# RESPONDING TO GLOBAL HIV/AIDS

# &

# INJECTION DRUG USE

# RESPONDING TO GLOBAL HIV/AIDS
# &
# INJECTION DRUG USE

By

GEETANJALEE KHOSLA
(Hon. B.A., Hon. B.S.W.)

A Thesis Submitted to the School of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree

Master of Social Work

McMaster University

MASTER OF SOCIAL WORK & SOCIAL WELFARE POLICY
(2004)

McMaster University
Hamilton, Ontario

TITLE: Responding to Global HIV/AIDS & Injection Drug Use

AUTHOR: Geetanjalee Khosla, Honours B.A., Honours B.S.W.

SUPERVISOR: Dr. Bill Lee

NUMBER OF PAGES: ix, 81

**MCMASTER UNIVERSITY**
**ABSTRACT**

# RESPONDING TO GLOBAL HIV/AIDS & INJECTION DRUG USE

by Geetanjalee Khosla

Internationally, HIV and injection drug use (IDU) are emerging under conditions of poverty, high unemployment, punitive drug-policies, and inadequate health care. Often lacking access to basic services, information about HIV, and social-economic opportunities, infection is often transmitted unknowingly by injection drug users (IDUs) to their sexual partners. This makes the epidemic difficult to contain, creating an AIDS pandemic. This paper reflects on the key health and development issues that emerge in preventing growing HIV infection among IDUs. The essential arguments are twofold. First, HIV and IDU are more than individual health issues, but rather complex development problems based in social situations and structures that further enable conditions of HIV infection and IDU. Second, from a public health and legal standpoint, IDUs are vulnerable citizens who are entitled to care. When their rights are not promoted and protected, the impact of infections and diseases on individuals and communities is worse and difficult to contain. A rights based approach (RBA) is then explored, which moves beyond simply providing services to meet human needs and uses a human rights perspective to health and development to strengthen the individual ability to demand such services. The suggested way forward is that responses should include the provision of a wide range of treatment and care options, social economic development to encourage social and economic security, and reform in the arenas of drug, welfare and economic policies.

# ACKNOWLEDGMENTS

The author wishes to thank her Thesis Supervisor, Dr. Bill Lee, and the Professors at the School of Social Work, McMaster University for their support, insight and critical questioning as the substance to this major research was fleshed out. In addition, a thank you to the fantastic people at UNHCR (Geneva) for enforcing the need to move beyond traditional approaches of relief towards holistic, durable, and sustainable solutions for development. Finally, a personal thank you to Adam Pearce and Domenico Calla and the communities surrounding Ghoom, India without whom, the importance of community development in all sectors as a means to address health-related epidemics, would never have become clear.

TABLE OF CONTENTS

# GLOSSARY

AIDS — Acquired Immunodeficiency Syndrome
Often referred to as an Epidemic and/or a Pandemic, the following definitions are used within this discussion to refer to AIDS:
***Epidemic:*** occurring suddenly in numbers clearly in excess of normal expectancy, said especially of infectious diseases but applied also to any disease, injury, or other health related event occurring in such outbreaks.
***Pandemic:*** an epidemic that affects a wide geographic area
(www.cancerweb.nc..ac.uk, Sep 2, 2004)

ARVs — Anti-Retroviral Treatment (also referred to as ARTs)

ASO — AIDS Service Organization

CBO — Community Based Organisation

CEE — Central and Eastern Europe
** The issue of borders is still not completely solved as the European border is still wide open and regions are waiting for signals from the European Union. Neither geography nor politics are consistent in this division as the main struggle is geography vs. geopolitics (Aslanyan, Garry, personal communication; 2003) **

The current World Health Organization distribution of the Central European region includes: Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Macedonia, Former Yugoslav Republic, Poland, Romania, Slovakia, Slovenia, Turkey, and Yugoslavia. The Eastern European region includes: Belarus, Georgia, Kazakhstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan

The current CIDA distribution of the CEE region includes: Czech Republic, Hungary, Poland, Slovak, Republic, Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Serbia and Montenegro, Macedonia, Romania, Slovenia, Estonia, Latvia, Lithuania, and Turkey

CHAPLR — Canadian HIV/AIDS Policy Law Review

CIDA — Canadian International Development Agency

| | |
|---|---|
| CIT | Countries in Transition |
| CSSP | Critical Social Science Perspective |
| CSW | Commercial Sex Worker |
| DFAIT | Department of Foreign Affairs & International Trade [Canada] (now known as FAC & ITC) |
| DFID | Department for International Development [UK] |
| DLHPN | Drug Law and Health Policy Network |
| FAC | Foreign Affairs Canada (formerly known as DFAIT) |
| FSU | Former Soviet Union<br>** The issue of borders is still not completely solved as the European border is still wide open and regions are waiting for signals from the European Union. Neither geography nor politics are consistent in this division as the main struggle is geography vs. geopolitics (Aslanyan, Garry, personal communication; 2003) **<br><br>The current CIDA distribution of the FSU includes: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyz Republic, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan |
| GDP | Gross Domestic Product |
| GNP | Gross National Product |
| HAART | Highly Active Anti-retroviral Treatment |
| HIV | Human Immune Deficiency Virus |
| ICAD | Interagency Coalition on AIDS & Development |
| IDU | Injecting Drug Use |
| IDUs | Injecting Drug Users |
| IHRD | International Harm Reduction Development |
| IMF | International Monetary Fund |

| | |
|---|---|
| INGO | International Non-Governmental Organization |
| ITC | International Trade Canada (formerly known as DFAIT) |
| NBA | Needs Based Approach |
| NEP | Needle Exchange Programs |
| NGO | Non-Governmental Organization |
| ODCCP | Office of Drug Control & Crime Prevention (now referred to as UNODC) |
| ODI | Overseas Development Institute |
| PLWHA | People Living with HIV/AIDS |
| RBA | Rights Based Approaches |
| SEP | Syringe Exchange Programs |
| SIDA | Swedish International Development Cooperation Agency |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UN | refers to the United Nations System |
| UNAIDS | The Joint United Nations Program on HIV/AIDS |
| UNDCP | United Nations Drug Control Programs (now referred to as UNODC) |
| UNHCHR | United Nations High Commission for Human Rights |
| UNICEF | United Nations Children's Fund |
| UNODC | United Nations Office on Drugs & Crime (formerly known as UNDCP) |
| WB | World Bank |
| WHO | World Health Organization |

*Chapter 1*

# INTRODUCTION

Injecting drug use (IDU), in tandem with burgeoning or currently existing HIV epidemics[1], is rapidly becoming an extremely serious social problem in developing countries. Although the reasons people use drugs vary, researchers and health workers in this sector suggest that many turn to drugs as an escape from the hardship and pain of joblessness, disillusionment, and social dislocation that has accompanied the political and economic transformations in various regions globally (IHRD, 2001.). In Central and Eastern Europe (CEE) and the former Soviet Union (FSU)[2] for example, political and economic change brought with it many new freedoms. Physical borders between regions opened, allowing goods to flow easily within and between countries. Despite the positive developments in trade and opportunities through this new openness, negative consequences and social problems also emerged. Among these negative consequences were a rising supply of illegal drugs to meet growing demand, the growing strength of organized crime networks, and a law enforcement system that was unable to control illegal activity (IHRD, n.d). The drug industry thrived in the social and physical insecurity after the collapse of communism.

From a social work perspective, these issues are of grave concern internationally as they are not isolated to CEE and the FSU alone. These social conditions have led to a variety of social problems globally as political, economic and social insecurity have led many people to turn to growing and selling drugs as a way to survive economically while many more become consumers of drugs to cope with their social conditions (IHRD, 2001). Crime rates have therefore increased, as has the spread of infectious diseases such as hepatitis, tuberculosis (TB) and the Human Immunodeficiency Virus (HIV) (CATIE, 2002). See Appendix A for the current UNAIDS Map depicting HIV/AIDS prevalence globally. HIV is of particular importance as it is the virus known to cause the Acquired Immune Deficiency Syndrome (AIDS). Appendix B provides an overview of HIV/AIDS basics and the various behaviours that place an individual at high or low risk for HIV transmission.

While all available indicators suggest that drug use continues its rapid rise globally, HIV prevention appears rarely to be a priority (Hamers & Downs, 2003). Appendix C provides a summary of the common modes of HIV transmission by

[1] Please see the glossary for a discussion on the use of the term Epidemic versus Pandemic in relation to AIDS
[2] Please see the glossary for a discussion of the tenuous nature of borders in CEE & the FSU

country. Generally, the extent of drug use is hard to assess because of its illicit nature and the tendency of target populations to keep themselves hidden. This 'hiding' increases the individual risk to health and also increases the risk to public health. As the 'UN task force on Drug Use and HIV vulnerability' note that "of all the different ways that the AIDS virus can be transmitted, directly injecting a substance contaminated with HIV into the blood stream is by far the most efficient" (Task Force, 2000: 31). Through these means, injection drug users often unknowingly become infected with HIV and unknowingly transmit the virus to their sexual partners in addition to those with whom they may share their injecting equipment. As a result, HIV infection is spreading throughout the general population, beyond groups such as IDUs that have typically been considered high-risk, creating an HIV/AIDS pandemic.[3] An additional consequence is the increasing number of people who require treatment and services. The combination of these effects makes localized AIDS epidemics even more difficult to contain in conditions of political turmoil, poverty, high unemployment, labour migration, inadequate health care and a lack of preventive health education. The challenges therefore become a complexity of social, political and economic issues.

Despite growing international, national and local attention to the AIDS pandemic, IDUs as a group continue to be sidelined in programming and policy interventions. Effective interventions such as access to clean needles and sterilization equipment to reduce the risk and transmission of HIV through IDU are urgently needed (IHRD, n.d.). Yet even the most basic information about HIV transmission is often not delivered to IDUs. Such information is essential before any effective intervention can be delivered. HIV/AIDS through unsafe drug injecting practices can be seen as the direct result of government policies and law enforcement which work at cross-purposes with public health and medical authorities in their attempts to contain the pandemic (DLHPN, 2002: 3, Burrows et al, 2000). The importance of all these issues in the pandemic of HIV/AIDS associated with IDU, will be explored in detail.

Before delving into a detailed discussion, it is important to note that while there is general agreement over the connection between HIV and IDU, there is no clear consensus about the best way to tackle the problems associated with drug use. In particular, there is much controversy over whether strategies should focus on the *promotion of abstinence*, which can be viewed as the 'traditional' approach, or *managing the consequences of drug use*, the 'typical' harm reduction approach (Hamers & Downs, 2003, Stover & Nelles, 2003). The traditional approach has typically involved drug laws and policies that support the criminalization, arrest and incarceration of drug users. By contrast, the typical harm reduction approach seeks to decrease the harm, injury and infections associated with drug injection behaviour. Such approaches include providing access to clean needles through needle exchange programs

[3] Please see the glossary for a discussion on the use of the term Epidemic versus Pandemic in relation to AIDS

(NEPs), syringe exchange programs (SEPs), sterilisation equipment and HIV education. While harm reduction approaches are more effective in addressing the public health issues around HIV and IDU, it is similar in its limitation to the punitive drug policy approach. Both are micro level health initiatives focusing on individual behaviour change through what is referred to herein as a 'needs based approach' (NBA). The extent to which both punitive and typical harm reduction approaches are used and their limitations as a NBA will be explored further in following chapters.

As will be argued here, macro social policy interventions are also needed to compliment micro level initiatives. The way forward as will be proposed here is through a holistic harm reduction approach. Such an approach would take the view that HIV/AIDS associated with IDU can be stopped and reversed. To do so would require reforming those very drug laws, policies and practices that stand in the way of effective public health interventions, and employing harm reduction based programs to IDUs that go beyond the traditional approach of changing individual behaviour. This need for both macro and micro interventions would first require a major shift in ideological thinking. In particular, the shift would require that HIV and IDU be recognized beyond a purely individual *health* context such that these social problems are considered as *development* related issues. As succinctly put the Swedish International Development Cooperation Agency (SIDA), a development approach to addressing HIV/AIDS will work on several levels: notably in policy, programs, social infrastructure, and citizen participation (Sida studies: no.7, n.d: 223.). Only from there can the quality and extent of delivery of interventions at the micro level be improved through macro policy reform. This is key since it is at the macro level where policies are developed to support or infringe on strategies to reduce both social problems. These strategies can then be expanded to recognize the *public* health concerns associated with individual IDU behaviour and HIV infection, and to address those other social determinants which promote risk for HIV and IDU. To do so would require yet another shift in thinking so that IDUs are considered and treated as citizens with a right to health for the individual good and for the public good, rather than being viewed as marginalized, undeserving drains on society.

The notion of a rights-based approach (RBA) is suggested here as a framework from which to challenge punitive, stigma-based interventions and move beyond needs based approaches (NBAs) towards IDUs. While a NBA simply provides services to meet needs, RBA seeks to strengthen people's ability, empowering them to demand such services from the state (Id21, 2001, Patterson, 2002). Empowerment as a concept under a rights based framework is understood herein as:

> ... (a) focus on beneficiaries as the owners of rights and the directors of development, and emphasize the human person as the centre of the development process (directly, through their advocates and through organizations of civil society). The goal is to give people the power, capacities, capabilities and access needed to change their own lives, improve their own communities and influence their own destinies (UNHCHR, nd.).

To begin however, a critical perspective will be employed in order to outline the shift in approaches from Health to Development that is required in order to effectively address HIV and IDU. The necessity for this change in approach is best understood by examining the challenges that frame these social problems in developing countries. In order to explore these challenges several questions will be asked in the following chapters. First, what do we know – what is currently happening globally – are there any similarities in the composition of the HIV pandemic or IDU behaviour from one country to another – why do similarities/differences exist? Second, how do we know what we know – what methods are researchers using to uncover this information – is the information appropriate – why are some methods used over others? Third, what do we not know – what information cannot be picked up through those methods – why is information 'missing' or not being considered? And finally, where do we go from here – what does this mean for the potential development of a global policy to reduce HIV infection related IDU? From this, the limitations of current responses can be assessed and give light to the way forward: A rights-based approach to outline the policy and programming responses that are needed. Appendix D serves as a visual outline to conceptualize the line of thinking explored here.

*Chapter 2*

# METHODOLOGY & METHODS

## Methodology

The intent of conducting research here is a reactive one. There is a gap in research on this topic yet research is needed in order to help develop those policy responses, which are essential but lacking. This intent is noted here as Weiss (1986) urges the researcher to first understand why they are conducting research and what using research actually means. Trying to incorporate a *critical methodologies perspective* as articulated by Neysmith (1995) would seem most appropriate here in problem solving as she states that, "methodology connects what we know (theory) with how we know it (method)." Similarly, for Neuman (1997), a critical social science perspective (CSSP) "does more than describe the unseen mechanisms that account for observable reality; it also critiques conditions and implies a plan for change." From this critical methodology perspective, the following questions frame the ensuing outline and analysis of this discussion: What do we know, How do we know it, What do we not know, and Where do we go from here? All these questions are positioned under the essential questions: why do we know what we know and why are some approaches utilized over others?

