Unintended Consequences:

Drug Policies Fuel the HIV Epidemic in Russia and Ukraine

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Designed by Jeanne Criscola | Criscola Design
Printed in the United States of America by Herlin Press, Inc.
Cover photo by Hans-Jürgen Burkard

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A policy report prepared for the
UN Commission on Narcotic Drugs and national governments
April 2003

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IHRD | INTERNATIONAL HARM REDUCTION DEVELOPMENT

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I. Executive Summary

By promoting strict compliance with United Nations drug control treaties, the UN Commission on Narcotic Drugs (CND) and other UN agencies are exacerbating the HIV epidemic in Central and Eastern Europe and the former Soviet Union. This linkage has become clear over the past five years as the number of people infected with HIV has increased by more than 500 percent in Russia and Ukraine, the hardest hit countries in the region.

The governments of those two countries—as well as others in the region—have tried to comply with the tough UN treaties by implementing repressive antidrug policies aimed at achieving a "drug free society." Not only do many of these policies violate basic human rights principles, but they also have catastrophic public health consequences in nations where the HIV epidemic is driven primarily by injecting drug use.

Russia and Ukraine, the region's most populous states, share the dubious distinction of having two of the fastest-growing drug use and HIV infection rates in the world.[1] As many as 1.5 million Russians[2] and 400,000 Ukrainians[3] are estimated to be living with HIV—and at least 80 percent of the officially registered infections in those countries are attributable to injecting drug use.[4] Such an explosive HIV epidemic could easily occur in other countries with rising rates of injecting drug use, such as Pakistan, Iran, and countries in Central Asia.

By adhering to UN drug conventions that focus on reducing demand, governments in Russia and Ukraine have allocated most of their resources to law enforcement institutions, including the police. This limited focus has inhibited public health authorities—both financially and legally—from pursuing effective HIV prevention and treatment policies, thus reducing opportunities for drug users to access information and resources to safeguard their health. Drug users are also more likely than ever to contract HIV and other bloodborne diseases from needle-sharing and other risky behaviors. Furthermore, they will continue to be marginalized by society, subject to widespread discrimination and stigma, and frequently denied basic health care and other social services. Because of such narrow policies and their

consequences, national governments are unlikely to meet target goals for effective HIV policies as agreed to at the 2001 UN General Assembly Special Session on HIV/AIDS.

The CND and other UN agencies that are committed to enforcing the existing treaties, including the UN Office on Drugs and Crime (UNODC), do not prescribe or recommend specific resource-allocation or drug-reduction strategies for national governments. However, their hard-nosed antidrug stances strongly influence individual governments' policies. This is especially problematic for drug users and people with HIV because the treaties are outdated. The first UN drug convention was enacted in 1961, before the global HIV epidemic and at a time when social and medical understanding of drug use and addiction was much more limited. The two other main treaties are more recent, but they, too, are outdated because they base many of their assumptions on the initial convention.

Many governments, including those in Russia and Ukraine, have failed to address the treaties' inherent flaws and continue to interpret them rigidly. Like the CND, they are unable or unwilling to consider the negative consequences of repressive antidrug policies.

It is not too late for international and national policymakers to reconsider their strategies. At a CND summit in Vienna in April 2003, UN officials and government ministers from around the world discussed progress toward meeting UN General Assembly Special Session on the World Drug Problem (UNGASS) drug-eradication goals, agreed to in 1998, as well as additional steps toward achieving them. UN officials and government ministers should reevaluate both their objectives and methods and take action to ensure that drug policies do not continue to bear increasingly deadly and disastrous results.

