Alternative Report to the Committee on Economic, Social and Cultural Rights on Kazakhstan's initial report on the implementation of the International Covenant on Economic, Social and Cultural Rights

Drug Use, HIV, Overdose and Harm Reduction: Articles 2, 12 and 15.1.b

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Individuals who use drugs do not forfeit their human rights. These include the right to the highest attainable standard of physical and mental health (including access to treatment, services and care)…a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV.

UN High Commissioner for Human Rights, 2009[2]

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I. Overview

People who use illicit drugs are vulnerable to a wide range of negative health consequences as a result of that use, consequences that include infection with blood borne viruses including HIV and hepatitis C, and death from overdose. It is well established that unsafe drug injecting practices are a primary driver of HIV and other blood borne viruses in many countries, including the Republic of Kazakhstan.[3] This is despite the fact that there exist inexpensive, evidence-based *harm reduction* interventions – such as the provision of sterile injecting equipment and the prescription of opioid substitution therapy – that have proven effective in reducing the spread of HIV and improving the overall health of people who inject. The effectiveness of such interventions is clear from the fact that HIV–related harm reduction has been adopted in the policies of, *inter alia*, the United Nations system,[4] specific UN programmes and funds,[5] the European Union,[6] the Council of Europe[7] and the International Federation of the Red Cross and Red Crescent Societies.[8]

In addition to the health risks related to HIV and hepatitis C infections, opiate overdose has been reported as the leading cause of death among people who use drugs in those Central Asian states for which any data are available. [9]

Section II of this report considers these issues within the framework of the Covenant on Economic Social and Cultural Rights.

As recognised by the High Commissioner for Human Rights, people who use illicit drugs do not forfeit their rights because of the illegal nature of their activities. Indeed, the High Commissioner, the Special Rapporteur on the Right to Health and the Special Rapporteur on Torture have both raised concerns about the failure of States to meet their human rights obligations vis-à-vis people who use drugs and the negative consequences of this failure on both the individual health of drug users and broader public health concerns.

Consideration of illicit drug use, its impacts on both individual and public health and the availability, accessibility, acceptability and quality of HIV prevention measures clearly fall within the remit of the Committee on Economic, Social and Cultural Rights under Article 12 of the Covenant - the right to the highest attainable standard of physical and mental health. This article is supported by article 15.1.b, which guarantees the right of everyone to benefit from scientific progress and its applications, and by article 2, which requires appropriate legislative and budgetary measures to ensure the progressive realisation of these rights.

Section III looks in more detail at the situation in the Republic of Kazakhstan, focusing on HIV prevention for people who inject drugs inside and outside prisons and overdose prevention and treatment.

The Republic of Kazakhstan has the highest rate of injecting drug use in Central Asia (100,000—160,000 people). Despite the efforts made by the Government of Kazakhstan, injecting drug use remains the primary driver of the epidemic in the country (73% of registered cases), and HIV prevalence amongst drug users is high (9.2%)

Opiate overdose has been reported as the leading cause of death of people who use drugs in Central Asia. National data for Kazakhstan, however, do not exist.

These issues, however, and the Government's responses to them are largely absent from the State party's initial report.

HIV prevention
On the positive side, the Government has recognised harm reduction as one of the main priorities in its National AIDS Program for 2006—2010 and the number of needle and syringe programmes (NSPs) has been gradually increasing, reaching a total of 159 sites in 2010. Coverage of these programmes, however, is still insufficient and hampered by factors that deter people from accessing services, such as drug user registration and police interference.

Another positive development has been that opioid substitution therapy (OST) with methadone has been also introduced in two pilot projects in November 2008, in which 50 people are enrolled. However, this programme is small and entirely dependent on international aid. The issue of OST remains highly politicised in the country. There is an urgent need for scale up of this evidence based intervention which has proven effective in reducing HIV and in treating opiate dependence.

Prisons
Prisoners in Kazakhstan are also at very high risk of HIV infection through unsafe injecting practices. However, efforts to address this problem have been insufficient. There are no NSPs in the Kazakhstan prison system, and OST is not permitted, despite successful implementation of both interventions in prisons in other countries. These gaps were specifically raised by the Special Rapporteur on Torture following his 2009 mission to Kazakhstan.

