populations.

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**Asia-Pacific High-Level Intergovernmental Meeting on the Assessment of Progress Against Commitments in the Political Declaration on HIV/AIDS and the Millennium Development Goals, 6-8 February 2012: Accelerating regional implementation of the internationally agreed commitments to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific** (UN Economic and Social Commission for Asia and the Pacific, 2012)

In February 2012 the Asia-Pacific High-Level Intergovernmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS and the
Millennium Development Goals was held in Bangkok. The Report and Regional Framework for Action that came out of this meeting were endorsed by ESCAP member states. Members that attended the meeting included Bangladesh, India, Nepal, Pakistan, and Sri Lanka. The Framework called for greater regional cooperation to accelerate progress towards meeting the commitments in the 2011 Political Declaration on HIV and AIDS and the MDGs. The Meeting noted that there has been an increase in HIV prevalence among MSM in the region, and recognised efforts made to promote greater access to HIV services for MSM by countries such as India, Indonesia, Thailand and Viet Nam. The Meeting acknowledged that TG people face heightened stigma and discrimination, including a lack of formal recognition of their gender identification. In order to meet global commitments countries must work to reduce HIV among MSM and TG populations. Punitive legal and policy environments that hinder interventions targeting key affected populations are a major constraint in Governments ability to develop effective HIV responses. This includes laws that criminalise same-sex relations and sex work, as well as laws that impose HIV-related restrictions on entry, stay and residence. Laws criminalizing same sex sexual activity coupled with stigma and discrimination limit access to HIV services for MSM and create conditions that encourage the spread of the epidemic. Interventions aimed at delivering services to MSM cannot succeed if the intended beneficiaries are fugitives of the law.


Australia’s aid program supports human rights through a framework of six principles:

1. Human rights are a high priority for the Government. Civil and political rights are ranked equally with economic, social and cultural rights.
2. The aid program will continue to undertake activities that directly address specific economic, social, cultural, civil and political rights. A particular emphasis will be on the creation of durable institutional capacity to promote and protect human rights.
3. The emphasis will be on the practical and attainable. AusAID, as the Government’s aid agency, will pursue practical aid activities in support of human rights. These activities complement and build upon high-level dialogue on human rights. Dialogue on human rights and representations about individual human rights cases will normally be carried out through diplomatic channels.
4. The aid program will develop activities primarily as a result of consultations and cooperation with partner countries on human rights initiatives. Regional and multilateral activities will also be undertaken.
5. Considerable care will continue to be applied to the use of aid sanctions associated with human rights concerns. The Government will consider such sanctions on a case-by-case basis. Aid conditionality based on human rights concerns would only be used in extreme circumstances since it can jeopardise the welfare of the poorest and it may be counterproductive.
6. AusAID will continue to link closely with other arms of the Australian Government on governance and human rights issues. AusAID will also liaise with NGOs and human rights organisations in Australia.

Practical action based on these principles means that the aid program continues to focus on its objective of helping developing countries reduce poverty and achieve sustainable development. These principles underpin our strong support for civil and political rights throughout our aid work. The aid program seeks to maximise the benefits for human rights in all development assistance activities. The Government helps promote and protect human rights through supporting grass roots activities for indigenous human rights groups and building the institutional capacity of national human rights bodies. With Australian support the Asia Pacific Forum for National Human Rights Institutions has provided advice and expertise to assist with the establishment of national human rights commissions in Korea, Malaysia, Mongolia and Thailand. With this support, the number of internationally accredited national human rights institutions in the Asia Pacific has grown from four to seventeen since 1996.
From an aid perspective, development and human rights are interdependent and mutually reinforcing. For development to be sustainable, individuals in developing countries need to have secure and long-term access to the resources required to satisfy their basic needs, be they economic, social, cultural, civil or political.

At the broadest level, therefore, the whole Australian aid program contributes to the realisation of human rights. Aid activities that contribute to employment or income generation, improve public services, strengthen sustainable management of natural resources, or provide emergency and humanitarian relief in response to crises all contribute to human rights, particularly economic, social and cultural rights. Similarly, public sector reform and the strengthening of civil society contribute strongly to the promotion and protection of civil and political rights. This highlights the indivisibility of all human rights. The Australian aid program attaches equal priority to all of them. (http://www.ausaid.gov.au/aidissues/humanrights/Pages/home.aspx)

Helping the World’s Poor through Effective Aid: Australia’s Comprehensive Aid Policy Framework to 2015-16 (AusAID, 2012)

Delivering on a promise made in July 2011, the Australian Government released a new Comprehensive Aid Policy Framework on 8 May 2012. The Framework is a four-year plan for how, why and where Australian aid will be spent to 2015-16 and the results that will be achieved with that investment. It will guide growth in the aid budget to 0.45 per cent of GNI, or an estimated $7.7 billion by 2015-16.