## Methods

In attempt to inform policy in the arena of HIV/AIDS and IDU, this research retrieved and analyzed a cross-section of literature exploring the issues of global HIV/AIDS, IDU, and development approaches. These included academic journal articles discussing approaches to and merits of harm reduction strategies across developing country contexts, and included a wide-spectrum of fields from journals of public health to community development to drug policy. Some journal articles took either a positivist approach in collecting quantitative data on localized epidemics in various countries, while other articles took a more interpretive approach in using research approaches that attempt to incorporate the needs of the community.

In addition, fact sheets, manuals, calls-for-action, and policy documents from non-governmental organizations (NGOs), international non-governmental organizations (INGOs), community-based organizations (CBOs), AIDS Service Organizations (ASOs), country specific harm reduction agencies, UN organizations

and donor branches of government departments at the local-field level and headquarters level were all reviewed to garner thoughts, approaches and recommendations on how to tackle these two social problems. Finally, online discussions groups looking at HIV/AIDS-related issues, IDU-issues and development challenges were also incorporated. The benefit of these discussion groups are the current, 'insider' and front line perspective that is gleaned from workers currently in the field, as well as international AIDS and IDU experts who add to the discussion. From this review, it was possible to get a sense of which countries are dealing with high incidences of IDU behaviour, and what the core issues are in effectively formulating interventions. In reviewing these sources, it appears that much is happening and being written about across China, India, Thailand, Central and Eastern Europe, and the Former Soviet Union. As a result, regions across these countries were focused on.

## Limitations

A major constraint that emerged early on was the limitation of material available in English. This reduced the potential to examine concerns of local voices, and unfortunately leaves room for omissions in translation. Furthermore, a methodological concern that looms is the appropriateness of extrapolating experiences, and lessons learned from various contexts to develop recommendations that will effectively inform policy responses globally and still capture the context specific needs of diverse settings. Despite the obvious contextual differences some similarities do exist and are explored in the next section in terms of what we know about HIV prevalence and IDU behaviour.

*Chapter 3*

# WHAT DO WE KNOW?

## BACKGROUND

There are obvious contextual differences in language, geography, cultural practices, ethnicity, political regimes, economic stability and other predominant routes of HIV infection from one country to the next. However, a review of the research undertaken in these countries suggests that generally, there are some aspects to IDU behaviour and HIV/AIDS that are common and this similarity can potentially form the initial framework for developing policy responses. The following is an overview of those similarities and differences.

### HIV Infection Rates

Infection rates are often used as an indicator to highlight the extent of a problem or emerging local epidemic, and the predominant mode of transmission in a region. In the FSU and CEE for example, IDU among young people remains the predominant mode of HIV transmission, accounting for over 80% of new infections (CHAPLR, 2002). According to fact sheets developed by the Joint United Nations Program on HIV/AIDS (UNAIDS, Q&A II Section II, n.d.), in less than eight years in the Russian Federation, HIV pandemics have been discovered in more than 30 cities, and in 86 of the country's 89 regions. They also note that the Ukraine remains the most affected country in this region, and in all of Europe, where approximately 250,000 people are living with HIV out of a total population of nearly 50 million. UNAIDS estimates at the end of the year 2000, there were between 2.3 and 4 million IDUs in the region and that the number of users is growing.

According to Rhodes et al, (1999), IDU is the predominant mode of HIV transmission in Eastern Europe, North Africa, the Middle East, Southern Europe, parts of the United States of America, and parts of Asia. The similarities in modes of transmission across these regions have not, however, led to similar policy responses. The typical harm reduction approach through needle exchange and substitution treatment is promoted in Western Europe, Australia, Canada, and Brazil, while the USA and many African and Asian countries oppose it, favouring instead an abstinence-based approach.

## Link between HIV & IDU

Worldwide, an estimated 10% of HIV/AIDS is attributed to IDU and this proportion is progressively increasing (UNAIDS Report, 18-11-03). While precise figures can be difficult to obtain or are inconsistent, research has shown that HIV can spread through drug using populations with a remarkable speed and also contributes to an increased overall incidence of HIV infection (ODCCP & UNAIDS, 2001: XV). IDUs risk HIV infection in two main ways: first through the sharing of used, unsterile syringes and other injecting equipment, and second, through unprotected sex with infected partners (UNAIDS, 2000:25).[4]

Kumar et al (2000) observe in Madras, India, that while the sexual transmission of HIV remains the primary route of infection in the region, the role of IDU in acquiring and transmitting HIV infection also deserves greater attention. The North-Eastern States of India, studied by Dorabjee & Samson (2000) are often pointed to as regions where high rates of IDU exist, contributing significantly to further HIV infection among the general population. Hamers and Downs (2003) meanwhile note that during the past five years, most countries of the FSU have been severely affected by HIV pandemics that continue to spread as a result of rapidly increasing IDU and a burgeoning sex-trade industry.

## IDU Behaviour

As noted earlier (and explored further in Appendix B), certain behaviours are known to increase susceptibility to HIV infection. It is important to note the type of behaviour that places individuals at risk in each country's context in order to develop appropriate interventions (Appendix C provides a global overview of HIV infection). Across the five major metropolitan cities in India researched by Dorabjee and Samson (2000), it was learned that most IDUs in India used the same needle and syringe repeatedly as new ones are unaffordable to IDUs, despite the low expense and availability of needles and syringes in pharmacies. These researchers also learned that awareness about cleaning injecting equipment was low, as were the numbers of IDUs who attempted to clean their injecting equipment before use. Kumar et al (2000) discovered several key behaviours that are putting heroin-using IDUs in particular at risk in Southern India (the other common injectable drug available is buprenorphine). These include the practice of sharing cotton swabs as filters for the substance, and using common solutions and caps or spoons in order to 'cook' the drug. This sharing of equipment among users is hazardous as the equipment may contain blood and/or body fluids, which, if infected with HIV or other transmittable infections, can infect others. The riskiest practice is a process called "flushing". This is where blood is withdrawn a few times into the syringe and then pushed back into one's system in the belief that it enhances the euphoria experienced.

[4] See Appendix B for an overview of risk behaviours

These researchers also note that IDUs using buprenorphine were more likely than IDUs using heroin to have more than two sexual partners in the past year, have sex with a commercial sex partner, and have had a history of a sexually transmitted infection (STI) (Kumar et al, 2000). This is important to note as having an STI magnifies the risk of HIV transmission by tenfold to an individual during unprotected sexual intercourse (UNAIDS Q & A III).

Meanwhile, Burrows et al (2000), and Rhodes et al (1999) highlight that it is the social and structural conditions in the Russian Federation that leads to high HIV infection rates. These include:

- High levels of mixing between IDUs from different social networks;
- The injection of liquid drugs sold in ready-made syringes (perhaps previously used and/or unsterile);
- The distribution of drugs through 'back-loading' and 'front-loading' (where a drug is directly transferred to a users syringe from a previously used/unsterile syringe);
- Informal and unsupervised 'shooting galleries' where IDUs gather to inject and injecting equipment is shared with strangers;
- The adding of blood during preparation of home-made drugs (believed to affect the toxicity of the drug);
- Proximity to drug supply routes; and
- Widespread unemployment, economic dislocation and social change.

According to Grassly (2003), in the northeast and several major cities across India, infection through IDU predominates as HIV prevalence ranges between 60-75% among IDU. Outside of these regions, Grassly (2003) notes, the majority of new infections in India are due to heterosexual transmission. The same is true in China. However in India, transmission is particularly high among sex workers (whose HIV prevalence is as high as 50% in some cities), their clients and the sexual contacts of their clients (Grassly, 2003). The scenario in Southern India reveals a different picture. Here, Kumar et al (2001) found that drug injecting was prevalent among the unemployed, fishermen, auto-rickshaw drivers, unskilled workers, rag pickers, and street children. It should be noted that all are highly marginalized groups that are rendered vulnerable to infection because of their difficulty in accessing health and social services. In addition, all regions and countries considered here reported that drug use is common in prisons as drug users are often heavily targeted for incarceration, which leads to IDU behaviour. This was emphasized by participants in an online discussion looking at prison incarceration as a common response to IDUs. In particular, participants pointed out that HIV transmission was

increasing among prisoners who either continue injecting or become new IDUs, or are involved in forced or consensual sex that is unprotected (SAATHI: 2003-07-23).

## Access/Availability of Drugs

Both the supply and availability of certain drugs is an indicator of drug using behaviour. In Imphal, India for example, drug injecting has and continues to be the predominant form of drug use rather than consumption of substances through other means such as snorting or smoking. Dorabjee & Samson (2000) suggest that consumption by injection is a result of rising costs, decreased availability and decreased quality of available heroin. This is important to note since heroin is a very common drug of choice that does not necessarily have to be injected but is being injected to increase the 'high' of an expensive productive that is available in limited quantity. Similarly, Malinowska-Sempruch et al (2003) note that when supplies are low and prices are rising, users often switch to injecting, as it is more cost-effective. This shift is a dangerous trend as it increases the risk to HIV and potential drug overdoses. As people are afraid to seek medical attention from potentially condemning health and law enforcement officials, the situation often ends in death. Furthermore, once users start injecting, they often do not revert to using drugs by other less harmful means, even if the price goes down and the purity increases. Kumar et al (2000) also note that a change in the marketing strategy in India of selling drugs in smaller quantities for a lower cost has facilitated access to injectable drugs among low-income groups.

The significant transition to injecting appears to be attributable to a combination of factors. In summary, according to Kumar (2000), these include the following:

- The escalating cost of heroin;
- A drought in the availability of heroin;
- Drug users' need to find a substitute for heroin;
- The availability and prescription of buprenorphine injections used by medical practitioners to treat agonising withdrawal symptoms; and
- The increased availability of injectable preparations in general.

## CURRENT RESPONSES

While the above highlights what we know about patterns in the global pandemic in terms of context for risk, the following is an overview of the various responses that have traditionally and typically been used.

### The 'Traditional' Approach: Drug Laws & Incarceration

Generally, countries dealing with IDU related HIV pandemics, have taken a legislation-based policy approach to the drug problem. The approach focuses on and punishes, to differing degrees from one country to the next, the trafficking and sale of drugs as the root of the two social problems. Meanwhile, the consideration of structural conditions and the political, economic and social insecurities that create conditions for risk-taking behaviour are overlooked.

Kumar et al (2000) highlights that IDUs in India were more likely to face the threat of arrest. Interestingly however, police harassment or arrests are less likely with respect to possession of buprenorphine than with heroin. Meanwhile, in the Russian Federation, the concern among health and other agencies, and injecting drug users as well, are certain legal provisions. These provisions could be interpreted to mean that even the distribution of any educational information or prevention counselling to someone, known to be a drug user, can be construed as encouragement to use drugs and is therefore punishable by prison terms (Burrows et al, 2000). In Thailand the government-sponsored 'war against drug dealers' involved extra-judicial executions, arbitrary detention and arrest, blacklisting and forced drug treatment which many global experts consider to be a campaign of human rights violations (Stigma-aids: 2003-09-23).

The Drug Law and Health Policy Network (DLHPN, 2002) note that among those few countries in the FSU and CEE that do have a national drug strategy, it is characterized by the arrest and incarceration of drug users. Malinowska-Sempruch et al (2003) outline some of the relevant laws and policies shared between the contemporary Russian and Ukrainian criminal codes (both share a legacy of Soviet legislation) that take a punitive approach to IDU:

- The prohibition of the production, sale, possession, storage and transportation of illicit drugs. Russian anti-drug laws, which were overhauled in 1998, are somewhat harsher toward offenders: criminal liability extends to smaller amounts of a drug than in the Ukraine, and offenders can be sentenced to longer prison terms.
- An individual charged with possession of illegal drugs may escape criminal responsibility if he voluntarily surrenders the drugs and 'actively' participates in the investigation of drug-related offences.

- Individuals charged with violating drug-trafficking laws are subject to 'administrative surveillance' after they have completed their prison terms.
- Pre-trial detention of those charged with drug-related offences remains accepted and common in certain circumstances (Malinowska-Sempruch et al, 2003; 8).

As a result, this has led to the large-scale detention of IDUs in many countries of CEE. This has greatly exacerbated the risk of HIV infection, along with Tuberculosis and Syphilis, adding to the already grave situation of HIV across CEE. With high rates of incarceration being the response to IDU behaviour, prisons are becoming overcrowded. This high population, combined with conditions of poor funding and criminal justice officials who often deny a drug use or HIV problem in state institutions, results in a fertile breeding ground for a range of opportunistic infections (DLHPN, 2002; 26).

**The 'Typical' Harm Reduction Approach: Community Initiatives**

Contrary to the punitive approach of incarceration is the Harm Reduction approach. In principal, harm reduction neither condones nor opposes drug use as it assumes that some people will continue to engage in IDU regardless of government policy on drugs. Workers engaged with IDUs believe that it is essential then that IDUs be given the tools (through education, services, and resources) to inject in a way that reduces risks and causes the least amount of harm to both themselves and others (Stigma-aids 1: 2003-09-23). This puts forth a humane public health response to drug use with the view that it is more productive to integrate drug users into society than to isolate them. Most importantly, harm reduction conveys the message to drug users that they are vital members of the general community whose well-being is valued (IHRD, 2001).

To respond to HIV and IDU, health workers often advocate for a typical harm reduction approach through community-based initiatives with an eye to the eventual development of a national drug and HIV strategy. Lunn (2002) provides a useful summary of common strategies that fall under the realm of harm reduction and includes such programs as:

- Needle/syringe exchange program (N/SEP) where a used (and possibly infected) needle/syringe can be exchanged for a new, clean one;
- Substitution therapies such as methadone treatment programs;
- Consumption rooms staffed by medical personnel where addicts may inject their drugs with increased levels of safety;
- Education on the risks of drug use through a variety of media to users and potential users; and

- Possibly the decriminalization of some drugs or providing treatment instead of jail time to defendants convicted of drug possession.

These programs are often complimented by other support services such as counselling, overdose prevention efforts, teaching of safer injecting techniques, basic medical treatment and referrals, and testing for infectious diseases and sexually transmitted diseases (IHRD, 2001).

Despite its merits for attending to the health needs of IDUs, harm reduction is criticized for not addressing larger structural issues of socio-economic inequality, which is especially relevant for countries in transition (CIT) and developing countries. Barnett et al (2000) note that the period of adjustment that these regions are facing has serious implications for the wealth and income levels of citizens. These are integral factors discussed earlier as indicators for risk to HIV and IDU behaviour. The economic crisis in particular, creates an environment for the spread of HIV, and also leads to a reduced capacity to respond (Barnett et al, 2000; 7).