Compulsory HIV testing is common practice in Kazakhstan prisons, and access to HIV antiretroviral treatment (ART) is limited. There is no possibility provided in legislation for court ordered drug dependence treatment as an alternative to imprisonment, meaning that in practice incarceration is the only policy option available for people arrested for drug offences.

Opiate overdose
Given the high rate of opiate use in Kazakhstan, fatal and non-fatal overdose is a high risk. For those who receive medical treatment for opiate overdose, the survival rate is far higher than for those who do not. This situation could be significantly improved by the distribution of Naloxone to lay practitioners and peers (a drug used already by medical staff in Kazakhstan to treat opiate dependence). Opioid substitution therapy has also been shown to greatly reduce the risk of overdose.

Section IV sets out 4 key recommendations relating to these issues for the Government of Kazakhstan

II. Harm Reduction and the International Covenant on Economic Social and Cultural Rights

Harm reduction and the right to health (Article 12)

Harm reduction interventions – including needle and syringe exchange programmes and the prescription of opioid substitution therapy such as methadone – have found considerable support among numerous UN human rights mechanisms, particularly in the context of HIV prevention and the right to the highest attainable standard of health.

The **Committee on the Economic, Social, and Cultural Rights**, has recommended on several occasions that States Parties scale up their harm reduction programmes in order to meet their obligations under Article 12. For example:

- In its Concluding Observations on Ukraine (2007), the Committee stated that it was "*gravely concerned at…the limited access by drug users to substitution therapy*," and recommended that the state party "*make drug substitution therapy and other HIV prevention services more accessible for drug users*."[10]

- In the context of the obligation to progressively realise the right to health, the Committee stated in its Concluding Observations on Tajikistan (2006) "*that the State party establish time-bound targets for extending the provision of free testing services, free treatment for HIV and harm reduction services to all parts of the country*."[11]

- In its Concluding Observation on Poland (2009), the Committee highlighted its concern at the limited access to HIV antiretroviral treatment, particularly among people who use drugs. It also raised its concern that "only a small number of drug users have access to substitute drug dependence treatment, and that such treatment is even more limited for those in detention".[12]

Both methadone and buprenorphine (the main medications used in opioid substitution therapy) are included on the WHO model essential medicines list. The Committee has noted that the right to health includes access to essential medicines.[13]

The obligation of States to provide access to harm reduction interventions has also received strong support from the **UN Special Rapporteur on the Right to the Highest Attainable Standard of Health**. For example, the former Special Rapporteur Prof Paul Hunt, stated that,

> [I]n seeking to reduce drug-related harm, without judgment, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs.[14]

Following his country mission to Sweden in 2006, Prof Hunt specifically called upon the Government to implement harm reduction programmes as a matter of priority.[15]

The current Special Rapporteur, Anand Grover, has also expressed strong support for harm reduction programmes.

> State Parties have obligations under international law and in particular under Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) to prevent epidemics. Therefore, states have an obligation under international law to pursue harm reduction strategies. Under the same provision, State Parties also are obliged to realize the right to highest attainable standard of health, particularly for marginalized communities, such as drug users. This means that drug user communities are entitled to, opioid substitution therapy and drug dependence treatment, both inside and outside prisons. This right has to be realized universally.[16]

In 2009, the **UN Human Rights Council** adopted a resolution on human rights and HIV/AIDS that explicitly supported harm reduction interventions, including needle and syringe exchange.[17] The resolution reflected existing Commitments made at the **General Assembly** in 2001 and again in 2006. In 2010, the **UN Commission on Narcotic Drugs** adopted a resolution giving its strongest support to date to the comprehensive package of interventions for HIV prevention treatment and care among injecting drug users – including needle and syringe exchange and opioid substitution therapy. Both **ECOSOC** and the **UNAIDS Programme Co-ordinating Board** have also endorsed these interventions.

The issue of harm reduction and the right to health in prisons has been has been a particular concern of UN human rights monitors. The **Committee on Economic Social and Cultural Rights** has explicitly stated in its General Comment on the Right to Health, that States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees.[18] In 2007, the Committee recommended that Ukraine "*continue its efforts and take urgent measures to improve the accessibility and availability of HIV prevention to all the population and the treatment, care and support of persons living with HIV/AIDS, including in prisons and detention centres… and make drug substitution therapy and other HIV prevention services more accessible for drug users*."[19]

Following his country mission to Kazakhstan, the **UN Special Rapporteur on Torture**, Prof Manfred Nowak, recommended that the Government make clean needles and syringes and opioid substitution therapy available in prisons.[20]

Overdose, however, has not featured prominently in human rights discourse to date.