The Framework forecasts expenditure of all government agencies involved in delivering Australian aid overseas. It has informed the 2012-13 Aid Budget and will inform future Aid Budgets to 2015-16. The budget forecasts, which are indicative, were informed by a comparative analysis between the regions by which the aid budget is organised (Pacific, East Asia, South and West Asia, Africa and the Middle East, and Latin America and the Caribbean) and were based on four criteria:

1. Poverty
2. National interest
3. Australia’s capacity to make a difference
4. Current scale and effectiveness of existing programs.

The outcome is that by 2015-16:

- Asia and the Pacific will continue to be the highest priority regions for the aid program, receiving an estimated 75 per cent of Australian aid
- our 12 largest bilateral aid recipients will be Indonesia, Papua New Guinea, Afghanistan, Solomon Islands, Vietnam, the Philippines, Bangladesh, Timor-Leste, Pakistan, Cambodia, Myanmar and Vanuatu
- over 30 per cent of our aid will be delivered through partnerships with multilateral organisations—with the World Bank, Asian Development Bank, World Food Programme and UNICEF our major partners
- 25 per cent of aid will be spent on education assistance, to get 4 million more children into school and provide 20 million children with a better quality of education
- at least 10 per cent of the aid budget (up from 6 per cent in 2007) will be delivered through partnerships with non-government organisations.

The budget forecasts are aligned to a set of key results to be achieved by 2015-16. For example, our aid will help:

- vaccinate more than 10 million children against disease to save lives
- provide a further 8.5 million people with access to safe water
- enable 1 million mothers to have their births attended by a skilled birth attendant.

Australia is one of few donors in the world to have developed such a high level of transparency and predictability in its medium-term aid allocations. Progress against the Framework will be assessed in an Annual Review of Aid Effectiveness. The Review findings will be considered by Cabinet each year as
part of the annual budget process, and made publicly available soon after.

2.2 Regional Human Rights Framework for HIV in relation to Harm Reduction and Drug Use

Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles (WHO, 2009)

This report has been prepared by the Western Pacific Regional Office of the WHO to describe the “compulsory treatment centres” in Cambodia, China, Malaysia and Viet Nam, and assess the treatment they provide. The main objective of this report is to use some key human rights principles as a lens through which to assess and document the situation in the compulsory drug treatment centres in a constructive way, as a basis for engaging in dialogue with policy-makers in these countries.

The assessment suggests that these centres lack effective drug treatment services. There is also a lack of prevention or care services for HIV in closed settings, where the spread of the disease is much faster than in the community. People who use drugs in the region are at risk in these settings because they do not receive drug treatment and HIV prevention services.

Relevant recommendations:
• First, a distinction needs to be made between PWUD occasionally and drug-dependent people. People who are dependent on drugs should have the choice to attend a drug treatment facility or not, since the right to health also includes the right to be free from non-consensual treatment. The decision to attend treatment in a centre should, therefore, be voluntary, not compulsory.
• Men, women and youth should be able to access specific services, where they can benefit from a treatment mindful of gender and lifecycle requirements.
• People who are dependent on drugs need to be provided with necessary medical care. Evidence shows that opioid substitution therapy is the most efficient way to treat heroin dependence.
• Minimum staffing requirements and training are needed so that the personnel can provide adequate treatment to the residents.
• The treatment should be free of charge, if so stipulated by the national laws. If the treatment cannot be entirely subsidized, the cost should not be an obstacle to have access to the treatment centres.
• HIV prevention education, condoms, and NSP should be provided to residents in the centres. If health care staff can be trained in it, ART should be introduced into the centres to enable PWUD living with AIDS to have access to the treatment and continue their treatment for those who have started it before beginning drug treatment. If staff capacity is insufficient in the centres, collaboration can be established between drug treatment facilities and HIV treatment centres to provide HIV care and treatment to PWUD living with HIV.
• Mandatory re-education labour is to be discouraged. Instead, the
development of voluntary vocational education can help create skills that enable residents to find work after their release.