The following policy recommendations should be considered as the officials and ministers seek to reform UN drug conventions and national drug and HIV laws:

- Antidiscrimination and equal-protection laws in all countries should be amended to guarantee the civil liberties and human rights of drug users and people living with HIV.
- The conventions should explicitly encourage national governments to view drug use primarily as a matter of public health, not law and order. Government policies should be constructed to reflect this reality.
- National governments should be encouraged to ensure that all people are provided with information and services to protect their health. Programs concerning drug use and HIV should encompass a full range of pragmatic, inclusive, and accessible harm reduction services, from education and drug treatment to substitution therapy and needle exchange. Drug conventions and national laws should include provisions that explicitly legalize needle exchange and the use of methadone for treatment purposes.
- Drug users and their advocates should be involved at all levels of decision making when national and international drug use policies are developed.

The CND must no longer resist calls to restructure its strategies and goals to reflect a difficult reality. Failure to do so will further intensify the extensive HIV epidemic and jeopardize the health of thousands of vulnerable people.

II. Background: UN Treaties and 'Demand-Reduction' Goals

Three UN conventions form the basis for international drug control coordination. Their influence cannot be overstated: Countries that have ratified and signed the conventions (including all of the countries in Central and Eastern Europe and the former Soviet Union) are expected to incorporate their provisions into domestic law. It was surely never the intention of UN policymakers and national government officials that these treaties would hinder efforts to adequately confront health epidemics. Yet, that has been the unforeseen consequence in the age of HIV and AIDS—especially in countries where injecting drug use plays a significant role in HIV transmission. Much of the blame for skyrocketing HIV rates in the region lies in the fact that current drug control conventions and the way governments seek to comply with them are outdated and inflexible.

The first treaty was the Single Convention on Narcotic Drugs. It focused on limiting access to what it defined as "dangerous" narcotic drugs and stipulated that those in Schedule I, the most restrictive category, can only be used for "medical and scientific purposes." Among the drugs in Schedule I are cocaine and opiates, including morphine, heroin, and methadone. Ten years later, the 1971 Convention on Psychotropic Substances expanded the UN's definition of "drugs of abuse" to include, for example, methamphetamines. The third major international drug treaty, the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, is considered the strictest of all three treaties. It referred back to the previous conventions and urged each signatory country to "adopt such measures as may be necessary to establish as criminal offences under its domestic law, when committed intentionally,"[5] the possession of illicit drugs. Because the language in the phrase "adopt such measures as may be necessary" is vague, it can be interpreted in a variety of ways by national governments that are drawing up domestic legislation. As a result, many governments have shown a readiness to take the easier road, which in most cases involves blunt, repressive antidrug policies that are potentially harmful to all individuals—not just drug users.

The governments claim they are forced to adopt such measures to comply with the conventions and related resolutions from the 1998 UNGASS. At that meeting, participating countries reaffirmed the three conventions' classifications and agreed to work toward achieving

"significant and measurable results" in reducing illegal drug consumption by 2008 (with a 50 percent reduction considered the formal target). That deadline has been criticized as unrealistic by most independent observers, and unrealistic goals inevitably lead to strategies that, while destined to fail, are draconian.

There are significant discrepancies in how the conventions are interpreted and how policies are formulated. For example, although the conventions seem to allow very few exemptions for Schedule I drugs, methadone is widely available for substitution treatment in many signatory countries as a key means of helping treat heroin addiction. In other nations, methadone is illegal under all circumstances, including substitution therapy—and policymakers justify these laws on the conventions' provisions. Inconsistencies are most pronounced when policies regarding methadone are compared with those regulating morphine.

Morphine is also a Schedule I drug, yet nearly all countries of the world allow its use as a pain medication. Even though methadone, like morphine, has been shown to have a "legitimate" medical application,[6] it cannot be prescribed at all in certain countries. The only possible explanation for this discrepancy seems to be discrimination against drug users.

