GLOBAL COMMISSION ON
HIV and the LAW

WORKING PAPER

Punitive Drug Law and the Risk Environment for Injecting Drug Users: Understanding the Connections

Jessica Chiu and Scott Burris[1,2]

Citation: Burris, S., and Chiu, J., (2011), *Punitive Drug Law and the Risk Environment for Injecting Drug Users: Understanding the Connections.* Working paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, 7-9 July 2011.

1. Introduction

1.1 The primary goal of international drug policy is to protect the health and welfare of the world's people [189]. In pursuit of this humane objective, international drug policy has traditionally focused on limiting non-medical access to controlled substances by strictly regulating their cultivation, manufacture, distribution, and use. .[165] The large scale deployment of criminal laws and punitive law enforcement practices have not succeeded in reducing global illicit drug supply or consumption, and have themselves created significant harm [122]. One of the worst consequences of punitive drug laws and law enforcement practices has been the spread of Human Immunodeficiency Virus (HIV) through the injection of illicit drugs. People who use drugs by injection (IDUs) live in a social and physical "risk environment" shaped powerfully by how police behave, by what prevention and treatment services may legally be offered, and so ultimately by the drug control laws that set the rules [244].

1.2 Studies conducted throughout the world consistently find that punitive drug policing increases risky injection behaviour and interferes with IDUs' access to prevention and health care services. The harder question – for research and policy -- is how to disentangle the effects of harsh law enforcement from the effects of the policies themselves. There are some obvious instances of laws themselves increasing the risk of HIV transmission: drug paraphernalia laws in the US prevent the establishment of syringe exchange programmes; Russia's drug control law bans the use of methadone in medication-assisted treatment for drug dependency. But there are also countries in which laws prohibiting drug use or possession are not actually enforced, and countries in which administrative alternatives to criminalisation, apparently benign, are enforced in a way that is more punitive to drug users than criminalisation. This difference between law on the books and law enforcement practice makes it difficult to rigorously document a correlation between harsh drug laws and HIV, let alone demonstrate that one causes the other, but there is a growing acceptance of the obvious: treating drug use as a crime and drug users as criminals is harmful to health, violates human rights, and fails to control illicit drug use.[1] In theory, the countries of the world remain committed to the punitive drug control strategies associated with the major drug control treaties. In practice, many countries,

1 Scott Burris is a Professor of Law at Temple University, where he directs the Center for Health Law, Policy and Practice, and the Robert Wood Johnson Foundation's Public Health Law Research programme. Jessica Chiu is a former legal fellow with the Center for Health Law, Policy and Practice.

2 The authors thank Temple Law School students M. Samer Budeir, Taramin Lourie and Hari Kowtha for their substantial assistance in researching and writing this paper. The authors would also like to thanks Anna Bergstrom, Azizbek Boltaev, Alisher Latypov, and the reviewers from the Technical Advisory Group.

observing the negative health and social effects of treating drug users as criminals, have over time developed less punitive practices, ramped up harm reduction services, and – in significant number – removed criminal penalties for individual use or possession from their laws.

1.3 This paper reviews the evidence documenting the effects of punitive laws and law enforcement practices on the HIV risk environment for IDUs. It then provides an overview of global drug policy, drawing on a mixture of regional reports and country case studies. Section III summarises the adoption of harm reduction practices and policies. Finally, we look at a selection of strategies that countries around the world have implemented to improve the HIV risk environment for IDUs. These include interventions to make law enforcement less harmful and more conducive to health; the integration of harm reduction and drug treatment programmes into the criminal justice system; and changes to national anti-drug laws for possession and individual use that move away from punitive anti-drug penalties.

2. Methods

2.1 This paper draws on three types of sources offering evidence on the relationship between laws, legal practices and HIV among IDUs: peer-reviewed studies and reviews from epidemiologists, social and behavioral scientists; reports from government agencies and non-governmental organisations; and submissions to Regional Dialogues convened by the Global Commission on HIV and the Law. Searches for peer-reviewed studies were conducted in PubMed, and additional studies and documents in the grey literature were located in the references of identified studies. Government and non-governmental organisation (NGO) documents were also sought in Google. Information on drug policy was obtained from regional reviews of the law and direct review of available legislation. Copies of laws discussed were obtained from the United Nations Office of Drug Control's (UNODC) Legal Library and via personal communication with United Nations Development Programme (UNDP) regional staff.

3. Drug Control Laws and the HIV Risk Environment for IDUs

3.1 Injection drug use is a driver – sometimes the main driver – of HIV epidemics in countries throughout the world. Research demonstrates that a punitive approach to drug control exacerbates health-related harms of drug use, including the transmission of HIV. [171] Studies in this topic area have known methodological limitations, including reliance on self-reported behaviour change and an inability to control for important ecological factors like differing law enforcement practices. [46] The number and consistency of the studies, however, provide substantial evidence of the harmful impact of punitive drug control laws and their enforcement on the HIV risk environment for drug users.

3.2 Impact on injection behaviour

The enforcement of drug control laws can create an environment marked by police surveillance, crime, mistrust, and violence [47] . In such risk environments, IDUs cope with the threat of police interference or arrest in ways that tend to increase their risk of acquiring or transmitting HIV. A large number of studies have shown that police often confiscate syringes or otherwise penalise syringe possession even where their possession is legal, and that IDUs are less likely to carry sterile injection equipment due to the fear of arrest [submission of Pun, 2011; 19, 34, 40, 90 34 121, 176, 245, 310349, 31, 45, 240]. The fear of encountering police while in possession of a syringe is particularly acute in countries where police enjoy a high degree of discretion in implementing criminal and public order laws [193, 197]

3.3 To evade police detection, IDUs hastily inject drugs [4, 91, 198, 268]. Hurried injection can increase risk of HIV transmission if IDUs share or reuse needles or syringes while rushing to inject drugs in public venues that grant some degree of privacy or camouflage (i.e. streets, parks, alleyways, stairwells, bathrooms, parking lots) [97]. Risk reduction requires time and resources. For example, cleaning a used syringe requires that it be flushed with water a few times and then flushed with bleach three times, leaving the bleach in the syringe for at least 30 seconds and flushed at least three times again to remove the bleach residue. Hurried or anxious injection reduces the likelihood of such risk reduction measures [40].

3.4 To evade police, IDUs may move to even more hidden settings [171]. Such physical displacement is exemplified by "shooting galleries," a term commonly used to describe hidden, indoor locations where IDUs can inject away from the watchful eye of local authorities or where people can access injection equipment without having to carry them on their person [55, 174, 86, 236]. In such settings, used syringes are often stored for future use [245], while "professional" drug injectors may use the same syringe to inject multiple customers. In Ho Chi Minh City, for example, much of the drug injecting takes place in off-street shooting galleries, with professional injectors administering injections, often drawing the solution from a common pot [16]. The sharing or reuse of injection

equipment in shooting galleries has been associated with HIV transmission in studies throughout the world [74, 55, 85, 58] , ranging from Bayamón, Puerto Rico [83]to Rajshahi, Bangladesh[140]. Indirect sharing may also occur during the hurried preparation of drug solutions or when paraphernalia needed to safely prepare drugs are not available [175, 277].

3.5 Numerous studies from Australia, Canada, and the United States have documented an increase in the improper disposal of syringes due to the fear of arrest, with IDUs often simply dropping them on the street to avoid being stopped by police with used syringes in their possession[4, 68, 91, 269]. Such disposal increases the likelihood that non-sterile equipment will be picked up and used by others [198]. Drug users themselves know the risks of improper disposal. A study published by the Australian Injecting and Drug Users League (AIVL) reported that vast majority of IDUs surveyed reported concerns about safe disposal, called for better access to safe disposal sites, and took precautions to "disable" needles to prevent re-use[168].

3.6 Impact on access to sterile injection equipment and health information

The criminalisation of drug use may not *inevitably* create a hostile climate for interventions that aim to reduce the harm of drug use and the spread of bloodborne disease among people who use drugs – but it often does so. The logic of drug criminalisation entails defining the person who uses drugs as a criminal, and leads many people to the conclusion that efforts to reduce the harm of drug use are condoning or even encouraging illegal behaviour. This logic has played itself out in high level policy-making, appearing in high level UN deliberations over the very use of the term "harm reduction" and in the behaviour of international donors and agencies. Over many years, for example, the US President's Emergency Plan for AIDS Relief (PEPFAR) programme was barred by Congress from using its funding to support syringe exchange, which had important impact on country-level programming [130]. Similarly, the International Narcotics Control Board was, until recently, consistently critical of harm reduction efforts like syringe exchange programmes (SEP), and continues to view safer injection facilities as illegal [18]. At the national level, Submissions to the Global Commission on HIV and the Law described barriers to harm reduction approaches arising from the dominance of a prohibitionist approach [Submission of Suzuki, 2011].

3.7 Punitive drug laws can interfere with public health and harm reduction in even more immediate ways. Laws that limit or ban the purchase or possession of syringes, or that forbid activities deemed to "encourage" drug use, can prevent syringe access programmes from being established. In the US, drug paraphernalia laws have been interpreted to forbid SEPs in some states [53, 280]; in others, uncertainty or conflict over the law has impaired the ability of SEPs to operate effectively, [33]while formal legal approval has been found to increase the number of syringes distributed and reduce the rate of police harassment of programme staff and clients [32]. Interpreting Russian drug control law, the Federal Drug Control Service has concluded that operating syringe exchange programmes constitutes illegal incitement to drug use [213]. In Canada, Australia and other countries, drug possession laws have complicated or limited the implementation of supervised injection facilities [47].

3.8 Even where syringe access is legal, it may still be hindered by laws and police practices. Widespread police interference with SEPs' operation is documented in several countries[148, 49, 225, 244]including the US, where police interference occurs regardless of state laws governing SEP operation [21]. IDUs in countries as varied as the US and Indonesia report reluctance to access SEPs due to the fear of arrest or confiscation of sterile syringes [90, 121, 310, submission of Gunawan, 2011]. IDUs may be particularly hesitant to access SEPs during police crackdowns – evidenced in Australia [197] , Canada[325, 326, 329], and the US [77]. Studies have linked low access to SEPs due to police presence with elevated rates of syringe sharing among IDUs [4, 197, 245, 325]. Even when SEPs and syringe possession are legalised, police may continue to find reasons to harass or arrest people carrying syringes [305].

3.9 Laws and practices that drive drug users underground also make it harder for health interventions to reach them [4, 245, 269]. In a criminalised environment, health service providers often find it difficult to reach IDUs to deliver prevention materials, diagnosis and treatment, and educational messages aimed at promoting health and preventing disease [39, 67, 75]. For example, when law enforcement authorities destroyed the informal settlement of Dorozhny in the Kaliningrad region of Russia, a known drug trading venue, drug use became more hidden. As a result, treatment options were lost, and public support for harm reduction services waned [307]. In heavily policed drug markets, service interruptions can occur because some IDUs avoid public contact with workers in order to avoid being identified as drug users [268].

3.10 Impact on access to treatment services for injection drug use and HIV

People who use drugs, like other people in the community, may from time to time need access to the full range of health and social services, including income support, housing, general health care and vocational training [248, 153, 269]. As a consequence of criminalisation, people who use drugs are often formally or in practice barred from receiving such services [153]. For people recovering from drug dependency, or seeking to restart their lives in the

community after a period of drug-related incarceration, these barriers can cause unnecessary suffering and even promote relapse. In this paper, however, we focus on two kinds of services with extremely well documented links to HIV: medication-assisted treatment for opioid dependence (MAT) and antiretroviral treatment (ART) for HIV.

3.11 MAT is proven to be effective in the prevention of HIV transmission and facilitating better ART outcomes [324]. Methadone and buprenorphine, prescribed for MAT, have been recognised by the World Health Organisation (WHO) as essential medicines [318, 342]. MAT is proven is proven to be an effective treatment for opioid dependence and to significantly reduce the risks of HIV and Acquired immunodeficiency syndrome (AIDS) and other harms associated with injection drug use [210]. According to the WHO, these medications should be "available within the context of functioning health systems at all times in adequate amounts [and] in the appropriate dosage forms." [343].

3.12 ART is essential to improving both survival and quality of life for people infected with HIV. It also lowers the risk of HIV transmission [81]. In Odessa, Ukraine, for example, where HIV prevalence is 50% and IDUs constitute 85% of people living with HIV, researchers estimate that 40-47% of new infections alone are attributable to inadequate access to ART [274]. Universal access to ART has been a global goal for more than a decade [6], and WHO guidelines emphasise that individuals should not be denied ART on the basis of either current or past drug use [338]. Nonetheless, ART is believed to only be available in 98 countries [205], and people who use drugs are under-represented among those able to access treatment. By current estimates, people infected through injecting drug use are receiving ART in only 50 countries, and appear to be less likely than others to receive ART even in countries where IDUs are the largest group living with HIV. In Russia, China, Malaysia, Ukraine, and Vietnam, for example, people injecting drugs made up 67% of HIV cases in 2008, but only 25% of IDUs receive ART [323].

3.13 Part of the problem lies in the stigmatising stereotypes of drug users promoted by defining them as criminals [308], but law works by more immediate means as well. In Russia, MAT is banned by law [146]). Most countries impose age requirements or require that an individual present documented attempts at abstinence(Ukraine, Georgia; [228]. In certain countries with injection-driven HIV epidemics, such as Georgia and Ukraine, those most in need of MAT or ART are required to have their names placed in registries in order to access government-operated clinics. Registries are shared with police, sometimes subjecting the individual to mandatory drug testing[247], denial of employment, driving licences, and child custody [261].

3.14 Police harassment targeting service providers and patients is also a concern. Such behaviour curbs MAT availability in countries as varied as Bangladesh, Kazakhstan, India, Indonesia, and Ukraine. In those countries, outreach workers face the denial or confiscation of essential medicines, extortion, planting of evidence, and arbitrary detention [78, 130, 202, 268, 279, 321]. Police have searched the homes of MAT providers and threatened them with arrest if they did not provide patient lists [137]. In China, drug dependent individuals report police harassment and detention near methadone clinics [Submission of Shan, 2011]. In Odessa, Ukraine, buprenorphine patients reported that police officers regularly extorted money and threatened to plant drugs on them [228]. Meanwhile, in Malaysia, despite formal government endorsement for methadone treatment programmes in 2005, researchers found evidence of continuing police raids and arrests at methadone programmes [241]. Drug dependent individuals in Sub-Saharan Africa, meanwhile, report reluctance to seek government health services, including for ART, for fear of police report [76].

3.15 In addition to the systemic barriers to harm reduction described above, IDUs are structurally barred from receiving effective treatment because of non-integrated health systems and because IDUs may more frequently engage with justice officials than health officials. In Russia, neither drug dependence treatment nor ART are available at infectious disease hospitals and general hospitals[submission of Zhavorankov, 2011]. In Vietnam, Malaysia, and China, between 10 and 20 times as many IDUs were detained at compulsory drug detoxification treatment and rehabilitation centres than were engaged by clinics providing ART [316]. In some places, policies may prohibit provision of ART to individuals who are currently drug dependent [318]. As a result of a traditional non-integrated health system, health professionals may maintain erroneous and stigmatising beliefs about the ability of drug dependent individuals to comply with ART regiments [165]. Given the prevalence of tuberculosis co-infection with HIV, non-integrated services further weaken treatment effectiveness [317].

3.16 Other law-related impacts on HIV risk for IDUs

The enforcement of punitive drug laws can have powerful negative impact on individuals who use drugs, but punitive laws and practices also affect drug users' families and friends. Prisons are high-risk sites for HIV transmission in most countries in the world. Incarceration puts those locked up at immediate risk, but can also endanger the communities they return to, both because of higher exposure to HIV and because large-scale drug arrests change the demographics of the most affected communities. Punitive drug laws and their enforcement is bound up with larger social attitudes, meaning that factors like gender, race, ethnicity and social class can influence who is arrested

and incarcerated in ways that produce health inequalities. The stigma of drug use can affect not just users but marginalise whole communities. The evidence documenting these effects is less than in other areas covered by this paper, in large part because these kinds of effects are difficult – and controversial – to measure.

3.17 Incarceration

Prisons are a key site for HIV transmission through both sex and injecting drug use. Existing research shows that the prevalence of HIV in the prison population is greater than the general population in several countries [166] . In many if not most countries, sex and/or drug use are going on in prisons, but prisoners do not have access to the information, condoms, sterile injection equipment or health care that can prevent transmission [43, 119,131, submission of Lyubenova, 2011, submission of Thu, 2011, submission of Uppakaew, 2011]. Outbreaks of HIV infection in prisons in are well documented[35, 93, 281].

3.18 The risk of transmitting HIV through drug use is high given the pervasiveness of risky injecting behaviour, particularly sharing needles [submission of Allard, 2011; 166; 303]. Multiple studies have established an independent association between HIV infection and incarceration of IDUs [291 312, 312, 27, 60]. Such evidence is of special concern for low and middle-income countries, where more IDUs may be found in prisons, pretrial detention facilities, police lock-ups, and forced rehabilitation centres than in the health system itself [321].

3.19 Qualitative investigations have documented how the prison environment encourages the adoption of riskier injection behaviour [106, 267]. Scarcity of syringes results in sharing among a large number of people, with the continual reuse of syringes posing serious health hazards and bleach distribution serving as an inadequate solution[267]. Researchers in Vancouver, Canada found that incarceration was independently associated with risky needle sharing for HIV-infected and HIV-negative IDUs [328]. Use of unsterile needles can also spread HIV via tattooing [56].

3.20 HIV is spread sexually in prison [181]. Voluntary sex is common in many prisons, and the risk of HIV can be exacerbated by lack of condoms, co-occurring sexually transmitted infections (STIs), and environmental barriers to safer sex [315, 346]. Although some prison sex is heterosexual, the stigma of same sex sexual behaviour can make prevention of disease more difficult [260]. Yet despite recommendations from the WHO and The Joint United Nations Programme on HIV/AIDS (UNAIDS) that condoms be made available to incarcerated individuals throughout their prison term [335, 292] access to condoms remains far from the norm. In the US, for example, only a handful of cities and states provide condoms despite the known incidence of sex and HIV [223]. In prisons that fail to provide basic physical security, rape can also be a source of HIV transmission [238].