Hamers' & Downs' 2003 review of HIV in CEE, suggests that various responses to HIV are being used. The countries of Central Europe for example seem to lean more towards the harm reduction approach than those of Eastern Europe, where other prevention strategies are evolving rapidly. However, as researchers (DLHPN, 2002, Hamers & Downs, 2003) point out, only a handful of countries have formulated drug policies. Drug policies are essential to setting out responses to IDUs, yet those that have been formulated thus far are more or less incomplete and only partially rooted in public health and harm reduction principles. Meanwhile, several other countries have quietly allowed international NGOs to establish and fund public health and harm reduction programs aimed at drug users, possibly in light of their weak drug policies and limited government support offered to IDUs. The concern is that without strong government support at the national level in these countries, many of these programs will only remain fledging attempts to reduce IDU and HIV infection rates (DLHPN, 2002; 26).

Burrows et al (2000) provide an overview of various HIV prevention responses that were employed among drug users in the Russian Federation. These include creative outreach and needle-exchange activities. The authors note that while these interventions were significant, they were not sufficient to prevent or control massive HIV infections among IDUs in the region since three key developments were required to initiate effective HIV prevention: 1) the training of several hundred Russian doctors, government officials, non-government organization staff and ex-drug users in the methods which have proved successful in preventing or controlling HIV infection among drug users in other countries; 2) the establishment of HIV prevention interventions in cities and regions throughout the state; and 3) the support by government policy for these prevention measures (Burrows et al, 2000). All developments require the need for some form of capacity development in terms of physical infrastructure and/or skills building among health and legal systems.

Others (Barnett, 2000, Hamers & Downs, 2003, Piot, 2001, Rhodes, 1999, and the UN system, 2000) note that without policies and interventions to address socio-economic inequality, HIV prevention efforts would be rendered ineffective. This again points to the broader development issues raised by the connection between HIV and IDU globally and the need to address policies at the macro level to inform programming at the micro level.[5]

[5] See Appendix D for a visual outline of this argument.

*Chapter 4*

# HOW DO WE KNOW IT?

## RESEARCH PROCESSES

Reflecting on the last 20 years, the Swedish development agency (Sida Studies: no 7, n.d.), notes that information about the HIV/AIDS pandemic has grown enormously in quantity. At the same time, methods for analysis have been refined and have greatly improved the quality of estimates and projections. They note that uncertainties remain about the extent and course of infection, and point to several limitations. These centre on the extent in coverage and function of national surveillance systems and the specific characteristics of HIV/AIDS that makes data collection difficult. Such issues are explored in further detail below.

### Traditional Methods of Data Collection

Typically, data on HIV prevalence in various populations are compiled through various systems set up to track and monitor HIV infection among specific groups in different countries. The use of one system versus another can differ both within and across countries based on the country's capacity, resources and expertise available. According to Hamers and Downs (2003), these different approaches can be broadly classified as either 1) specific epidemiological surveys or 2) reporting of data from large-scale HIV testing activities. In epidemiological surveys, the objective is to determine the prevalence of HIV in a given population. This testing may be 'unlinked' so that the results are not traceable to the individual being tested and is undertaken anonymously to keep participation biases to a minimum. By contrast, in large-scale diagnostic HIV testing activities, the primary objective is to provide individuals with their HIV status (as in testing to inform someone if they carry the HIV infection or not). Such testing may be mandatory (for example, with blood donors) or voluntary (such as for pregnant women, in some countries). Prevalence data based on diagnostic testing are more subject to participation bias, because they involve only individuals who seek testing or agree to be tested.

### Newer Methods of Data Collection

The 1980s and 1990s saw the development of 'rapid methodologies', which were neither heavily discussed in mainstream journals nor as actively utilized, as epidemiological surveys or large scale diagnostic testing. Rapid methodologies were utilized by international organizations to prevent pandemics of HIV among IDUs

and to instruct drug policy reform (Fitch et al, 2000). Three items dominated the agenda of designing a research study to meet the aim of moving beyond the need for statistics and prevalence data. Fitch et al, 2000, elaborate these three items. Firstly, it was agreed that information was the key to preventing further rapid infections among injectors. Moving beyond positivist notions of data and information, rapid methodologies sought out that data that was much needed. Taken from a number of sites, data was collected on the types of risk behaviour taking place in different populations of drug injectors (including drug use, sexual activity and other risk behaviour), the prevalence of HIV among these groups, and the impact of wider environments on patterns of injecting and HIV infection. In line with the critical social science perspective, the impact of wider environments is key to this discussion of those conditions which enable public health concerns around IDU behaviour and HIV transmission. Secondly, it was noted that although a great number of studies had already been conducted in a number of countries, the different methods of sampling, data collection, and analytical techniques being used have made regional and cross-country comparison difficult. It was therefore concluded that a standardised sampling methodology and a common data collection practice should be developed to enable comparisons to be made across different sites. Thirdly, it was decided that the study should be conducted in cities with different experiences of HIV among IDUs. This would achieve the wider aim of documenting pandemics at different stages in their development.

## Benefits/Limitations of Methods

Traditional approaches of epidemiological surveying and diagnostic testing are often relied upon for the concrete, quantitative data they yield. In the context of IDU, however, more is needed than just quantitative data on prevalence rates for HIV among this group. This is perhaps the role for qualitative-based research, or the impetus for designing new indicators in quantitative surveying, so that information can be gathered on the specific behaviours and conditions that allow for infection. Such information is crucial to fully understanding the behaviours and conditions behind the modes of transmission. This suggests the appeal of rapid methodologies that aim to do just that. In addition, traditional approaches are less ideal as there is a reliance on an expert for data collection, which poses challenges in resource-limited contexts. Furthermore, such an approach does not aim to put research capacity in the hands of non-traditional researchers, such as IDUs, who may be able to gather-much needed, sensitive behavioural information by virtue of their membership in a risk group. Considering the resource limited context of this discussion and the need for local capacity building, what is again signified is the need for an ideological shift in thinking from HIV and IDU as a development issue rather than a purely health issue.

Contrary to the traditional approach, and in line with development thinking, the rapid methodologies are favourable for their intent to train and use locals who

are often ex-users themselves rather than using external-foreign experts (Burrows et al, 2000, Dorabjee et al, 2000, Fitch et al, 2000). As a result, these methodologies can build and strengthen local capacity to respond to local issues and are highly useful in gathering behavioural and contextual information. However, Fitch et al (2000) point out that there are also limits to these approaches. In particular, rapid methodologies are not held in the same value as longer term or more in-depth studies. Instead it is often suggested that such an approach be used in tandem with traditional research technologies (either quantitative or qualitative surveys). There has also been a widespread tendency to associate these methodologies with research approaches designed for/by developing countries alone. This limits the perceived credibility and acceptability of these approaches as legitimate and useful research methods with potential for international use. On the other hand, growing enthusiasm and popularity for this approach (or any approach for that matter) may also prove to be counter-productive if they are too rapidly adopted, over-utilized, and/or badly executed.

A limitation, often not recognized in any method, is the tendency of a research design or the researcher themselves, to focus solely on major urban centres as research sites. The rapid methodologies studies referred to earlier, analyzing the virtues of rapid methodologies were guilty of this just as prevalence and diagnostic testing are. Potential policy implications therefore are only truly relevant for those cities where the study was carried out, as the subtler needs of rural communities remain uncovered. In addition, while rapid methodologies versus traditional ones are effective in gathering contextual information that highlights gaps and structural barriers to effective program development, it is still up to policy makers reviewing the research to correctly interpret the information and go beyond traditional, individual focussed interventions and instead develop interventions that tackle those larger structural issues. Thus far, regardless of the method used, research has either led to or been unable to change the all-too-common responses referred to in the previous chapter. Meanwhile, there is ever growing risk among IDUs to HIV infection. The extent of challenges within these current responses and what information is missing are explored in the following section.

*Chapter 5*

# WHAT DO WE NOT KNOW?

## CHALLENGES: The Low Priority of IDU in HIV Policies and Responses

### Stigma

Kumar et al (2000) note that in India, as in other parts of Asia, the lack of an effective and holistic harm reduction response or the use of an incarcerating approach to HIV among IDU stems from several factors. These factors include a lack of concern towards IDUs, a failure to recognise the risk of HIV to IDUs, difficulties at the state level in dealing with issues of illegal drug use, and general perceptions of IDUs as non-compliant, difficult to work with or deserving of punishment.

Stigma in general follows IDUs and frames how both the public and government treats them. Conditions of abuse of users were described in Manipur, India where users had their heads shaved and their names and pictures published in the local newspaper while a faith-based treatment centre in the district was noted for chaining up drug users as a form of treatment (Stigma-aids 1: 2003-09-23). In China, government facilities treating addiction rely on such methods as physical rehabilitation to overcome addictions through labour and rigorous physical exercise and psychological rehabilitation through self-criticism (Stigma-aids 1: 2003-09-23). Meanwhile, in Thailand, the government sponsored a three-month war against drug dealers at the beginning of 2003 which involved over 2,200 adults and children who were rounded up and murdered – many of whom were actually users, not dealers (Stigma-aids 1: 2003-09-23).

These examples reflect the zero tolerance policies that are used in most countries and result in the stigmatisation of users. Global experts on such issues also note that in countries where HIV is predominantly transmitted sexually, the health of drug users is particularly ignored (Stigma-aids 1: 2003-09-23). Thailand for example which is renowned for its successful condom promotion interventions leading to a reduction in STI and HIV infections, has not been able to decrease the percentage of IDUs who are HIV positive (Stigma-aids 1: 2003-09-23), suggesting that IDUs are not being reached in education and prevention efforts.

Dorabjee & Samson (2000) note that in India (as can also be noted elsewhere) conducting further research on IDU and sex-related risk behaviour is essential, as there is a lack of data on IDU behaviour. The lack of data is a serious hindrance in the design of appropriate and effective HIV prevention and treatment responses. Yet it is more than just poor research design; limited data is also a result of the denial of IDU as a problem. Kumar et al (2000) conclude that at the government level in India, the issue of drug users in HIV transmission has not been given the attention it requires, since the Government has not initiated a comprehensive intervention program targeting IDUs. As highlighted earlier, Hamers and Downs (2003) note that the extent of drug use is hard to assess, yet all available indicators suggest that abuse continues to rise rapidly. As a result, there is consensus that IDUs are not receiving the attention and care required to effectively address a public health pandemic. This is largely due to prejudice and stigma towards drug use in general and IDUs in particular. Such stigma and prejudice has slowed efforts to establish appropriate services and policies such as harm reduction strategies to reduce the risk of IDU and prevent HIV (IHRD, 2001). Stigma is also reflected in the punitive attitudes by governments and the public alike who hold the view that drug users should face stiff criminal punishment. Speaking generally about human rights for people living with HIV/AIDS (PLWHA), Jurgens states:

> How a government – local, regional or national – chooses to confront the AIDS epidemic reflects its underlying interests, values and systems, as well as those of the society it claims to serve. How it treats its own PLWHAs – or those at risk for HIV – thus reflects its general approach to human rights (Jurgens, 2004: 1).

As a result of the illicit nature of injecting drug use and possession of injecting equipment and the ensuing stigma experienced, many users go underground which increases the likelihood of sharing injecting equipment and thus causing more harm (Stigma-aids 1: 2003-09-23).

In Russia, the public health needs of IDUs at risk for HIV are complicated by stigmatising attitudes held by many health professionals toward HIV-positive drug users. It is noted that in Russia some health care providers show open contempt for IDUs by refusing them pain medication, breaching the confidentiality of service users, and demanding a fee for treatment that should be free (Stigma-aids 1: 2003-09-23). While demanding a fee for treatment may also be partly caused by the poor economic situation in Russia, contributors to the online forum on HIV among IDUs (Stigma-aids) point to stigma and discrimination as the causes of inequitable treatment. This results in many users not getting access to treatment because they fear rejection or in more extreme cases, arrest. Those who do access health care systems may keep their drug use secret for fear of discrimination, which can result in misdiagnoses or unfavourable drug interactions (Stigma-aids 1: 2003-09-23).

## Values & Goals

Two values and corresponding goals are apparent when considering the aims of implementing a harm reduction policy. The first goal is sound economic development for CIT and developing countries through maintaining a healthy population. This is based in the value that development must be holistic and cannot come at the cost of sacrificing public health. The second goal focuses on demonstrating compassion towards IDUs based on the value that all human beings deserve equal treatment. Considering the stigma and discrimination IDUs typically experience, compassion-based arguments are harder to make and do not lend themselves well to program/policy development. Rather, economic-based arguments, with connections to the potential economic impact of programming, would be more appropriate.

Malinowska-Sempruch et al (2003) provide an effective economic-based argument. They suggest that Russia could have as many as eight million infections in the next decade, which would equal about 10% of the workforce. They also suggest that approximately 1.44 million people in the Ukraine will be infected with HIV/AIDS by 2010. They argue (as do Jurgens, 2004, Sida Studies, no.7, n.d.) that this increasing death rate will not only accelerate population declines, but will also have serious consequences for economic growth. This becomes clear when it is considered that 95% of new infections are in low and middle-income countries, with 50% of overall infections among persons aged 15-49 years (UNAIDS, July 2004). This significance of this is important to recognize since this age group represents youth and adults of working age. From a long-term economic perspective, it would seem that providing IDUs with the basics of a typical harm reduction strategy is more cost effective than treating a person with AIDS or imprisoning them. Similarly, it is also much less costly for a society's overall health and welfare in the long run to engage in such prevention activities (IHRD, 2001).

## Limitations of Micro-Level Interventions

Considering the implied cost savings of pursuing a typical harm reduction approach and the social and economic insecurity of the various regions discussed here, what is needed to respond to both social problems is the development of social welfare programs beyond the current responses identified earlier. Titmuss's (1974) model of social welfare is useful to help frame a discussion on the limits of current responses and suggest the way forward for an ensuing social welfare response to HIV and IDU.

Titmuss (1974) sees "social welfare as a major integrated institution in society, providing universalist services outside the market on the principle of need." This view he says "is in part based on theories about the multiple effects of social change and the economic system, and in part on the principle of social equality. It is

basically a model incorporating systems of redistribution in command-over-resources-through-time" (Titmuss 1974: 31). This view of social welfare is perhaps a better fit with the typical harm reduction approach, rather than criminalisation and incarceration. However neither approach adequately addresses what Burrows et al (2000) refer to as the macro risk environment including health, welfare and economic status as conducive factors to creating and sustaining the pandemic. Instead, both approaches are simply micro level interventions focussed on individual actions.

As cited by Titmuss (1974), Hagenbuch's position on social policy "may be said to be the desire to ensure every member of the community certain minimum standards and certain opportunities" (Titmuss, 1974: 29). Although not perfect, an approach of harm reduction aims to reconcile the inequality in access to service experienced by IDUs so that a minimum standard of health can be reached that is comparable to the general population. In contrast, incarceration through drug laws aims to segregate IDUs, which prevents them from achieving comparable minimum standards.

