Human Rights and HIV Prevention, Treatment, and Care for People Who Inject Drugs: Key Principles and Research Needs

Daniel Wolfe, MPH, MPhil,* and Jonathan Cohen, JD, MPhil†

Abstract: Efforts to provide HIV prevention, treatment, and care to injecting drug users (IDU) are shaped by tensions between approaches that regard IDU as criminals and those regarding drug-dependent individuals as patients deserving treatment and human rights. Advocates for IDU health and human rights find common cause in urging greater attention to legal frameworks, the effects of police abuses, and the need for protections for particularly vulnerable populations including women and those in state custody. Arbitrary detention of drug users, and conditions of pretrial detention, offer examples of how HIV prevention and treatment are adversely impacted by human rights abuse. National commitments to universal access to prevention and treatment for injecting drug users, and the recognition that users of illicit substances do not forfeit their entitlement to health services or human dignity, offer a clear point of convergence for advocates for health and rights, and suggest directions for reform to increase availability of sterile injection equipment, opiate substitution treatment, and antiretroviral therapy. For IDU, protection of rights has particular urgency if universal access to HIV prevention and treatment is to become an achievable reality.

Key Words: antiretroviral, buprenorphine, drug dependence, human rights, methadone, prison, police, substance abuse

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OVERVIEW: DRUG-USER HEALTH IN A HUMAN RIGHTS FRAME

“Drug users are vulnerable people. They suffer from inadequate medical assistance. They experience discrimination, invasion of privacy, police harassment, and social marginalization. They have to endure arbitrary deprivation of rights, such as mandatory medical treatment. Their capacity to defend their interests is impaired by social stigmatization. One would assume that society’s majority would oppose such violations. After all, arbitrary searches, nightclub raids, compulsory urine tests, and wrongful appropriation of confidential medical files are injustices suffered by nonusers as well. But the majority accepts the invasion of privacy in an attempt to have a drug-free environment”—Judit Fridli, Chair, Hungarian Civil Liberties Union, 2003.

Efforts to provide HIV prevention, treatment, and care to injecting drug users (IDU) are shaped by a basic tension. On the one hand, public health agencies and clinicians recognize that drug-dependent individuals suffer from a chronic and relapsing condition. On the other, law enforcement officials pressured to curb demand and supply for illicit drugs regard IDU primarily as participants in illegal exchange, rather than as individuals in need of services. These tensions are borne out in policies that simultaneously seek to increase access for IDU to prevention and treatment services and to reduce demand for illegal drugs through punitive measures, including arrests and imprisonment. Conflicting strategies are frequently pursued simultaneously in developed and developing countries alike, and at the international level where tensions between those who call for a “drug-free world” and those who urge public health approaches to contain drug dependence and HIV have led to what some have called “double vision,” “systematic incoherence” or a “dis-United Nations.”

HIV/AIDS attributed to injecting drug use is currently reported in 119 countries, and IDU account for nearly one-third of new HIV infections outside sub-Saharan Africa. The need for a public health response to the intertwined epidemics of drug abuse and HIV is clear, and fortunately, so is the evidence on the best practices available to contain them. Provision and exchange of sterile injecting equipment is among the most thoroughly studied and effective of these, having been demonstrated to reduce the spread of HIV by taking contaminated syringes out of circulation without encouraging or increasing drug use. Methadone and buprenorphine, prescribed as opiate substitution therapies (OST), are effective in reducing craving and use of opiates and have been added to the list of essential medicines by the World Health Organization (WHO). Citing evidence that IDU, when offered HIV testing and antiretroviral (ART) adherence support, can achieve significant virologic benefits, WHO has issued guidelines for the use of first-line and second-line ART for IDU, with instructions that drug users should not be denied treatment on the basis of their IDU history or active drug use. In countries such as the Netherlands, Switzerland,...
Human Rights and IDU: Key Principles

The pragmatic alliance between public health and human rights is affirmed by many governments and international organizations, needle exchange and methadone treatment programs in many low-income and middle-income countries remain few in number, underfunded, and constrained by regulation and lack of political will. In Russia, OST for opiate addiction is banned by law. IDU and outreach workers in countries as varied as Bangladesh, Kazakhstan, India, Indonesia, and Ukraine, experience denial or confiscation of essential medicines, extortion, planting of evidence, and arbitrary detention by police. "Harm reduction is like a sandcastle," a Malaysian peer educator active in syringe provision told an international conference last year. "Community builds it up, and law enforcement tears it down."