3.21 Imprisonment may also serve as a barrier to accessing life-saving MAT or ART. Among developing and transitional countries across Eastern Europe and Asia, where injection drug use is a major driver of HIV, few countries (notably Indonesia, Iran, and Moldova) permit patients to begin MAT while in prison. Poland offers short-term treatment only to those patients who were on medication prior to incarceration [228]. In general, access to ART in prisons in many low and middle-income countries is poor. When ART is available in a prison, ART may be interrupted for a variety of reasons [165]. Meanwhile, in China, Malaysia, Cambodia and Vietnam, the suspicion of drug use or a positive drug test can result in detention in compulsory rehabilitation centres run by the military or police. Despite a reported HIV prevalence ranging from 10% to 65% in such facilities, ART is largely unavailable to detainees [82, 150, 321].

3.22 Network effects

Increasing attention is being paid to the role of network dynamics in the spread of HIV among IDUs [111, 180]. In theory, a network of IDUs who share injection equipment only with others in their network may limit the spread of HIV, even if other networks become saturated with the virus [49]. However, high arrest and incarceration rates, among other police practices, may disrupt otherwise stable or non-injecting networks, thus facilitating the spread of HIV [113, 244].

3.23 Social Identity at the Intersection of HIV and Drug Control

People who use drugs also have gender, racial or ethnic identities, and occupy places in the social hierarchy. Identity and social position shape vulnerability to HIV. These mechanisms contribute to the fact that HIV globally is an "uneven pandemic," striking different parts of the world differently in ways that reflect and magnify the importance of social position to health [65]. People who use drugs may also identify or practice homosexual behaviour, or exchange sex for money. The intersection of drug use and other social identities may influence how people who use drugs are treated by the police. Racial disparities in HIV and drug law enforcement are well-identified – and linked – in the US, for example [46]. These social factors can impair a sex worker's ability to negotiate condom use and thus, increase HIV risk [262]. Sex workers in Canada, including substance-using sex workers, are vulnerable to violence and fear police detection of their illegal activities; they are at increased HIV risk because of sexual violence

within crack houses or other hidden places of consumption [submission of Crago, 2011]. Roma sex workers in Serbia are at increased risk of severe police abuse because of their ethnic identity [243]. Abuse by clients, pimps, and police can affect condom negotiation for sex workers, thereby affecting HIV risk [263]. Police targeting of Roma sex workers worsens the HIV risk environment for Roma individuals, a group that experiences general health inequalities [243].

3.24 Evidence suggests that women who use drugs may be especially vulnerable to HIV infection. Women experience faster progression from first use to dependence and higher rates of HIV [250]. A woman is more likely than a man to need assistance in injecting, which may contribute to her subordination in relationships where sex and drugs are intertwined [286] and possibly increase the risk of HIV infection if she is "second on the needle." Women who use drugs or whose sexual partners use drugs may need to or be pressured into selling sex, which also increases risk of HIV transmission. Policing that targets female IDUs exacerbates risk of HIV infection, particularly for female IDU sex workers who experience coerced sex and police abuse [68]. Finally, the drug treatment needs of female IDUs are rarely recognised in research or in treatment programmes. The UNODC has identified a range of barriers faced by female IDUs including judgmental staff, lack of child care, lack of sufficient services provision, fear of partner violence and fear of losing children to a government agency [250].

3.25 Stigma

Stigma associated with drug use is an often reported barrier for IDUs seeking health services. Criminal laws and policies reinforce such attitudes. Some public campaigns to combat drug use for example have included public beatings of people who use drugs and public executions [165]. Stigmatisation of IDUs by health providers poses a barrier for IDUs to access health services, especially in countries where public campaigns cast drug use as a social evil and where health providers are seen as closely linked to systems of social control [100, 149, 316]. IDU's fears are not unfounded. Pharmacists interviewed in Kaliningrad stated that they sometimes refused to sell syringes to people who use drugs, believing their refusal to be a contribution to combating drug use [307]. Fewer than half of New York pharmacists interviewed after syringe sales to IDUs were legalised were willing to provide them [63]. Government policies that bar or discourage ART to IDUs and may cause patients to lie about their drug use reinforce prejudices that label IDUs as untrustworthy [316]. An 18-city survey conducted in Russia revealed that all cities required external review of patient files before the initiation of ART and 10 cities deny treatment if active drug use is found [201] A submission to the Global Commission on HIV and the Law reported that stigma remains an essential element of drug policy in Nepal, and that a recent effort to legally protect drug users from discrimination has had little impact on enforcement [submission of Pun, 2011].

3.26 Because of discriminatory attitudes about drug use, IDUs are often excluded from research and policymaking. Yet the experiences of people who use drugs are critical in understanding drug risks and developing policies that affect their welfare. Drug user organisations mobilise the experiences of people who use or have used drugs to influence policy that will protect their rights and security. In New York City, for example, the drug users' union Vocal documented police intimidation of users and worked with local legislators to amend the state's penal law to clearly legalise the possession of used syringes [305]. Drug user organisations also create a point of institutional contact between health services and people who use drugs. In Poltova, Ukraine, Light of Hope NGO works with law enforcement and medical personnel, social workers, and people who use drugs to promote the rights of people who use drugs by injection [submission of Demchenko, 2011].

3.27 In 2007, the International Network of People who Use Drugs (INPUD) conducted research that revealed the broad range of activities that drug user organisations are involved in – including peer support and counselling, harm reduction education, and broader advocacy work [154]. INPUD is credited with improving the representation of people who use drugs in international forum such as the EU Civil Society Forum on Drugs, UNGASS Regional Consultations, UN Civil Society Task Force and the Commission on Narcotic Drugs (CND) [154, 155]. Since it was established, the group has also become a partner with wider civil society including with groups like the International Drug Policy Consortium (IDPC) and AIDS actors like the Global Network of People living with HIV/AIDS [215]. In 2010, INPUD was an active member in the CND and focused its advocacy efforts on highlighting the harms resulting from national policies that resist adequate access to harm reduction services.

4. Global Overview of Anti-Drug Laws and Law Enforcement Practices

4.1 The international drug control regime is principally constituted in three treaties: the *1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol (Single Convention)*, the *1971 Convention on Psychotropic Substances*, and the *1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*. The primary goal of international drug control policy is to improve the health and welfare of mankind [189, 128], but despite their references to health, and even drug treatment, the Conventions embody a criminal rather than public health

Depenalisation vs. Decriminalisation

Depenalisation is a national or local decision to forgo criminal prosecution and/or punishment of drug possessors or users [141]. In a depenalisation regime, a nation will not enforce -- i.e. arrest or prosecute those violating -- the law prohibiting drug possession and use [125]. Many countries in the European Union have depenalised the possession and use of small amounts of illicit drugs. Depenalisation varies by region or administrative district within a country. Because depenalisation does not include a formal change in the law on the books, the practice of depenalisation can be vulnerable to a change in political climate and/or police discretion (Godinho & Veen, 2006).

Decriminalising the possession of a minimal amount of drugs is a clearer legal alternative to criminalisation (Cook, 2010). Decriminalisation removes drug use and/or possession from the sphere of criminal law (EMCDDA, 2008), though in some instances the criminal penalties are replaced with equally punitive administrative mechanisms of punishment or forced treatment. True decriminalisation has the advantage of addressing the negative role of drug policy on HIV risk at its roots. Decriminalisation can be expected to allow most dependent drug users an opportunity to seek drug treatment without facing punitive sanctions; reduce negative interactions with law enforcement, the courts and the prison system; and facilitate the provision of harm-reduction services and therapeutic drug treatment for dependent drug users [125, 141].

approach to drug use. Any form of illicit drug use is treated as inherently pathological. The goal of the enterprise is not so much to reduce harmful drug use as to eliminate illicit use entirely – to produce, ultimately, a "drug-free world" [122]. Virtually all nations are parties to these treaties, and have adopted drug laws consistent with them.

4.2 Though they are all designed to adhere formally to the Conventions, national drug laws and policies vary considerably. Different cultural histories with drugs and different legal traditions produce different regulatory approaches. Moreover, the law on the books – statutes, regulations, court decisions, decrees – is often not closely related to how the rules are actually defined and enforced on the streets. As one observer cautioned, it is "hazardous" to generalise about the implementation of drug control legislation because the responses of police, prosecutors, courts and tribunals will be influenced by the general climate in a particular regional or locality and by the circumstances of the particular case [96] Some nations formally prohibit, vigorously pursue and harshly punish individual drug use or possession. Some continue to criminalise these activities in their statutes but have formally or in practice "depenalised" them. Others, meanwhile, removed criminal penalties for some level of use or possession entirely (called "decriminalisation"). No signatory to the Conventions can legalise drug trafficking, so the sale of drugs, even in small amounts, remains a crime.

4.3 The enforcement of criminal drug laws, like other criminal laws, is subject to national and international human rights norms. The Global Commission on Drug Policy notes that 'certain fundamental principles underpin all aspects of national and international policy.' These include the rights to life, to health, to due process and a fair trial, to be free from torture and cruel, inhuman or degrading treatment, from slavery and from discrimination in the application of drug policy.[122] The well-recognised "collateral" or "unintended" consequences of prohibitionist drug control policies have led to increasing attention to their tension with human rights (Costa 2008). In 2010, for example, Antonio Maria Costa, Executive Director of the UNODC, emphasised the need for international drug policy to "respect, protect, and contribute to the fulfillment of rights," specifically the right to health and the right to development. He released a statement that described the ways in which drug control policy could be "better synchronised" with protecting the human rights of drug users. In particular, the document cautioned that imprisonment for drug possession/ use that precludes drug dependency treatment could be tantamount to a violation of the right to health and the right to be free from cruel, inhuman, and degrading treatment [72]. The statement called for the integration of a human rights perspective in UNODC's work, specifically in dealing with drug control, criminal justice, and crime prevention [72]. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health took an even harder line, reporting that the criminalisation of drug possession and use neglects evidence-based approaches and inappropriately directs resources to result in "countless human rights violations" [126].

4.4 In the remainder of this section, we briefly describe national drug policy, relying on available reviews of regional drug policy and practice, supplemented by information drawn from country studies. The paper intends to provide a snapshot, rather than a detailed account, of the diversity (and sometimes the contradictions) of national drug policies and practices.

4.5 Europe

European drug policy exhibits diversity both in law on the books and enforcement strategies. Although some countries, most notably Portugal, have decriminalised drug possession, most European countries, both European Union (EU) members and non-members, continue to make individual drug possession a criminal act. Many of these countries, however, have instituted more or less formal policies of depenalisation. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has reported that, in the EU, people are rarely prosecuted or punished for merely possessing drugs. Arrest and incarceration rates for drug users are low in relation to the total number of drug users, and the often-quoted maximum sentences are rarely, if ever, used [102]. A more recent study notes some divergence within the criminal justice systems, with police continuing to arrest users in a deterrence mode while courts generally pursue a depenalisation approach, dismissing cases, ordering probation or referring arrestees to treatment [103].

4.6 Outside of the EU, particularly in Eastern Europe and Russia, criminalisation remains the law on the books and in practice. Russia has the world's second highest incarceration rate (after the US) and the third largest prison population in the world. Drug dependent individuals make up a large portion of Russia's prison population. Recent estimates are that more than 10% of all individuals in the entire prison system have been diagnosed as drug dependent [255]. These data are particularly striking in light of the fact that Russia formally decriminalised possession of a small amount of drugs in 2004. Its law now provides only administrative sanctions (fine or community service) for individuals possessing "small amounts" (for example, 1 gram or less of heroin) [51]. Because the "small amounts" are indeed small, and probably because more users are now prosecuted as traffickers, large numbers of people who use drugs continue to experience incarceration despite the 2004 legislation. In some cities such as Saint Petersburg, nearly half of the prison population is imprisoned for drug-related offences [255]. These reforms themselves may be reversed, with the Duma debating draconian legislation that would recriminalise drug possession and force arrested drug users to choose between prison and forced treatment [233]. Research has also shown that police harassment of people who use drugs is pervasive in Russia, [230] where intense police surveillance, enforcement of criminal laws on possession and harsh application of non-drug related administrative codes result in widespread fear among IDUs [247,256].

4.7 In Eastern Europe, many countries maintain punitive drug laws and enforcement policies. In Georgia, a 2006 order permitted law enforcement personnel to test individuals for illicit drug use so long as "reasonable suspicion" existed (*Decree No 1049–233/n*). In 2006, 2007, and 2008, EMCDDA reported a sharp increase in the number of drug-related criminal proceedings. Because of a disproportionate increase in the number of minor crimes prosecuted, the group hypothesises that the increase was due to intensified police activity, including "massive random searches…and testing" for drugs [104]. A recent count of individuals incarcerated in Belarus also suggests a strict enforcement-based response. In 2007, 72% of individuals incarcerated for drug-related offences were incarcerated under charges of processing, purchase, possession, transportation and sending of drugs or precursors *without* the intent to sell [105]. In Armenia, despite recent amendments to the Criminal Code in 2008 to decriminalise personal drug use, a punitive approach to drug use prevention persists [submission of Sakunts, 2011]. In Azerbaijan, while the law enables a judicial authority to require treatment for an individual convicted of a drug related crime, no treatment or rehabilitation programmes exist for incarcerated individuals [submission of Mustafaeva, 2011]. A recent law enacted by Ukraine (N634) makes it a crime for individuals to possess as little as 0.005 grams of acetylated opium or "black tar heroin," Ukraine's most widely used opiate. The new law reduced the legal limit to 20 times lower than what it had previously been and 100 times lower than the legal limit in Russia. Offenders face up to three years in prison [158]. As in Russia, police intimidation of people who use drugs is widely reported [230]. Poland retains one of the most punitive drug policies in Europe – possession of any amount of illicit substance could result in a three-year prison sentence [159]. However, in May 2011, the Polish president signed a new law (*Amendment 62.a*) that enables prosecutors to avoid charging individuals in possession of small amounts of drugs with criminal penalty and instead in favor of mandating treatment if the defendant is found to be drug dependent.

4.8 Central Asia (Tajikistan, Kazakhstan, Kyrgyzstan, Uzbekistan)

Drug policy and policing in Central Asia generally reflect their roots in the Soviet past [231]. Continuity of Soviet era policy is seen in the national drug laws of several Central Asian countries. For example, Tajikistan, Kazakhstan, Kyrgyzstan, and Uzbekistan maintain policies found in Soviet era law: compulsory treatment of drug dependence, compulsory testing for suspected drug use, and mandatory registration of drug users [230, 51, 298]. Police and other internal law enforcement forces in the region are also widely characterised as politicised and corrupt and are known to participate in the drug trade [296, 230].

4.9 Kazakhstan, Uzbekistan, and Turkmenistan pursue the most punitive law enforcement approaches to drug control in the region. In recent years, Kazakhstan has enacted legislation to stiffen penalties for drug sale and trafficking,

and the government has expressed renewed interest in mandatory drug testing for students. Criminal liability for possession of minimal quantities of drugs is strictest with harshest penalties in Uzbekistan and Kazakhstan [298]. Turkmenistan is the only country of this group that maintains a "treatment-labour" camp for compulsory treatment, run by the Ministry of the Interior. In all other countries, compulsory treatment is operated under the auspices of the Ministry of Health [298]. Compulsory treatment for individuals charged with possession without intent to sell is characterised primarily by "detoxification" in all countries [298] The three countries are also resistant to harm reduction expansion. In 2009, Uzbekistan shut down its single pilot MAT site without plans for future MAT operation [187]. Local experts specialising in HIV and drug use are concerned that a draft law on "Drug abuse prevention and treatment" that is under review in the Uzbek Parliament will prohibit MAT in the future. [37]. In Kazakhstan, the two sites that currently provide MAT are under review and closure is possible by the end of 2011 [37].

4.10 Events in the region suggest some divergence in drug policies. Kyrgyzstan and Tajikistan may be moving away from criminalisation. Since the 1999, Kyrgyzstan has aggressively incorporated various harm reduction approaches into national drug policy [322]. Both countries have increased the legal amounts for possession for individual use in recent years [230]. Kyrgyzstan has also taken action to change the HIV risk environment for IDUs by creating a framework for police and public health collaboration. *Order 417 of 2003* is a ministry-level instruction that provides for police training by HIV NGOs, both at the national level and for the rank and file [22]. Data on the number of individuals incarcerated for drug-related offences as a proportion of the total prison population in this region is unavailable.

4.11 The Americas

Latin (Central and South) America may be the region most affected by drug-related violence and harms. In Guatemala, Honduras, and El Salvador, intense drug-related violence challenges governance and the murder rate is highest in areas affected by the drug trade [298]. Since 2006, an estimated 30,000 people have been killed as the result of drug-related violence in Mexico alone [264]. Traffickers operate with impunity, buying or coercing the cooperation of law enforcement and other government officials [9, 297]. In 2009, the Latin American Commission on Drugs and Democracy, led by former heads of state Cesar Gaviria of Colombia, Ernesto Zadillo of Mexico, and Fernando Henrique Cardoso of Brazil, released a report that called for the decriminalisation of drug use and possession [186]. Today, there is no penalty for possession of small quantities of certain drugs for personal use in Argentina, Paraguay, Mexico, Peru (for certified drug dependent users) and Uruguay (which never criminalised possession for personal use). Other countries employ administrative sanctions, educational measures, or compulsory treatment instead of criminal penalties [163]. While Colombia maintains criminal penalties for possession of small quantities, its president has publicly declared that he is open to discussions about alternative approaches to enforcement in order to reduce harms associated with drugs [161]. Other countries, such as Honduras and Guatemala, appear to maintain criminal penalties for possession of small quantities of drugs.

