Reason and rights in global drug control policy

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Among a number of compelling reasons for the international community to reconsider the "war on drugs," the HIV/AIDS epidemic is the most urgent. The prevailing emphasis on law enforcement in drug policy has failed to produce its purported benefits, yet many countries insist on enforcing prohibition and resist the implementation of evidence-based measures to reduce the health-related harms of drug use. These policies disregard the available scientific evidence, and in so doing directly contribute to the harms associated with illicit drug use, including the spread of HIV/AIDS.[1] Moreover, they contravene human rights obligations under international law. Developments in the coming weeks will indicate whether the World Health Organization and the member states of the United Nations can rise to the challenge of mitigating the negative health impacts of global drug control treaties or whether timidity in the face of ideological bullying will prevail.

Roughly 40 million people are infected with HIV worldwide, of whom an estimated 5 million were infected during 2003 alone.[2] Some 3 million people died of HIV/AIDS last year.[2] In many settings, opioid dependence and associated sharing of drug injection equipment is a principal factor fuelling the epidemic.[3] It is estimated that there are over 13 million illicit injection drug users (IDUs) worldwide.[4] Of the 136 countries that reported injection drug use in 2003, 93 also reported HIV infection among IDUs.[5] The HIV epidemic is growing exponentially in Eastern Europe and countries of the former Soviet Union; in these regions, IDUs and their sexual contacts account for most new infections.[6,7] A similar pattern is seen in Asia.[8] An estimated 10% of all new HIV infections worldwide are now attributable to injection drug use; this figure rises to 30% outside Africa.[9] Although antiretroviral drugs have improved HIV care, access to these drugs is notoriously limited, including in many regions where the epidemic is driven largely by injection drug use.[10] Even where antiretroviral treatment is available, access for drug users has been particularly poor.[1,11] In Russia, for example, over 90% of cumulative HIV cases as reported by government HIV/AIDS programs by 2002 were among IDUs, yet AIDS service programs in Moscow and St. Petersburg reported that none of the patients receiving antiretroviral drugs were IDUs.[12]

Given the major role played by injection drug use in the HIV/AIDS epidemic, opioid substitution therapy, which facilitates both prevention and treatment, is a critical element of a comprehensive response. Access to oral methadone or buprenorphine can reduce or eliminate injection of heroin and the frequently associated sharing of injection equipment.[13] Clinical studies have demonstrated that access to addiction treatment programs significantly increases uptake of HIV treatment among IDUs.[14–20] Substitution therapy has been recognized as the most effective treatment for opioid dependence[21] and has been widely implemented.[22] Yet opiate substitutes are unavailable or banned in many of the countries where HIV prevalence and incidence are high among IDUs.[22]

Because a significant number of people living with HIV/AIDS are IDUs, current global efforts to scale up access to antiretroviral treatment will necessitate universal access to substitution therapy as a matter of equity and of pragmatism. Proposals to add methadone and buprenorphine to the WHO's Model List of Essential Medicines[23] will be considered by the WHO's Expert Committee on the Use of Essential Drugs this month. The addition of these drugs to the list would encourage their integration into national health systems, facilitate funding from such mechanisms as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and signal to governments that access to such therapy for drug users must be integrated into HIV prevention and treatment plans.[24]

The international community also faces the larger question of whether it will continue to endorse failed strategies of drug prohibition and law enforcement or finally embrace evidence-based harm-reduction measures such as opioid substitution, syringe exchange and supervised injection facilities. All UN member states have a treaty obligation to cooperate with the UN in solving international health problems and in realizing human rights for all.[25] The Universal Declaration of Human Rights, reaffirmed by all UN member states for more than 50 years, declares that all people have the right to a standard of living adequate for health and well-being, including access to medical care.[26] The International Covenant on Economic, Social and Cultural Rights[27] recognizes the right of all people to enjoy the highest attainable standard of health (Article 12). Furthermore, it requires all parties to the covenant to take steps to "progressively realize" this right "by all appropriate means, including particularly the adoption of legislative measures" (Article 2) and to take the steps necessary to prevent, treat and control epidemic diseases and to create conditions that assure medical services and attention in the event of sickness (Article 12). At the very least this means that countries must not block harm-reduction measures that reduce the spread of HIV among drug users, and that they must facilitate access to health services.

At its upcoming session this month, the UN Commis-

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sion on Narcotic Drugs, the central policy-making body within the UN system with regard to drug control, will be holding a thematic discussion on "HIV/AIDS in the context of drug use." Already, hard-line prohibitionist countries such as the US are preparing to resist interpretations of UN treaties on illicit-drug control that encourage a harm-reduction approach. Among other tactics, the US administration continues to disingenuously cast doubt on the proven benefits of syringe exchange programs, regularly invoking misinterpretations of the Canadian experience in cities such as Vancouver and Montreal.[28]

Canada is bound by the human rights obligations it has undertaken as a member state of the UN, and human rights are stated as a central part of Canadian foreign policy.[29,30] Canada has implemented a wide range of harm-reduction measures domestically (partly in response to HIV/AIDS), and the declared central objective of our national drug strategy is harm reduction.[31,32] Canada should therefore play the role of strong global advocate for harm reduction, including at the UN Commission on Narcotic Drugs. This debate needs rational voices informed by public health evidence and a firm commitment to the human rights of all people, including those who are drug dependent.

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