HUMAN RIGHTS AND HIV PREVENTION AND TREATMENT FOR IDU: A SHARED FRAMEWORK

Increasingly, scientists have been looking beyond individual IDU to their "risk environments," the various physical, geographic, social, economic, and political structures that influence IDU risk behaviors and adverse health outcomes. Some have urged attention to the "case of the missing cop": the effects, often unacknowledged, of criminal law and law enforcement on IDU risk for overdose, treatment interruption, and HIV or other blood-borne infections. Police crackdowns, arrests, and incarceration are correlated with hurried injections, sharing of injection equipment, treatment interruption, and other adverse health effects. Policies and practices in health care settings, including denial of ART to current or former IDU, erroneous physician assumptions about patient compliance, and lack of access to methadone treatment for IDU requiring hospitalization or tuberculosis treatment have been shown to impede an effective HIV response. In multiple countries with injection-driven HIV epidemics, those most in need of drug-dependence treatment or ART are required to have their names placed in registries to access public clinics. Registries are shared with the law enforcement, and those registered subjected to mandatory drug testing and stop-and-frisk actions by the police, and to denial of employment, driving licenses, and child custody. Fear of being added to such registries is a major barrier to IDU in need of health services.

Researchers and health providers who work with IDU have long examined the nexus of service provision, risk environments, and human rights. The most elemental concerns of human rights law are also determinants of the health outcomes of IDU, including incarceration, violence, stigmatization, isolation, and discrimination. A second generation of human rights standards protects economic and social rights including "the right to the highest attainable standard" of health. While human rights advocates generally draw upon a different set of normative standards from those used by health providers—they are more likely to cite the Universal Declaration of Human Rights or one of the 9 cornerstone, core principles of human rights include liberty and security of the person, autonomy, privacy, and freedom from cruel, inhuman, or degrading treatment. These clearly overlap with elements of effective health programming for IDU, where client trust and the building of "therapeutic alliances" have proven critical. Researchers and health providers working with IDU have long recognized the importance of understanding how hostile police environments impact individual risk behaviors. Health services are ineffective if people are unable or afraid to use them.

As debates over provider-initiated HIV testing make clear, the pragmatic alliance between public health and human rights continue to be tested. The emphasis by human rights advocates on limiting state action ranksle both public health officials concerned that protection of individual liberties such as informed consent will impede protection of public health, and policymakers who believe that national policy should not be dictated by multilateral agreements monitored in foreign capitals. Human rights proponents differ as well over the degree to which the concept of the "right to health" should be used to influence decisions on allocation of resources by national governments. In the case of HIV, however, explicit commitments to universal access to HIV prevention and treatment, and recognition that constraints on individual liberty in the name of law enforcement impede public health, are clear points of converge for advocates of health and human rights. The special concern of human rights conventions toward such vulnerable groups as women, children, racial and ethnic minorities, persons with disabilities, and those in prison or other custodial settings also resonates with HIV prevention and treatment professionals who are increasingly focused on “most at-risk populations.” Table 1 provides a shared framework where human rights principles and best practices for HIV prevention and treatment for people who inject drugs can be seen to converge (Table 1).

The importance of human rights protections in HIV services is underscored by the epidemiology in places where these protections have been ignored. In Thailand, for example, a 2003 government-sponsored war on drugs led to arrest quotas, blacklists, forced drug testing, the detention of more than 50,000 people in military-run "treatment camps," and the death of more
Researchers and HIV service providers reported dramatic declines in participation in clinical trials and HIV prevention programs, although HIV infection rates among IDU continued unabated. In Russia, the United States, and many other countries, prolonged imprisonment and pretrial detention of drug users for nonviolent offenses concentrates HIV-infected and uninfected individuals in penitentiary settings where HIV risk behaviors continue but where basic precautionary measures to prevent HIV, such as condoms or sterile injection equipment, are unavailable. The obvious result is that needle sharing and unsafe sex occur, with ensuing spread of HIV among inmates in the institution and eventually into the wider community when they are released.

Even when guided by evidence, the health benefits of HIV prevention for IDU do not always translate to increased popular or political support. As recently as January 2010, after years of declines in HIV prevalence among New York City IDU as a result of needle exchange and safer injection education, a special narcotics prosecutor and chair of the City’s Council’s public safety committee charged that a Department of Health publication on safer injection was a “how-to manual” for drug use and should be withdrawn. Table 2 explains why this and other health-detering approaches may violate international human rights conventions and basic human rights.

### TABLE 1. Shared Frameworks: Human Rights Principles and Best Practices for HIV Prevention and Treatment for IDUs

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<td>Autonomy; dignity; freedom from discrimination, cruel, inhuman, and degrading treatment; and access to health and information. Special protection for the most vulnerable: prisoners, women, children, ethnic minorities, etc. Focus on the responsibilities of the state.</td>
<td>Trust, therapeutic alliance, confidential and respectful approach. Targeted services for high-risk or “most at risk populations” (MARPS). Move from the individual to the structural; attention to “risk environment”.</td>
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...than 2800 individuals in what human rights experts termed “extrajudicial executions.” Researchers and HIV service providers reported dramatic declines in participation in clinical trials and HIV prevention programs, although HIV infection rates among IDU continued unabated. In Russia, the United States, and many other countries, prolonged imprisonment and pretrial detention of drug users for nonviolent offenses concentrates HIV-infected and uninfected individuals in penitentiary settings where HIV risk behaviors continue but where basic precautionary measures to prevent HIV, such as condoms or sterile injection equipment, are unavailable. The obvious result is that needle sharing and unsafe sex occur, with ensuing spread of HIV among inmates in the institution and eventually into the wider community when they are released.