The UN treaties and the UNGASS political declaration do contain some language that can be construed as compassionate to drug users. The CND went one step further in March 2002 when it adopted a resolution on HIV and drug use that "encourages Member States to implement and strengthen efforts to raise awareness about the links between drug use and the spread of HIV, hepatitis C and other bloodborne viruses" and "further encourages [them] to consider the potential impact on the spread [of these diseases] when developing, implementing and evaluating policies and programs for the reduction of illicit drug demand and supply. . . ."[7]

Resolutions and political declarations are not binding under international law, however, and such explicit language does not appear in the actual treaties. Therefore, the treaties themselves remain outdated. The first two were conceived and enacted before HIV was even identified. The third treaty came into force in the age of AIDS, but was enacted before the explosive growth of injecting drug use in many parts of the world. To date, neither the CND nor the UNODC (formerly known as the UN Office for Drug Control and Crime Prevention, or UNDCCP) has proposed revising any of the conventions to better reflect the myriad economic, cultural, social, and public health issues that are likely to prevent most countries from meeting the user-reduction goals. In the absence of revisions, the legally binding conventions remain hostile to drug users.

III. 'Reducing Demand' at the National Level: Common Government Policies

How does a national government go about "reducing demand" for drugs and meeting the goals specified by the UN drug conventions? In the absence of targeted guidance, suggestions, or assistance from the UN drug agencies, the most superficially attractive approach is to crack down on drug users directly and attempt to deny them the ability to "demand" drugs. Several signatory countries have passed laws and implemented so-called zero tolerance policies intended to severely punish drug users and serve as a deterrent to others. Authorities are often charged with more aggressively rounding up drug users to meet quotas, and they sometimes restrict (or terminate) the activities of organizations that help drug users but do not require them to stop using.

Such policies are often backed by the general public, which in most societies views drug users as nuisances at best, dangerous criminals at worst. However, in no country have harsh policies contributed to eliminating demand for drugs and they do nothing to address any of the economic, social, or health factors associated with the use of illicit drugs. Locking people up in prisons is not a solution—especially when those incarcerated have even greater access to drugs than they do outside prison walls. (In Russia, for instance, about 8 percent of inmates surveyed in 2000 by Médecins Sans Frontières acknowledged injecting drugs in prison.[8] That percentage is thought to be significantly higher now.) Drug users who avoid arrest are driven further underground and are less likely to access medical and social services, including those that would help the motivated to stop using, because of fear of harassment or incarceration.

These trends do not bode well for efforts to reduce HIV transmission or improve public health in general. Instead, drug users face increased discrimination and have little or no incentive to take measures to protect their own health or the health of those around them. It is in such circumstances—when hope for a better future and compassion from society are both limited—that drug use and HIV spread most rapidly.

IV. Current Drug Policies in Russia and Ukraine

Russia and Ukraine have already fallen into the deadly drug use/HIV spiral. In both countries, the number of drug users and HIV infections has surged in tandem since the mid-1990s, twin epidemics that are inextricably linked. At the same time, each nation has also revised its antidrug laws and policies as part of an effort to suppress drug use and make headway toward meeting the UN conventions' drug-eradication goals. Such revisions are considered necessary because both the Russian and Ukrainian constitutions recognize the priority of international agreements. In an unusually candid comment, Russian Minister of Interior Affairs Boris Gryzlov, in a speech to the Russian Parliament (Duma) in October 2001, said that "total prohibition" of illicit drug use was "not the [government's] own initiative . . . but rather a responsibility to implement the UN drug conventions of 1961, 1971, and 1988."[9]

Although there are some notable differences in penalties and how the laws are ultimately applied, the contemporary Russian and Ukrainian criminal codes have much in common because they share the legacy of Soviet legislation. Some of the relevant laws and related criminal justice procedures are noted below:

- The production, sale, possession, storage, and transportation of illicit drugs are prohibited in both countries. Russian antidrug laws, which were overhauled in 1998, are somewhat harsher toward offenders: Criminal liability extends to smaller amounts of a drug than in Ukraine, and offenders can be sentenced to longer prison terms.

- In both countries, an individual charged with possession of illegal drugs may escape criminal responsibility if he voluntarily surrenders the drugs and "actively participates in the investigation of drug-related offences."