Titmuss (1974) points out several objectives contained in Hagenbuch's position, two of which are explored here to help guide a comparison of the limitations in these two approaches to responding to HIV and IDU. The first objective aims for a policy that provides welfare for the population at large. While drug laws, it can be argued, serve the social welfare of the general population through the incarceration of criminals, the benefit does not appear to be for the entire population since there is no benefit to IDUs either while incarcerated or after. Harm reduction policies, however, propose welfare provision through public health related service delivery for the benefit of both IDUs and the population at large, thus reaching Hagenbuch's first objective.

The second objective looks for economic as well as non-economic considerations in policy development. In harm reduction the aim is to reduce HIV prevalence and IDU behaviour in the hopes of promoting public health and leading to economic growth. The line of thinking behind this is that economic growth is interdependent on the state of public health. The benefit of harm reduction in this regard becomes apparent when compared to drug laws. Punitive legal approaches are associated with rising rates in incarceration of IDUs and have proven to be economically costly. First there is the cost of funding the institutions (IHRD, 2001), the increased incidence and treatment of HIV and STI infections generated during incarceration (Stover & Nelles, 2003), and the removal of potential labour force participants from society rather than rehabilitating or at least supporting them to re-enter the community. Though imprisonment can be seen as a form of rehabilitation, it is not able to prevent individuals from engaging in drug-using behaviour and/or reducing infection rates in ways that a harm reduction approach can.

The biggest limitations of both approaches however, become obvious when reflecting on Burrows et al (2000), who refer to the macro risk environment. They note that health, welfare, and economic status are conducive factors to creating and sustaining the pandemic. As can be seen, both common approaches fall short in not adequately addressing these macro-level issues. These are explored below.

## MACRO-LEVEL ISSUES

### The Social, Economic, and Political Context

As has been highlighted above, the socio-economic-political context in which IDUs live creates obstacles to risk reduction, as many IDUs may feel powerless to maintain safer injecting and sexual behaviours (Kumar et al, 2000). Significant numbers of IDUs, for example, are from poor socio-economic backgrounds (Kumar et al, 2000). As a result, problems of HIV transmission and other adverse health consequences among IDUs are linked to related issues of high levels of demoralisation, poverty, slum dwelling, unhygienic surroundings, and limited access to primary health care, clean water, sterile syringes, and pro-social opportunities. Barnett et al (2000) argue that societies in transition whether it be economic, social or political, are susceptible to the rapid spread of HIV. Such is the case of South Africa, which is currently going through a transition from apartheid to democracy and has one of the fastest growing infection rates in the world. Similarly, in the Ukraine, the position is compounded by the fact that the transition has been from a period of certainty to uncertainty (Rhodes, 1999).

### International Conventions/Legislation/Policies

In looking at arenas for change, the role of international conventions, legislation and policies are often not considered as a challenge impeding on a country's ability to address IDU related HIV pandemics at the national level. National legislation is typically based on several international drug control conventions which were set out to form the basis for international drug co-ordination and to help guide policy responses to drug related pandemics. The international conventions include 1) The Single Convention on Narcotic Drugs of 1961, 2) the 1971 Convention on Psychotropic Substances, and 3) the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.[6]

Despite the potential for these conventions to hold states accountable to international standards, they are proving ineffective to the attainment of public health aims. In particular, these conventions fail to recognise the rapid spread of infectious diseases that result particularly from injecting drug use and drug policy. This is not surprising as two of the three above conventions pre-date the HIV/AIDS

[6] For a summary of the UN treaties, see Malinowska-Sempruch et al, 2003; p5

epidemic, while the third was enacted before the growth of IDU associated epidemics globally. Malinowska-Sempruch et al (2003) contend that by adhering to these outdated UN drug conventions, the focus is on reducing demand and supply of substances, rather than reducing the harm of drug use. These authors suggest that the governments in Russia and Ukraine have taken the easy route in allocating most of their resources to law enforcement of the conventions, rather than channelling resources to support much needed HIV prevention and treatment policies. Without revisions, they argue, these conventions allow state responses through drug policy to remain hostile to drug users and can be blamed for burgeoning HIV rates.

**National Drug Laws & Policies**

As a result of the continued implementation of these outdated international policies as they currently stand into national law, the ability of public health and medical authorities are limited in their attempts to contain the pandemic. Barriers are also posed in the creation or expansion of harm reduction programs (DLHPN, 2002: 2). Never-the-less, it is primarily up to the willingness and ability of governments to enforce laws which impact on public health conditions and determine the types of interventions that health workers are able to employ. Furthermore, as it has been described, in many countries law enforcement has engaged in the brutal harassment of drug users. Certainly, the way in which law enforcement officials deal with drug sellers and users can dramatically impact the extent of the HIV/AIDS pandemic and other drug-related infectious diseases (DLHPN, 2002; 11).

What should be highlighted are the unforeseen consequences of punitive drug laws. These further exacerbate the HIV/AIDS pandemic since drug use is seen as a crime rather than a health or development issue. Firstly, the more that drug users are viewed as criminals instead of citizens in need of health care, with a right to equitable services and important partners in a broad public health campaign to combat HIV/AIDS, the less likely a country's health and medical establishment will be motivated to address burgeoning HIV infection and IDU behaviour (DLHPN, 2002: 11). To emphasize the point made earlier, such an approach to drug use prevents law enforcement authorities from collaborating with public health authorities to expand access to prevention and treatment programs.

Secondly, harshly sanctioning both low-level sellers and drug users, and prohibiting both drug use and possession, increases the likelihood of IDUs engaging in riskier behaviour to avoid detection and detention (DLHPN, 2002; 11). Lunn (2002) notes that as people fear arrest and incarceration, drug use is pushed further underground and beyond the reach of standard medical and public health services. As discussed earlier, to avoid detection, users have begun to inject in areas of their body that are not readily visible to officers which increases their risk for potentially

hitting an artery or incurring nerve damage during injecting (IHRD, 2001, Lunn, 2002).

Finally, often ignored, is the reality that the enforcement of such laws leads to increasing numbers of active IDUs incarcerated in prisons that are often overcrowded. Such conditions can spawn the rapid transmission of HIV, Hepatitis, TB and a host of STIs[7] when prisoners share illicit, unsterile injection equipment and engage in unprotected sex (DLHPN, 2002; 27, IHRD, 2001; 3, Lunn, 2002, Stovers & Nelles, 2003).

## Targeted versus Population-wide Programming

As highlighted above, there are significant barriers of political, legal, and most importantly, economic constraints to developing sound responses to HIV and IDU in virtually all developing countries and CIT. The economic constraints reflect the absence of consistent and diverse funding, substantive government support, and wider public acceptance. Without consistent and diverse funding, harm reduction efforts will fail to contain HIV infection rates (IHRD, 2001). Because of these barriers and limited resources, it becomes difficult to decide which policies and programs to prioritise, which are most suitable, and how best to implement them. In addition, with the implementation of prevention strategies and development of policies are concerns over whether to take a targeted approach: one that focuses on those at greatest risk to infection, or a general one that focuses on general public health. For example, sex workers who engage in injection drug use are at an increased risk for infection (Hamers & Downs, 2003, IHRD, 2001, Rhodes, 1999), and often tend to be women. The challenge then becomes, to better respond to the needs of sex workers, should resources be given exclusively to harm reduction agencies that have typically focused on IDUs, or to organisations that work specifically with sex workers but have not previously addressed IDU issues or focused on harm reduction services? The dilemma is that taking such targeted approaches may lead non-targeted groups to perceive themselves as not at risk, while general approaches may miss the complex needs of marginalised groups.

The debate continues since for racialised minority groups, targeted approaches are very much needed in order to reach out to them effectively. For example, the 'Romani' are a widely spread ethnic group who are considered the most vulnerable population throughout CEE (IHRD, 2001). As a group they are subject to the worst conditions: slum like housing, chronic unemployment, poor health care, lack of access to public services, and inferior segregated schools. Given these conditions, many Romani are at risk of drug use and to HIV infection, both of which are controversial subjects in the community, without access to specialised services to help respond. As might be expected, reliable figures are difficult to obtain, but

[7] See the glossary section and Appendix B for definitions descriptions of these infections and diseases.

researchers report a rise in IDU within Romani communities. According to the IHRD, this situation:

> ...will remain unchanged as long as countries lack culturally competent education and prevention services for Romani communities. HIV testing, drug treatment, and harm reduction programs rarely take into consideration Romani cultural attitudes toward, for example, explicit sex education, or their general distrust of government institutions (IHRD, 2001).

In discussing the twin social problems of HIV and IDU generally, Hamers & Downs (2003) and Donoghoe (2003) agree that HIV prevention among IDUs should be the cornerstone of regional and national prevention strategies. They point out that strong evidence exists, showing that when targeted interventions are implemented rapidly on a sufficiently large scale, HIV infection among IDUs can be averted, and that by reducing the incidence of HIV in drug injectors, generalised pandemics can be avoided. Considering however the economic and resource limitations of the contexts we are considering here, such arguments for targeted programming focusing exclusively on IDUs will potentially be at the expense of programming for the non-specific needs of the general population. This becomes of concern as authors like Donoghoe (2003) point out that in Eastern Europe targeted interventions such as harm reduction programs for IDUs, lack scale and coverage. According to Donoghoe (2003), investing scarce resources in interventions to respond to HIV in general populations at the expense of targeted interventions could be premature and unnecessary. Such fears of whether to target or not are echoed by advocates who are fearful about the impact of increased attention to the AIDS pandemic in general. The concern being that such attention is perhaps to the detriment of other global health issues, as resources are directed primarily to HIV/AIDS. This speaks to a larger challenge, the existence of weak health infrastructure.

## Poor Health Infrastructure

The current state of health care infrastructure for CIT and developing countries is often quite weak or inadequate to respond to HIV/AIDS in the general population, let alone the complex needs of a high-risk group such as IDUs. This becomes further complicated as the international community focuses attention on improving access to HIV treatment, specifically antiretrovirals (ARVs), as a global response to AIDS. One of the major concerns for many developing countries with the focus on ARVs, is the over-medicalisation of responses to AIDS. Such an approach undertakes large appeals for the provision of treatment to those currently living with HIV/AIDS without identifying how the venture will be funded or supported in the long term either locally or from abroad. In addition, certain issues

are glossed over: the capacity of a country to produce its own generic versions of patented HIV medication, the support needed to build health care infrastructure for generic drug production and distribution, and the capacity of health care facilities, and/or health care personnel to provide such a service (Patten and Dolan, 2002, Canadian HIV/AIDS Legal Network, 2003). For this reason, such initiatives must be secured in tandem with building infrastructure for health care. Priya (2003) articulates this complexity well: "if free treatment and holistic harm reduction programming is not through a structured, health care system, the suffering due to HIV will only get further compounded" (Priya, 2003). The same argument must also be applied to building infrastructure such as legal and social-welfare to support non-medical approaches to HIV/AIDS.

Similarly, Dr. Ajithkumar from India echoes these fears as he wonders about his country's preparedness for HIV/AIDS, which requires a life-long treatment process. He critically questions how regular supplies of medications will be ensured, how prescriptions will be monitored, how side-effects of medications will be coped with, and if patients who cannot tolerate the WHO recommended medications will be denied treatment as a result (AIDS-INDIA, 2003 Dec 6). Whether the concern is with access to medications or expanding harm reduction approaches, things become further complicated since at the same time, under-resourced countries have difficulty meeting even basic needs. Provisions lacking could include access to clean water, adequate housing and nutrition, and decent schools and highways, while also facing serious epidemics of other diseases such as tuberculosis and malaria (ICAD, 2001). Unfortunately however, when a country is considered to have poor infrastructure, it is primarily understood along the lines of its ability to provide medical treatment, rather than the range of environmental and structural areas just identified.

As suggested earlier, there are concerns that increased attention to ARVs in particular and AIDS in general may draw resources away from other programs. This is certainly a grave fear in India (AIDS-INDIA, 2003 Dec 6), while similarly in Africa, leaders are noted to be open to the opportunity for treatment availability, yet are aware of their frail health systems. They note "...in Africa, you have to make choices between where you spend your money: do you spend it on education or on health? And then, if you spend it on health, what do you spend it on – the disease that is killing most children, which is malaria – on immunisations which would provide long-term protection, or on antiretroviral therapy?" (IRIN, 2004, Mar 29). According to background documents from ICAD (2002), African governments have made repeated appeals for help in salvaging their health infrastructures debilitated by structural adjustment programs. Langley (2004) states that the WHO urgently needs $200 million in the next few months to upgrade health systems infrastructures in fourteen African states, but funds are slow to accumulate.

For Dr. Jayasree in India, the demand for ARVs would be better served as a demand to improve a deteriorated health care system (AIDS-INDIA, 2003). This

would include a demand for affordable medicines, access to treatment, and health care. All of which will improve the health care system to optimally utilise the resources to benefit others as well. The extent of these comments suggest that what is truly essential here, again, is the need to view HIV pandemics as a development issue, not just a health issue. It also suggests that perhaps service provision should no longer solely respond to the needs of individuals, but rather their entitlement and rights to service. This line of thinking is explored in the following chapter.

*Chapter 6*

# FRAMEWORKS FOR RESPONDING

Clearly, the rapidly emerging problem of IDU in the AIDS pandemic is complicated by a multitude of factors. Frameworks from which to develop programming and policy responses in the field of international development vary greatly by virtue of a country's sectoral priorities (i.e. health versus education), its' social values, dominating perspectives (i.e. economics vs. human rights) and traditional models for sustainable development within a specific country context. The same is of course true when considering which framework to use when responding to the sector of health and more specifically to HIV/AIDS in developing countries, in light of the stigma and specific challenges that surround it. Further complicating responses to the AIDS pandemic is the rapidly emerging problem of IDU which in turn raises the issue of entitlements to service and treatment by questioning the morality of IDUs. Global responses to those at risk for and living with HIV/AIDS have over time moved from inaction based on stigma and discrimination, to steady international commitments in recognition that the pandemic is impacting millions worldwide. Unfortunately, IDUs as a group at risk for HIV infection have not fared as well in the global HIV response and continue to be side-lined as a priority in international AIDS efforts (Burrows, 2004) and as just described, in domestic efforts as well.

A framework that may prove useful in helping to develop and articulate appropriate responses to IDUs at risk for HIV is the concept of a rights-based approach (RBA) and the Macro-risk environment (Rhodes, 1999 & 2002). Both RBA and the consideration of a Macro-risk environment can be seen to move beyond a NBA, but are still in infancy stages of being effectively utilized globally, and there is limited information on how to incorporate either. The discussion below begins by comparing RBA to NBA, and then considering an overview of what a RBA means in terms of development. This is followed by an analysis of RBA in terms of HIV prevention as a health *and* development issue. From there a sense of what a RBA might mean for policy and practice interventions for IDUs will be explored in consideration of the various limitations that have emerged in practice and may emerge in theory. Following this is a discussion of Macro-risk environments, which emphasises the potential influence of macro-level issues: the social and economic context that is conducive to the spread of HIV.