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### SOCIAL DETERMINANTS AS HUMAN RIGHTS VIOLATIONS? THE CASE OF ARBITRARY DETENTION

In virtually all low-income and middle-income countries, greater numbers of IDU are found in prisons, pretrial detention facilities, police lock-ups, and forced rehabilitation centers than in the health system. Although the exact numbers are unknown, estimates are that 30% of prisoners worldwide are drug users who have never been tried or convicted of any offense. In Asian countries such as China and Vietnam, an estimated 400,000 drug users or more are interned in “detoxification” or “rehabilitation” centers where they spend 2 years or longer without criminal charges, appearance before a judge, right of appeal, or evaluation by an addiction treatment professional.

Pretrial and arbitrary detention subject detainees to numerous health risks associated with overcrowding, violence, physical and psychological abuse, and poor infection control. Asian drug-detention centers are run by police and the military. They provide no evidence-based treatment for drug dependence and limited or no treatment for HIV or tuberculosis, despite the high prevalence of these infections. In China and Vietnam, those who test positive for illicit drug use are forced to labor in the service of private companies, and beatings, food deprivation, and even torture are punishments for those who fail to meet production quotas or attempt to escape. In all countries, detainees are most at risk for beatings, torture, or cruel and degrading treatment immediately after their arrest. Police in Ukraine and Kazakhstan have reportedly used the threat of painful withdrawal symptoms to coerce confessions from drug-dependent individuals. This has been identified as torture by a United Nation (UN) special rapporteur. Detention environments that contribute to infection and death have also been identified as sites of multiple other violations of human rights, including the right to due process, the right to health, and when detainees die without medical attention, the right to life.

Identifying arbitrary and pretrial detention practices as human rights violations may also lead to practical, political, and structural improvements. In recent cases before the European Court of Human Rights, the governments of Ukraine and Russia were ordered to compensate the families of drug users who had died in pretrial detention, thus increasing pressure on the governments to improve health in detention; the Court also ordered the release of detainees suffering life-threatening conditions. The European Court found the Republic of Georgia negligent for not providing hepatitis C treatment to a detainee infected while in prison. The Standard Minimum Rules on the Treatment of Prisoners, together with independent monitoring bodies such as the Committee on the Prevention of Torture and the Working Group on Arbitary Detention, have exerted additional pressure on governments to make needed reforms to reduce overcrowding and attendant health effects; these reforms may include the provision of legal aid, standardization of bail policies at the pretrial stage, and inspection of pretrial detention facilities by independent experts. Such reforms can have a significant impact on the health of prison populations, arguably even more significant than allowing access to condoms, sterile syringes, or opiate substitution treatment because they address both the worst forms of abuse and some of the root causes of adverse health trends within the criminal justice system.

### TOWARD A RESEARCH AGENDA ON HEALTH AND HUMAN RIGHTS OF DRUG USERS

Recent years have seen leading medical journals and UN officials, such as the UN High Commissioner for Human Rights and the Executive Director of the UN Office on Drugs...
Support the importance of protecting the human rights of people who use drugs. The programmatic features of an “enabling environment” for HIV prevention and treatment for IDU, however, have yet to be identified and evaluated. Implementers of programs for IDU have observed that the integration of legal aid and harm reduction can deter police from conducting surveillance nearby, giving providers the space needed to treat drug users with respect and ensure access to health services. Legal aid at the pretrial stage may help to persuade a judge not to detain a criminal defendant, thus averting the harmful effects of incarceration. Unfortunately, there are few evaluations of these commonsense observations or of the pathways by which they may lead to improved health outcomes for IDU.

Evaluative studies are also needed on whether the risk environment for people who use drugs and have HIV improves as a result of changes by law enforcement and health officials. Various tools, including police training, protocols, complaint mechanisms, and anticorruption measures have been used to change law enforcement practices that deter drug users from seeking health services, but their precise public health benefits, if any, remain unknown. Similarly, an extensive literature documents the effects of individual-level barriers to and support for adherence by IDU, but few metrics are available to measure systemic barriers that decrease ART adherence by people who use drugs or the efficacy of systemic remedies. Policies that prohibit active drug users from receiving ART, that require collateral fees and paperwork before treatment initiation, or that prohibit ART substitution treatment before receiving tuberculosis treatment or ART are unethical and likely lead to “treatment failure.”