- Individuals charged with violating drug-trafficking laws are subject to "administrative surveillance" after they have completed their prison terms.

- Pretrial detention of those charged with drug-related offenses remains accepted and common in certain circumstances. Policymakers in both countries are trying, with varying degrees of success, to reduce the number of detainees through the implementation of new concepts such as bail. Recently in Russia, decision-making responsibility regarding detention was transferred from the prosecutor's office to the court, which has been instructed to use pretrial detention in exceptional cases only.

These laws and policies are often interpreted broadly by law enforcement authorities (especially the police) as a license to harass, arrest, and maintain administrative pressure on those suspected of using drugs. As a result, the number of injecting drug users (IDUs) in

prison has increased dramatically over the past few years—not only because there are more drug users in general but also because they are more likely to be incarcerated. The notoriously horrendous conditions in Russia's overcrowded prisons continue to deteriorate, posing additional health risks for imprisoned drug users. Few of them have access to even the most rudimentary health care, let alone harm reduction services such as condom and clean needle distribution, and HIV and tuberculosis (TB) are rampant in some prisons. Official government figures indicate that more than 36,000 Russian prisoners are currently infected with HIV,[10] a number that likely is much higher in reality. Some 10 percent of the one million inmates in Russian prisons are thought to have TB, a third of whom have a multidrug-resistant strain.[11] A prison sentence is increasingly a death sentence for many IDUs.

Such horrifying statistics indicate why IDUs are understandably terrified at the prospect of imprisonment. For those who manage to avoid being incarcerated, however, Russian and Ukrainian policies concerning their health needs are mixed at best. On the positive side, in both countries it is legal to buy and possess needles and syringes—the Ukrainian Law on HIV/AIDS Prevention actually guarantees access to sterile injecting paraphernalia [12]—and they are sold in most pharmacies. More comprehensive harm reduction services are often available at needle exchange projects operated by local nongovernmental organizations (NGOs) and some government agencies, usually with support from international NGOs and foreign aid agencies from Western Europe. These projects are limited in number, however, and their scope and reach are often further hampered by resistance from local authorities and the police, who believe needle exchange promotes heroin use, and community members who fear rising crime. As a result, potential clients frequently stay away.

Those who seek treatment find that weaning themselves off addictive opiates is made more difficult by the fact that methadone is classified as an illicit drug by the UN conventions—a classification that requires member states to significantly limit use of the drug. Under a rigid interpretation of the treaties, this precludes the establishment of substitution therapy programs that have shown great success in Western Europe and other places where methadone is an accepted treatment for heroin addiction. (In many of those countries, methadone treatment started as pilot projects and clinical trials 20 years ago.)

Besides this clear-cut denial of their right to health, IDUs in Russia and Ukraine face additional violations of their human rights under existing laws or widely accepted practices. For example, although compulsory testing for HIV is against the law in both countries, IDUs and sex workers in Ukraine are still often tested without their consent when entering treatment facilities or pretrial detention centers. Also, existing Russian and Ukrainian policies require drug-treatment clinics to officially register IDUs who seek assistance (although some facilities decline to do so); similarly, a person who visits an AIDS center for treatment is automatically registered with the public health authorities. Such practices violate an individual's right to autonomy and privacy. Both countries also have controversial laws that hold all HIV-

positive people, including IDUs, criminally liable if they knowingly endanger or infect another person with the virus.

Another human rights concern is that IDUs are more likely than most people to be subjected to unwarranted harassment and abuse from law enforcement authorities, including arbitrary searches, entrapment, racial profiling, and assorted other rights violations. Victims rarely report abusive incidents because to do so could draw attention to themselves and make them targets for additional abuse.

V. A Relentless Rise: Drug Use in Russia and Ukraine

So far, government policies have failed to stem the surge in drug use in either Russia or Ukraine. Several factors are behind this epidemic, most of which relate to ongoing post-Soviet transitions to democratic, capitalist societies. The transitions have been wrenching for much of the population as living standards have fallen, social inequality has worsened, and public health and other social support systems have deteriorated.