4.12 Despite the diversity of national anti-drug laws and apparent move towards decriminalisation, incarceration rates for drug possession and use remain high in the region. In countries like Argentina, Bolivia, Brazil, Colombia, Mexico and Ecuador, the number of persons incarcerated for drug offences has increased significantly in recent years. Researchers have found that a high percentage of individuals are incarcerated for simple possession, including for small amounts of drugs which are not technically illegal [submission of Corda, 2011]. For example, an estimated 75% of prisoners held on drug charges in Mexico were detained for possession of small amounts of drugs although Mexico decriminalised possession of small amounts of drugs in 2009 [285]. Incarceration is thus attributed to an unclear legal distinction between traffickers and drug users and poor interpretation of those distinctions by the police and courts [290].

4.13 Historically, the US has pursued one of the most punitive drug policies in the world. As a consequence, it has experienced a steep rise in drug-related incarcerations since 1970, with more than half of the federal prison population currently incarcerated on a drug-related charge [26]. Punitive drug policies are also associated with a striking racial disparity in incarceration [138]. Related policies that mandate disproportionate penalties in drug cases, like the "three strike" or mandatory sentencing provisions, contribute to the high incarceration rates [26]. In the last two decades, diversion programmes like drug courts have become common, but only 35% of the federal drug control budget goes towards treatment and prevention [182 . In formal anti-drug policy, Canada seems to pursue an anti-drug policy that similarly emphasises enforcement. Recently, the country enacted mandatory minimum sentencing for drug offences [155]. Yet, researchers note that the country has slowly shifted away from the prohibitionist model shared with the US, spending 70% of its counter-narcotic budget on demand reduction rather than criminal enforcement. Incarcerated drug offenders constitute a much lower proportion of the total prison population than in the US [26].

4.14 Data about injecting drug use and incarceration rates for the Caribbean are not readily available. In general, researchers find that injecting drug use is rare in the region, not counting Puerto Rico. Severe criminal penalties are administered for individuals convicted of illicit drug use [155].

4.15 Asia

In Asia, a significant number of countries punish drug possession for personal use with imprisonment and/or compulsory treatment. Some countries penalise drug use independent of drug possession. Thailand, the Philippines (for specific classes like students and military) and Malaysia implement mandatory drug tests, which can lead to treatment or incarceration. Many Asian countries differentiate "addicts" from others convicted of drug offences and either mandate or allow courts to require treatment instead of jail time. Countries such as Cambodia and Nepal permit prosecutors to decide whether to prosecute or release first time offenders. In both countries, recidivism after treatment is punished with prison sentences. Some countries mandate treatment for first-time offenders of drug possession laws and issue jail time for subsequent offences. In the Philippines, for example, second-time offenders may face six to 12 years for violating possession laws. Still other countries, such as Pakistan, require jail time as well as compulsory treatment for individuals who violate drug possession laws.

4.16 While Asian drug control laws on the books illustrate varying degrees of prohibitionism, enforcement practices in the region reflect the continued pursuit of a punitive, prohibitionist regime. In Indonesia, individuals determined to be an "addict" are required to go through medical and social rehabilitation and are subject to prison sentences (*Indonesia Narcotics Law*, Articles 54 and 111 (2009)). In Nepal, laws against possession mean that possession of even a small amount of drugs is severely penalised, and even possession of a needle may be punished by imprisonment [submission of Pun, 2011]. In India, where courts may require treatment instead of jail for possession of minimal quantities of illicit drugs, treatment is rarely offered. Instead, there are significant rates of arrest and incarceration of low-level drug users [57]. Thailand's incarceration rates fell sharply between 2003 and 2007, reportedly due to a change in policy that diverted 20% of drug-related offences to treatment programmes instead of prison [26, *Narcotics Addict Rehabilitation Act* B.E. 2545 (2002)]. At the same time, however, a systematic campaign of extrajudicial killings took the lives of 1200-4000 people supposedly suspected of being drug traffickers [66]. Researchers have questioned whether compulsory treatment programmes in the country are much different from incarceration in terms of living conditions, therapeutic value or respect for the rights of "patients" [26]. In India, for example, privately run compulsory drug treatment centres do not have standardised procedures or methods for operation and have been sites of client abuse and death [submission of Dorabjee, 2011; submission of Raju, 2011]. Cambodia is considering enacting laws that give courts the option to recommend or require treatment if a defendant is found to be drug dependent instead of delivering criminal sentence (Draft Law on Drug Control, Article 45).

4.17 China and Vietnam have formally decriminalised drug possession for personal use by substituting administrative regulations for criminal law in matters of drug possession. Though not classified as a crime, drug use is nonetheless considered a "social evil" [130]. Drug users are not tried by courts and punished with prison. Instead, drug possession results in mandatory treatment in closed rehabilitation facilities, accomplished by administrative order with virtually no protection of due process. The mandatory treatment programmes in East Asia have faced international criticism for various rights violations. Rehabilitation treatment and the overall conditions of the facilities are recognised to be of such poor quality that they violate human rights principles and fail to comply with evidence-based treatment for drug dependency or HIV/AIDS treatment. Forced labour – effectively slavery – has been identified in compulsory treatment centres in China and Vietnam [340]. Drug offenders face lengthy detention in treatment facilities and suffer degrading and inhumane treatment and abuse, regardless of whether they are actually dependent on drugs. According to UNAIDS, half a million people are confined in Chinese drug detention centres at any given time [150].

4.18 The Middle East and Africa

The Middle East and Northern Africa (MENA) has historically imposed severe criminal penalties for drug offences [159]. As a result, imprisonment and repeated imprisonment are common among the region's IDUs [2]. In recent years, some movement towards enabling prevention and treatment for arrested IDUs has become evident in the region. The IDPC notes that Iran presents one model for serious prevention and treatment for IDUs in the region. Since the 1990s, Iranian drug control policy adopted two drug control policies to respond to overcrowding in prisons: compulsory treatment and expansion of MAT and needle exchange programmes (NEP). As a result, over 200,000 IDUs in Iran are currently undergoing MAT [221]. Yet, records indicate that incarceration is still common in the country. In Iran, 94% of IDUs in community centres report a history of incarceration. Recent figures estimate that about half of the incarcerated people in Iran are first time drug offenders [2].

4.19 Though some countries have established drug treatment centres to provide compulsory treatment for arrested IDUs, little is known about the quality of treatment or patient outcomes. As in other regions, compulsory treatment

tends to be problematic both therapeutically and from a human rights point of view. There are questions about who is mandated to treatment and whether the human rights of those assigned to treatment are respected. For example, prior to a change in Egyptian law in 2009 to make drug dependency treatment voluntary, not compulsory, individuals deemed 'drug dependent' were required to undergo compulsory treatment for an unspecified amount of time. The 2009 *Mental Health Act*, sets rules for admission to drug dependency treatment; including admission on voluntary basis, for a specified length of treatment time, and with routine clinical assessments [221]. The effects of this change in law on the quality of care are unknown.

4.20 While injection drug use has not historically been a major determinant for HIV infection/ transmission in Sub-Saharan Africa, a growing injection-driven HIV epidemic has emerged in recent years [submission of Adeolu, 2011; 76]. Injection drug use has been reported in over 30 countries in the sub-Saharan region [178]. Sub-Saharan Africa is the least documented region in the world with respect to drug crimes and incarceration rates. Drug policies in the region are historically punitive, characterised as a "quit or die" approach by at least one youth advocate [submission of Adeolu, 2011]. In Zambia, police reportedly enjoy broad discretion in enforcing drug laws and have arrested and detained family members, friends, and others when primary targets are not found [submission of Malembeka, 2011]. UNODC estimates that the proportion of drug users in the prison population in the 1990's ranged from 90% in Namibia to 3% in Nigeria with drug related convictions in the early 2000's ranging from 3.3% in Ethiopia to 56% in Mauritius; the reliability of these data, however, have been questioned [26]. Drug users in East Africa report that they face police repression and social exclusion. In informal reports, individuals living in Kenya and Tanzania report reluctance to seek government health services because of fears that they will be turned over to police [76]. In addition, buprenorphine and methadone prescribed for MAT are generally unavailable in the government health system [76].

4.21 Oceania

Australia and New Zealand have adopted a generally public health-oriented approach to individual drug use. Australia pursues a policy of depenalisation for possession of small amounts of certain illicit drugs. In Australia "the official response to drug possession and use is primarily a civil [not criminal] procedure" [26]. National drug policy gives police and courts the power to divert identified users from criminal proceedings to assessment, prevention, and treatment programmes [50]. New Zealand maintains criminal penalties for possession and use of drugs, but is currently reviewing national drug control law and the possibility of decriminalising possession [219].

4.22 Incarceration rates in the region are consistent with a policy of minimising criminal penalties for simple possession of drugs. The majority of individuals incarcerated for drug offences in both Australia and New Zealand are convicted of import-export, dealing-trafficking and manufacture-cultivation offences, not possession for personal use. In Papua New Guinea and the Solomon Islands, however, drug related offences including possession and use result in severe criminal penalties. Data on incarceration rates is unavailable [26].

5. Adoption of Harm Reduction Policies and Practices

5.1 *Harm reduction* refers to policies, programmes, and practices that focus on minimising the health risks involved with drug use, like the risk of drug overdose and transmission of blood-borne diseases like HIV and hepatitis. The defining features of harm reduction are the focus on preventing harm associated with drug use to people who use drugs, not ending drug use, and acceptance of the individual who uses or has used drugs [157]. Harm reduction has been controversial in drug policy because it makes no assumption that abstinence is the only, or even the best, way to reduce the individual and social harms of drug use. As a therapeutic practice, it aims to meet each user's individual needs. As a policy rubric, it defines drug-related harm, rather than drug use, as the primary target. There is considerable evidence that core harm reduction interventions like SEPs and (MAT for opiate dependence are effective in reducing HIV risks among IDUs. Other harm reduction approaches include adequate provision ofART, targeted educational programmes and ensuring access to condoms, and drug consumption rooms [155]. This paper focuses primarily on SEPs and MAT, the most widely used and best supported harm reduction methods.

5.2 SEPs are considered a cornerstone of harm reduction for people who inject drugs. Statistical comparison of jurisdictions with and without SEPs reveals a consistent association between harm reduction and the control of HIV epidemics [89]. For example, a study comparing HIV prevalence rates among 80 cities worldwide showed that in 29 cities with established SEPs, HIV prevalence *decreased* on average by 5.8% per year, while it *increased* on average by 5.9% per year in 51 cities without SEPs between 1988 and 1993 [152]. Observational studies consistently show strong correlation between provision of harm reduction services like SEPs and control or prevention of HIV among IDUs [87, 271, 19]. SEPs reduce risky injecting behaviours [274, 164] and are often the primary point of contact between marginalised IDU populations and public health workers. Strathdee et al. estimated that the elimination of laws prohibiting MAT in Kenya and the scaling-up of services to 80% of IDUs could reduce the number of new

HIV infections by 14%, while more than 40% of HIV infections in IDUs could be averted in Odessa, Ukraine through scale-up of MAT, ART, and SEPs [274]. Harm reduction programmes are proven to be safe and effective in preventing new cases of HIV, and cost-effective. Where ART is estimated to cost United States Dollars (USD) 2000 per life-year saved, a comprehensive package of harm reduction interventions cost USD 39 per disability adjusted life year saved [155]. In addition, harm reduction programmes have been shown to provide other, broader, social benefits. Several studies have shown that SEPs do not lead to increased crime or drug use [118, 203, 184]. Similarly, research shows that supervised injecting facilities do not lead to increased crime or increased drug use [332, 101].

5.3 MAT for opiate dependence has three objectives: (i) encouraging people with opiate dependence to seek drug treatment, (ii) stabilising opiate dependence and (iii) providing medical treatment for drug dependency [133]. Evidence shows MAT reduces drug dependence and increases safe injection practices in IDUs, as well as reducing crime as MAT patients do not have to commit crimes to obtain illicit drugs. It is shown to be especially effective when coupled with other harm reduction measures [81].

5.4 The effectiveness of harm reduction services such as MAT and SEPs have been evaluated in high, middle, and low income countries. MAT and SEP are also shown to provide social benefits and to be cost-effective. Methadone treatment is the most extensively researched form of MAT. Research shows that methadone treatment provides significant social benefits. It "reduces deaths by about 80%, substantially reduces crime, drug use and HIV infection and improves the physical and mental health and social functioning (such as parenting and employment) of heroin users" [314]. A study conducted in New South Wales, Australia found that for every 100 methadone patients for one year, "it was estimated that there were 12 fewer robberies, 57 fewer break and enters and 56 fewer motor vehicle thefts" [314]. MAT and SEPs are also cost-effective. For every dollar invested in NEPs and SEPs, more than four were returned in health care savings. [155]. The return on every dollar invested in methadone treatment for opiate dependency meanwhile is estimated to be USD 4-7 [314].

5.5 International support for incorporating harm reduction programming in national drug control policies has grown as the evidence for its effectiveness has accumulated. International health and drug policy agencies have recognised the effectiveness of SEPs, MAT, and targeted outreach programmes for IDUs, as well as the consistency of harm reduction programmes with national obligations under international drug treaties such as the Single Convention [189]. In 2004, the WHO, UNODC and UNAIDS, issued a joint statement, advising that MAT, "is a critical component of community-based approaches in the management of opioid dependence and the prevention of HIV infection among injecting drug users." [337]. In 2009, the WHO, UNODC, and UNAIDS identified nine interventions that "have the greatest impact on HIV prevention and treatment." The combined "comprehensive package" includes both MAT and SEPs [340]. The Political Declaration of the 2011 United Nations General Assembly High Level Meeting on AIDS calls upon countries to consider expanding harm reduction programmes. Some form of harm reduction policy has been supported – either explicitly in national policy or otherwise provided – in 93 territories and countries. Seventy-nine of these countries support harm reduction in their national policy while 82 countries actually implement or allow harm reduction programmes [155]. While the best prevention or control of HIV epidemics among IDUs has occurred in countries that adopt harm reduction *and* reduce the punitiveness of drug laws and/or enforcement practices, the mitigating effects of harm reduction are also evident in countries that maintain relatively punitive practices. The countries with the worst injecting drug use-related epidemics are those where harm reduction policies have been rejected or stunted by punitive drug strategies.

5.6 Several European countries, Canada, Australia, and New Zealand have adopted policy and enforcement changes that reflect a public health approach to drug use, including significant implementation of harm reduction. Although definitive evidence of causation is not available, in these countries HIV epidemics among IDUs have been prevented or controlled [205]. Prior to adoption of a harm reduction approach, HIV prevalence among IDUs in Edinburgh, Scotland was over 50%, with high reported levels of syringe sharing among IDUs. Targeted interventions for IDUs and harm reduction programmes such as SEPs, expansion of methadone treatment, and increased outreach were implemented in response to what was perceived as an injection-driven HIV epidemic. By 1993, six years after harm reduction services were provided, syringe sharing was no longer the norm and HIV prevalence among IDUs had sharply declined and stabilized [271]. In 2010, the HIV prevalence rate among IDUs in the UK was less than 5% [89].

5.7 There are countries that combine a punitive drug laws and law enforcement practices with the implementation of harm reduction programmes. In the US, where drug policy is made and enforced at the local, state and national levels, harm reduction co-exists, often uneasily, with punitive laws and policies. Until 2009, federal law prohibited the use of federal funds for SEPs. SEPs have been operating in many locales since the 1990s [46, 158] and MAT is well established in the US [207], but services are subject to state policies and are unevenly distributed across the country [158]. Researchers estimate that less than one third of IDUs in the US have been reached by a behavioral HIV intervention and less than one-fifth of IDUs in the US are receiving MAT at any given time [274]. Despite the torturous politics and suboptimal implementation of harm reduction, programmes have been deployed in most of

the areas of highest prevalence with evident impact. Today HIV prevalence among IDUs in the US is about 15.6%, much lower than the prevalence rates in Russia, Central Asia, and parts of South America and much lower than in the past [274].

5.8 China offers another instance of the potential for harm reduction to operate within a generally punitive law enforcement environment. Home to one of the world's largest IDU populations and experiencing a serious epidemic of HIV, the country pursues a strict prohibitionist, zero-tolerance, anti-drug policy resulting in mass detention of IDUs [177, 64]. At the same time, China has taken significant steps to implement public health interventions [177]. Between 2006-2008, China initiated a rapid roll out of MAT and SEP. In China, the number of operational SEPs rose from 92 in early 2006 to 775 in 2007 and 897–901 in 2010. Meanwhile, the highest numbers of MAT clients in Asia are in China (94,973) and Taiwan (12,598). The number of MAT providers has increased from 503 to 600–675 in China since 2008 [158]. As in the US, the evolution of Chinese harm reduction efforts illustrates the complex politics of HIV and drug control. The implementation of harm reduction in spite of a prohibitionist tradition grew out of the interplay of factors including negotiation and cooperation within government health and law enforcement agencies, the impact of scientific evidence, external assistance and pressure for action, and increasing support at the apex of government [344] .

5.9 Donor programmes and donor countries can also have profound influence in shaping national drug control policies abroad. PEPFAR, for example, spends significant resources on HIV prevention and treatment in Africa. While some of the funding focused on HIV prevention and education efforts for IDUs on the continent, funding for NEPs was denied [76]. The US funding ban has since been lifted by the Obama Administration, presenting a new opportunity for PEPFAR to fund targeted HIV interventions for IDUs. The opportunity is important because of the growing numbers of IDUs living in Sub-Saharan Africa, one of the worst affected HIV regions in the world [234]. Recent figures suggest that up to three million people who used drugs by injection live in Sub-Saharan Africa and HIV prevalence among IDUs in some countries now exceeds HIV prevalence in those general populations [76]. PEPFAR now focuses on SEPs and MAT in addition to community outreach programmes as core components of comprehensive HIV prevention for people who inject drugs. Finally, harm reduction services such as SEPs and MAT often serve as a primary point of contact for other HIV services, like ART. Thus, PEPFAR support for MAT and SEPs will not only reduce HIV risk for IDUs but can also facilitate broader HIV treatment and support.