## NEEDS VERSUS RIGHTS BASED APPROACHES

For Patterson (2002), the needs based approach maintains the beneficiary as a passive object of development while the rights based approach centres the beneficiary as the subject of development. The rights of the beneficiary then become obligations for state action. The following table is a summary from Patterson's (2002: 6) review on programming in HIV/AIDS, human rights and development. It serves as a useful outline of the shift in thinking that is essential to moving beyond traditional approaches that are used in development to HIV but can also be extended to how IDUs are - and should be - responded to.

| Needs Approach | Rights Based Approach |
|---|---|
| Works towards outcome goals | Works towards outcome and process goals |
| Emphasizes meeting needs | Emphasizes realizing rights |
| Recognizes needs as valid claims | Recognizes that rights always imply obligations of the state |
| Meets needs without empowerment | Recognizes that rights can only be realized with empowerment |
| Accepts charity as the driving motivation for meeting needs | states that charity is insufficient motivation for meeting needs; acknowledges legal obligations to act |
| Focuses on manifestations of problems and immediate causes of problems | Focuses on structural causes of problems as well as manifestations and immediate causes of problems |
| Involves narrow sectoral projects | Involves intersectoral, holistic projects and programs |
| Focuses on social context with little emphasis on policy | Focuses on social, economic, cultural, civil and political context, and is policy-oriented |

## RIGHTS BASED APPROACHES TO HEALTH

### What is RBA?

Generally, a RBA reflects a human rights standpoint (ODI, 1999). For this reason, a RBA draws on international legal conventions on human rights. After the United Nations Charter and the Universal Declaration of Human Rights were enacted in 1948, countries entered into legally binding treaties to protect human rights.[8] Two of these treaties of most relevance to the discussion here include:

[8] See Appendix E & F for an outline of these treaties and rights at issue in the discussion of RBA

- The International Covenant on Civil and Political (CP) Rights (1966), - the right to a trial, not to be tortured - under which states are bound to respect the rights concerned, to ensure respect for them and to take the necessary steps to put them into effect. Some rights claimed in some jurisdictions may not be justifiable before a court, but all rights must be enforceable (UNHCHR, n.d). These are generally expressed in national constitutions or international conventions (DFID, 2003).
- The International Covenant on Economic, Social and Cultural (ESC) Rights (1966), - the right to food, housing, a job - under which states are required to take immediate steps for the progressive realization of the rights concerned, so that a failure to take the necessary steps, or any retrogression, will flag a breach of the state's duties (UNHCHR, n.d.). These rights are enshrined in both oral and written traditions, and which include rights to education, food, shelter, health care, and so on (DFID, 2003).

Within this framework, a RBA is articulated as a means through which to meet the following objectives:

- Empowering people to exercise their 'voice', and acquire immediate benefits but also influence processes of change and social transformation.
- Helping the state to clarify its responsibilities towards citizens, in terms of respecting, protecting, promoting or fulfilling rights.
- Helping donors to identify how pro-poor political change can best be supported.
- Helping to translate the lofty principles of international declarations and conventions into practice (DFID, 2003).

These objectives are clearly in line with development thinking, but again, the use of a RBA is still in its infancy in informing both policy and program development. This explains key enforcement issues that continue to hover over the whole process. Rights discourse that encompasses the objectives outlined earlier, and both CP and ESC rights are not new as both CP and ESC rights are both found in the Universal Declaration of Human Rights (1948), in subsequent covenants and conventions, and are included in the scope of RBA to development (UNHCHR, n.d., ODI, 1999). The discussion later will suggest that rights are typically honoured more in their breech than their observance.

**RBA to Development**

Since the United Nations was founded, human rights have been at the core of its activities, including in the area of development (UNHCHR, n.d). In 1986, the

Declaration on the Right to Development was drafted, articulating development as a comprehensive process, taking an integrated and multidisciplinary approach in considering economic, social, cultural, and political rights. From the declaration itself, "the right to development is an inalienable right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development" (UNHCHR, n.d). As noted earlier, the conceptual framework for a RBA to development is based on international human rights standards, integrating norms, standards, and principles of the international human rights systems into all aspects of development, from plans, to policies and processes (ODI, 1999). Such an approach links human development goals to existing human rights obligations, emphasising the obligations on state authorities to make possible the realisation of these rights (Patterson, 2002:4). As such, they have been used to push responses to HIV/AIDS forward as a development issue.

**RBA to HIV/AIDS**

Though debates are plentiful on this topic, HIV/AIDS can be best served when it is seen as both a health *and* development issue, rather than solely a health issue. Beyond the rights and covenants articulated above, the following serve as international guidelines and commitments in the sphere of HIV/AIDS:

- The International Guidelines on HIV/AIDS and Human Rights (1996), provide comprehensive, detailed and specific guidance on how human rights should be promoted and protected in the context of the HIV/AIDS epidemic (Canadian HIV/AIDS Legal Network, n.d).
- The Declaration of Commitment on HIV/AIDS (2001), acknowledges that the full realization of human rights is an essential element in all areas of the global response to the epidemic, and sets out specific goals and actions to realize those rights (Canadian HIV/AIDS Legal Network, n.d).

From a human rights perspective, people are entitled to enjoy the conditions that would enable them to realize their health and well being. An RBA approach to AIDS then would put people at the centre of development programming – not as objects of charity but rather as subjects with inherent rights for which governments must be held accountable (Patterson, 2001). This means that under international law, governments are obliged *to respect, protect, and fulfill* the rights of people (Canadian HIV/AIDS Legal Network, n.d, Patterson, 2001, UNHCHR, n.d). The weight of these terms is outlined below:

- *Respecting* a human right means that governments cannot violate the right directly. For example, governments cannot deny

prisoners with HIV/AIDS the same quality of medical care that is available in the community.

- *Protecting* a human right means that governments have to prevent others from violating the right, and to provide some form of redress when the right is violated.
- *Fulfilling* a human right means that governments have to take steps – pass laws, make regulations, set up programs, provide funding – to realize the right (Patterson, 2001).

## RBA to HIV & IDU

Worldwide, IDUs are often denied equitable treatment in health care systems and within the criminal justice system because of stigma, discrimination, and punitive approaches towards their drug use (Burrows, 2004). It is argued that there is an undeniable link between human rights and health (Canadian AIDS Society, 2002), such that when human rights are not promoted and protected, it is harder to prevent HIV transmission and the impact of the AIDS on individuals and communities is worse and difficult to contain (Canadian HIV/AIDS Legal Network, n.d).

One of the elements in RBA to development is *non-discrimination and attention to vulnerable groups* (UNHCHR, n.d). Advocates (Canadian HIV/AIDS Legal Network, n.d., Burrows, 2004) point out that this means that safety mechanisms need to be incorporated in development strategies at levels of policy and programming, to protect against threats to the rights and well being of such populations as prisoners, minorities, migrants and other often domestically marginalized groups. Furthermore, all development decisions should work towards empowering local participants in all spheres of their lives and counter the potential to simply reinforce existing power imbalances along social, economic, and political lines. From this standpoint, IDUs who are incarcerated, much like populations at large, are dependent on the state to make resources available to them to prevent HIV infection and other diseases. This dependency includes protection of their privacy, protecting them from violence, and providing them with health care to the same quality that is available in the community (Canadian HIV/AIDS Legal Network, n.d).

## Enforcement

To enforce international guidelines, conventions, and covenants, international committees have been established to monitor the degree to which both CP and ESC rights are respected, promoted and fulfilled regionally. The UN has six treaty monitoring bodies covering the main rights instruments: CP, ESC, torture, race, women and children (ODI, 1999). These committees receive reports from countries on their attention to the covenants, and in response, the committees issue 'General Comments' (ODI, 1999). Within countries however, it has often been

through the innovative work of NGOs, and not the committees, that performance standards and codes of conduct have been developed which perform as enforcement measures of human rights. This is particularly true in the arena of humanitarian assistance. It could be argued, however, that perhaps, 1) NGOs have had to be innovative in this regard in light of the inability of international communities to enforce human rights, and/or 2) NGOs are in a better position to regulate what happens at the field level. This generally speaks to the limits of utilizing a RBA that need to be explored in more detail.

**Limitations of Utilizing RBA**

The main limitation of effectively utilizing a RBA lies in the ability to enforce it. Perhaps this reflects the inevitable challenge of attempting to develop and utilize a single, uniform approach centered on something as multifaceted and intricate as rights. Two things complicate the issue: first, the sheer number of variables involved in development work. These could include various cultural elements that impact the understanding and interpretation of human rights from one context to another. They are discussed further in the following section under restrictions and contradictions. Second, there are competing or conflicting values and priorities to contend with, which may or may not be compatible with a RBA. These are explored later as issues of universality and efficiency.

For these reasons, problems could theoretically emerge in the endorsement and implementation of a RBA at the donor level, and consistency at the international, national, and regional levels. This area becomes further complicated as 'rights' are an often locally defined, adapted and disputed concept. Furthermore, the context is *international* development where the aim is to promote local empowerment, not cultural imperialism or risking the repetition of the devastation of colonialism. To illustrate the scope of the concerns, the UK development organization, DFID, is thoughtful in considering how far donors can realistically go to strategise the promotion of rights, and still avoid anything that may be construed as interference in a country's internal affairs (DFID, 2003). On the other hand, the Committee on Economic, Social and Cultural Rights warns that proposals for the integration of human rights into development activities can too easily remain at a level of generality (UNHCHR, n.d), a statement that highlights the potential for restrictions and contradictions in the use of RBA.

**Restrictions & Contradictions**

As highlighted earlier, the International Guidelines on HIV/AIDS and Human Rights are detailed and specific, yet despite this, they are similar to other treaties and guidelines (which are not as specific), in that these guidelines are not a treaty that binds governments to uphold a standard. Instead, these guidelines merely set an internationally recognized standard that governments should aim for. The

importance and usage of these international statements however, are incomplete since not all countries have ratified the guidelines and covenants. Furthermore, few countries have even translated international obligations into national legislation (ODI, 1999). Therefore, the protection that could be afforded by such international laws is limited.

Delving further into the Covenants, which are general in nature, the potential for restrictions and contradictions within it become obvious. With regard to the International Covenant on Civil and Political Rights, the following is noted: a restriction on a human right is legitimate only when all of the following criteria (the Siracusa Principles as cited in Canadian HIV/AIDS Legal Network, n.d.) are met:

- The restriction is provided for and carried out in accordance with the law;
- It is in the interest of legitimate objective;
- It strictly necessary to achieve this objective;
- It is the least intrusive and least restrictive means available;
- It is not drafted or imposed in an unreasonable or discriminatory way.[9]

These restrictions and contradictions challenge the universality of a RBA across regions and contexts, and question the potential to efficiently implement a RBA, especially when resources are limited. In particular, these restrictions and contradictions weaken the very basis of rights based discourse: its universality and efficiency.

### Universality & Efficiency

The review above suggests that there is at least the appearance of an emerging consensus on the basic constituent elements of a RBA and growing popularity of programming and policy-making based in a RBA. Yet, there is still no single, universally agreed upon rights-based approach or process through which to implement it. Commentators therefore wonder whether a RBA offers additional benefits over 'poverty' or 'human development' approaches which are common in development thinking (ODI, 1999). In addition, it is essential to consider such questions as: Are all rights equally important or is there a hierarchy? Are rights really indivisible (ODI, 1999)? Who has the responsibility to operationalise, protect and fulfil those rights (DFID, 2003, ODI, 1999)? Is it the state in which the right-holder lives, or do others (other states, non-state actors) carry a share of the burden (DFID, 2003, ODI, 1999)?

[9] Full Reference: United Nations Economic and Social Council. The Siracusa Principles on the Limitations and Derogation Provisions in the International Covenant on Civil and Political Rights. 1985

Perhaps what is really at issue here is feasibility. It is important to recognize that while rights are typically and ideally recognized as universal, it is rarely recognized that they are also expensive. With respect to financial constraints, what level of financial responsibility should be born and by whom? Nelson and Dorsey (2003) note that Governments' compliance (or non-) with human rights has in some instances emerged as a reason for why donors are withholding aid. The Overseas Development Institute (ODI) eloquently articulates this contradiction and unintended consequence: "If states are the ultimate duty-bearers, and those states are poor, then immediate and universal fulfilment of rights is simply not an option" (ODI, 1999). This fundamentally goes against the spirit and objectives of a RBA.

**International versus State Responsibility**

In terms of process, the various international guidelines, conventions, covenants, and standards that inform a RBA are intended to initiate basic needs advocacy and identify legal mechanisms for public service accountability (ODI, 1999). In order to accomplish this, universal standards need to be translated into local contexts with the development of local standards from which to measure and enhance a RBA. Nelson and Dorsey (2003) stress that a tension exists in the translation of international standards into local initiatives, since balancing the power of universal rights is difficult to accomplish, given the desire for policies and programs to respond foremost to local initiatives and local cultural practices. While primary responsibility of the human rights system appears to lie with individual states, it needs to be asserted that the international community *still* has a responsibility to address shortages of resources and capacities in developing countries that may prevent their promotion of human rights. Furthermore, while there is some consensus building around the importance and use of these human rights instruments, a lack of clarity exists as some non-state actors, including the World Bank, the IMF, multinational companies and NGOs, are formally outside the system of ratification. As a result, they cannot be held accountable internationally for the degree to which they respect rights (ODI, 1999).

This reality places even further pressure, which is perhaps unrealistic, on individual states to meet international obligations. As asserted earlier, for all human rights, states must have both the political will *and the means* to ensure their realization, and they must put in place the necessary legislative, administrative and institutional mechanisms that are required to achieve that aim (DFID, 2003). Again, for developing countries or CITs where weak political and/or health-care systems exist, the immediate and universal fulfilment of rights is simply not an option (ODI, 1999). This highlights the fundamental tension that exists not only between a country's political will and ability to plan under a RBA, but also the obligation a country might be placed under to enforce a RBA. So the biggest challenge remains that while many

countries may have ratified international instruments for ESC rights, some have still yet to integrate the provisions into their domestic laws.

### Role of Donors

Considering that a RBA is discussed here in the context of international development, among countries that are heavily reliant on foreign aid, it appears that implementation of a RBA requires at least some endorsement at the donor level. Furthermore, the approaches of donors and their priorities are factors in how development issues are framed. The Canadian HIV/AIDS Legal Network (n.d) suggests that wealthier donor countries have an obligation in fulfilling rights beyond their own borders and should provide technical and financial support to poorer countries to enable them to undertake a RBA.

Despite the international obligation that wealthier countries may have to help poorer countries, limitations of a RBA again emerge. The U.S as an example, although it complies in large part with the standards laid down in international law, has never ratified key instruments of ESC rights (ODI, 1999). Canada on the other hand has articulated support for a RBA in general, yet a rights based approach to development is given lip service and is not adequately represented in strategy documents developed by the Canadian International Development Agency (CIDA) (Patterson, 2001). In particular, in such documents as CIDA's "Strengthening Aid Effectiveness" (2002) (seen as CIDA's model for development), 'development' is not referred to as a right. In addition, 'development' is also not viewed as an international legal obligation for Canada or a vehicle to address such rights concerns as poverty or gender inequality in developing countries (Patterson, 2001).