Both countries are located on the main heroin trans-shipment routes from Afghanistan, where most of the world's opium is grown, to Western Europe. The flow of drugs has increased substantially in recent years and law enforcement authorities have had little luck combating organized crime groups that control most drug trafficking in the region. Authorities' efforts to curb trafficking are hindered by corruption, lack of adequate funding, and their inability to confront the sheer magnitude and economic power of the drug trade. According to James Wolfensohn, the president of the World Bank, opium production in Afghanistan reached record levels in 2002, making opium-related revenues in that country higher than the combined foreign aid currently provided.[13] Three-quarters of Afghani opium is shipped to Europe, usually through Russia and Ukraine. As a result, drugs are relatively plentiful and cheaper than ever, especially in major cities along trafficking routes. Regional disparities mean that drug use rates are as much as four times higher than national averages in urban areas such as Samara, Russia, and Odessa, Ukraine.

It is estimated that there may be as many as four million active drug users in Russia[14] and perhaps one million in Ukraine,[15] higher percentages of the population than almost anywhere else in the world. Efforts throughout the region to crack down on drug trafficking may have the unintended effect of increasing the proportion of those users who inject drugs. When supplies are low and prices are rising, users often switch from smoking to injecting because the latter method is more cost-effective. This shift is a dangerous trend: It increases HIV risk

as well as drug overdoses, with the latter often ending in death because people are afraid to seek medical attention from potentially censorious health and law enforcement officials. Furthermore, once users start injecting, they often do not revert back to using by other, less harmful means, even if the price goes down and the purity increases.

IDUs also face grave risks for contracting HIV and other bloodborne diseases because needle-sharing is common and condom usage is low. Nonjudgmental and easily accessible harm reduction programs providing needle-exchange services, free condoms, counseling, and education about HIV transmission are rare, largely because of opposition from authorities who believe that such services "promote drug use." IDUs are reluctant to seek assistance from public health facilities out of fear that they will be turned over to authorities, denied health care, or even forced into repressive, custodial treatment programs against their will.

Stigma against drug users is fairly constant throughout the region, especially since national governments and the media strongly disapprove of such behavior regardless of the circumstances. They focus on destructive elements—drug-related crime, overdose, disengagement from society at large—and adopt "blame the victim" mentalities that remain punitive. Few organizations or policymakers have identified or explored the link between addiction to illegal drugs and similar high-profile addictions to legal substances (nicotine and alcohol, for instance) that are approached from a health perspective and are generally free of moral condemnation. Like those trying to fight alcohol addiction, drug users cannot be expected to take action to safeguard their own health or the health of those around them without support and assistance from public health officials and the public at large. In Russia and Ukraine, as in many other countries, the lack of such empathy and understanding is a major reason that the drug use epidemic continues unchecked.

VI. Looming Catastrophe: HIV in Russia and Ukraine

The warning signs of massive dual drug use and HIV epidemics in Russia and Ukraine have been apparent since the late 1990s. Few observers, though, ever thought that HIV would reach catastrophic levels so quickly. Although the absolute number of people infected remains below that in many sub-Saharan African countries, UNAIDS reported at the end of 2002 that the "unfortunate distinction of having the world's fastest-growing HIV/AIDS epidemic still belongs to Eastern Europe and Central Asia."[16]

As of March 2003, the total number of Russians officially registered as having HIV stood at about 230,000, nearly triple the number recorded in 2000.[17] Even government officials, how-

ever, concede that this number is far too low; both the Russian Federal AIDS Center and UNAIDS believe that at least 1.5 million people in the country of 144 million are currently infected with HIV.[18] According to a U.S. National Intelligence Council Report released in 2002, Russia could have as many as eight million infections in the next decade, which would equal about 10 percent of the workforce and an HIV prevalence rate of 11 percent.[19]