5.10 In the nations with the worst epidemics of injecting drug use-related HIV, punitive policies have made it difficult or impossible to implement robust, sustained harm reduction efforts. The starkest example comes in the nation of the former Soviet Union, where injecting drug use is a major driver of HIV [submission of Askenov, 2011]. Although all countries in the region provide SEPs in at least some locales, and most provide MAT, coverage is severely inadequate and programmes are under constant threat of lost funding and police pressure [158]. Many of the countries in the region pursue punitive anti-drug policies, emphasising law enforcement and treatment of IDUs over prevention services. Russia, the region's dominant power, has been consistently and openly hostile to harm reduction in spite of its uncontrolled and disastrous epidemic of injecting drug use-related HIV. As recently as 2009, authorities warned against the "risks" of MAT and called SEPs "drug propaganda" [253]. Russian law does not provide for harm reduction services, and funding for such services is absent from the federal HIV programme [107]. The result is a morass of preventable suffering and death. HIV prevalence among Russian IDUs is over 37%, one of the highest in the world [274] – and much higher than rates found where harm reduction policies are in place.

6. Creating an Enabling Environment: What Countries Are Doing

6.1 The goal of minimising the individual and social harms of drug use animates the international drug control Conventions. Sadly, the pursuit of this goal through criminal laws and law enforcement approaches has itself been a source of enormous harm. A renewed commitment to the public health mission in drug policy requires that both the harms of drugs and the harms caused by efforts to control them be counted. The evidence we have reviewed here leaves little room for doubt that punitive drug laws, and especially punitive law enforcement practices, exacerbate the HIV risk faced by people who use drugs. A public health approach to drug use and drug dependency would not treat drug users as criminals, and would intervene to reduce vulnerability and risk wherever the evidence suggested that intervention is likely to be effective. Where criminal law remains an instrument for addressing drug-related harm, those who enforce the law must take explicit responsibility for the health-related consequences of their work. This includes affirmative efforts to harmonise the goal of controlling illicit use with the goal of assuring access to health care and harm reduction services; and ensuring that health services offered or managed by law enforcement and corrections agencies meet the standards generally applicable to such services in the community. "Harm reduction" on this view is not just an approach to working with drug users, but the ultimate goal of all efforts [48].

Case Study in Decriminalisation: PORTUGAL

Background: On July 1, 2001, Portugal implemented legislation decriminalising the sale, possession and consumption of drugs, including cocaine and heroin for personal use. The policy has served as a test of the impact of decriminalising illicit drug possession and use on national drug-related health outcomes [141]. Personal use, according to the law, is defined as a 10-day supply of the drug for one person. Individuals discovered in possession of illegal drugs are not charged with a crime, but are liable to be referred to an administrative proceeding overseen by specialised drug commissions (CDTs), made up of law enforcement and health officials. CDTs (1) differentiate offenders suffering from drug dependency from healthy users, and (2) encourage addicted offenders to enter drug treatment. Individuals who are deemed "non-addicted" may be fined [12].

Effects: Prior to decriminalisation, IDUs in Portugal had the second highest prevalence of HIV in the European Union [141]. Since the decriminalisation law when into effect, drug-related harms have substantially declined: the number of newly reported HIV/AIDS cases has declined significantly every year; the percentage of newly diagnosed HIV/AIDS cases steadily decreased over the same time; and there has been no significant increase in new drug use [submission of Roque, 2011,141,95]11).

6.2 Countries around the world have responded to HIV and the problems with punitive drug control laws in a variety of ways, which we summarise as:

1. Decriminalising or depenalising individual drug use and possession;
2. Integrating harm reduction into law enforcement and drug control policy; and
3. Providing drug treatment and harm reduction services within the criminal justice system.

6.3 Evidence for the effectiveness of initiatives to reconcile law and enforcement and public health goals is limited, and the challenge of doing so is daunting. We describe efforts to harmonise punitive approaches with public health not as best practices, but as plausible steps forward.

6.4 Changing Basic Laws and Policies: Decriminalisation and Depenalisation

HIV prevention is part of the broader set of drivers that have led some countries to move away from punitive approaches to drug possession and individual use [186]. Less punitive approaches include depenalisation and decriminalisation. (See box above). Just as punitive policies have generally failed to substantially suppress drug use, removing criminal penalties alone leads to little or no increase in the prevalence of drug use or drug-related harms (141, 196]. While most existing research evaluates the effects of decriminalising small amounts of cannabis, evaluation of decriminalisation of other drugs for personal use in Portugal has similarly found no increase in drug use. In addition, decriminalisation in Portugal reduced overcrowding in prisons and reduced administrative burden in the criminal justice system [95]. As a result, a greater number of IDUs accessed treatment and the number of drug-related harms, such as overdose, in prisons declined [160].

6.5 Although it can do so, decriminalisation of small amounts of illicit substances does not always result in improvement to the HIV risk environment for IDUs. Certain Australian jurisdictions, for example, have decriminalised personal cannabis use only. Police diversionary programmes in the country primarily focus on diverting individuals discovered with cannabis although police diversionary programmes that cover other drugs also exist [44]. The Italian decriminalisation experience in comparison to the Portuguese experience is instructive in demonstrating the benefits of multi-pronged action, including decriminalisation. In 1975, Italy decriminalised the possession and use of all drugs. The *Drug Act* allowed users to carry a small amount of illicit drugs without facing punitive sanctions [270]. In practice, however, police continued to arrest drug users, charging them as traffickers. Treatment services were not founded on harm-reduction principles and exhibited limited effectiveness [270]. HIV infection among IDUs actually increased after the Act [270]. By contrast, the decriminalisation statute in Portugal provides for funding for drug treatment centres and introduced harm reduction services to dependent drug users including MAT and SEP [125]. After enactment of the Portuguese statute, the number of dependent drug users seeking treatment increased threefold and drug-related harms have significantly declined, including the incidence of HIV [125].

6.6 Integrating Harm Reduction into Drug Control and Enforcement Strategy

To the extent that law enforcement continues to be a component of a strategy to reduce the harms of drug use, its negative effects on the health of people who use drugs can be reduced by better integrating health and law

Case Study in Police Training and Integrated Harm Reduction-Law Enforcement Approach: KYRGYZSTAN

Background: Kyrgyzstan enacted a drug law reducing criminal penalties for drug possession. The Kyrgyz government also issued *Ministerial Order 417* in 2003, which creates a framework for building police-public health collaboration around infectious disease by bundling provisions on police occupational safety with those facilitating an enabling environment for HIV prevention. The initiative included police trainings administered by HIV service NGOs, both at the national Police Academy that prepares elite officers, and at the police high schools, which train rank-and-file police. Researchers developed training for law enforcement personnel to improve acceptance of harm reduction principles, based on the public health framework of prevention, monitoring and response. Training first identified the root causes for police abuse of people who use drugs by injection and developed training to prevent such abuse based on their findings. Training bundled occupational and harm reduction principles, showing how supporting sterile syringe possession can also reduce the risk of needle-sticks for police; engaged police institutions in collaborative activities with service providers and advocacy groups; cultivated "horizontal" networks between public agencies; and conducted empirical evaluations of training effect in changing police attitudes. Systematic monitoring and surveillance was also conducted to assess prevalence of police abuse. Periodic surveys sent to targeted populations, such as people who use drugs, were evaluated. Finally, the integrated model included mechanisms for responding to reports of police abuse including triaging complaints to the Prosecutor or Internal Security Service; maintaining confidentiality of complaints; and working with NGOs to expand legal services [20].

Effects: Early findings indicate that police training has reduced law enforcement's stigmatising attitudes surrounding drug use and IDUs and police confiscation of IDUs' syringes and drug paraphernalia (personal communication, [21].

enforcement interventions in a common strategy founded on respect for human rights. At best, this takes the form of what are often referred to as a "four pillars" model. This approach to drug policy combines prevention of new drug use, treatment of drug dependence, law enforcement and harm reduction. At least, it entails sustained efforts to educate and motive law enforcement officers to avoid treating people who use drugs in harmful ways. Where harm reduction is not voluntarily adopted, or where in other ways police continue to mistreat people who use drugs, human rights litigation has been useful in some places in enforcing change.

6.7 Enabling multisectoral collaboration

Efforts to formally and systematically integrate harm reduction into law enforcement have been successful in improving acceptance of harm reduction in law enforcement. First developed by the Swiss government and implemented in the late 1980s, the four-pillars approach to drug policy is credited with producing a drop in HIV incidence among IDUs in the first ten years of its implementation [257]. Later adopted in Vancouver, Canada the four-pillars approach has since been widely adopted as a model for integrated harm reduction policy [206]. In Vancouver, collaboration between police health workers has been identified as a key outcome of the approach [204]. Also, a change in local law enforcement culture surrounding injection drug use can be seen by the cautious support of a number of police for the city's first supervised injection site. City police have further demonstrated improved acceptance of the harm reduction pillar of the four-pillars approach in changes to police policy, including police non-attendance to non-fatal overdose [266]. It is important to note that implementation of the four-pillars approach in Vancouver has not historically been even across each "pillar" (prevention, treatment, law enforcement, and harm reduction). A police crackdown on people who use drugs by injection in Vancouver, "Operation Torpedo," resulted in widespread rights violations and curtailed use of available harm reduction services. The event caused one local advocate to characterise the city's implementation of the four-pillars approach as "a tree trunk [law enforcement] and three toothpicks" [142]. The numbers of IDUs who access harm reduction services today in Vancouver are unknown [155]. The Ministry of Health credits the city's sustained and multi-level response as contributing to a decline in HIV prevalence among IDUs in the region [169].

6.8 The four-pillars approach is not the only model. Consistent with practice at the intersection of policing and mental health [333], some jurisdictions have developed interdisciplinary teams or co-located services as a means for moving people detained with drugs from the criminal justice to the health care and social services systems. In Western Australia, public health officials, social services and law enforcement officers created Drug Action Teams (DATs) to curb criminal activity related to drug use while increasing IDUs' access to drug treatment. These interdisciplinary teams were tasked with providing local police with harm reduction training. The DATs also equipped local police with referral cards with drug treatment contact information to distribute to drug users. The DATs enabled the two sectors to collaborate in a shared goal – improving access to harm reduction services [212].

6.9 In London, United Kingdom , public health workers have been placed in police stations to offer voluntary drug treatment options to dependent drug users apprehended for minor drug-related crimes [151]. Although the in-house health workers initially felt their relationship with law enforcement officers was distant, working in close proximity improved the relationships soon and significantly [151].

6.10 Police training

Growing recognition of police influence on the HIV risk environment for IDUs has resulted in a variety of interventions targeting police abuse of people who use drugs. For example, public health officials harm reduction experts and drug user organisations have undertaken police training to facilitate the smooth implementation of harm reduction policies. Law enforcement officials have also implemented broader policy changes, including training and collaboration with public health officials, to integrate harm reduction services into law enforcement practices. Police training can provide basic education and understanding about the HIV risk environment for IDUs and is shown to better integrate public health policy into drug enforcement strategy. Coordination and collaboration between law enforcement and health officials can also have positive influence over the HIV risk environment for IDUs with respect to advocacy based on aligned interests [294]. For example, in Australia the recommendation to establish the Sydney Medical Supervised Injecting Centre came from 1996 Wood Royal Commission into the New South Wales Police Service. Eleven independent evaluations find that the site is meeting its objectives, has no adverse outcomes and is cost-effective. Today, the Centre is responsible to the New South Wales Department of Health as well as the New South Wales Police Force [279].

6.11 Perhaps two of the most important outcomes of police training are improving police understanding about drug use, including reducing stigmatising attitudes about drug users, and improving across-agency collaboration. In Australia, for example, the National Community Based Approach to Drug Law Enforcement provided police officers in four trial sites with training in harm reduction for IDUs. Trained officers demonstrated willingness to direct people who use drugs towards harm reduction services instead of resorting to arrest or confiscation [212]. The change in and police response was monitored with respect to whether changed attitudes resulted in greater referrals [165]. Some IDUs seeking treatment from referral services noted that police had referred them to treatment centres. The programme was subsequently expanded and comprehensive harm reduction training was provided to all police officers in two of the four trial sites. Trained officers spoke highly of a trainer who had formerly used drugs and the experiences shared with them [212]. Most importantly, however, health officials and police reported significant improvements in the quantity and quality of inter-agency collaboration [212].

6.12 Research shows that police officers are receptive to harm reduction training, "particularly when that information is coupled with content directly relevant to the health of the law enforcement trainees and is delivered by a trusted source" [78]. In New York, United States of America (US), the state Department of Health funded the New York State Association of Chiefs of Police to provide training about state syringe law and harm reduction programmes to law enforcement. Education materials include podcasts and fliers that summarise syringe laws and harm reduction policy in the state. Fliers include practical information such as the limits of possession laws, whether an identification card is necessary for exemption under the law, and provides examples of what an identification card for a participating SEP looks like [218].

6.13 Integrating harm reduction into drug control: a role for courts

Courts may play a role in promoting the availability of harm reduction services and to protect IDUs from abusive behaviour [318]. In the US, courts have issued orders to stop police from continuing to stop or arrest drug users following the implementation of SEPs and pharmacy sales of syringes. Canadian courts have upheld the authority of the province of British Colombia to sponsor Insite, Vancouver's supervised injection facility [239]. A moratorium on new applications to open supervised injection facilities is in place, however, while the Supreme Court of Canada reviews the federal government's appeal of Insite's continued operation [submission of Allard, 2011].

6.14 The power of courts to push for better quality and access to health services is especially clear in cases that arise out of the prison system. The European Court of Human Rights has ordered the governments of Russia and Ukraine to pay damages to the families of people who used drugs and died in pretrial detention, emphasising the need to improve health services available to all detainees, including IDUs [318, 345].The European Court of Human Rights has also held that a failure to provide requisite care to detained IDUs, including access to drug dependency treatment, can constitute a violation of the right to health and cruel, inhuman and degrading treatment [300, 207]. A complaint from a Russian national that Russia's legal bar to MAT constitutes a violation of human rights law was submitted to the European Court of Human Rights in November 2010 [283].

Case Study in Court Supervised Drug Treatment: PROP 36 in California (USA)

Background: The diversion model created under California's voter-*initiated Substance Abuse and Crime Prevention Act* (Proposition or Prop 36) may offer some improvements to the standard drug court approach. Unlike traditional drug courts, courts under Prop 36 must make treatment available to all defendants that meet conviction-based eligibility requirements. The law provides courts with flexibility in monitoring and does not require intensive judicial supervision. Upon failure of treatment, Prop 36 mandates that a defendant be allowed up to three opportunities for treatment.

Effects: Considerable county-level variation in Prop 36 courts exists and the effectiveness of Prop 36 continues to be debated. Research from eight high-performing counties, identified by indicators such as program completion, re-incarceration, and re-arrest, finds that four core strategies determine drug court success. "High-performing" shared these traits: (1) fostered participant engagement by making treatment easy, monitored participant progress, and sustained cooperation among participants; (2) cultivated buy-in among key stakeholders, including a knowledge base and core group of local experts; (3) capitalised on the role of the court and the judge, including the judge's ability to facilitate communication between stakeholders and sustain political support for the program; and (4) created a setting which promoted a high quality treatment system that responded to individual patient needs, and broad financial and political support for the programme [108](

6.15 Drug Treatment and Harm Reduction within the Criminal Justice System

Court-supervised or instigated drug treatment

Programmes that divert drug arrestees from prison to treatment are found throughout the world. The value – and justice – of these programmes depends on how people are assessed and referred to treatment, how much actual say they have, and the quality and fit of the treatment. The administrative systems of compulsory referral used in a number of counties in the former Soviet Union and Asia, discussed earlier in this paper, have been strongly criticised on each of these points. In a number of Western countries, diversion programmes have been embedded in the criminal justice system with judges taking on the tasks of assessing, referring and even supervising individuals in drug treatment. Though the drug court approach is continuing to grow, it too is subject to basic questions of efficacy and fairness arising from the use of criminal justice rules and standards to make decisions that are essentially medical and therapeutic in nature [48].

6.16 There are over 2000 drug courts operating in the US today, with more planned. Drug courts allow drug arrestees a chance to avoid criminal sanctions, such as incarceration, so long as they maintain attendance in drug treatment centres and do not commit other crimes while in treatment [109]. US drug courts typically operate on a diversionary (pre-plea) basis, meaning that the individual has the option to avoid prosecution if s/he agrees to a court designed treatment regimen, but faces criminal prosecution if s/he does not succeed [272]. In accepting the offer of treatment, the arrestee generally is treated as voluntarily "exiting" the judicial process, meaning that he or she agrees to accept the drug court judge's decisions (for example, on the treatment modality to be used, or punishments for non-compliance within the programme) without a right to appeal. Little evidence exists to prove their effectiveness in long-term drug dependency treatment, and their costs are high [272, 42].

6.17 According to the International Association of Drug Treatment Courts (IADTC), drug courts now operate or are being planned in fifteen other countries (Australia, Jamaica, Ireland, Brazil, Cayman Islands, Bermuda, Trinidad, Barbados, New Zealand, Scotland, Norway, Italy, Macedonia, and the UK (England and Wales)). Recently, the UK Ministry of Justice evaluated its Dedicated Drug Courts (DDC) programme. Established in 2005, six DDCs adjudge cases where the defendant has tested positive for drugs on arrest or charge [170]. The UK model is like the US model in that the courts operate on a pre-plea basis, permitting individuals who test positive for drugs on arrest or charge the informal opportunity to speak to in-house drug treatment personnel immediately after arrest on a drug-related charge. Individuals may seek to enroll in voluntary drug treatment as an alternative to appearing in court to plead their case [151]. The UK model differs from the US model in that the defendant can enter the DDC at varying stages in their court process, including after the defendant has entered a guilty plea to the original charge. However the individual comes into the DDC, the DDC will order drug rehabilitation and regular review. If the defendant fails drug treatment, s/he is re-sentenced based on the original charge only [170]. The DDCs encourage collaboration between law enforcement and a whole host of social services including employment services, probation and drug treatment services [170].