Molyneux and Lazar (1999) point out that recently donors have stressed the need to integrate democratic principles into development work. As might be expected, this is supported by most NGOs since it backs up their own emphasis on rights-based initiatives. Despite this however, donor policies continue to prioritise short-term funding of projects, rather than long-term funding of institutions. This is an important fact to recognize since the promotion of rights is a process, through which results cannot be measured in the short term. Clearly then, a RBA must be articulated as a core principle of all donors, not as an optional component and must have a commitment of long-term funding.

## MACRO-RISK ENVIRONMENTS

### Constructing "Risk Environments"

It was noted earlier that there is a fundamental impact of socio-economic factors in promoting and preventing both HIV and IDU across countries. However, researchers often fall short in fully uncovering this analysis or advocating along these lines for a policy response. In reflecting on the limitations in current research

methods and challenges described earlier, particularly with respect to cross-cultural transference of models for intervention, what would be of better use is to look at each country separately along the lines of a 'risk environment'. This methodology as discussed by Rhodes et al (1999) and Rhodes (2002) emphasises the potential influence of macro-level issues, the social and economic context that is conducive to the spread of HIV. This does not render previous approaches invalid, but rather highlights the limitation of those approaches to see beyond micro-level issues. The conclusion of macro-level analyses on HIV infection that can be associated with IDU issues is that:

> Understanding of the social and economic *[political also needs to be added here]* contexts mediating HIV spread is a prerequisite to identifying the environmental 'pre-conditions' of epidemic outbreaks, and thus also, for predicting and preventing HIV transmission. The 'risk environment' may influence the efficacy of individual and community-level HIV prevention and highlights the concomitant urgency for interventions targeting social and environmental change (Rhodes et al, 1999, italics added).

Barnett et al (2000) are also quite effective in articulating the need to take a macro-level approach to understanding HIV/AIDS. These authors state that the spread of HIV and the impact of AIDS does not happen in a vacuum. They have to be seen in their economic and social context. They point to the Soviet Union where since its break-up, its former members have experienced deterioration in economic and social conditions – the very conditions that are both conducive to the spread of HIV and yet are essential to shore-up and curtail HIV/AIDS pandemics.

Macro factors creating these environmental conditions were explored earlier but in summary include:

- Diffusions in drug use and increases in the size of IDU populations;
- Transitions towards drug injecting associated with law enforcement and interdiction activities restricting drug supply and production;
- Transitions towards drug injecting associated with the transference of new drug production and distribution technology;
- Transitions towards drug injecting associated with the 'globalisation' of drug markets and distribution networks;
- Population migration, mobility and mixing;
- Lack of public health tradition, revenue and infrastructures;
- Lack of structures or resources for non-government and community organisation; and

- Rapid transitions in economic, health and welfare status (Rhodes et al, 1999).

The intent of considering a Macro-risk environment approach along with a rights based approach is in keeping with the critical perspective. As insightful and helpful as it is to have uncovered similarities and challenges across contexts in IDU related HIV infection, the critical methodological approach taken by Neysmith urges the researcher to question the 'givens' and the 'facts' which she suggests are always suspect, primarily because they exclude so much (Neysmith, 1995: 114). Working in Neuman's (1997: 75) terms, the critical researcher should question social situations and place them in a larger, macro-level context, as the previous discussion attempted to do. Clearly then the information synthesised above is only the beginning of understanding IDU related AIDS pandemics. This raises the question: where do we go from here to develop effective policy?

*Chapter 7*

# THE WAY FORWARD

## Need for Social Policy Responses

Despite the national laws/policies and international conventions that dictate the course of treatment towards IDUs, it appears that both regional organisations and the international community are aiming towards a more humane response in service delivery and policy development. The DLHPN (2002), puts forth two general findings and recommendations for the effective deployment of public health interventions: 1) development of comprehensive community based services, and 2) ensuring the compatibility of drug laws and HIV policies. Essentially what this is pointing to is that there should be no drug law, policy, or practice that impedes the implementation of proven public health programs that prevent the spread of HIV among IDUs. Harm reduction is such a pragmatic approach to drug policy encompassing a variety of means to addressing substance use problems in a non-punitive, non-judgmental manner (Lunn, 2002).

As noted earlier, harm reduction frequently includes such proven programs (UN system, 2003, IHRD, 2001, Stover & Neeles, 2003) as needle/syringe exchange, substitution therapies such as methadone treatment programs, consumption rooms staffed by medical personnel where addicts may inject their drugs with increased levels of safety, education through a variety of media to users and potential users, and possibly the decriminalization of some/all drugs or providing treatment instead of jail time to defendants convicted of drug possession (Lunn, 2002). These programs are often complimented by other support services, counselling, overdose prevention efforts, teaching of safer injecting techniques, basic medical treatment and referrals, and testing for infectious diseases and sexually transmitted diseases (IHRD, 2001). This is in line with the 'risk environment' approach which includes a wide range of treatment options. Harm reduction should be seen then as a social intervention subject to the "relativity of risk and to variations in population behaviour in different social, cultural, economic, legal, policy, and political environments (Rhodes, 2002)." The next step is to move beyond the typical harm reduction approach and address those factors that make up the macro-risk environment, beginning with legal reform and scaling up state responsibility to respond to individual rights.

## Role of the State & Law Reform

The necessity of a state response to HIV/AIDS and IDUs is premised on the idea that both social problems can be stopped and reversed by reforming current drug laws, policies, and practices that stand in the way of effective public health interventions. As Titmuss (1974: 24) urges us to see, "the concept of policy is only meaningful if we (society, a group, or an organization) believe we can affect change in some form or another." For many of the authors noted here, there is a strong belief that harm reduction policies can in fact affect change which is urgently needed to prevent the pandemic from escalating. Yet pressure on the state to also recognize the 'right' of IDUs to services and equitable treatment is essential.

Enforcing the need for a macro perspective, it is the national and state laws which regulate (or do not regulate) such interventions as syringe distribution and exchange. National and state laws are key structural determinants of the transmission and prevention of HIV. In addition, Dorabjee and Samson's (2000) report highlighted community concerns that drug use should not be considered a crime punishable by imprisonment and that drug users who were arrested by police should have the option of undergoing treatment. All of which suggests the need for legal policy reform in order to support public health aims. For Rhodes (2002), "macro issues of drug, welfare and economic policies ... shape the micro social relations of risk and risk resistance as well as individual drug user practices". The existence of macro issues suggests the essentialness of employing macro-approaches.

## Constructing the "Risk Environment" through Macro-approaches

Kumar et al (2000) urges us to see that without addressing larger, macro-level issues linked to poverty in India, it is doubtful that the full potential of HIV interventions for IDUs will be realised. Similarly, Rhodes et al (1999) state that, in addition to developing interventions with proven HIV prevention efficacy (such as needle and syringe distribution and methadone treatment), there is a need to consider the 'risk environment'. This includes consideration of the social, economic, and policy environments, in which they take place, and tackling any structural barriers to effective HIV prevention. Recommendations in this regard are: 1) the development of basic health care facilities to respond to the reality of weak health infrastructure (Canadian HIV/AIDS Legal Network, 2003, ICAD, 2002, Langley, 2004, Priya, 2003, Patten and Dolan, 2002,); 2) and the provision of vocational opportunities through economic development to help retain IDUs in intervention programs and reduce their risk to HIV (Barnett et al, 2000, Hamers & Downs, 2003, Piot, 2001, Rhodes, 1999, the UN system, 2000)). The first step however, is the effective integration of 'rights' into development discourse, analysis, and initiatives. The key challenge remaining is how to move from simply providing services to meet people's needs (needs-based approach) to seeking to strengthen people's ability to demand such services from the state (rights-based approach). To make this possible, all

stakeholders in the arena of international development would need to take responsibility and ownership for developing and incorporating a RBA.

**Incorporating a RBA**

On a micro-level, Molyneux and Lazar (1999) point to the need for *local* definitions of a RBA, definitions of best practices, and a possible framework to evaluate rights-based projects. Clayton et al (2000) meanwhile suggest that on a macro-level, further policy work is needed in ensuring cooperation among governments signing on to international conventions, and among community service organisations to promote awareness among disadvantaged populations of their right to adequate services. It is suggested here that this integration and consideration is essential at various levels: the international, donor and state level.

The UNHCHR offers practical advice on how integration can be better achieved at the international level:

- UN development strategies should expressly recognise the 'intimate relationship' between development activities and efforts to promote respect for human rights;
- The development co-operation activities should be subject to human rights impact assessment;
- That development personnel should receive human rights training; and
- Human rights obligations should be taken into account at every stage of development projects (i.e. needs assessment, project identification, project implementation, project monitoring and project evaluation) (UNHCHR, n.d).

At the donor level, the following are recommendations to donors such as CIDA:

- Assist multi-lateral (UN) organisations shift to rights-based development programming (UNICEF has been noted for breaking ground in this area with its focus on the Convention on the Rights of the Child, 1989);
- Incorporate a rights-based approach into CIDA's development strategy;
- Develop tools and train CIDA staff on rights-based programming;
- Encourage and fund Canadian development NGOs to adopt or strengthen rights-based approaches;
- Support partnerships between Canadian NGOs and their counterparts in developing countries which adopt rights-based approaches (Patterson, 2001).

At the state level, the following are listed as key elements for success in RBA to HIV/AIDS that can be taken as recommendations:

- Development of government capacity to address HIV/AIDS from a rights perspective, including through law and policy reforms;
- Acknowledgement of the central role of affected communities in these reforms, both in policy development and implementation; and,
- Direct support to local civil society organisations, particularly those representing groups most vulnerable to HIV infection and the impact of AIDS, to enable them to participate in at all levels (Patterson, 2001).

Despite the limitations of a rights based approach as described in the previous chapter, there is potential for effectively addressing IDU related AIDS epidemics if a RBA is considered along with the construction of a macro-risk environment. This of course would not only require the essential ideological shift in thinking from HIV/AIDS as a health issue to a development issue but also would require investment in political systems so that they have the capacity to incorporate rights based approaches.

*Chapter 8*

# CONCLUSION

In response to the methodological question posed earlier, how can one policy document address the context-specific needs of a variety of countries that already differ along so many fundamental lines, perhaps an answer lies in a principle of maintaining a critical approach. This includes being critical either in undertaking or reviewing research that would ideally lend itself to an effective policy response. This is difficult however, as Grassly et al (2003) point out, since data on those risk behaviours that are driving the pandemics are limited and poor in quality across several countries. Attempts then to compare epidemics across countries are also hampered by the use of different indicators and survey methods from one context to the next.

In reference to research methodology, it is suggested that "standardisation would be a major advance ...[to] aid policy formulation and understanding of [the dynamics] in HIV and sexually transmitted infections" (Grassly et al, 2003). Similar arguments are made for the standardisation of services provided to those at risk to HIV/AIDS based on international best practices. However, the critical approach would urge the researcher to utilize context-specific approaches, recognizing country-specific differences so that context-specific programming and policy can be developed. The advice of a UNAIDS and ODCCP study is relevant here; "despite many common elements in intervention policies and strategies, the collection of case studies shows the different adaptations that occur in response to local contexts, and illustrates that the relative success of HIV preventive interventions is inextricably linked to the social, cultural and political contexts in which they occur" (Rhodes, 1996 as cited in UNAIDS & ODCCP, 2001: 2).

To do this, understanding the 'risk environment', and incorporating a rights-based framework would be most suitable in order to move beyond the traditional drug law and typical harm reduction approaches that take a needs-based approach to the individual-health issues of those at risk to HIV/AIDS. The benefits of a RBA include providing a mechanism for accountability and a framework for programming and policy development from which to work from. However, clear limitations exist due to the extent of legal recourse and for the inability or unwillingness of states to reconcile and incorporate the international legal system into their own. This becomes even more complex when the issue is as grave as HIV/AIDS, and involving controversial populations such as IDUs.

Despite the limitations of a RBA and the complexity of responding to HIV/AIDS among IDUs, a RBA at least offers a mechanism from which to move forward in addressing the needs of marginalized populations. Nelson and Dorsey (2003) reveal two findings of utilising a RBA; 1) the motivating power of the idea of a universal human right is more significant in these movements than precise legal appeals to specific human rights standards; and 2) applying civil and political rights have been the strongest mechanism for drawing the traditional, international human rights organizations into the arena of development. For IDUs, a RBA framework at least leads to an entry point from which to discuss access and rights issues. From there, it falls to the range of agencies involved in development to recognize their obligation to embrace a RBA, and incorporate it into their priorities and programming (Nelson & Dorsey, 2003).

Focusing on the rights of IDUs as citizens entitled to care and taking a 'risk environment approach' to understand the differing environmental determinants of harm would be the most useful. From there, appropriate, context-specific and effective policy responses can be developed. Yet, as this paper aims to highlight, this would call for a huge shift in traditional policy responses to IDUs; the responsibility for harm and the focus for change from individuals alone to the very social situations and structures in which individuals find themselves that further enable conditions of HIV infection.

Arguments explored above point to the need to develop a new approach of 'holistic' harm reduction, one that combines approaches both at the micro and macro level. Activists in this area concur that the only way forward at micro or macro levels is to involve drug users in policy design and in planning, implementing and evaluating programs, rather than allowing non-users to patronizingly believe that they know what is best for users (Stigma-aids 1: 2003-09-23).

The call then is for policy reform, inclusive of:

1) Legal measures to achieve greater congruence and compatibility between HIV and drug policies, ensuring that there are no legislative impediments that constrain the implementation of necessary measures to prevent HIV transmission between IDUs and their sexual partners (DLHPN Report July 8, 2002);
2) Policy makers must recognise that increasing HIV infection rates are linked to an increase in poverty in these regions, with a direct association to increasing crime (such as drug trafficking), sex work, and drug use as a regular or occasional means for economic survival (Barnett, 2000, Burrows et al, 2000, Hamers & Downs, 2003, Piot, 2001, Rhodes, 1999, UN system);
3) Policy makers should be urged to consider employing prevention and treatment approaches that are in line with the principles of

'public health' and 'health promotion' in preference to law enforcement approaches that emphasize punishment as the principal means of promoting behaviour change (DLHPN Report July 8, 2002); and

4) Governments should play an active role in establishing and supporting a large, strategically located network of harm reduction programs (Malinowska-Sempruch et al, 2003 & DLHPN Report July 8, 2002).