The situation and the trajectory are similar in Ukraine, where the national HIV prevalence rate is already higher than 1 percent of the total population of 49 million.[20] In a report released in February 2003, Oleksander Yaramenko, the head of the Ukrainian Institute for Social Studies, said recent data indicate that "about 1.44 million people will be infected with HIV/AIDS by 2010" in Ukraine.[21] Treatment options that have prolonged the lives of people with HIV in wealthier countries are severely limited in both countries. The increasing death rate will not only accelerate population declines, but will have serious economic consequences. According to a recent projection, a "mild" HIV epidemic alone would keep the Russian economy from growing at all through 2025; a more serious "intermediate" epidemic would prompt a 40 percent decline in economic growth over that period.[22]

The current epidemic in Russia and Ukraine is unique in that the majority of infections continue to be linked to injecting drug use. It is already apparent, however, that an increasing number of infections will occur through other transmission modes, thus affecting the general population more directly. According to a study in the *Lancet,* published in March 2003, the number of reported cases in the region of HIV transmission through heterosexual sex has risen recently.[23] Among those most at risk from this development are IDUs' sex partners, sex workers, women, and prisoners. Like IDUs, members of these groups are more likely than most to be marginalized by society, harassed by authorities, and frustrated in efforts to obtain health services. Government prevention efforts have been nonexistent or ineffective, largely because they have not targeted at-risk groups that could conceivably benefit the most from comprehensive and realistic outreach and education programs.

VII. How Russia and Ukraine Should Respond

In some countries, such as Russia and Ukraine, that have barely begun to consider how to tackle the HIV epidemic, the sheer magnitude of the problem may be so daunting that the political will to take action remains muted. This inaction may be politically feasible while the epidemic primarily affects powerless, uninfluential communities such as drug users. Once HIV has spread further into the general population, however, the public will demand action

and accountability from their government. By then it may be too late to prevent an epidemic similar to those ravaging certain sub-Saharan African countries.

Taking action now to reduce HIV transmission rates and treat those already infected is critical. With the goal of avoiding adverse effects on social welfare and public health, the Russian and Ukrainian governments should reconsider how they interpret international treaties. Policy changes should be made in the following areas:

- *Harm reduction*. The governments should play an active role in establishing and supporting a large, strategically located network of harm reduction programs that provide services for IDUs, including needle exchange, HIV transmission education, condom distribution, and access to viable treatment programs such as methadone substitution. Similar services should be available in all prisons.

- *Education*. Simple, direct, and clear information about HIV transmission should be made available to all citizens—especially those most at risk. Similarly, society at large should be educated about the realities of drug use and addiction as part of an effort to reduce stigma.

- *Discrimination and law enforcement abuse*. Public health and law enforcement authorities should take the lead in eliminating discrimination, official and de facto, toward people with HIV and marginalized risk groups such as drug users. Authorities must no longer condone or ignore harassing and abusive behavior, including physical attacks, arrest quotas, arbitrary searches, detainment without charges, and other violations of due process. HIV-positive people, including IDUs, should be included in all policy discussions related to them in the public health and legal spheres.

- *Legislation*. Laws that violate the human rights of people with HIV and at-risk groups should be repealed or restructured to better reflect public health concerns.

Moving forward with the above strategies may make it appear that the governments are backing away from the goals and guidelines of the UN drug conventions. They may be criticized severely by those who are unable or unwilling to understand that meeting the goals of the conventions, some of which were promulgated more than 40 years ago, is far too great a price to bear for countries in the midst of drug use and HIV epidemics. Governments ultimately have no choice, though, if they hope to maintain any semblance of moral legitimacy among their own people.