6.18 Diversion of arrestees from jail to treatment makes sense from a public health standpoint, but it is not clear that judges and parole or probation staff are properly trained, equipped or monitored to make treatment decisions competently or fairly [5, 30]. Many drug courts treat all drug use as pathological, though many if not most people arrested for drug use are not drug-dependent. Anecdotal reports and some evidence indicate that US drug court judges tend to disfavor MAT in favor of abstinence-based treatment, despite the evidence of MAT's effectiveness [251,222]. Judges may have little training in substance abuse, and little appreciation of its chronic nature, leading to premature determinations of treatment failure or non-compliance and neglect of harm reduction. This concern is consistent with data showing that drug courts eventually incarcerate many and in some cases most of the dependent IDUs in the programme, and rarely if ever provide for harm reduction services [30, 3]. All these concerns are heightened by the inherently coercive nature of the process, and the lack of outcome accountability for the decision makers.

6.19 Providing harm reduction in prison

Prisons are being recognised as essential sites for harm reduction services. Generally, HIV prevalence among incarcerated IDUs exceeds the HIV prevalence among IDUs in the general population [165]. Individuals with a history of drug use are known to be overrepresented in prison [26, 94] and research demonstrates that dependent drug users continue to inject while in prison [submission of Allard, 2011; 166, 94]. International organisations such as the WHO, UNAIDS, and UNODC have issued guidelines for comprehensive HIV prevention in prison, including SEPs and MAT, in recent years [311, 339]. Currently SEPs are offered in prisons in 12 countries spanning western and Eastern Europe and Central Asia [166] and at least 37 countries provide MAT in prison [155].

6.20 The results are encouraging, both in terms of health and correctional administration. Since the implementation of SEPs in some 50 prisons in Switzerland, for example, all but one prison reported the complete eradication of syringe-sharing among inmate-IDUs [166]. Confidential and accessible services are keys to prison-based SEP success. Moldova, for example, began its prison SEP by providing access to the service through the prison health centre, which meant that people had to ask health personnel for a syringe. When the prison staff trained prisoners to distribute clean syringes directly among themselves without the involvement of health staff, needle stick injuries and the transmission of HIV among incarcerated individuals subsided [166]. Recent figures from Moldova suggest that its SEP programme, in conjunction with other harm reduction programmes like MAT in prison, have contributed to a reduction in the number of new HIV infections among inmates between 2004 and 2010 [submission of Burduzha, 2011]. MAT in prison has also been proven to reduce HIV transmission among people using drugs in prison [166, 94]. In prison, MAT has also been associated with other positive outcomes such as reduced drug use and reduced recidivism for participating IDUs [273]. Spain provides an example of how effectively a combination of SEP and MAT in prison can improve the HIV risk environment in prison for IDUs. Since the late 1990s, Spain has provided both SEPs and MAT for drug- dependent inmates in some prisons [165, 10]. In 2001, the national head of prisons issued an edict requiring SEP implementation in all Spanish prisons [166]. By the mid-2000s, 82% of incarcerated dependent IDUs received MAT [165]. As a result of the harm reduction services in prison, new cases of HIV among incarcerated IDUs dropped 17% between 1992 and 2009 [10]. Evaluations of SEPs in prison have found no adverse events after implementation, e.g., overall increase in injection drug use and violence involving needles [190].

Conclusion

7.1 Global drug policy stands at a historic crossroads. There is no doubt that drugs cause significant harm to health, but this is true of both legal and illegal drugs [214]. At the same time, there is no doubt that many drugs, both legal and illegal, offer benefits to those who use them, even if only hedonistic ones, that make them desirable and sustain demand for them. Simple prohibition is evidently incapable, in most settings, of overcoming this demand, at least in a manner consistent with justice and human rights [196]. Moreover, punitive strategies of drug control themselves cause enormous harm, including but not limited to the harms that have been described in this paper [122, 126]. To achieve its welfare goals, drug control policy must follow the public health evidence. The challenge of drug control today is to adopt regulatory methods that minimise both the harms caused by drug use and the harms caused by drug control.

7.3 The road to a healthier drug policy is neither straight nor smooth, but the journey can be postponed no longer. The Vienna Declaration presents a plausible way forward, a set of steps that reflect the evidence reviewed in this paper [1]. They include:

- Submitting current drug policies to the scrutiny of a transparent, evidence-based review.

- Implementing – and rigorously evaluating – a science-based, public health approach to minimising the individual and community harms of illicit drug use, including the harms caused by the laws and other interventions we use to do so.
- Decriminalising drug use, scaling up evidence-based drug dependence treatment and abolishing ineffective compulsory drug treatment schemes that violate the human rights of people who use drugs.
- Removing legal barriers to, and providing adequate funding for the implementation of comprehensive, evidence-based HIV interventions, including harm reduction.
- Meaningfully involve people who use drugs in developing, monitoring and implementing services and policies that affect their lives. This means financial support and legal standing for organisations representing people who use drugs.

7.3 Global society is not likely to achieve consensus on the morality or value of drug use. If we can agree on the goal of minimising drug-related harm, and to accept the guidance of scientific evidence, it should be possible to pursue reforms that will do a far better job than the strategies in place today.

Submissions Cited

Submission made by Alejandro Corda, Intercambios Asociacion Civil, Argentina, for the Latin America Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Anan Pun, Recovering Nepal, Nepal for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Anna Louise Crago/ Stella, Canada for the High Income Countries Dialogue of the Global Commission on HIV and the Law.

Submission made by Anna Lyunbenova, Initiative for Health Foundation, Bulgaria for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Artur Sakunts, Helsinki Citizens Assembly, Armenia for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Fumi Suzuki, Space Allies, Japan, for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Huang Shan, Yunnan University, Legal Aid Centre, China for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Ilona Burduzha, Medical Management of the Department of Penitentiary institutions of the Ministry of Justice of the Republic of Moldova, Moldova for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Jimmy Dorabjee, ANPUD, India for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Kamon Uppakaew, Thai AIDS treatment Action Group (TTAG), Thailand for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Kyaw Thu, Swifts (IDU-SHG), Myanmar for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Godfrey Malembeka, Prisons Care and Counselling Association, Zambia for the Africa Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Maxim Demchenko, Light of Hope NGO-Poltova, Ukraine for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Ogunrombi Adeolu, Youth RISE, Nigeria for the Africa Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Patricia Allard/ Canadian HIV/AIDS Legal Network, Children Can't Wait! Dying for Drugs in Developing Countries, Canada for the High Income Countries Dialogue of the Global Commission on HIV and the Law.

Submission made by Pavel Askenov for Elena Romanyak, ESVERO NGO, Russia for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Raj Kumar Raju, Indian Drug Users Forum, India for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Ricky Gunawan, LBH Masyarakat, Indonesia, for the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Ivan Zhavoronkov, Russia, for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

Submission made by Zulfiya Mustafaeva, Rule of law Development and Democracy NGO – Baku, Azerbaijan for the Eastern Europe & Central Asia Regional Dialogue of the Global Commission on HIV and the Law.

References

2010. The Vienna Declaration. Available at http://www.viennadeclaration.com/ (accessed May 11, 2011).

Abu-Raddad, L., Akala, F., Semini, I., Riedner, G., Wilson, D., and Tawil, O. Characterizing

the HIV/AIDS epidemic in the Middle East and North Africa. (Washington, D.C., World Bank, 2010).

Aceijas, C., Oppenheimer, E., Stimson, G.V., Ashcroft, R.E., Matic, S., and Hickman, M.

(2006), Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the 'Treating 3 million by 2005. Making it happen. The WHO strategy' ('3by5'). Addiction, 101: 1246.

Aitken, C., Moore, D., Higgs, P., Kelsall, J., and Kerger, M. (2002). The impact of a police crackdown on a street drug scene: Evidence from the street. International Journal of Drug Policy, 13, 189–198.

Anderson, J.F. What to do about "much ado" about drug courts?,12 Int'l J. Drug Policy 469 (2001).

Annan, K. et al., United Nations millennium declaration, United Nations Millennium Summit (September 2000), available at http://www.un.org/millennium/sg/report/full.htm

Aoyagi, M.T., Beyond punitive prohibition: Liberalizing the dialogue on international drug policy, 37 N.Y.U. J. Int'l L. & Pol. 555 (2005).

APN+ (2010), Knowledge and access of injecting drug users to HIV, drug dependence and hepatitis C treatment: a five country survey. Bangkok, Thailand: Asian Pacific Network of People living with HIV/AIDS.

Archibold, R. C. (2011). Suspicion and Disunity Impede Central America's Effort to Fight Drug Violence. New York Times. June 8 .

Arroyo-Cobo, Public health gains from health in prisons in Spain, 124 Public Health 629 (2010).

AusAID, Tool 2: Guidelines for addressing police concerns about harm reduction, HIV/AIDS Asia Region Program (2007), available at http://www.leahrn.org/resources/

Australian Institute of Criminology, Australian Responses to Illicit Drug Use, available at http://www.aic.gov.au/crime_types/drugs_alcohol/illicit_drugs/diversion.aspx.

Australian Institute of Criminology, Australian Approaches to Drug Crime Prevention, 2008.

Azim, T. et al., Prevalence of infections, HIV risk behaviors and factors associated with HIV infection among male injecting drug users attending a needle/syringe exchange program in Dhaka, Bangladesh, 43 Substance Use & Misuse 2124 (2008).

Ball, A. L. (2007), Universal access to HIV/AIDS treatment for injecting drug users: keeping the promise. International Journal of Drug Policy; 18:241-245.

Ball, A. L., Rana, S., and Dehne, K. L. (1998), HIV prevention among injecting drug users:

Responses in developing and transitional countries. Public Health Reports, 113(Suppl. 1), 170–181.

Ball, A.L. & Nick Crofts, HIV risk reduction in injection drug users, from Peter R. Lamptey & Helene D. Gayle, HIV/AIDs prevention and care in resource constrained settings: A handbook for the design and management of programs, Family Health Int'l 517-545 (2001).

Barrett, D. (2008). 'Unique in International Relations'? A Comparison of the International Narcotics Control Board and the UN Human Rights Treaty Bodies. London: International Harm Reduction Association.

Bastos, F. I. and Strathdee, S. (2000), Evaluating effectiveness of syringe exchange programmes. Social Science & Medicine, 51, 1771–1782.

Beletsky, L. Aligning law enforcement and public health efforts targeting vulnerable groups: Strengthening the Kyrgyz model, Open Society Institute 1 (In press).

Beletsky, L., Grau, L. E., White, E., Bowman, S. and Heimer, R. (2011), The roles of law, client race and program visibility in shaping police interference with the operation of US syringe exchange programs. Addiction, 106: 357–365. DOI: 10.1111/j.1360-0443.2010.03149.x.

Beletsky L., Macalino G.E., and Burris S. (2005), Attitudes of Police Officers towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States. International Journal of Drug Policy, 16(4), 267-274.

Beletsky, L. et al., Can police training help align law enforcement and HIV prevention? Preliminary evidence from the field, Am. J. Pub. Health (In press).

Bergmire-Sweat, D., Barnett, B. J., Harris, S. L., Taylor, J. P., Mazurek, G. H., and Reddy, V. (1996), Tuberculosis Outbreak in a Texas Prison, 1994. Epidemiology & Infection 117:485–92

Berkman, A. et al., A critical analysis of the Brazilian response to HIV/AIDS: Lessons learned from controlling and mitigating the epidemic in developing countries, 95 Am. J. Pub. Health 1162 (2005).

Bewley-Taylor, D., C. Hallam, et al. (2009). The Incarceration of Drug Offenders: An Overview Beckley Foundation Drug Policy Programme: 1-18.

Beyrer, C., Jittiwutikarn, J., Teokul, W., Razak, M. H., Suriyanon, V., Srirak, N., Vongchuk, T., Tovanabutra, S., Sripaipan, T., & Celentano, D. D. (2003). Drug use, increasing incarceration rates and prison-associated HIV risks in Thailand. AIDS and Behavior, 7, 153–161.

Beyrer, C. et al., Time to act: a call for comprehensive responses to HIV in people who use drugs, 37 Lancet 551 (2010).

Bidordinova, A. (2002), Who Benefits from the War on Drugs in Russia. Paper presented at the 4th National Harm Reduction Conference, Seattle, WA.

Blankenship, K.M. et al., Black-White disparities in HIV/AIDS: The role of drug policy and the corrections system, 16 J. Health Care Poor Underserved. 140 (2005).

Blankenship, K. M. and Koester, S. (2002), Criminal law, policing policy, and HIV risk in female street sex workers and injection drug users. Journal of Law, Medicine and Ethics, 30(4), 548–559.

Bluthenthal, R.N., K.G. Heinzerling, R. Anderson, N.M. Flynn, and A.H. Kral. 2008. Approval of syringe exchange programs in California: results from a local approach to HIV prevention. Am J Public Health 98: 278-83.

Bluthenthal, R.N. 1997. Impact of law enforcement on syringe exchange programs: a look at Oakland and San Francisco. *Medical Anthropology* 18: 61-83.

Bluthenthal, R. N., Lorvick, J., Kral, A. H., Erringer, E. A., and Kahn, J. G. (1999), Collateral

damage in the war on drugs: HIV risk behaviors among injection drug users. International Journal of Drug Policy 10:25-38.

Bobrik, A., Danishevski, K., Eroshina, K., and McKee, M. (2005), Prison health in Russia: the larger picture. Journal of Public Health Policy, 26: 30-59.

Bobrova, N., Rhodes, T., Power, R., Alcorn, R., Neifeld, E., Krasiukov, N., Latyshevskaia, N., and Maksimova, S. (2006), Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities. Drug Alcohol Dependence; 82 (Supplement 1): S57-S63.

Boltaev, A. (2011). Personal Communication, J. Chiu.

Bourgois, P. (1998), The moral economies of homeless heroin addicts: confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. [See comments]. Substance Use & Misuse 33:2323-2351.

Broadhead, R. S., Heckathorn, D. D., Weakliem, D. L., Anthony, D. L., Madray, H., Mills, R. J., and Hughes, J. (1998). Harnessing peer networks as an instrument for AIDS prevention: Results from a peer-driven intervention. Public Health Reports, 113 (Supplement 1), 42–57.

Broadhead, R. S., Kerr, T. H., Grund, J. P., and Altice, F. L. (2002), Safer injection facilities in North America: Their place in public policy and health initiatives. Journal of Drug Issues 32(1), 329–355.

Broadhead, R.S., van Hulst, Y., and Heckathorn, D.D. (1999), The impact of a needle exchange's closure. Public Health Reports; 114(5):439–447.

Brown, R. (2010) "Associations with substance abuse treatment completion among drug court participants." Subst Use Misuse 45(12): 1874-91.

Buavirat, A., Page-Shafer, K., Griensven, G. J. P. v., Mandel, J. S., Evans, J., Chuaratanaphong, J., Chiamwongpat, S., Sacks, R., and Moss, A. (2003), Risk of Prevalent HIV Infection Associated with Incarceration among Injecting Drug Users in Bangkok, Thailand: Case-Control Study. British Medical Journal; 326:308.

Bull, M. (2003). just treatment: a review of international programs for the diversion of drug related offenders from the criminal justice system, Queensland University of Technology.

Burris, S. C., Anderson, E. D., Davis, C. S., & Case, P. (2011). Racial Disparities in Injection-Related HIV: A Case Study of Toxic Law. Temple Law Review, 82, 1263.

Burris S., Anderson E., Craigg A., Davis C., and Case P., Racial Disparities in Injection-Related HIV: A Case Study of Toxic Law (November 3, 2010). Temple Law Review, Forthcoming; Temple University Legal Studies Research Paper

Burris, S., E. D. Anderson, et al. (2009). "Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility." St Louis Univ Law J 53: 1089-1154.

Burris, S., & Burrows, D. (2009). Drug policing, harm reduction and health: Directions for advocacy. ***International Journal of Drug Policy, 20***(4), 293-295.

Burris, S., Blankenship, K. M., and Donoghoe, M. (2004), Addressing the "risk environment" for injection drug users: The mysterious case of the missing cop. Milbank Quarterly, 82(1), 125–156.

Burton, K. (2004). Illicit Drugs in Australia: Use, Harm and Policy Responses. Parliament of Australia Parliament Library, e-brief, available at http://www.aph.gov.au/library/intguide/sp/illicitdrugs.htm.

Butler, W. E. (2005). Narcotics and HIV/AIDS in Russia: Harm Reduction Policies Under Russian Law. London: Wildy, Simmonds & Hill Law Publishing.

Calsyn, D. A., Saxon, A. J., Freeman, G., and Whittaker, S. (1991), Needle-use practices among intravenous drug users in an area where needle purchase is legal. AIDS 5:187-193.

Case, P., Meehan, T., and Jones, T. S. (1998), Arrests and incarceration of injection drug users for syringe possession in Massachusetts: Implications for HIV prevention. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 18 (Supplement 1), S71-S75.

Caulkins, J. P. Law enforcements' role in a harm reduction regime, 64 Crime and Justice Bulletin 1 (2002), available at http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/CJB64.pdf

/$FILE/CJB64.pdf

Celentano, D. D., Vlahov, D., Cohn, S., Anthony, J. C., Solomon, L., and Nelson, K. E. (1991), Risk factors for shooting gallery use and cessation among intravenous drug users. American Journal of Public Health, 81(10), 1291–1295.

Centers for Disease Control and, P. (2006). HIV transmission among male inmates in a state prison system--Georgia, 1992-2005. MMWR - Morbidity & Mortality Weekly Report, 55(15), 421-426.

Charles, M., D. Bewley-Taylor, et al. (2005). Drug Policy in India: Compounding Harm? Briefing Paper, Beckley Foundation Drug Policy Programme.