Given the impact of pretrial and arbitrary detention on health, structural interventions are needed to enhance protections in police lockups and to reform pretrial justice systems. Pretrial justice programs in Russia, Mexico, and Nigeria currently seek to reduce the numbers of persons detained, yet these same countries disproportionately detain IDU at risk for HIV. The goals and outcomes of these pretrial

### TABLE 2. Impediments to HIV Prevention and Treatment and Corresponding Rights Violations

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<th>Human Right</th>
<th>Health Deterring Policy or Practice</th>
<th>Human Rights Standard Violated</th>
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<tr>
<td>The right to freedom from torture and cruel, inhuman and degrading treatment</td>
<td>Investigators force drug users into unmicated withdrawal to extract confessions.</td>
<td>ICCPR 7: 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.</td>
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<td>Drug users entering “treatment” are caned, verbally abused, and made to crawl through animal excrement as “orientation.”</td>
<td>Drug users are involuntarily committed to years of “treatment” without medical or judicial review or right of appeal.</td>
<td>ICCPR 10(1): All persons deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person.</td>
</tr>
<tr>
<td>Patients are chained, handcuffed or caged during withdrawal or as punishment for insubordination.</td>
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<td>An HIV-infected drug user is held for months in pretrial detention without medical care.</td>
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<td>ICCPR 9(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...</td>
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<td>Police demand drug tests from or detain those who “look like drug users.”</td>
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<td>ICCPR 17(1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, or to unlawful attacks on his honor and reputation.</td>
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<tr>
<td>A clinic gives lists of drug treatment patients to police.</td>
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<td>ICCPR 17(1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, or to unlawful attacks on his honor and reputation.</td>
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<td>The government bans publications about methadone or safer injection, claiming they encourage illegal activity.</td>
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<td>ICCPR 19(2): Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds.</td>
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<td>The government confiscates syringes from drug users or bans methadone treatment for opiate dependence.</td>
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<td>ICESCR 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 ... shall include those necessary for... the prevention, treatment and control of epidemic, endemic, occupational and other diseases.</td>
</tr>
<tr>
<td>A former drug user is denied work, driver’s license and child custody because of medical history.</td>
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<td>ICCPR 26: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.</td>
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<tr>
<td>Those with a history of drug use are denied ARV.</td>
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<td>ICCPR 26: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.</td>
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justice programs need evaluation, particularly regarding their effects on HIV acquisition and progression, HIV treatment, and treatment for drug dependence.

Reforming laws that authorize police surveillance and pretrial detention of drug users, particularly laws that criminalize so-called “internal possession” or positive urine tests and the possession of sterile injection paraphernalia, will likely be among the most powerful levers for structural reduction of HIV risk. UN Secretary General Ban Ki Moon has highlighted the need for removal of criminal penalties on people who use drugs and other groups vulnerable to HIV. The Executive Director of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, an HIV researcher and physician with over 50 peer-reviewed publications, has called for removal of penalties for personal drug possession. Portugal decriminalized possession of all drugs in 2001 and has subsequently reported increases in numbers of persons seeking drug-dependence treatment, decreases in HIV related to drug use and decreases in heroin use and heroin-related deaths. Its experiences demonstrate the importance of examining the public health effects of drug penalty reform. Studies are also needed of other law reforms, including those related to prostitution, sodomy, and intentional HIV transmission, to understand their impacts on access and use of health services and on the incidence and prevalence of HIV/AIDS and other infectious diseases.

CONCLUSIONS

The Joint United Nations Program on HIV/AIDS (UNAIDS) has proposed a package of interventions to remove legal and policy impediments to effective HIV prevention policies, including legal aid and empowerment for populations at risk, legal reforms, “know your rights” campaigns, training for service providers, programs to reduce violence against women and girls, and programs to reduce stigma and discrimination. A 2009 UNAIDS survey of 56 countries, however, reveals the challenge of moving from rhetorical commitments to implementation of programs that safeguard human rights. Although 85% of national strategic plans on AIDS mentioned stigma and discrimination or human rights concerns, few included specifics: nearly 7 in 10 made no mention of populations at risk, including IDU, sex workers, or men who have sex with men, or any programs to address human rights violations against them.

Given the scale of police abuses against and detention of IDU, national commitments to universal access to HIV prevention and treatment must recognize that drug users do not forfeit their entitlement to health services or human dignity. “Combination prevention” for HIV—frequently cited as the best hope for containing the spread of HIV—must be reconceptualized for criminalized populations to include such measures as legal aid, access to justice, and protection against police abuses. Without protection of these basic human rights, universal access for IDU is unlikely to change from a utopian ideal to anything approaching an achievable reality.

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