Harm reduction, scientific progress and progressive realisation (Articles 15.1.b and 2)

The realisation of the right to health in the context of injection driven HIV and harm reduction is further supported by Articles 15.1.b and 2. Together, these articles support the implementation of health systems for HIV prevention that are available, accessible, acceptable and of high quality.

Article 15.1.b guarantees the right of everyone to benefit from scientific progress and its applications. In the context of injecting driven HIV, this means the right to benefit from evidence-based, scientifically proven interventions that can prevent, treat and control HIV/AIDS and that can control and treat drug dependence and drug related harm. Needle and syringe programmes and opioid substitution therapy have a considerable scientific evidence base demonstrating their effectiveness at reducing injecting-related risk behaviours.[21]

Opioid substitution therapy has also proven to be effective as an overdose prevention measure, reducing deaths from overdose by as much as 80%. The administration of Naloxone by health practitioners, harm reduction workers and peers is also effective in reducing mortality rates related to overdose. (See further below)

Article 2 obliges States Parties to take steps to the maximum of available resources to progressively achieve the full realisation of the rights contained in the Covenant. This requires appropriate budgetary planning and allocation of resources for the prevention of injecting driven HIV. In this regard, it should be noted that NSPs and OST have proven to be very cost effective across a range of settings, in both the community and in places of detention.

Article 2 also requires legislative reform in order to create a legal and policy environment conducive to the scale up of these services and the removal of barriers to access and coverage to improve accessibility.

III. Drug Use, HIV and Harm Reduction in the Republic of Kazakhstan

As of July 2009, official records indicated approximately 12,801 people living with HIV in Kazakhstan (62 per 100,000 people). The epidemic is concentrated largely among specific vulnerable populations, primarily people who inject drugs and prisoners. Kazakhstan has the largest number of people who inject drugs in Central Asia (100,000–160,000),[22] and injecting drug use is currently the primary driver of the HIV epidemic in the country, accounting for 73% of registered cases.[23] Estimates from the Reference Group to the United Nations on HIV/AIDS and Injecting Drug Use suggest that approximately 9.2% of people who inject drugs in Kazakhstan are living with HIV.[24]

Almost one in three new cases of HIV infection in the country is diagnosed in penal institutions. In 2007, 600 new HIV cases were registered in Kazakhstan's prisons, representing an increase in HIV prevalence among prisoners from 1% in 2006 to 2% in 2007.[25]

These issues, however, and the State's responses to them are largely absent from the initial report of Kazakhstan

Harm reduction is a stated priority in Kazakhstan's National AIDS Program for 2006—2010,[26] which includes support for needle and syringe programmes. However, while there have been positive developments in recent years that must be welcomed, measures for HIV prevention among people who use drugs and prisoners remain inadequate, and reach a only minority of people in need. Key issues relate to the *availability*, *accessibility* and *quality* of such services.

Needle and syringe programmes (NSPs)

In 2007, estimates showed that NSPs regularly reached only 8.7% of the estimated number of people who inject drugs in the country. Since that time, NSPs have expanded and there are now an estimated 159 sites across the country (up from 129 in 2008).[27] While this scale up is to be welcomed and encouraged, there are a range of restrictions on these programmes and barriers to access that continue to impede their effectiveness and coverage.

- **Policing practices**: Police interference with legal needle and syringe programmes has been documented. This serves to deter service users from attending such services for fear of prosecution on other grounds.[28]

- **Opening hours and location**: Client oriented "trust points" are intended to attract target groups to HIV prevention services. However, individuals often find contacts with these facilities unacceptable. In many cities, for example, people who use drugs are afraid to approach trust points because being identified as a drug user may result in further targeting by police. In addition, restricted opening hours mean that these services are not available at times when people need to access sterile injecting equipment. Trust points are located within outpatient facilities, which can present a threat to patients' right to confidentiality. The Government has recognised that the trust points are not sufficiently effective and efficient due in part to these issues.