Chitwood, D. D., Griffin, D. K., Comerford, M., Page, J. B., Trapido, E. J., Lai, S., McCoy, C.B.(1995), Risk factors for HIV-1 seroconversion among injection drug users: A case–control study. American Journal of Public Health, 85(11), 1538–1542.

Choo, M., Paxton, S., and Kamarulzaman, A. (2009), Exploring discrimination from HIV-related stigma in Malaysia. IX International Congress on AIDS in Asia and the Pacific; Bali, Indonesia; Abstr WeOD10-06.

Choopanya, K., Des Jarlais, D. C., Vanichseni, S., et al. (2002), Incarceration and risk for HIV infection among injection drug users in Bangkok. Journal of AIDS, 29, 86–94.

Cintra, A. M., Caiaffa, W. T., Mingoti, S. A. (2006), Characteristics of male and female injecting drug users of the AjUDE-Brasil II Project. Cad Saude Publica; 22: 791-802.

Clatts, M., J., Sotheran, L., Luciano, P. A., Gallo, T. M., and Kochems, L. M. (1998), The Impact of Drug Paraphernalia Laws on HIV Risk among Persons who Inject Illegal Drugs: Implications for Public Policy. In How to Legalize Drugs, edited by J. M. Fish, 80-101. Northvale NJ & London: Jason Aronson Inc.

Coffin, P. O., Linas, B. P., Factor, S. H., & Vlahov, D. (2000). New York City pharmacists' attitudes toward sale of needles/syringes to injection drug users before implementation of law expanding syringe access. Journal of Urban Health, 77(4), 781-793.

Cohen, E. and Amon, J. J. (2008), Health and Human Rights Concerns of Drug Users in Guangxi Province, China, PLoS Med 5(12): e234. doi:10.1371/journal.pmed.0050234

Commission on HIV/AIDS and Governance in Africa Globalised Inequalities and HIV/AIDS. Addis Ababa: Economic Commission for Africa.

Connors, M. (2009) Ambivalent about Rights: "Accidental" Killing Machines, Democracy and Coups D'etat. Southeast Asia Research Center, Working Paper Series No. 102.

Conviser, R. and Rutledge, J. H. (1989), Can public policies limit the spread of HIV among IV drug users? Journal of Drug Issues, 19, 113–128.

Cooper, H., Moore, L., Gruskin, S., and Krieger, N. (2004), Characterizing perceived police violence: Implications for public health. American Journal of Public Health, 94(7), 1109–1118.

Cooper, H. et al., The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study, 61 Soc. Sci & Med 673 (2005).

Cooper, H. et al., Geographical approaches to quantifying the risk environment: Drug-related law enforcement and access to syringe exchange programmes, 20 Int'l J. of Drug Policy 217 (2009).

Costa, A. M. (2008). Making drug control "fit for purpose": Building on the UNGASS decade. Vienna: United Nations Office of Drugs and Crime.

Costa, A. M. (2010). Drug control, crime prevention and criminal justice: A Human Rights perspective. Vienna: United Nations Office of Drugs and Crime.

Cotton-Oldenburg, N. U., Carr, P., DeBoer, J. M., Collison, E. K., Novotny, G. (2001), Impact of pharmacy-based syringe access on injection practices among injecting drug users in Minnesota, 1998 to 1999. JAIDS 27: 183-192.

Craib, K., Spittal, P., Wood, E., Laliberte, N., Hogg, R., Li, K., Heath, K., Tyndall, M. W., O'Shaughnessy, M. V. and Schechter, M. T. (2003), Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver. Canadian Medical Association Journal; 168(1):19–24.

Curtis, R., Friedman, S. R., Neaigus, A., Jose, B., Goldstein, M., and Ildefonso, G. (1995), Street-level drug markets: Network structure and HIV risk. Social Networks; 17, 229–249.

Csete, J. Gathumbi, A., Wolfe, D., Cohen, J. (2009) Lives to save: PEPFAR, HIV, and injecting drug use in Africa. Lancet 373: 2006-2007.

Davis, C. S., Burris, S., Kraut-Becher, J., Lynch, K.G., and Metzger, D. (2005), Effects of an intensive street-level police intervention on syringe exchange program use in Philadelphia, PA. American Journal of Public Health; 95: 233-6.

Davis, C. S. and Beletsky, L. Bundling occupational safety with harm reduction information as a feasible method for improving police receptiveness to syringe access programs: evidence from three U.S. cities, 6 Harm Reduct J. 16 (2009).

Davis, S. L., Triwahyuono, A., and Alexander R. (2009), Survey of abuses against injecting drug users in Indonesia. Harm Reduction Journal; 6:28.

DeBeck, K., Kerr, T., Li, K., Milloy, M.-J., Montaner, J. and Wood, E. (2009), Incarceration and drug use patterns among a cohort of injection drug users. Addiction; 104: 69–76. DOI: 10.1111/j.1360-0443.2008.02387.x.

Degenhardt, L. et al., Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed, 376 Lancet 285 (2010).

Department of Social Evils (2009), Assessment of effectiveness of treatment for drug addiction and preventive measures, care and treatment for HIV/AIDS at centers for treatment education and social labor in Vietnam. Hanoi, Vietnam: Ministry of Labor, Invalids and Social Affairs.

Deren S., Kang, S.-Y., Col**ó**n, H. M., Andia, J. F., and Robles, R. R. (2004), HIV incidence among high-risk Puerto Rican drug users: a comparison of East Harlem, New York, and Bayamon, Puerto Rico. Journal of Acquired Immune Deficiency Syndromes, 36(5):1067–1074.

Des Jarlais, D. C. (2000), Structural interventions to reduce HIV transmission among injecting drug users. AIDS, 14 (Supplement 1), 41–46.

Des Jarlais, D. C., Hagan, H., Friedman, S. R., Friedman, P., Goldberg, D., Frischer, M., Green, S., Tunving, K., Ljungberg, B., and Wodak, A. (1995), Maintaining low HIV seroprevalence in populations of injecting drug users, 274 JAMA 1226.

Des Jarlais, D. C. and Friedman, S. R. (1990), Shooting galleries and AIDS: Infection probabilities and 'tough' policies. American Journal of Public Health, 80(2), 142–14.

Des Jarlais, D. C., Marmor, M., Paone, D., Titus, S., Shi, Q., Perlis, T., Jose, B., and Friedman, S. R. (1996), HIV incidence among injecting drug users in New York City syringe-exchange programmes. The Lancet; 348(9033):987–991.

Des Jarlais, D. C., K. Arasteh, et al. (2011) "HIV among drug users at Beth Israel Medical Center, New York City, the first 25 years." Subst Use Misuse **46**(2-3): 131-9.

Des Jarlais, D. C. (2010). "Learning from HIV epidemics among injecting drug users " International Journal of Drug Policy **21**(2): 97-99.

Diaz, T., Vlahov, D., Hadden, B., and Edwards, V. (1999), Needle and syringe acquisition among young injection drug users in Harlem, New York City. National HIV Prevention Conference, 654.

Dixon, D. and Maher, L. (2002), Anh Hai: Policing culture and social exclusion in a street heroin market. Policing & Society, 12(2), 93–110.

Doe v. Bridgeport Police Dep't, 198 F.R.D. 325, 328 (D. Conn. 2001).

Dolan, K. and Wodak, A. (1999), HIV transmission in a prison system in an Australian State. Medical Journal of Australia, 171, 14-17.

Dolan, K., E. Khoei, et al. (2007). Prisons and Drugs: A global review of incarceration, drug use and drug services, Beckley Foundation.

Domoslawski, A. (2011). Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use, Open Society Foundations.

Dorn, N. and A. Jamieson (2000). Room for Manoeuvre: Overview of comparative legal research into national drug laws of France, Germany, Italy, Spain, the Netherlands and Sweden and their relation to three international drugs conventions. London, DrugScope.

Dovey, K., Fitzgerald J., and Choi, Y. (2001), Safety becomes danger: dilemmas of drug-

use in public space. Health & Place 7:319-331.

Dolan, K. et al., HIV in prison in low-income and middle-income countries, 7 Lancet Infect Dis 32 (2007).

Drug Policy and Health in Kazakhstan (2002), A Profile Prepared by the Drug Law and Health Policy Resource Network.

Elovich, R. and Drucker, E. (2008), On drug treatment and social control: Russian narcology's great leap backwards. Harm Reduction Journal; 5:23.

Elliott, R., I. Malkin, et al. (2002). Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues, Candadian HIV/AIDS Network.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2002). Prosecution of drug users in Europe — varying pathways to similar objectives. Insights. Lisbon. **5**.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2005), *Illicit drug use in the EU: legislative approaches* available at http://www.emcdda.europa.eu/attachements.cfm/att_34042_EN_TP_IllicitEN.pdf.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) "Country Overview: Georgia." from http://www.emcdda.europa.eu/publications/country-overviews/ge.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) "Country Overview: Belarus." from http://www.emcdda.europa.eu/publications/country-overviews/by.

Estébanez, P., Zunzunegui, M. V., Aguilar, M. D., Russell, N., Cifuentes, I., and Hankins, C (2002), The role of prisons in the HIV epidemic among female injecting drug users. AIDS Care; Feb; 14(1):95–104.

ESVERO (n.d.). "Our Mission." Retrieved June 16, 2011, from http://www.eng.harmreduction.ru/index.shtml.

Evans, E., Anglina, D., Uradaa, D., and Yanga, J. (2011), Promising practices for delivery of court-supervised substance abuse treatment: Perspectives from six high-performing California counties operating Proposition 36. Evaluation and Program Planning 34(2): 124-134.

Festinger David S., et al., Status hearings in drug court: When more is less and less is more, 68 Drug & Alcohol Dependence 151 (2002).

Fischer, B. et al., Drug use, risk and urban order: examining supervised injection sites (SISs) as 'governmentality', 15 Int'l J. Drug Policy 357 (2004).

Friedman, S.R. and Aral, S. (2001), Social Networks, Risk-Potential Networks, Health, and Disease. Journal of Urban Health; 78:411–8.

Friedman S. R., Cooper, H., Tempalski B., Keem, M., Friedman, R., Flom, P. L., and Des Jarlais, D. C. (2006), Relationships of Deterrence and Law Enforcement to Drug-Related Harms Among Injectors in U.S. Metropolitan Areas, AIDS 20 no. 1.

Friedman, S. R., Kottiri, B. J., Neaigus, A., Curtis, R., Vermund, S. H., and Des Jarlais, D. C. (2000), Network-Related Mechanisms May Help Explain Long-Term HIV-1 Seroprevalence Levels That Remain High but Do Not Approach Population-Group Saturation. American Journal of Epidemiology; 152:913–22.

Friedman, S. R., Perlis, T., and Des Jarlais, D. C. (2001), Laws prohibiting over-the-counter syringe sales to injection drug users: Relations to population density, HIV prevalence, and HIV incidence. American Journal of Public Health, 91 (5), 791-793.

Friedman, S. R. et al., Harm reduction theory: Users' culture, micro-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups, 18 Int'l J. Drug Policy 107 (2007).

Frost, L. and Tchertkov, V. (2002), Prisoner risk taking in the Russian Federation. AIDS Education and Prevention; 14, 5 Supplement B: 7-2.

Fuller, C. M., Vlahov, D., Latkin, C. A., Ompad, D. C., Celentano, D. D., and Strathdee, S. A. (2003), Social circumstances of initiation of injection drug use and early shooting gallery attendance: Implications for HIV intervention among adolescent and young adult injection drug users. Journal of Acquired Immune Deficiency Syndromes and Retrovirology, 32(1), 86–93.

Galea, S., J. Ahern, et al. (2001). "Needle Exchange Programs and Experience of Violence in an Inner City Neighborhood." Journal of Acquired Immune Deficiency Syndromes 28(3): 282-288.

Galea, S. and Vlahov, D. (2002), Social Determinants and the Health of Drug Users:

Socioeconomic Status, Homelessness, and Incarceration. Public Health Reports;

117:S135–45.

Galvão, J. Access to antiretroviral drugs in Brazil, 360 Lancet 1862 (2002).

Gleghorn, A. A., Jones, T. S., Doherty, M. C., Celentano, D. D., and Vlahov, D. (1995), Acquisition and use of needles and syringes by injecting drug users in Baltimore, Maryland. Journal of AcquiredImmune Deficiency Syndromes and Retrovirology, 10(1), 97–103.

Global Commission on Drug Policy, Report of the Global Commission on Drug Policy, June 2011.

Grange, J.M. and Zumla, A. (2002), The Global Emergency of Tuberculosis: What Is the Cause? Journal of the Royal Society of Health; 122:78–81.

Graubner, C. How (not) to promote autocracy in Central Asia, Open Society blog, April 11, 2011.

Greenwald, G. (2009) Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies, Cato Institute 2.

Grover, A. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on "The right to health and international drug control, compulsory treatment for drug dependence and access to controlled medicines" A/65/255 (2010).

Grund, J. P. C. (2001), A candle lit from both ends: the epidemic of HIV infection in central and eastern Europe. In HIV and AIDS: International Perspectives, edited by K. McElrath. Westport, CT: Greenwood Press.

Grund, J. P., Stern, L. S., Kaplan, C. D., Adriaans, N. F., and Drucker, E. (1992), Drug use contexts and HIV-consequences: The effect of drug policy on patterns of everyday drug use in Rotterdam and the Bronx. British Journal of Addiction, 87(3), 381–392.

Hagan H. (2003), The relevance of attributable risk measures to HIV prevention planning. AIDS (London, England) 2003; 17:911–913.

Hammett, T. M., Wu, Z., Duc, T. T., Stephens, D., Sullivan, S., Liu, W., et al. (2008). "Social evils" and harm reduction: the evolving policy environment for human immunodeficiency virus prevention among injection drug users in China and Vietnam. Addiction, 103(1), 137-145.

Hammett, T.M., Harmon, M. P., and Rhodes, W. (2002), The Burden of Infectious Disease among Inmates of and Releases from US Correctional Facilities, 1997. American Journal of Public Health; 92:1789–94.

Hammett, T. M. et al., Law enforcement influences on HIV prevention for injection drug users:Observations from a cross-border project in China and Vietnam, 16 Int'l J. Drug Policy 235 (2005).

Hartnoll, R. Heroin maintenance and AIDS prevention: Going the whole way, 4 Int'l J. Drug Policy 36 (1993), updated December 1, 2008, available at http://www.drugtext.org/Opiates-heroin-methadone/heroin-maintenance-and-aids-prevention.html

Hartsock, P. I. (1995), The availability of disposable syringes in Russia. American Journal of Public Health 85:1586.

Heimer, R. & Abdala, N. (2000), Viability of HIV-1 in syringes: Implications for interventions among injection drug users, AIDS Read; 10: 7.

Hilton, B.A. et al. (2001), Harm reduction theories and strategies for control of human immunodeficiency virus: A review of the literature.J. Adv. Nursing 33: 357.

HIV/AIDS Alliance of Ukraine (2010), Law enforcement abuses in the provision of opiate substitution therapy in Ukraine. Kyiv, Ukraine: HIV/AIDS Alliance of Ukraine.

Hogg, R. S., Druyts, E. F., Burris, S., Drucker, E., & Strathdee, S. A. (2008). Years of life lost to prison: racial and gender gradients in the United States of America. *Harm Reduct J, 5*(4), doi:10.1186/1477-7517-1185-1184.

Holden, C. (1999), Stalking a Killer in Russia's Prisons. Science; 286:1670.

Hossain, M. (2000), Injecting drug users, HIV risk behaviour and shooting galleries in Rajshahi, Bangladesh. Drug and Alcohol Review, 19: 413–417. DOI: 10.1080/713659428

Hughes, C. E. and A. Stevens (2010). "What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?" Br J Criminol **50**(6): 999-1022.

Human Rights Watch (2003)(a), Abusing the User: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver (No. Vol 15, No. 2(B)). New York: Human Rights Watch.

Human Rights Watch (2003)(b), Fanning the Flames: How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan (No. Vol. 15, No. 3(D)). New York: Human Rights Watch.

Human Rights Watch (2003)(c), Injecting Reason: Human Rights and HIV Prevention for

Injection Drug Users (No. Vol 15, No, 2(G)). New York: Human Rights Watch.

Human Rights Watch (2003)(d), Locked Doors: The Human Rights of People Living with

HIV/AIDS in China (No. Vol. 14, No. 7(C)). New York: Human Rights Watch.

Human Rights Watch (2004)(a), Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation (No. April 2004, Vol. 16, No. 5(D)). New York: Human Rights Watch.

Human Rights Watch (2004)(b), Not enough graves: the war on drugs, HIV/AIDS and violations of human rights in Thailand. New York: Human Rights Watch.

Human Rights Watch (2006), Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS (New York: Human Rights Watch), vol. 18:2D.

Human Rights Watch (2007), Deadly denial: barriers to HIV/AIDS treatment for people who use drugs in Thailand. New York, USA: Human Rights Watch.

Human Rights Watch (2010). Where darkness knows no limits. New York, USA: Human Rights Watch.

Hunter, G. et al. (2005), The introduction of drug Arrest Referral schemes in London: A partnership between drug services and the police. Int'l J. Drug Policy 16: 343.

Hurley, S. F., Jolley, D. J., and Kaldor, J. M. (1997), Effectiveness of needle-exchange

programmes for prevention of HIV infection. The Lancet, 349, 1797–1800.

Iguchi, M. Y., London, J. A., Forge, N. G., Hickman, L., Fain, T., & Riehman, K. (2002). Elements of Well-Being Affected by Criminalizing the Drug User. Public Health Reports, 117(Supplement 1), S146-S150.

International Harm Reduction Association (IHRA) (2008), Global State of Harm Reduction.

International Harm Reduction Association (IHRA) (2010), Global State of Harm Reduction.