VIII. Conclusions and Recommendations

Russia and Ukraine are facing a major challenge: to confront HIV successfully and ensure a brighter future for all their citizens. They cannot achieve these goals on their own, however. The international community must take measures to prod and assist them in their efforts to develop realistic strategies. By insisting that member countries comply with rigorous antidrug standards and goals under a one-size-fits-all rubric, UN drug agencies are limiting the ability of nations to implement appropriate, epidemic-specific HIV policies that can save lives. It is morally imperative for the agencies to revise their expectations.

It is also clear that the UN drug conventions—and the way certain countries interpret their provisions—conflict with the priorities and recommendations outlined in the Declaration of Commitment on HIV/AIDS, which was signed by all participants (including Russia and Ukraine) at the UN General Assembly Special Session on HIV/AIDS in June 2001.[24] Countries that emphasize rigid adherence to the conventions' goals—a strategy condoned by the CND—will find it nearly impossible to develop effective HIV programs that meet the declaration's standards. They will undoubtedly fall short of crucial targets, in particular those related to HIV and human rights, vulnerability, and access to care and treatment.

Anachronistic concepts, discredited by experience, cannot be applied when lives hang in the balance. The CND's inadequate consideration of the global HIV epidemic indicates that it considers drug use to be an isolated problem that can be eliminated in a vacuum primarily through law enforcement measures. This is a false and misguided assumption. Drug use is a complicated social issue that is rarely influenced solely by laws and oppression. Inevitably, some people will continue to seek out and use drugs regardless of the penalties involved or the risks to their personal health. Categorically demonizing their behavior and choices only casts them further out of society and denies them the services they need to protect themselves and others from harm. It also restricts their ability to take measures to change the very behavior that is being attacked.

The CND and other UN drug agencies claim that they have the moral high ground because they seek to prevent people from the destruction wrought by drug use. Their intentions may be honorable: there are indisputably negative repercussions from drug use, from personal tragedies such as overdose to money laundering related to trafficking in illegal drugs. However, the agencies' approach is flawed because it fails to recognize the consequences of the eradication crusade as it is currently interpreted and implemented. The drug conventions place unrealistic expectations on national governments. Their leaders often feel that they have little choice but to adopt repressive policies in an effort to eliminate demand for drugs, regardless of the human costs involved not only for drug users but also for society in general.

Antidrug policies that increase HIV transmission are antithetical to core public health precepts and adversely affect countries such as Russia and Ukraine that are ill-equipped to

deal with surging HIV infection. International agencies and national governments must summon the political will to devise and implement humane policies that start with revising the UN drug conventions and reforming national drug and HIV laws. They should consider the following policy recommendations:

- Antidiscrimination and equal-protection laws in all countries should be amended to guarantee the civil liberties and human rights of drug users and people living with HIV.
- The conventions should explicitly encourage national governments to view drug use primarily as a matter of public health, not law and order. Government policies should be constructed to reflect this reality.
- National governments should be encouraged to ensure that all people are provided with information and services that enable them to protect their health. Consequently, programs concerning drug use and HIV should encompass a full range of pragmatic, inclusive, and accessible harm reduction services, from education and drug treatment to substitution therapy and needle exchange. In particular, the drug conventions and national laws should include provisions that explicitly legalize needle exchange and the use of methadone for treatment purposes.
- Drug users and their advocates should be involved at all levels of decision making when national and international drug use policies are developed.

Rejecting long-accepted policies regarding drug use will undoubtedly be difficult for those who have staked their careers on fighting drugs worldwide and have always promoted the kind of language and strategies contained in existing international documents and national action plans. It is clear, however, that these strategies have serious flaws that harm the people they are meant to protect. It would be a sign of strength, not weakness, to revisit UN conventions and revise them appropriately from a global public health perspective, in recognition of the deadly realities of one of the world's greatest epidemics.

Notes

1. UNAIDS, *AIDS Epidemic Update,* December 2002. The report notes, "In recent years, the Russian Federation has experienced an exceptionally steep rise in reported HIV infections. In less than eight years, HIV/AIDS epidemics have been discovered in more than 30 cities and 86 of the country's 89 regions."