- **Drug user registration**: There is a procedure to register people who use drugs in Kazakhstan on the basis of diagnosis of mental and behavioural disorders related to drug use. Registration usually lasts for 5 years. Being placed on a narcological registry entails certain limitations on employment, adoption and driving, and may entail violations of confidentiality of information. A 2006 research survey among injecting drug users of the Republican Center for Applied Research on Drug Addiction in Pavlodar revealed that fear of being registered as a drug user was the single most important factor pushing people away from drug dependence treatment and other healthcare services, with consequent implications for undermining HIV prevention and treatment among this vulnerable population.[29]

- **Lack of confidentiality of patient information**: Under the Law of Kazakhstan *"On Health Protection"*, a patient's health information, including information on HIV/AIDS and drug dependence, must be disclosed at the request of health care authorities, police, a prosecutor's office, investigative bodies or a court. If people have reason to fear that information held by health care workers will be shared in ways that could expose them to discrimination or even criminal or administrative prosecution (e.g., for drug-related activities), this is a powerful disincentive to seeking health services.

Opioid Substitution Therapy (OST)

Kazakhstan has recently begun to develop an OST programme in the country. In November 2008, two pilot programmes were initiated in two cities (Pavlodar and Temirtau), serving 50 people. These remain, however, the only such services in the country, and the limited number of places means these programmes are insufficient to have an effect on HIV incidence or prevalence. The programme is financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, meaning that the programme is very much dependent on international support. There is a disagreement between different ministries (Ministry of Health and Ministry of Interior) on the use of OST and the issue is highly politicised.

These pilot projects are to be welcomed. However, scale up of access to OST for people who are dependent on opiates must be a core element of a comprehensive HIV prevention package.

Drug use, HIV and harm reduction in prisons

Under international law, persons in detention retain all rights except insofar as these are necessarily limited by the fact of incarceration. This includes the right to the highest attainable standard of health. Consequently, it is recognised that people in prisons have a right to access to equivalent health services and care as persons outside prisons, and that denial of such services is not a necessary or justified aspect of incarceration.[30] However, there are no NSPs in the correctional system of Kazakhstan, even though such health services are provided by the Government to the general population outside prisons as a HIV prevention measure.

It should be noted that prison needle and syringe programmes have been implemented successfully in other prison systems, and have not been shown to increase drug use or to pose a risk of injury to staff or to risk prison safety in other ways.[31]

Similarly, OST is not provided in prisons in Kazakhstan. This is despite the fact that in a survey of people in prison conducted in 2006:

- 44% of respondents agreed that drug injecting occurs in the penitentiary system;
- 24% of them said that people share syringes inside prison;
- 12.9% asserted that people use means other than syringes for injecting;
- 12% of the respondents confirmed that drug injecting equipment was treated with disinfectant solutions before use.

In the same survey, 40% of respondents reported that people in prison are having sexual relations, with condom use in "less than half of cases".[32] In addition, based on responses, the researchers characterised roughly one-third of people in the country's prisons as generally ill-informed about HIV.[33]

The Special Rapportuer on Torture, Prof Manfred Nowak, recently completed a mission to Kazakhstan. He noted that "*the number of drug users among detainees was fairly high. They were isolated upon arrival and provided with some medical treatment, but no substitution therapy as such*." He further raised concerns about the lack of needle and syringe exchange in prisons and

recommended that the Government of Kazakhstan "*initiate harm-reduction programmes for drug users deprived of their liberty, including by providing substitution medication to persons and allowing needle exchange programmes in detention*."[34]

Moreover, prisoners are subject to compulsory HIV testing upon admission and six months after admission,[35] a practice explicitly rejected as being unethical and ineffective HIV policy by UNODC, WHO and UNAIDS[36], and access to antiretroviral treatment for prisoners living with HIV is limited. According to the Government, 115 persons with HIV were receiving antiretroviral treatment in prisons in 2006, but by 2007 only 63 persons were continuing treatment.[37]

Diversion from the prison system is also an important element in reducing HIV risk among people who inject drugs. However, Kazakhstan's law does not currently provide for court-ordered drug dependence treatment *as an alternative* to imprisonment. In this respect, the national law does not take full advantage of the flexibility offered under international drug control treaties ratified by Kazakhstan, which explicitly allow States Parties to those treaties to include, in their domestic legislation, alternatives to conviction and incarceration for drug offences, including measures for treatment.[38]

Opiate overdose: prevention and treatment

In addition to HIV and hepatitis C infection, fatal and non-fatal overdose represents a significant health risk for people who inject drugs. Opiate overdose has been reported as the leading cause of death among people who use drugs in those Central Asian states for which any data are available.[39]