Considering then that the determinants of the disease include both economic and social factors, any effective intervention must also include economic and social strategies (Rhodes, 1999). As this analysis aims to outline, without adequate government support, and policy developments, harm reduction efforts will fail to contain the HIV infection rates, which are rapidly growing among IDUs. Using the words of Titmuss (1974) on the importance of social policy, the concept of holistic harm reduction as a policy response is meaningful since HIV and IDU workers believe that through such approaches, change can be affected in some form or another. The onus then is on all of society, national and local governments, and the international community to act quickly before the window of opportunity closes (IHRD, 2001).

BIBLIOGRAPHY

Aslanyan, Garry. Canadian International Development Agency. Personal communication; 2003

Barnett, T., Whiteside, A., Khodakevich, L., Kruglov,Y., Steshenko, V. (Nov 2000). The HIV/AIDS epidemic in Ukraine: its potential social and economic impact. *Social Science & Medicine*, v51 (9), p1387-1403.

Burrows, D. M., (2004). HIV/AIDS, Injecting Drug Use and Human Rights in the Asia-Pacific Region. Expert Meeting on HIV/AIDS and Human Rights in Asia-Pacific, Bangkok, 23-24 March 2004. Retrieved on Mar 29 2004, from www.un.or.th/ohchr/issues/hivaids/papers.htm

Burrows, D., Trautmann, F., Frost, L., Bijl, M., Sarankov, Y., Sarang, A., Chernenko, O. (Mar 2000). Processes and outcomes of training on rapid assessment and response methods on injecting drug use and related HIV infection in the Russian Federation. *International Journal of Drug Policy*, v11 (1-2), p151-167.

Canadian AIDS Society. (Feb 2002). Health is a Human Right: Lessons from the Community-Based AIDS Movement. A Brief Prepared for the Commission of the Future of Health Care in Canada. Retrieved on Feb 10 2004, from www.cdnaids.ca

Canadian HIV/AIDS Legal Network. (n.d.) A Human Rights Approach to HIV/AIDS. Retrieved on Mar 2 2004, from www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach_discriminatio n.pdf

Canadian HIV/AIDS Legal Network. (2003, Nov 6). Canada can set global precedent with Patent Act changes, but flaws in legislation could undermine potential benefit [Press Release]. Toronto. Retrieved Mar 2 2004, from www.aidslaw.ca/Media/press-releases/e-press-no0603.htm

(CIDA) Canadian International Development Agency. (2002). Canada Making a Difference in the World: A Policy Statement on Strengthening aid Effectiveness. Minister of Public Works and Government Services Canada, September 2002.

(DFID) Department For International Development. (2003). Policy Planning & Implementation, Fact Sheet 18: Rights-Based Approaches. Overseas Development Institute. Retrieved on Mar 24 2004, from http://www.keysheets.org/red_18_rights_based_approaches.html

Donoghoe, Martin C. (2003, May 31). HIV-1 in Eastern Europe. *The Lancet*, v361 (9372), p1910.

Dorabjee, J., Samson, L. (Mar 2000). A multi-centre rapid assessment of injecting drug use in India. *International Journal of Drug Policy*, v11 (1-2), p99-112.

(DLHPN) Drug Law and Health Policy Network. (2002). Drug Policies = Death: HIV/AIDS in Central and Eastern Europe. A Report by the Drug Law and Health Policy Network on the Current Impact of Law and Policy on Spread of HIV in Central and Eastern Europe and the Former Soviet Union. Retrieved Oct 4 2003, from http://www.drugpolicy.org/docUploads/drugpolicies_death.pdf

Fernandez, Irene. (2002). Global Battle Cry: Health is a Right, Not a Commodity. From Barcelona 2002: Law, Ethics, and Human Rights. *Canadian HIV/AIDS Policy & Law Review, v7 (2/3),* December 2002, p80-84.

Fitch, C., Rhodes, T. and Stimson, G. V. (2000). Origins of an epidemic: the methodological and political emergence of rapid assessment. *International Journal of Drug Policy*, v11 (1-2), p63-82.

Grassly, Nicholas C., Lowndes, C.M., Rhodes, T., Judd, A., Renton, A., Garnett, G.P. (Feb 2003). Modelling emerging HIV epidemics: the role of injecting drug use and sexual transmission in the Russian Federation, China and India. *International journal of Drug Policy,* v14 (1), p25-43.

Hamers, F. F., Downs, A. M. (Mar 2003). HIV in Central and Eastern Europe. *The Lancet*, v361 (9362), p1035-1044.

(ICAD) Interagency Coalition on AIDS and Development. (Apr 2002). Access to Treatment and Care in Africa for HIV/AIDS and Other Diseases [Brochure].

(ICAD) Interagency Coalition on AIDS and Development. (Aug 2001). Access to HIV/AIDS Treatment in Developing Countries [Brochure].

Id21 Communicating Development Research. (2001). At your service: a rights-based approach for CSOs? Id21 Research Highlight: 5 June 2001. Original source: Clayton, A., Oakley, P., Taylor, J. (2000). Civil Society Organisations and Service Provision. UNRISD Programme on Civil Society and Social Movements, Programme Paper #2, (October 2000). Retrieved on Mar 24, 2004, from www.id21.org/society/s8cac1g2.html

Id21 Communicating Development Research. (2000). Rights here, rights now: democratisation of development in Latin America. Id21 Research Highlight: 24 May 2000. Original Source: Molyneux, M. and Lazar, S. (1999). Rights citizenship and participatory development. ESCOR Research Report #7183. Retrieved on Mar 24 2004, from www.id21.org/society/8bmm1.html

(IHRD) International Harm Reduction Development. (2001). Drugs, AIDS and Harm Reduction: How to slow the HIV epidemic in Eastern Europe & the Former Soviet Union. Open Society Institute. Retrieved Oct 4 2003, from http://www.soros.org/harm-reduction/resourceguide/index2.html

(IHRD) International Harm Reduction Development. (n.d.) Drug Use & HIV in Eastern Europe & The Former Soviet Union. Retrieved Oct 4 2003, from http://www.soros.org/harm-reduction/frame_drug.htm

Kumar, M. S., Mudaliar, S., Thyagarajan, S.P., Kumar, S., Selvanayagam, A., Daniels, D. (Mar 2000). Rapid assessment and response to injecting drug use in Madras, South India. *International Journal of Drug Policy*, v11 (1-2), p83-98.

Jacobi, Jantine. (Winter 2003). Taking stock of progress in the national response to HIV/AIDS in Ukraine. *Sexual Health Exchange*, v2003 (1), p12-14.

Jurgens, Ralph. (2004). Human Rights for People Living with HIV/AIDS. Presented at the Living with HIV/AIDS Panel: Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia. Dublin, 24 Feb 2004.

Langley, A. (2004, Mar 14). African AIDS drug plan faces collapse. The Observer.

Lunn, Renate J. (Summer 2002). Harm Reduction, The EU Accession Process and EU Drug Policy: Position Paper. *Public Interest Law Initiative*. Columbia University Budapest Law Center.

Malinowska-Sempruch, Kasia, Hoover, Jeff & Alexandrova, Ana. (Apr 2003). Unintended Consequences: Drug Policies Fuel the HIV Epidemic in Russia and Ukraine. Open Society Institute. Retrieved Oct 4 2003, from www.soros.org/harm-reduction

Malinowska-Sempruch, Kasia. (Dec 2002). The Need for Harm Reduction Approaches in Eastern Europe and the Former Soviet Union. *Canadian HIV/AIDS Policy & Law Review*, v7 (2/3), p84-88.

McKeehan, I.V. (Nov 2000). A multilevel city health profile of Moscow. *Social Science & Medicine*, v 51(9), p1295-1312.

NACO. (1999). National AIDS Prevention and Control Policy. *National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India,* 1999. Retrieved Nov 17, 2003, from www.naco.nic.in/nacp/ctrlpol.htm

Nadelmann, Ethan. (n.d.). Challenging the global prohibition regime. The Lindesmith Centre. Retrieved Oct 10 2003, from www.drugtext.org/library/articles/98921.htm

Nelson, P.J., Dorsey, E. (2003). At the Nexus of Human Rights and Development: New Methods and Strategies of Global NGOs. World Development, v31 (12), December 2003, p2013-2026.

Neuman, L. (1997). The meanings of methodology. In Social Research Methods: Qualitative and Quantitative Approaches. Boston: Allyn & Bacon, p60-87.

Neysmith, S.M. (1995). Feminist Methodologies: A Consideration of Principles and Practice for Research in Gerontology. *Canadian Journal on Aging,* v14(1), p100-118.

(ODI) Overseas Development Institute. (1999). What Can We Do With a Rights-Based Approach to Development? ODI Briefing Paper 1999 (3) September.

Patten, S. & Dolan, L. (Jun 2002). Briefing paper: Corporate Globalization and the G8 Summit: What do they mean to Canadians concerned about HIV/AIDS? Alberta Community Council on HIV.

Patterson, D. (2002). Revieweing programming on HIV/AIDS, human rights and development. Canadian HIV/AIDS Legal Network for the Canadian International Development Agency.

Patterson, D. (2001). Strengthening Aid Effectiveness: New Approaches to Canada's International Assistance Program. Submission by the Canadian HIV/AIDS Legal Network.

Piot, P., Seck, A.W.C. (2001). International response to the HIV/AIDS epidemic: Planning for success. World Health Organization. *Bulletin of the World Health Organization,* v79 (12), p1106-1113.

Priya, R. (2003, Dec 13). Health Services and HIV Treatment: Complex Issues and Options. Economic and Political Weekly, EPW Commentary. Retrieved Mar 4 2004, from www.epw.org.in/showArticles.php?root=2003&leaf=12&filename=6604&filetype=html

Rhodes, T. (Jun 2002). The 'risk environment': a framework for understanding and reducing drug related harm. *International Journal of Drug Policy,* v13 (2), p85-94.

Rhodes, T., Ball, A., Stimson, G.V., Kobyshcha, Y., et al. (Sep 1999). HIV infection associated with drug injecting in the Newly Independent States, Eastern Europe: The social and economic context of epidemics. *Addiction,* v94 (9), p1323-37.

Stover, H., Nelles, J. (2003). Ten years of experience with needle and syringe exchange programmes in European prisons. *The International Journal of Drug Policy.* Article in Press, accepted 11 August 2003.

Task force on Drug Use and HIV vulnerability. (Oct 2000). Drug Use and HIV Vulnerability: Policy Research Study in Asia. UNAIDS & UNDCP.

Titmuss, R.M. (1974). Social Policy: an introduction. London: George Allen & Unwin Ltd, p23-32.

UNAIDS Q&A II Basic facts about the HIV/AIDS epidemic and its impact, Section II. Retrieved Oct 10 2003, from http://www.unaids.org/en/resources/questions_answers.asp

UNAIDS Q & A III Selected Issues: Prevention & Care, section VIII. Retrieved Apr 11 2004, from http://www.unaids.org/en/resources/questions_answers.asp

UNAIDS Report 18-11-03. The Warsaw Declaration: a framework for effective action on HIV/AIDS and injecting drug use. 2nd International Policy Dialogue on HIV/AIDS, held in Warsaw, Poland, November 12 – 14, 2003.

UNAIDS. (2000). Innovative Approaches to HIV Prevention: Selected Case Studies. UNAIDS Best Practice Collection. Geneva, Switzerland.

UNAIDS & ODCCP. (Apr 2001). Drug Abuse and HIV/AIDS: Lessons Learned – Case Studies Booklet – Central and Eastern Europe and the Central Asian States. ODCCP Studies on Drugs and Crime, & UNAIDS Best Practice Collection. Vienna & Geneva.

UNAIDS & WHO. Global Summary of the HIV/AIDS Epidemic December, 2003. (July 2004). Retrieved July 31, 2004 from www.unaids.org/bangkok2004/graphics/GAR2004-epigraphs.ppt

(UNHCHR) United Nations High Commission for Human Rights. (n.d.) Rights-based approaches. Retrieved Mar 24 2004, from www.unhchr.ch/developent/approaches.html

United Nations System. (Sep 2003). Preventing the Transmission of HIV among Drug Abusers. Annex to the Report of 8th Session of ACC Subcommittee on Drug Control. Retrieved Oct 4 2004, from http://www.unaids.org/EN/other/functionalities/document.asp?href=http://www.unaids.org/html/pub/Publications/IRC-pub03/HRAIDS_en_DOC.htm&PDFHref=&FileSize=51712

Weiss, C. (1986). The Many Meanings of Research Utilization. In M. Bulmer (ed) Social Science and Social Policy. London: Unwin Hyman.

Wharf, B. (1997). Community Organizing: Canadian Experiences. In Community Organizing: Canadian Experiences. Oxford U Press.

Wharf, B. & Clague, M. (1997). Lessons and Legacies. In Community Organizing: Canadian Experiences. Oxford U Press.

**Online List-serves**

AIDS India e-forum, Accessed from May 2003 – present.

Ajithkumar. Comments on NACO draft Guidelines for ARV. AIDS-India eforum, 2003-12-06

An Observation on why North East States are Prone to Drug Use: AIDS-India eforum, 2003-10-02.

ETHIOPIA: Focus on local manufacture of anti-retroviral drugs. IRIN, 2004-03-10

Heaviside, Geoff. Re: NACO: Invitation to join the partnership forum on HIV/AIDS in India: AIDS-India eforum, 2003-11-17.

Hussain, S. Z. Mizoram State Elections: Drugs-AIDS epidemic non-issues: AIDS-India eforum, 2003-11-18.

IRIN Plus News – AIDS in Africa newsgroup, Accessed from April 2003 – present.

Jayasree. RE: NACO Guidelines on ARVs. AIDS-India eforum, 2003-12-09

Saathi – AIDS in India newsgroup, Accessed from May 2003 – present.

Sharma, Umesh. Stigma-aids Discussion 17: Stigma, HIV and drug users, Stigma-AIDS eforum, 2003-07-31.