2. CanWest News Service as reported in the *Edmonton Journal,* "HIV/AIDS Spreads Rapidly in Russia," April 19, 2003.

3. Oleksander Yaramenko, the director of the Ukrainian Institute for Social Research, quoted this figure in November 2002 in a speech at a conference in Crimea. The estimate is based on research his organization carried out for the British Council. Also quoted in "Every 10th Ukrainian Lives with HIV," November 11, 2002: *NEWSru.com,* online in Russian.

4. UNAIDS, *AIDS Epidemic Update,* December 2002.

5. United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (December 20, 1988), Article 3, E/CONF.82/15.

6. According to "Harm Reduction Approaches to Injecting Drug Use" on the World Health Organization's website, "Whilst the primary goal of drug substitution treatment is abstinence from illicit drug use, many patients are unable to achieve complete abstinence, despite improvements in their health and well being. However, there is clear evidence that methadone maintenance significantly reduces unsafe injection practices of those who are in treatment, and hence the risk of HIV infection." Online: http://www.who.int/hiv/topics/harm/reduction/en/

7. CND 1223rd Meeting, Res.45/1, "Human immunodeficiency virus/acquired immunodeficiency syndrome in the context of drug abuse," March 15, 2002.

8. Mark Schoofs, "Jailed Drug Users Are at the Epicenter of Russia's Growing AIDS Scourge," *Wall Street Journal,* June 25, 2002.

9. Excerpted from remarks made by Russian Minister of Interior Affairs Boris Gryzlov at the State Duma, October 17, 2001. Online in Russian at the Russian Ministry of the Interior: http://www.mvdinform.ru/index.php?section=reaction_t

10. Council of the Baltic Sea States' Task Force on Communicable Disease Control in the Baltic Sea Region. Additional information can be found online at http://www.baltichealth.org/cparticle65128-7717a.html.

11. Nina Schwalbe, "TB is the Largest Killer of Those with HIV," letter to the *Wall Street Journal,* July 18, 2002.

12. Law "On Prevention of AIDS and Social Protection of the Population" (1992), N11, Article 4.

13. Faisal Islam, "World Bank Chief Issues Opium Alert," *The Observer,* March 16, 2003.

14. Mark Schoofs, "Jailed Drug Users Are at the Epicenter of Russia's Growing AIDS Scourge," *Wall Street Journal,* June 25, 2002.

15. Radio Svoboda, "News of the Day," June 26, 2001. The estimate was provided by the Ukrainian Ministry of Health.

16. UNAIDS, *AIDS Epidemic Update,* December 2002, supra note 9.

17. AIDS Foundation East-West, based on data from the Russian Federal AIDS Center, March 2003.

18. CanWest News Service as reported in the *Edmonton Journal,* "HIV/AIDS Spreads Rapidly in Russia," April 19, 2003.

19. "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China," U.S. National Intelligence Council Report, September 2002.

20. UNAIDS, Ukraine Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 update. Online: http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Ukraine_en.pdf

21. Olena Horodetska, "AIDS Epidemic May Break Ukraine's Health System," Reuters Foundation AlertNet, February 19, 2003.

22. Nicolas Eberstadt, "The Future of AIDS," *Foreign Affairs,* November 2002–December 2002.

23. Francoise Hamers and Angela Downs, "HIV Rising in the East," *Lancet,* March 22, 2003.

24. See in particular points 58, 62 and 96 in the Declaration of Commitment on HIV/AIDS agreed to at the conclusion of the UN General Assembly Special Session on HIV/AIDS, June 2001.

Strict UN drug control treaties directly undermine HIV prevention efforts by discouraging countries from implementing effective, realistic, and compassionate public health policies. The UN Commission on Narcotic Drugs (CND) and national governments must take steps to reform UN drug treaties and national drug and HIV laws to better protect the health of those at risk for HIV transmission, especially injecting drug users, and to improve access to treatment.

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