In Kazakhstan, data on drug overdose on a national level is not available. National AIDS Centre 2008 data from surveillance in Almaty showed that 22% of injecting drug users surveyed reported having an overdose event in the previous year. Of these cases of overdose, approximately 50% will receive formal medical attention while the other 50% will be managed by surrounding witnesses.[40] The great majority of victims of opiate overdose who receive timely medical attention survive, while according to recent reports, the estimated mortality among opiate overdose victims whose care is managed by witnesses is 10%. Anecdotal data from people who inject drugs reveal that witnesses to opiate overdose often hesitate to seek medical care due to a fear of police involvement or an inability to recognise the symptoms of overdose.

In conjunction with training in rescue breathing and expanded methadone and buprenorphine maintenance, preliminary evidence indicates that the lay distribution of Naloxone is an important intervention in reducing the rate of opiate overdose mortality. Naloxone is an opioid antagonist used to treat depression of the central nervous system and respiratory system caused by opiate overdose. Currently in Kazakhstan, Naloxone is used by medical professionals in hospitals and outpatient emergency settings .

The administration of Naloxone, however, does not require specialised medical skills and can be provided by a witness to an opiate overdose. Data from Naloxone distribution programs around the world, including in Russia and Tajikistan, indicate that distribution of free doses of Naloxone by non-medical professionals who regularly work with people who inject can effectively reduce

mortality associated with opiate overdose. When combined with existing HIV prevention and/or harm reduction interventions, programmes for Naloxone distribution require minimal financial investment, as one ampoule of Naloxone costs on average $3.00 USD. Naloxone distribution, therefore, is an affordable and proven strategy for effectively reducing opiate overdose morality, a leading cause of preventable mortality among people who inject opiates.

Although not designed as overdose prevention programmes per se, OST is strongly associated with significantly reduced overdose.[41] In France, for example, the implementation of OST with buprenorphine saw a decline of almost 80% in deaths from opiate overdose.[42]

IV. Recommendations

In accordance with Articles 2, 12 and 15.1.b of the Covenant, the Government of Kazakhstan should:

1. Ensure, to the maximum of available resources, that evidence based HIV prevention services for people who inject drugs are available and accessible both inside and outside prisons, and that such services are appropriate and of high quality. In particular, the Government should:

- Continue to scale up needle and syringe programmes, taking due regard of adequate resourcing for and coverage of such services, and ensuring that such services meet the specific needs of target groups (e.g. appropriate opening hours and appropriate location; police co-operation; confidentiality).
- Scale up, as a matter of urgency, opioid substitution therapy on a national level
- Ensure access to the comprehensive package of HIV prevention, treatment, care and support for people in prisons, including needle and syringe exchange, opioid substitution therapy, confidential testing and counselling, access to condoms and free antiretroviral treatment. Pilot prison needle and syringe exchange programmes and opioid substitution therapy should be implemented as a priority with a view to the progressive realisation of the right to health of people who use drugs in prisons.

2. Abandon the practice of mandatory registration of people who use drugs as a significant and unjustifiable barrier to the realisation of the right to the highest attainable standard of health

3. Amend the law to permit evidence-based drug dependence treatment as an alternative to imprisonment. This treatment, however, should be subject to a right of refusal and harsher penalties should not be imposed for refusing treatment or for relapse. Such treatment should wherever possible be provided in the community.

4. Improve the prevention and treatment of opiate overdose as a matter of urgency. In particular the Government should:

- Amend the regulations governing the use of Naloxone for the prevention and treatment of opiate overdoses
- Ensure adequate budgetary allocation for Naloxone procurement

- Provide adequate training and awareness raising of the administration of Naloxone to harm reduction services, health workers and injecting drug users to prevent deaths from overdoses
- Scale up access to opioid substitution therapy

ENDNOTES

[1] The International Harm Reduction Association (IHRA) is on of the leading international NGOs promoting policies and practices that reduce drug-related harms, a mandate that has a significant intersection with human rights issues. Drug-related harms in this context include not only increased vulnerability of people who use drugs to HIV and hepatitis C infection, but also includes poor access to healthcare, discrimination, police harassment, imprisonment, invasion of privacy, social marginalization and, in some countries, capital punishment. IHRA is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

[2] High Commissioner calls for focus on human rights and harm reduction in international drug policy, Press release, 10 March 2009

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