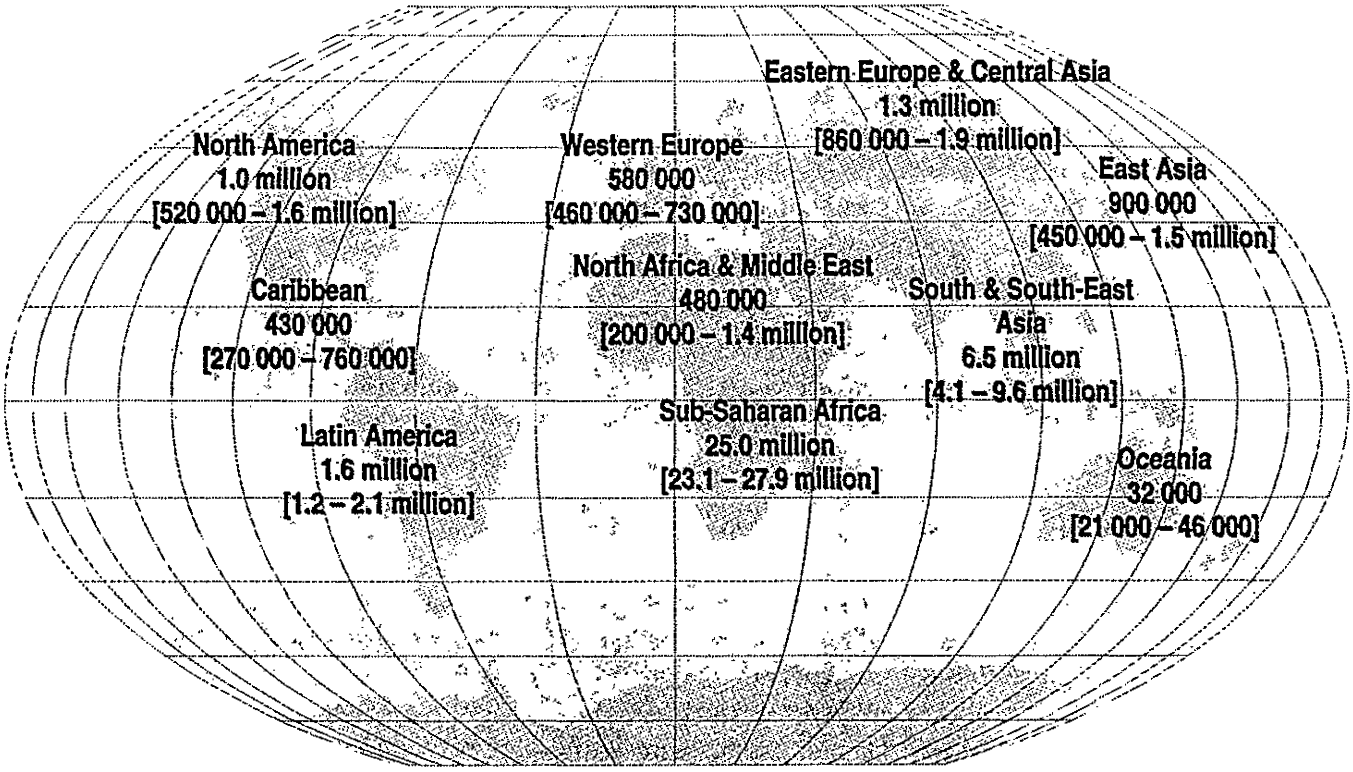
Stigma-aids Discussion, Stigma-AIDS e-forum, Accessed from June 2003 – August 2003.

Stigma-aids Discussion Summary 1: Stigma, HIV and drug users, Stigma-AIDS eforum, 2003-09-23.

Stigma-aids Discussion 34: Stigma, HIV and drug users, Stigma-AIDS eforum, 2003-08-18

## Appendix A: Global HIV/AIDS Map

### Adults & Children Estimated to be Living with HIV end of 2003




**TOTAL: 37.8 (34.6 – 42.3) Million**

- 14,000 new infections per day in 2003
- More than 95% are in low and middle income countries
- Almost 2000 are in children under 15 years of age
- Almost 12000 are in persons aged 15-49 years, of whom:
  - almost 50% are female
  - about 50% are 15-24 years old

Original source: Global Summary of the HIV/AIDS Epidemic December, 2003. (July 2004). UNAIDS & WHO Retrieved July 31, 2004 from www.unaids.org/bangkok2004/graphics/GAR2004-epigraphs.ppt

## Appendix B: HIV/AIDS & Injection Drug Use 101

### WHAT IS HIV?

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). HIV is spread from person to person through these bodily fluids:

- Blood
- Semen
- Vaginal secretions
- Breast Milk

HIV is often spread through **unprotected sex** and **sharing needles** and **other drug use equipment**. The virus attacks the immune systems, which is the body's tool for fighting disease. When HIV weakens the immune system, it is easy to get serious infections, some of which can kill you. Having HIV does not mean you have AIDS. If you are HIV positive, and you have had HIV-related illnesses and your immune system is very weak, then your doctor will diagnose you as having AIDS.

### HIGH/LOW/NO RISK BEHAVIOUR (for HIV & other STIs, STDs)

- High-risk: unprotected vaginal and anal sex, sharing of drug use equipment (spoons, cookers, filters, ties, straws, pipes), or sharp materials – razors, toothbrushes, nail clippers, tattooing and piercing instruments.
- Low-risk: unprotected oral and anal sex
- No-risk: wet kissing, massages, hugging, mutual masturbation

Original source: CATIE. (2002). Prefix – Harm Reduction for Positive Users. Canadian AIDS Treatment Information Exchange.

## Other IDU-related Illnesses

| Illness | What is it? | How you get it: | How to prevent it: |
|---|---|---|---|
| ***Hepatitis C (Hep C)***<br><br>** Because Hep C and HIV are both spread thorugh the blood, many people have both viruses. This is called co-infection. It's hard to deal with both infections at the same time: having HIV makes Hep C progress faster and harder to treat because the immune system is weaker. Having Hep C makes HIV harder to treat because HIV meds can damage the liver even more. | Hep C virus causes serious disease of the liver, which can destroy the liver's ability to break down nutrients, medicine and drugs. Sometimes Hep C can cause severe scarring of the liver called "cirrhosis", and can also lead to liver cancer. Most people who get Hep C will have the virus for the rest of their lives. | Like HIV, Hep C travels in the blood. Because Hep C can live for a long time outside the body, it is much easier to get than HIV. It is transmitted easily from sharing needles and other drug use equipment as well as razors, toothbrushes, nail clippers and tattooing and piercing instruments. Many IDUs have Hep C from sharing pipes and straws. Hep C can also be spread by sex if either partner is bleeding or has genital sores | Don't share any drug use equipment – including spoons, cookers, filters, ties, straws, pipes or water. Clean your hands and the surfaces around you before and after shooting up. Don't share razors, toothbrushes, nail clippers or tattooing and piercing instruments. |
| ***Hepatitis B (Hep B)*** | Hep B is a virus which is easier to catch than Hep C | From unprotected sex and sharing needles and spoons | Vaccines are the best protection. Don't share drug use equipment, don't save or collect filters for doing a 'wash'. Use condoms or dams for sex. |
| ***Tuberculosis (TB)*** | TB is a disease caused by bacteria that can affect any part of the body, usually the lungs. With inactive or latent TB infection, you have the TB germ but don't have any symptoms and are not contagious. You may develop active TB disease later on. With active TB disease, you may feel sick and can pass it on to others. If your immune systems is weak from HIV, inactive TB can become active TB disease. | TB is spread by germs through the air. You can get TB from people with active TB disease if they cough or sneeze very near to you or if you come in contact with their saliva. It is easier to get TB if HIV has weakened your immune system. | If you smoke or snort crack or cocaine, use your own pipe or straw. If you smoke tobacco or pot, try to avoid sharing cigarettes or joints. If you sniff glue or other solvents, use your own bag. If you have TB, cover your mouth when you cough or sneeze. |

Original source: CATIE. (2002). Prefix – Harm Reduction for Positive Users. Canadian AIDS Treatment Information Exchange.

## Appendix C: Country Profile of Risk Behaviour

### Regional Summary of the HIV/AIDS Epidemic, end of 2001

| Region | Epidemic started | Total no of people with HIV/AIDS | Adult prevalence rate* (%) | Per cent women among HIV-positive adults | Main mode(s) of transmission** for adults living with HIV/AIDS |
|---|---|---|---|---|---|
| Sub-Saharan Africa | Late '70s–Early '80s | 28.1 million | 8.4 | 55 | Hetero |
| North Africa and Middle East | Late '80s | 440 000 | 0.2 | 40 | Hetero, IDU |
| South and South-East Asia | Late '80s | 6.1 million | 0.6 | 35 | Hetero, IDU |
| East Asia and Pacific | Late '80s | 1 million | 0.1 | 20 | IDU, hetero, MSM |
| Latin America | Late '70s–Early '80s | 1.4 million | 0.5 | 30 | MSM, IDU, hetero |
| The Carribean | Late '70s–Early '80s | 420 000 | 2.2 | 50 | Hetero, MSM |
| Eastern Europe and Central Asia | Early '90s | 1 million | 0.5 | 20 | IDU |
| Western Europe | Late '70s–Early '80s | 560 000 | 0.3 | 25 | MSM, IDU |
| North America | Late '70s–Early '80s | 940 000 | 0.6 | 20 | MSM, IDU, hetero |
| Australia and New Zealand | Late '70s–Early '80s | 15 000 | 0.1 | 10 | MSM |
| **TOTAL** | | **40 million** | **1.2** | **48** | |

* Per cent with HIV/AIDS among people 15–49 years.

** Hetero (heterosexual transmission), IDU (transmission through injected drug use), MSM (sexual transmission among men who have sex with men).

**Source:** UNAIDS/WHO 2001

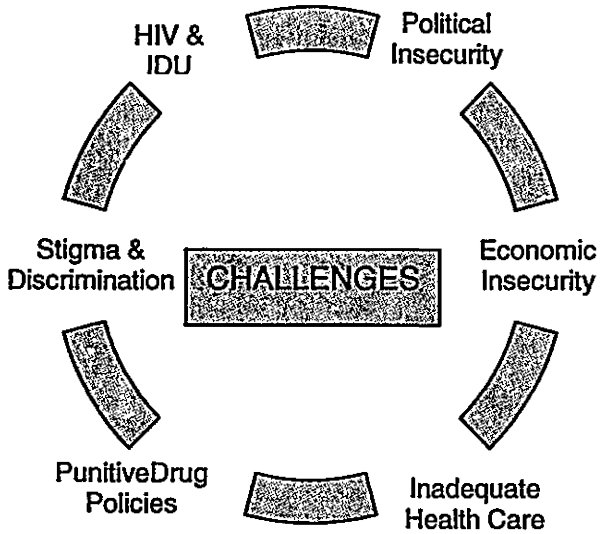
Original source: pg 192 of Sida Studies, no. 7. (n.d.). One Step Further – Responses to HIV. Retrieved on Mar 27 2004, from www.sida.se

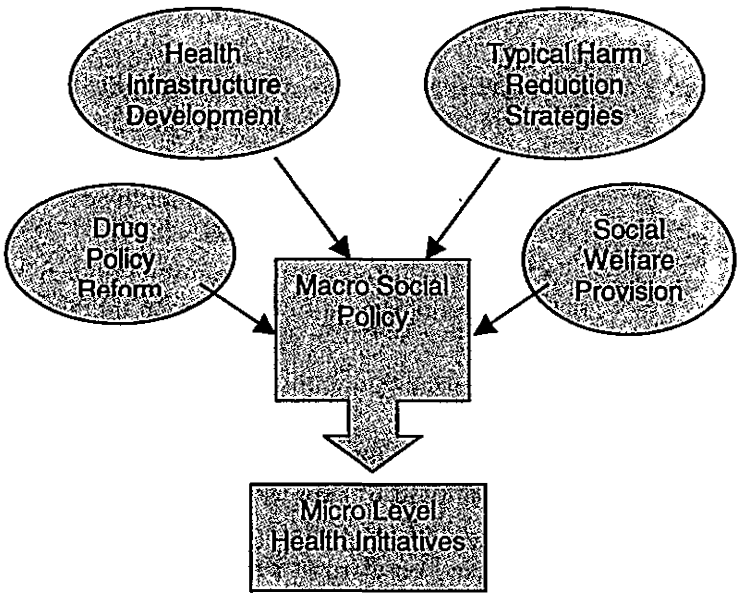
## Appendix D: The Holistic Approach to HIV/AIDS & Injection Drug Use

**Injection drug use (IDU), in tandem with burgeoning or currently existing HIV epidemics, is rapidly becoming a serious social problem in developing countries.**

**The objectives of this study were:**

- To uncover the challenges that frame responses to HIV and IDU, and
- Outline potential policy responses at the individual state level in order to effectively curb the impacts of these interdependent epidemics.




**Challenges (Results):**

In developing countries, IDU and HIV epidemics often coincide with political and economic uncertainty, which further promote HIV and IDU behavior if broader socio-economic issues are not addressed. Challenges such as stigma, and punitive drug policies are framed by: Conditions of poverty and high unemployment; The number of people in need of treatment/services which increases as infection is transmitted to the general population; and, Inadequate health care systems.

**Policy Responses (Conclusions):**

Despite the creativity of current micro-level community health initiatives, in order to be fully sustainable, macro-level social policy responses are also urgently needed. These responses must involve drug policy reform/development, harm reduction strategies, and most importantly social welfare provisions that attend to the health, social and economic needs of HIV & IDU endemic countries.

**Methods:**

Secondary analysis from journal articles of varied disciplines, publications from non-governmental organizations and UN bodies. Analysis of the variety of socio-economic issues related to HIV/AIDS, community initiatives, and approaches to, and merits of, harm reduction strategies across international contexts.

## Appendix E: A Summary of Human Rights

Human rights necessary for survival and dignified living include:

- The rights to life and liberty
- The right to a standard of living adequate for health and well-being of the individual and his/her family
- The right to social protection in times of need
- The right to the highest attainable standard of physical and mental health
- The right to work and to just and favourable conditions of work
- The rights to food, and housing
- The rights to privacy and to family life

Human rights also cover those rights and freedoms necessary for human dignity, creativity and intellectual and spiritual development, for example:

- The right to education and to access to information
- Freedoms of religion, opinion, speech, and expression
- Freedom of association
- The right to participate in the political process
- The right to participate in cultural life

They also include those rights necessary for liberty and physical security, for example:

- Freedom from slavery or servitude
- The right to security of person (physical integrity)
- The right to be free from arbitrary arrest or imprisonment
- Freedom from torture and from cruel, inhuman or degrading treatment or punishment
- Cross-cutting are the twin principles of the equal rights of women and men, and the prohibition of discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

** Summary from: Overseas Development Institute. (1999). What Can We Do With a Rights-Based Approach to Development? ODI Briefing Paper 1999 (3) September.

Original source: Häusermann, J. (1998). "A Human Rights Approach to Development". Rights and Humanity. London: Department for International Development of the UK Government, p56

## Appendix F: Milestones in a Rights-Based Approach

- 1948 Universal Declaration of Human Rights
- 1950 European Convention on Human Rights
- 1965 Convention on the Elimination of all forms of Racial Discrimination
- 1966 International Covenant on Civil and Political Rights
- 1966 International Covenant on Economic, Social and Cultural Rights
- 1969 American Convention on Human Rights
- 1979 Convention on the Elimination of Discrimination Against Women
- 1981 African Charter on Human and People's Rights
- 1984 Convention Against Torture
- 1986 Declaration on the Right to Development
- 1989 Convention on the Rights of the Child
- 1993 World Conference on Human Rights, Vienna
- 1994 Convention on the Status of Refugees
- 1998 Treaty setting up the International Criminal Court

** Summary from: Overseas Development Institute. (1999). What Can We Do With a Rights-Based Approach to Development? ODI Briefing Paper 1999 (3) September.

Original source: Häusermann, J. (1998). "A Human Rights Approach to Development". Rights and Humanity. London: Department for International Development of the UK Government, p56