**Follow-up**

- Cooperation between the family and the drug treatment centres needs to be promoted. The family and the resident should receive information about the different stages of the treatment provided in the centre. Upon release, the families should receive information on how to help them support their relatives to prevent relapse.
- Particular efforts are needed to encourage community-based activities to monitor and follow up on the health of the residents in a non-discriminatory manner. Attention should also be given to helping him/her find employment, providing support to PWUD and PLHA and establishing a network for relapse prevention.
- The use of community-based voluntary treatment centres/services as an alternative to incarceration should be encouraged.

**Recommendations for governments**

At the governmental level, close collaboration is needed between the different ministries dealing with illicit drugs to treat the problem of PWUD as a health issue, and not as a criminal one. There is a need to review drug control legislation and practices to ensure that inconsistencies in the laws do not hinder HIV prevention efforts. In some countries, such as Malaysia, Viet Nam or Cambodia, drug use is stigmatized, and a shift in policies from criminalization of PWUD to considering drug use mainly as a health problem will require educational campaigns addressed to the overall population to fight stigma and discrimination towards PWUD.

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**Press-Statement: United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mr. Anand Grover in the Country Visit to Viet Nam. (Grover, 2011)**

The UN Special Rapporteur on the right to health, Anand Grover, concluded his mission to Viet Nam by stressing that detention and compulsory treatment of injecting drug users and female sex workers in the so-called rehabilitation centres violate their right to health.

Mr Grover stated that detainees are denied the right to be free from non-consensual treatment as well as the right to informed consent in all medically related decisions. Calling the practices “ineffective and counterproductive”, the UN independent expert underscored that the centres perpetuate stigmatization and discrimination of those groups in the society, impede the Government’s HIV/AIDS efforts and have proven futile in reducing drug use and sex work, their stated objective.

“I wholeheartedly support the closure of the rehabilitation centres”, said Mr Grover, “it is essential to ensure that the considerable resources now invested in these centres are used instead to expand alternative treatments for injecting drug users”. In that context, he commended the Government on initiating a number of pilot methadone and community-based programmes, which “are less costly and more effective in reducing drug use and facilitating the reintegration of injecting drug users back into the society”.

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The Special Rapporteur further underlined that participation of affected populations in health decision-making was an essential component of the right to health, and encouraged the Government of Viet Nam to empower its people, including vulnerable groups, to actively participate in formulating and implementing all decisions concerning their health. The Special Rapporteur is an independent expert appointed by the UN Human Rights Council to help States, and others, promote and protect the right to the highest attainable standard of health (right to health).

### Report of the Second Regional Consultation on Compulsory Centres for Drug Users in Asia and the Pacific (UNODC, ESCAP, UNAIDS, 2012)

The Second Regional Consultation on Compulsory Centres for Drug Users (CCDUs) was organized by the UNODC1 Regional Centre for East Asia and the Pacific, ESCAP2 and the UNAIDS3 Regional Support Team for Asia and the Pacific, with the participation of officials from nine Governments in East and South-East Asia.

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<th>Relevant sections include:</th>
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<td>The meeting adopted the following recommendations:</td>
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<td>Countries should consider:</td>
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<tr>
<td>a. Initiating, as appropriate, in line with national priorities, multi-sectoral consultations and reviews of laws, policies and practices that hinder access to voluntary and effective drug dependence treatment;</td>
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<td>b. Undertaking cost-effectiveness studies comparing CCDUs and voluntary community-based treatment;</td>
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<td>c. Improving follow-up and aftercare in voluntary community-based treatment;</td>
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<td>d. Undertaking a mapping of existing resources allocated to different treatment systems;</td>
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<td>Mobilizing additional human resources, including involvement of affected populations, such as recovering drug users, and enhancing specialized training for the delivery of voluntary community-based services;</td>
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<td>f. Reallocating human and financial resources from CCDUs to voluntary community-based treatment, in accordance with national laws and policies;</td>
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<td>g. Increasing government investments for voluntary community based treatment;</td>
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<tr>
<td>h. Raising awareness and building capacity regarding community-based treatment among governmental, nongovernmental and private organizations, as well as community members, health professionals, religious leaders, social workers and those working in charities.</td>
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1. UNODC (United Nations Office on Drugs and Crime)
2. ESCAP (Economic and Social Commission for Asia and the Pacific)
3. UNAIDS (Joint United Nations Programme on HIV/AIDS)
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