International Harm Reduction Association (IHRA), et al. (2011), Human rights violations associated with Thailand's anti-drug laws. Thailand Submission of the International Harm Reduction Association, Asian Harm Reduction Network, the Open Society Institute Public Health Program, Canadian HIV/AIDS Legal Network and Thai AIDS Treatment Action Group to the UN Universal Periodic Review Twelfth session of the UPR Working Group of the Human Rights Council, Feb. 17, 2011, available at http://www.ttag.info/pdf/Thailand.final.pdf.

International Harm Reduction Association (IHRA)(n.d.), What is harm reduction? available at http://www.ihra.net/files/2010/05/31/IHRA_HRStatement.pdf.

International Drug Policy Consortium (IDPC) (2010). Drug Policy Guide. London.

International Drug Policy Consoritum (IDPC) (2011), *IDPC Report - First IDPC seminar on drug policy in the Middle East and North Africa* available at http://www.idpc.net/it/node/1480,

International Drug Policy Consortium (IDPC) (2011), *Polish Drug Law Reform Goes Forward, April 11, 2011* available at http://www.idpc.net/alerts/polish-parliament-amends-drug-law.

International Drug Policy Consortium (IDPC) (2011). "Count the costs: 50 years of the war on drugs." Retrieved June 16, 2011, from http://www.idpc.net/alerts/count-the-costs.

International Network of People who Use Drugs (2010). 2010 Annual Report.

Jelsma, M. (2010). Drug Law Reform Trend in Latin America, TNI.

Jones, L. et al. (2010), Optimal provision of needle and syringe programs for injecting drug users: A systematic review, Int'l J. Drug Policy 21: 335.

Jürgens R., Csete J., Amon J.J., Baral S., and Beyrer C. (2010), People who use drugs, HIV, and human rights. The Lancet, 376, 475 - 485; DOI:10.1016/S0140-6736(10)60830-6.

Jürgens, R. Interventions to reduce HIV transmission related to injecting drug use in prison, 9 Lancet Infect Dis 57 (2009).

Kamarulzaman, A. (2009), Impact of HIV prevention programs on drug users in Malaysia. Journal of Acquired Immune Deficiency Syndrome 52(S1):17-19.

Kelsall, J., Lloyd, S., Crofts, N. (2002), National Injecting Equipment Disposal Study. AIVL, Canberra; available at http://www.aivl.org.au/files/AIVLNationalDisposalStudyReport.pdf.

Kendall, P. R. W. (2011). Decreasing HIV infections among people who use drugs by injection In British Columbia: Potential explanations and recommendations for further action. Vancouver, Office of the Provincial Health Officer.

Kerr, J. et al., The dedicated drug courts pilot evaluation process study, United Kingdom Ministry of Justice Research Series (January, 2011), available at http://www.justice.gov.uk/publications/docs /ddc-process-evaluation-study.pdf

Kerr, T., Small W., and Wood E, The public health and social impacts of drug market enforcement: A review of the evidence. International Journal of Drug Policy - August 2005 (Vol. 16, Issue 4, Pages 210-220, DOI: 10.1016/j.drugpo.2005.04.005).

Kerr, T. et al. (2007), The role of safer injection facilities in the response to HIV/AIDS among injection drug users. Current HIV/AIDS Reports 4:158.

Khudobin V. Russia. 59696/00. Strasbourg, France: The European Court of Human Rights (Third Section); 2007.

Kimber, J. and Dolan, K. (2007), "Shooting gallery operation in the context of establishing a medically supervised injecting center: Sydney, Australia" Journal of Urban Health, 84 (2), pp 255-266.

Koester, S. (1996). The prevalence of additional injection-related HIV risk behaviors among injection drug users. Journal of Acquired Immune Deficiency Syndromes, 12(2), 202-207.

Koester, S. (1994), Copping, running, and paraphernalia laws: Contextual variables and needle risk behavior among injection drug users in Denver. Human Organization, 53(3), 287–295.

Koester, S. (2008), The Disconnect between China's Public Health and Public Security Responses to Injection Drug Use, and the Consequences for Human Rights. PLoS Med 5(12): e240. doi:10.1371/journal.pmed.0050240

Kools, J.-P. (2008). *Drug Use and HIV risk among young people in sub-Saharan Africa*. Amsterdam: Stop AIDS Now.

Kothari, G. et al., (2002), Opportunities and obstacles for effective treatment of drug misusers in the criminal justice system in England and Wales, Brit. J. Criminology 42(412).

Kottiri, B.J., Friedman, S. R., Neaigus, A., Curtis, R., and Des Jarlais, D. C. (2002), Risk Networks and Racial/Ethnic Differences in the Prevalence of HIV Infection among Injection Drug Users. Journal of Acquired Immune Deficiency Syndromes; 30:95–104.

Krebs, C. P., & Simmons, M. (2002). Intraprison HIV transmission: an assessment of whether it occurs, how it occurs, and who is at risk. AIDS Education & Prevention, 14(5 Suppl B), 53-64.

Kreit, A. (2009), Toward a Public Health Approach to Drug Policy. *Advance: The Journal of the American Constitution Society Issue Groups* 3: 43

Krusi, A., Wood, E., Montaner, J., and Kerr, T. (2010), Social and structural determinants of HAART access and adherence among injection drug users. International Journal of Drug Policy; 21: 4-9.

Johnson, B. D., A. Golub, et al. (2006). "Nonimpact of the Expanded Syringe Access Program Upon Heroin Use, Injection Behaviours, and Crime Indicators in New York City and State" Justice Research and Policy; 8(1): 24.

Larney, S. (2010) Does opioid substitution treatment in prisons reduce injecting-related HIV risk behaviours? A systematic review. Addiction; 105 (2): 216–223.

Latin American Commission on Drugs and Democracy (2009). *Drugs and Democracy : Toward a Paradigm Shift*.

Latypov, A., D. Otiashvili, et al. (2010). Opioid Substitution Therapy in Central Asia: Towards Diverse and Effective Treatment Options for Drug Dependence.

Levine, H.G. (2002), The secret of worldwide drug prohibition: The varieties and uses of drug prohibition, The Independent Review ; 7(165).

Lines, R. Death penalty for drug offences: A violation of international human rights law, presented at Commission on Narcotic Drugs, 51st Session (2008), available at http://www.ihra.net/files/2010/06/21/Lines-DeathPenaltyCND2008.pdf

Lines, R., Jürgens, R., Betteridge, G., Stöver, H., Laticevschi, D., and Nelles, J. (2006), Prison Needle Exchange: Lessons from A Comprehensive; Review of International Evidence and Experience, 2 ed. Canadian HIV/AIDS Legal Network, available at http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1173.

Lines, R. (2011) Deliver us from Evil? The Single Convention on Narcotic Drugs, 50 Years On. 1 Intl J. on Hum. Rights and Drug Policy, 3-13.

Long, J., Allwright. S., Barry, J., Reynolds, S., Thornton, L., Bradley, F., Parry, J., and Bird, S. (2001), Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in entrants to Irish prisons: a national cross sectional survey. British Medical Journal; 323(7323):1209–1213. DOI: 10.1136/bmj.323.7323.1209.

Lovell, A. M. (2002), Risking risk: the influence of types of capital and social networks on the injection practices of drug users. Social Science & Medicine 55:803-821.

Loxley, W. Doing the possible: harm reduction, injecting drug use and blood borne viral infections in Australia, 6 Int'l J. Drug Policy 407 (2000).

Lurie, P. and Drucker, E. (1997), An opportunity lost: HIV infections associated with lack of a national needle-exchange programme in the USA. The Lancet; 349: 604–608.

MacCoun, R. J., & Reuter, P. (2001). *Drug War Heresies: Learning from Other Vices, Times and Places*. Cambridge: Cambridge University Press.

Maher, L. and Dixon, D. (1999), Policing and public health: Law enforcement and harm minimization in a street-level drug market. British Journal of Criminology, 39(4), 488–512.

Maher, L. and Dixon, D. (2001), The cost of crackdowns: Policing Cabramatta's heroin market.Current Issues in Criminal Justice, 13(1), 5–22.

Malinowska-Sempruch, K., Hoover, J., and Alexandrova, A. (2001), Unintended Consequences: Drug Policies Fuel the HIV Epidemic in Russia and Ukraine, Open Society Institute, New. York.

Malinowska-Sempruch, K. Poland steps towards more liberal drug policy, Open Society blog, May 26, 2011. Available at http://blog.soros.org/author/kasia-malinowska-sempruch/.

Maron, E. (2010), Assessment of HIV treatment barriers in 20 Russian cities. St Petersburg, Russia: SIMONA.

Maru, V. (2003), Ravaging the Vulnerable: Abuses Against Persons at High Risk of HIV Infection in Bangladesh. Vol. 15. New York: Human Rights Watch :6(C).

Marx, M. A., B. Crape, et al. (2000). "Trends in crime and the introduction of a needle exchange program." Am J Public Health 90(12): 1933-1936.

Mason, M. (2007). "Collaborative partnerships for urban development: a study of the Vancouver Agreement. ." Environment & Planning A. 39(10): 2366-2382.

Mathers, B. et al., HIV prevention, treatment, and care services for people who inject drugs: A systematic review of global, regional, and national coverage, 375 Lancet 1014 (2010).

McCann, E. (2008). "Expertise, truth, and urban policy mobilities: global circuits of knowledge in the development of Vancouver, Canada's `four pillar' drug strategy." Environment & Planning A. 40: 885-904.

McGlinchey et al. V. United Kingdom. Appln No 50390/99. Strasbourg, France: The European Court of Human Rights; 2003.

Médecins du Monde (2008), Living but not well: health and social status report of injection drug users in Chengdu, China. Chengdu, China: Médecins du Monde France.

Mendelevich, P. T. V. (2006), Fighting for drug substitution treatment. The Lancet; 368: 279.

Metzger, D. S., H. Navaline, et al. (1998). "Drug Abuse as AIDS Prevention." Public Health Rep. 113(Supp. 1): 97-106.

Milloy, M.J., Buxton, J., Wood, E., Li, K., Montaner, J. S., and Kerr, T. (2009), Elevated HIV risk behavior among recently incarcerated injection drug users in a Canadian setting: a longitudinal analysis. BMC Public Health; 9:156.

Midford et al., Cops, drugs and the community: Establishing consultative harm reduction structures in two Western Australian locations, 13 Int'l J. Drug Policy 185 (2002).

Mikhailov, A.G. 2003. *Newsletter*. edited by R.F.D.C. Service. Moscow.

Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004). Actual causes of death in the United States, 2000. *JAMA, 291*(10), 1238-1245.

Mortimore, G., H. Cripps, et al. (2011). Annual Report, 2010, International Network of People who Use Drugs.

National Academy of Sciences (Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries), Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence (Washington, DC: National Academies Press, 2006).

Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995), Gender differences in drug addiction and treatment: implications for social work intervention with substance-abusing women. 40 Social Work 45-54.

New York State Assc. of Chiefs of Police, I. (2010). Syringe Law and Harm Reduction Programs in New York State Information for Law Enforcement. New York State Assc. of Chiefs of Police, Inc. I. New York State Assc. of Chiefs of Police. Schenectady, New York State Association. ver 09/16/2010.

New Zealand Law Commission, Controlling and Regulating Drugs: A Review of the Misuse of Drugs Act 1975 (2011).

Normand J., Vlahov, D., and Moses, L. E. (editor) (1995), In Preventing HIV transmission (the role of sterile needles and bleach). Washington, DC: National Academy Press.

Nougier, M. (2011), First IDPC seminar on drug policy in the Middle East and North Africa. IDPC, available at http://www.idpc.net/sites/default/files/library/IDPC%20report%20on%20MENA%20seminar%20FINAL%20web_0.pdf.

O'Donnell, C. and Trick, M. (2006), Methadone Maintenance Treatment and the Criminal Justice System. Washington, D.C. National Association of State Alcohol and Drug Abuse Directors (NASADAD). http://nasadad.org/resources/MethMaintenance%20Issue%20Brief%20Apr06.pdf

Okie, S. (2007), Sex, drugs, prisons, and HIV. New England Journal of Medicine, 356(2), 105-108.

Oinam, A. (2008), Exploring the links between drug use and sexual vulnerability among young female injecting drug users in Manipur. New Delhi: Population Council.

Open Society Institute, 2001. Directory: Harm Reduction Programs in Eastern Europe and the Former Soviet Union. Available at http://www.soros.org/harm-reduction/resourceguide/ text/IHRD7.html (accessed April 10, 2011).

Open Society Institute, 2003. International Harm Reduction Development Program. Unintended Consequences: Drug Policies Fuel the HIV Epidemic in Russia and Ukraine.

Open Society Institute, 2006. Harm Reduction Developments 2005: Countries with Injection Driven Epidemics. New York, NY: International Harm Reduction Development Program.

Open Society Institute, 2008(a). Barriers to Access: Medication-Assisted Treatment and Injection-Driven HIV Epidemics. New York, NY: International Harm Reduction Development Program.

Open Society Institute (2008)(b). Police, Harm Reduction, and HIV. International Harm Reduction Development Program.

Open Society Institute (2009). At What Cost? HIV and Human Rights Consequences on the Global War on Drugs. International Harm Reduction Development Program. [Note: Utyasheva and Elliott, Effects of UN and Russian Influence on Drug Policy in Central Asia, pp.78-110].

Open Society Institute (2011). Reassessing the Role of OSCE Police Assistance Programing in Central Asia. Open Society Central Eurasia Project. (David Lewis).

Pandey, I., Davis, C. S., and Burris, S. (2009), Unkept Promises: 'Law on the Books' and High Risk Populations in Thailand.

Parfitt, T. (2011). Russia defies growing consensus with declaration of 'total war on drugs': Under new laws being drawn up addicts would be forced into treatment or jailed, and dealers 'treated like serial killers'. *The Guardian*. June 8.

Parry, C.D.H., Carney, T., Petersen, P., Dewing, S., and Needle, R. (2009), HIV-Risk Behavior Among Injecting or Non-Injecting Drug Users in Cape Town, Pretoria, and Durban, South Africa. Substance Use & Misuse, 44:886–904.

Peak, Maitland J. "Aaron,""Summary of Fact Finding Mission to Kazakhstan," Eurasia Policy Forum, Eurasianet.org for Soros Foundation, Open Society Institute, International Harm Reduction Development Program, July 25, 2001.

Philbin, M. M., Mantsios, A., Lozada, R., Case, P., Pollini, R.A., Alvelais, J., Magis-Rodriguez, C.and Strathdee, S. A. (2009), Exploring stakeholder perceptions of acceptability and feasibility of needle exchange programmes, syringe vending machines and safer injection facilities in Tijuana, Mexico. Int J Drug Policy; 20:329–335.

PHS Community Services Society v. Canada (Attorney General), 2010 BCCA 15 (B.C. Court of Appeal)

Pinkerton, S. D., Galletly, C. L., & Seal, D. W. (2007). Model-Based Estimates of HIV Acquisition Due to Prison Rape. Prison J, 87(3), 295-310.

Pollini, R. A., Brouwer, K. C., Lozada, R. M., Ramos, R., Cruz, M.F., Magis-Rodriguez, C., Case, P., Burris, S., Pu, M., Frost, S. D., Palinkas, L. A., Miller, C., Strathdee, S. A. (2008), Syringe possession arrests are associated with receptive sharing in two Mexico-US border cities. Addiction, 103(1):101–108.

Racz, J., Gyarmathy, V. A., Neaigus, A., & Ujhelyi, E. (2007). Injecting equipment sharing and perception of HIV and hepatitis risk among injecting drug users in Budapest. AIDS Care, 19(1), 59-66.

Reid, G., Kamarulzaman, A., and Sran, S. K. (2007), Malaysia and harm reduction: the challenges and responses. International Journal of Drug Policy, 18:136-40.

Reyes, J. C., Robles, R. R., Colon, H.M., Freeman, D.H., Sahai, H. and Matos TD. (1996), Risk factors for shooting gallery use among drug injectors in Puerto Rico. Puerto Rican Health Sciences Journal; 15(3):227–231.

Rhodes, T., M. Simić, et al. (2008). "Police violence and sexual risk among female and transvestite sex workers in Serbia: qualitative study." BMJ 337.

Rhodes, T. (2002), The "Risk Environment": A Framework for Understanding and Reducing Drug-Related Harm. International Journal of Drug Policy; 13:85–94.

Rhodes, T., Mikhailova, L., Sarang, A., Lowndes, C. M., Rylkov, A., Khutorskoy, M., Renton, A. (2003), Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City Russian Federation: A qualitative study of micro risk environment. Social Science and Medicine, 57(1), 39–54.

Rhodes, T. et al., (2004) Injecting equipment sharing among injecting drug users in Togliatti City, Russian Federation, 35 J. Acquir Immun Defic Syndr 293.

Rhodes, T., Platt, L., Sarang, A., Mikhailova, L., and Monaghan, G. (2006), Street policing, injecting drug use and harm reduction in a Russian city: a qualitative study of police perspectives. Journal of Urban Health; 83:911-92.

Richie, B. E., Freudenberg, N., & Page, J. (2001). Reintegrating women leaving jail into urban communities: a description of a model program. Journal of Urban Health, 78(2), 290-303.

Roe v. City of New York, 232 F. Supp. 2d 240, 246–47 (S.D.N.Y. 2002).

Roberts, A., B. Mathers, et al. (2010). Women who inject drugs: A review of their risks, experiences and needs. Syndey, Secretariat of the Reference Group to the United Nations on HIV and Injecting Drug Use.

Rogers, A.B. et al., A comprehensive approach: preventing blood-borne infections among injection drug users, Academy for Educational Development 1 (December 2000), available at http://www.cdc.gov/idu/pubs/ca/comprehensive-approach.pdf

Rotily, M., Weilandt, C., Bird, S. M., Kall, K., Van Haastrecht, H. J., Iandolo, E., and Rousseau, S. (2001), Surveillance of HIV Infection and Related Risk Behaviour in European Prisons. A Multicentre Pilot Study. European Journal of Public Health; 11:243–50.

Russian Federation (2009). Strategy for the Implementation of the National Anti-Drug Policy of the Russian Federation in the Period Until 2020, available at http://stratgap.ru/pages/strategy/3662/4434/4437/index.shtml.

Sabin, L. L., Desilva, M. B., Hamer, D.H., Keyi, X., Yue, Y., Wen, F., Tao, L., Heggenhougen, H. K., Seton, L., Wilson, I. B., and Gill, C. J. (2008), Barriers to adherence to antiretroviral medications among patients living with HIV in southern China: a qualitative study. AIDS Care; 20: 1242-1250.

Sarang, A., T. Rhodes, et al. (2006). "Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions: qualitative study." Addiction 101: 1787-1796.

Sarang, A., T. Rhodes, et al. (2010). "Policing drug users in Russia: risk, fear, and structural violence." Subst Use Misuse 45(6): 813-864.

Savary, J., C. Hallam, et al. (2009). "The Swiss Four Pillars Policy: An Evolution from Local Experimentation to Federal Law."

Schleifer, R. (2006), Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS. New York, USA: Human Rights Watch.

Schmitt, G.R. Drug courts: The second decade, Nat'l Inst. Just. 1 (June 2006), available at http://www.ncjrs.gov/pdffiles1/nij/211081.pdf

Seal, D., Belcher, L., Morrow, K., G, Binson, D., Kacanek, D., Margolis, A., et al. (2004). A qualitative study of substance use and sexual behavior among 18- to 29-year-old men while incarcerated in the United States. *Health Education & Behavior, 31*(6), 775-789.

Shields, A. (2009), The Effects of Drug User Registration Laws on People's Rights and Health: Key Findings From Russia, Georgia, and Ukraine. International Harm Reduction Development Program, Open Society Institute.

Shannon, K., T. Kerr, et al. (2008). "Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work." Social Science & Medicine 66: 911-921.

Shannon, K. and J. Csete (2010). "Violence, condom negotiation, and HIV/STI risk among sex workers." JAMA 304(5): 573-4.

Shirk, D. (2011). The Drug War in Mexico: Confronting a Shared Threat. Council Special Report. New York, Council on Foreign Relations.

Seal, D., Belcher, L., Morrow, K., G, Binson, D., Kacanek, D., Margolis, A., et al. (2004). A qualitative study of substance use and sexual behavior among 18- to 29-year-old men while incarcerated in the United States. Health Education & Behavior, 31(6), 775-789.

Small, D., A. Palepu, et al. (2005). "The establishment of North America's first state sanctioned supervised injection facility: A case study in culture change." International Journal of Drug Policy 17: 73-82.

Small, W., Kain, S., Laliberte, N., Schechter, M. T., O'Shaughnessy, M. V., and Spittal, P. M. (2005), Incarceration, addiction and harm reduction: inmates experience injecting drugs in prison. Substance Use Misuse; 40(6):831-43.

Small, W., Kerr, T., Charette, J., Wood, E., Schechter, M. T., and Spittal, P. M. (2005), Impact of intensified police activity upon injection drug users in Vancouver's Downtown Eastside: Evidence from an ethnographic investigation. International Journal of Drug Policy 7(2), 85.sol

Sobeyko, J., Leszczyszyn-Pynka, M., Duklas, T., Parczewski, M., Bejnarowicz, P., Burris, S. C., et al. (2006). Bridging the Gaps between Needs and Services in the Health and Criminal Justice Systems: Szczecin Rpar Final Report and Recommendations. Szczecin, Poland: RPAR. Available at http://www.temple.edu/lawschool/phrhcs/rpar/about/RPAR%20and%20RAR%20Reports%20and%20Presentations/RPAR%20POLAND%20FINAL%20REPORT.pdf

Solivetti, L. (2001). Drug Use Criminalization v. Decriminalization: An Analysis in the Light of the Italian Experience. Rome.

Stimson, G.V. (1995). AIDS and injecting drug use in the United Kingdom, 1987–1993: The policy response and the prevention of the epidemic, *Social Science & Medicine* 41 (5): 699–716.

Stinchcomb, J. (2010). "Conceptual foundation, empirical findings, and policy implications. ." Drugs: education, prevention and policy 17(2): 148-167.

Stover, H. and I. Michels (2010). "Drug use and opioid substitution treatment for prisoners." Harm Reduct J **7**(17).

Strathdee, S. A., Hallett, T. B., Bobrova, N., Rhodes, T., Booth, R., Abdool, R., and Hankins, C. A. (2010), HIV and risk environment for injecting drug users: the past, present, and future. The Lancet; 376(9737):268-84.

Strathdee, S. A., Noya, G., Mahboobeh, S., Celentano, D. D., Vlahov, D., Johnson, L. and Nelson, K. E. (2001), Sex differences in risk factors for HIV seroconversion among injection drug users: a 10-year perspective. Arch Intern Med.;161(10):1281-1288.

Strathdee, S. A., et al., Social and structural factors associated with HIV infection among female sex workers who inject drugs in the Mexico-US border region, 6 PloS ONE 4 (2011), available at http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0019048

Strathdee, S. A., Fraga, W. D., Case, P., Firestone, M., Brouwer, K. C., Perez, S. G., et al. (2005). "Vivo para consumirla y la consumo para vivir" ["I live to inject and inject to live"]: high-risk injection behaviors in Tijuana, Mexico. Journal of Urban Health, 82(3 Suppl 4), iv58-73.

Struthers, M. and Csete, J. (2003), Fanning the Flames: How Human Rights Abuses are Fueling the AIDS Epidemics in Kazakhstan. New York, NY: Human Rights Watch.

Sydney Medical Supervised Injecting Centre Fact Sheet (2010) available at http://www.leahrn.org/wp-content/uploads/2010/03/fact-sheets-msic_singles-oct-2010.pdf.

Taussig, J. A., Weinstein, B., Burris, S., & Jones, T. S. (2000), Syringe laws and pharmacy regulations are structural constraints on HIV prevention in the US. AIDS, 14 (Supplement 1), S57–S63.

Taylor, A., Goldberg, D., Emslie, J., Wrench, J., Gruer, L., Cameron, S., Black, J., Davis, B., McGregor, J., and Follett, E. (1995), Outbreak of HIV Infection in a Scottish Prison. British Medical Journal; 310:289–92.

Taylor, A.L. 2007). Addressing the global tragedy of needless pain: Rethinking the United Nations Single Convention on Narcotic Drugs, J Law Med Ethics 35:556.

Teplinskaya, I. (2010) On November 14, 2010 Aleksey Kurmanaevsky, a drug user, filed a lawsuit against Russia to the European Court of Human Rights. Eurasian Harm Reduction Network News.

Thomas, G. Harm reduction policies and programs for persons involved in the criminal justice system, Canadian Centre on Substance Abuse 1 (May 2005), available at http://www.ccsa.ca/2005%20CCSA%20Documents/ccsa-003900-2005.pdf

Tinajero, J. H. and C. Z. Angles (2009). Mexico: The Law Against Small-Scale Drug Dealing. Series on Legislative Reform of Drug Policies Washington, D.C., TNI: 1-8.

Tompkins, C. N. E., Sheard, L., Wright, N. M. J., Jones, L., Howes, N. (2006), Exchange, deceit, risk and harm: the consequences for women of receiving injections from other drug users. Drugs: Education, Prevention, and Policy; 13: 281-297.

Trebucq, A. (1999), Tuberculosis in Prisons. The Lancet; 353:2244–5.

Thompson, D., (2005). "The 'people's war' Against Drugs and HIV," China Brief 5 no. 14 (Washington, D.C.: The Jamestown Foundation).

Tibbetts, J. Supreme Court to decide future of safe injection facilities, Vancouver Sun (June 25, 2010), available at http://www.canada.com/vancouversun/news/westcoastnews/story.html?id=be747a7e-1dc3-436c-8c3e-9a7ec24d60f3

Transnational Institute (TNI) (2011) Systems Overload: Drug Laws and Prisons in Latin America. Amsterdam, Transnational Institute.

Tyndall, M. W., Currie, S., Spittal, P., Li, K., Wood, E., O'Shaughnessy, M. V., and Schechter, M. T. (2008), Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic. AIDS (London, England) 2003;17:887–893.

UNAIDS (1997), "Prisons and AIDS: UNAIDS point of view."

UNAIDS and World Health Organization (2002), AIDS Epidemic Update: Geneva.

UNAIDS (2009), Regional Consultation on Role of Police and Law Enforcement in AIDS Response in Asia and the Pacific, available at http://www.leahrn.org/wp-content/uploads/2010/03/Report_Police-Workshop_August-3_reviewedfinal.pdf

UNODC (2004), Substance abuse treatment and care for women: case studies and lessons learned. Vienna: United Nations.

UNODC, WHO, et al. (2006). HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response. New York, United Nations.

UNODC (2007), Why Central America is vulnerable to crime. Vienna: United Nations.

UNODC (2010), Drug control, crime prevention and criminal justice: A Human Rights perspective", 53rd Session of the Commission on Narcotic Drugs, Vienna.

UNODC (2010). Accessibility of HIV Prevention, Treatment, and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkemenistan, and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform. R. O. f. C. Asia. Tashkent, United Nations Office on Drugs and Crime, Regional Office for Central Asia.

UNODC (2010). World Drug Report. Vienna: United Nations.

UNDP (2004), Thailand's Response to HIV/AIDS: Progress and Challenges (Thematic MDG Report). Bangkok.

United States President's Emergency Plan for AIDS Relief, Comprehensive HIV Prevention for People who Inject Drugs, Revised Guidelines (July 2010) available at http://www.pepfar.gov/guidance/combinationprevention/combprevidu/index.htm .

Urban Health Research Initiative of the British Columbia Centre for Excellence in HIV/AIDS and the Thai AIDS Treatment Action Group (TTAG), Reducing Drug-Related Harm in Thailand: Evidence and Recommendations from the Mitsampan Community Research Project, September 2011.

Vienna Convention 2010

Vocal-NY Users Union, & Urban Justice Institute (2010). *Stuck in the System: Eanding Syinge Access by Reconciling the Penal Code with the Public Health Law*. New York City: New York City AIDS Housing Network

Vychavka, O. (2010), Problem of prophylaxis of HIV infection and AIDS in Ukrainian penitentiary system. Kyiv, Ukraine: College of the Ministry of Health.

Vyshemirskaya, I., Osipenko, V., Koss, A., Burkhanova, O., Lazzarini, Z., Burris, S., Case, P. and Chintalova-Dallas, R. (2008), HIV and Drug Policy in Kaliningrad: Risk, Silence and the Gap Between Human Needs and Health Services.

Ware, N. C., Wyatt, M. A., & Tugenberg, T. (2005). Adherence, Stereotyping And Unequal HIV Treatment For Active Users Of Illegal Drugs. Social Science & Medicine, 61(3), 565-576.

Wang, H., He, G., Li, X., Yang, A., Chen, X., Fennie, K. P., and Williams, A. B. (2008), Self-reported adherence to antiretroviral treatment among HIV-infected people in Central China.AIDS Patient Care STDS; 22: 71-80.

Weinstein, B., Toce, P., Katz, D., and Ryan, L. L. (1998), Peer education of pharmacists and supplying pharmacies with IDU packets to increase injection drug users' access to sterile syringes in Connecticut. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 18 (Supplement 1), S146–S147.

Werb D., Kerr, T., Small, W., Li, K., Montaner, J., and Wood, E. (2008), HIV risks associated with incarceration among injection drug users: implications for prison-based public health strategies. Journal of Public Health (Oxford, England).

Werb, D., Wood, E., Small, W., Strathdee, S., Li, K., and Montaner, J. (2008), Effects of police confiscation of illicit drugs and syringes among injection drug users in Vancouver. Int J Drug Policy; 19:332-8.

Wodak, A. and McLeod, L. (2008), The role of harm reduction in controlling HIV among injection drug users, AIDS 22: S81.

Wodak, A. (2011), Demand Reduction and Harm Reduction. Working Paper; Geneva, Global Commission on Drug Policies.

Wolfe, M. I., Xu, F., Patel, P., O'Cain, M., Schillinger, J. A., St Louis, M. E., et al. (2001). An outbreak of syphilis in Alabama prisons: correctional health policy and communicable disease control. American Journal of Public Health, 91(8), 1220-1225.

Wolfe, D (2007), Paradoxes in antiretroviral treatment for injecting drug users: access, adherence and structural barriers in Asia and the former Soviet Union. Int J Drug Policy; 18: 246-254.

Wolfe, D., Carrieri, P., and Shepard, D. (2010), Treatment and care for HIV-infected injecting drug users: a review of barriers and way forward. The Lancet; 376:355-366.

Wolfe, D. and Cohen, J. (2010), Human rights and HIV prevention, treatment, and care for people who inject drugs: key principles and research needs. Journal of Acquired Immune Deficiency Syndrome, 2010; 55 Supplement 1: S56-62.

Wolfe, D. and Malinowska-Sempruch, K. (2004), Illicit drug policies and the global HIV epidemic: Effects of UN and National Government approaches. New York: Open Society Institute.

Wolfe, D. and Saucier, R. (2009), At What Cost? HIV and Human Rights Consequences of the Global "War on Drugs". New York, NY: Open Society Institute.

Wolfe, D. and Saucier, R. (2010), In rehabilitation's name: ending institutionalized cruelty and degrading treatment of people who use drugs. International Journal of Drug Policy; 21: 145-146

Wolfe, D. (2005). Pointing the Way: Harm Reduction in Kyrgyz Republic, OSI NY and Soros Foundation Kyrgyzstan

Wolfe, M. I., F. Xu, et al. (2001). "An outbreak of syphilis in Alabama prisons: correctional health policy and communicable disease control." American Journal of Public Health 91(8): 1220-1225.

Wood, E., T. Kerr, et al. (2009). "Longitudinal community plasma HIV-1 RNA concentrations and incidence of HIV-1 among injecting drug users: prospective cohort study." BMJ 338.

Wood, E., Kerr, T., Small, W., Jones, J., Schechter, M. T., and Tyndall, M. W. (2003), The impact of police presence on access to needle exchange programs. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 34(1), 116–118.

Wood, E., Kerr, T., Spittal, P. M., Tyndall, M. W., O'Shaughnessy, M.V., and Schechter, M. T. (2003), The healthcare and fiscal costs of the illicit drug use epidemic: The impact of conventional drug control strategies and the impact of a comprehensive approach. British Columbia Medical Journal, 45(3), 130–136.

Wood, E., Kerr, T., Tyndall, M.W., Montaner, J.S. (2008), A review of barriers and facilitators of HIV treatment among injection drug users. AIDS ; 22: 1247-1256.

Wood, E., Li, K., Small, W., Montaner, J.S., Scheter, M.T., and Kerr, T. (2005), Recent incarceration independently associated with syringe sharing by injection drug users. Public Health Reports;120:150–6.

Wood, E., Tyndall, M. W., Spittal, P. M., Li, K., Anis, A. H., Hogg, R. S., et al. (2003), Impact of supply-side policies for control of illicit drugs in the face of the AIDS and overdose epidemics: Investigation of a massive heroin seizure. Canadian Medical Association Journal, 168(2), 165–169.

Wood, E., Tyndall, M. W., Stoltz, J.-A., Small, W., Lloyd-Smith, E., Zhang, R., Montaner, J. S. G. and Kerr, T (2005), Factors associated with syringe sharing among users of a medically supervised safer injecting facility. American Journal of Infectious Diseases; 1: 50-54.

Wood E., et al., Vienna Declaration: A call for evidence-based drug policies, 376 Lancet 310 (2010).

Wood, E., M. W. Tyndall, et al. (2006). "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility " Can Med Assoc J 175(11).

Wood, J., Swanson, J., Burris, S., & Gilbert, A. (2011). *Police interventions with persons affected by mental illnesses: A critical review of global thinking and practice*. New Brunswick: Center for Behavioral Health Services & Criminal Justice Research, Rutgers University.

Wood, R. A., Zettel, P., and Stewart, W. (2003), Harm reduction nursing practice: The Dr. Peter Centre supervised injection project. Canadian Nurse, 99(5), 20–24.

World Health Organization, (1993), WHO Guidelines on HIV Infection and AIDS in Prisons.

World Health Organization and UNAIDS (1993). "WHO Guidelines on HIV and AIDS in Prison."

World Health Organization (2004), Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention, WHO/UNODC/UNAIDS position paper available at http://www.unodc.org/documents/hivaids/Position%20Paper%20sub.%20maint.%20therapy.pdf.

World Health Organization (2006), WHO HIV/AIDS Programme: Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach. 2006 revision.

World Health Organization, United Nations Office on Drugs and Crime, et al. (2007). Interventions to Address HIV in Prisons: Comprehensive Review. Evidence for Action Technical Paper. Geneva, World Health Organization.

World Health Organization Western Pacific Region (2009), Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights.

World Health Organization, United Nations Office of Drug Control, and UNAIDS (2009). Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users available at http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf

World Health Organization (2011) WHO Model List of Essential Medicines, 17th list.

World Health Organization (n.d.) "Health topics: Essential Medicines." from http://www.who.int/topics/essential_medicines/en/.

Wu, Z., Sullivan, S. G., Wang, Y., Rotheram-Borus, M. J., & Detels, R. (2007). Evolution of China's response to HIV/AIDS. *Lancet, 369*(9562), 679-690.

Yakovenko V. Ukraine. 15825/06. Strasbourg, France: The European Court of Human Rights (Fifth Section); 2008.

Zachariah, R., Harries, A. D., Chantulo, A. S., Yadidi, A. E., Nkhoma, W., & Maganga, O. (2002). Sexually transmitted infections among prison inmates in a rural district of Malawi. Transactions of the Royal Society of Tropical Medicine & Hygiene, 96(6), 617-619.

Zule, W. A. (1992). Risk and reciprocity: HIV and the injection drug user. Journal of Psychoactive Drugs, 24(3), 243–249.